This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1336 Worksheet S Peri od: From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: 1/24/2024 11:48 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 1/24/2024 Time: 11:48 am use only Manually prepared cost report If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. JOSEPHS HOSPITAL-HIGHLAND LL (14-1336) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1	2	SIGNATURE STATEMENT	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

			Title	XVIII			
		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	-32, 561	-250, 111	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	152, 652	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	120, 091	-250, 111	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 HOSPITAL-HIGHLAND IL
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA
Provider CCN: 14-1336
From 07/01/2022
From 07/01/2022
To 06/30/2023 Date/Time Prepared:

	TAL AND HOSPITAL HEALTH CARE COMPLEX	TOURTH CATTON DATA	110010	er con:	14-1336	Period: From 07/01/ To 06/30/	2022	Workshe Part I Date/Ti		
	1.00	0.00		2 00				1/24/20		
	1.00 Hospital and Hospital Health Care Co	2.00		3. 00			1. 00			
1. 00	Street: 12866 TROXLER AVENUE	PO Box:								1.00
2. 00	Ci ty: HI GHLAND	State: IL	Zip Code	e: 62249	Coun	ty: MADISON				2.00
	1 2	Component Name	CCN	CBSA	Provi der		Paymer	nt Syst	em (P,	
		·	Number	Number	Туре	Certi fi ed	T,	0, or		
							V	XVIII		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7.00	8. 00	
	Hospital and Hospital-Based Compone					I			_	
3. 00	Hospi tal	ST. JOSEPHS	141336	41180	1	06/01/2004	N	0	0	3.00
4. 00	Subprovi der - IPF	HOSPITAL-HIGHLAND IL							-	4.00
5. 00	Subprovider - IRF								1	5.00
6. 00	Subprovi der - (Other)									6.00
7.00	Swing Beds - SNF	ST. JOSEPHS	14Z336	41180		08/19/2004	N	0	N	7.00
		HOSPITAL-SWING BED								
8. 00	Swing Beds - NF									8.00
9. 00	Hospi tal -Based SNF									9.00
	Hospi tal -Based NF									10.00
	Hospi tal -Based OLTC									11.00
	Hospi tal -Based HHA									12.00
	Separately Certified ASC								-	13.00
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC								-	15.00
	Hospital -Based Health Clinic - FQHC								1	16.00
	Hospital -Based (CMHC) I									17.00
	Renal Dialysis									18.00
	Other				İ					19.00
					·	From:		То	:	
						1. 00		2. (00	
	Cost Reporting Period (mm/dd/yyyy)					07/01/2	022	06/30/	/2023	20.00
21.00	Type of Control (see instructions)					1				21.00
				_						1
	Langeti and DDC Langermenti an				1. 00	2. 00		3. 0)()	
22. 00	Inpatient PPS Information Does this facility qualify and is in	t currently receiving na	vmonts for		N	N				22. 00
22.00	di sproporti onate share hospi tal adju									22.00
	§412.106? In column 1, enter "Y" for									
	facility subject to 42 CFR Section									
	hospital?) In column 2, enter "Y" fo	or yes or "N" for no.								
22. 01	Did this hospital receive interim U				N	N				I
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	for the portion of the cost reportion									22. 01
			r to Octol	per						22. 01
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22. 03 22. 04	1. Enter in column 2, "Y" for yes or cost reporting period occurring on a instructions) Is this a newly merged hospital that determined at cost report settlement. 1, "Y" for yes or "N" for no, for the period prior to October 1. Enter in for the portion of the cost reporting that it is a result of the OMB standard adopted by CMS in FY2015? Enter in a for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afform accordance with 42 CFR 4 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMI adopted by CMS in FY 2021? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMI adopted by CMS in FY 2021? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afform the shospital contain at least counted in accordance with 42 CFR 4 yes or "N" for no. Which method is used to determine Mobel ow? In column 1, enter 1 if date	r"N" for no for the por or after October 1. (see t requires a final UCP t t? (see instructions) En the portion of the cost r column 2, "Y" for yes on geriod on or after October 1. (see instruction of the cost of the column 1, "Y" for yes or period prior to October 1. (see instance in the portion of the lineations for statical column 1, "Y" for yes or not period prior to October 1. (see instance in the portion of the portio	r to Octol tion of the obe ter in col eporting r "N" for tober 1. m urban to istical an "N" for ructions) 99 beds (; 3, "Y" for m urban to stical ar m urban to stical ar r "N" for er 1. Ento he cost ructions) 99 beds (; n 3, "Y" for and/or 2: us days, o	per ne lumn no, lo reas no ler lumn solo reas no lumn solo reas		N		N		22. 02 22. 03 22. 04
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22. 03 22. 04	1. Enter in column 2, "Y" for yes of cost reporting period occurring on a instructions) Is this a newly merged hospital that determined at cost report settlement, "Y" for yes or "N" for no, for the period prior to October 1. Enter in for the portion of the cost reportion for the portion of the cost reportion column 2, "Y" for yes or "N" for reporting period occurring on or aftile to the own of the cost reportion accounted in accordance with 42 CFR 4 yes or "N" for no. Did this hospital contain at least counted in accordance with 42 CFR 4 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMI adopted by CMS in FY 2021? Enter in for the portion of the cost reportion for the portion of the cost reportion of the cost reportion in column 2, "Y" for yes or "N" for reporting period occurring on or aftile to the portion of the cost reportion in column 2, "Y" for yes or "N" for reporting period occurring on or aftile to the portion of the cost reportion of the cost reportion in column 2, "Y" for yes or "N" for reporting period occurring on or aftile to the portion of the cost reportion of the co	r"N" for no for the por or after October 1. (see t requires a final UCP t t? (see instructions) En the portion of the cost r column 2, "Y" for yes on period on or after Ochic reclassification frods for delineating statcolumn 1, "Y" for yes or period prior to Octobeno for the portion of t ter October 1. (see inst 100 but not more than 4 12.105)? Enter in column hic reclassification fro B delineations for staticolumn 1, "Y" for yes on period prior to Octobeno for the portion of t ter October 1. (see inst 100 but not more than 4 12.105)? Enter in column ter October 1. (see inst 100 but not more than 4 12.105)? Enter in column of the portion of t ter October 1. (see inst 100 but not more than 4 12.105)? Enter in column tedicaid days on lines 24 of admission, 2 if cens of identifying the days method used in the prio	r to Octol tion of the obe ter in col eporting r "N" for tober 1. m urban to istical an "N" for i er 1. Ento he cost ructions) 99 beds (a 3, "Y" for m urban to stical are r "N" for he cost ructions) 99 beds (a n 3, "Y" and/or 2! us days, in this or	per ne lumn no, lo reas no ler lumn solo reas no lumn solo reas		N		N		22. 02 22. 03 22. 04

Health Financial Systems ST. JOSEPHS HOSPITAL-HIGHLAND IL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1336 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 11:48 am In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 \cap n in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν 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) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 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 accordance N N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 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 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν 48.00 Teachi ng Hospi tal s Is this a hospital involved in training residents in approved GME programs? For cost reporting Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, Ν 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or

"N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der C	CN: 14-1336	Period: From 07/01/ To 06/30/		Worksheet S-2 Part I Date/Time Pre 1/24/2024 11:	pared
						1.00	XVIII XIX 2.00 3.00	1
	If line 56 is yes, did this facility elect cost reimled defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	comple	te Wkst. D-5.		s as	N		58.0
v. 00	Are costs claimed on line 100 of Worksheet A? If yes	s, comp	iete WKST. D-2	NAHE 413.8!	5 Workshee Li ne		Pass-Through Qualification Criterion	59.0
				1. 00	2. 00		Code 3. 00	1
0.00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent of adjustment? Enter "Y" for yes or "N" for no in colur	85? (umn 1. CR) NAH mn 2.	see If column 1 E MA payment	N				60.0
		Y/N	I ME	Direct GME	I I I I I I I I I I I I I I I I I I I		Direct GME	
		1. 00	2. 00	3. 00	4. 00		5. 00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports	N				0. 00	0.00	61. (
. 02	ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of							61.
. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)							61.
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's							61.
. 06	primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							61.
		Pro	ogram Name	Program Cod	IME FTE (Count	Unweighted Direct GME FTE Count	
. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME		1.00	2.00	3.00	0.00	4. 00 0. 00	61.
. 20	FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0. 00	0. 00	61.
							1. 00	
00	ACA Provisions Affecting the Health Resources and Se				oried for	ai ob		42
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction for the number of FTE residents that rotated from a feet of the form of the	ctions) a Teach	ing Health Cer	nter (THC) in				62.
OΩ	during in this cost reporting period of HRSA THC progreaching Hospitals that Claim Residents in Nonprovider so your facility trained residents in nonprovider so	er Sett	i ngs		a period? Fr	nter	N	63.

Health Financial Systems	ST. JOSEPH	S HOSPITAL-HIGHLAND II	L	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE CO			CN: 14-1336 Pe	eriod: com 07/01/2022	Worksheet S-2 Part I	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Base period that begins on or afte			·lhis base year	is your cost	reporting	
64.00 Enter in column 1, if line 63 in the base year period, the resident FTEs attributable to settings. Enter in column 2 resident FTEs that trained in of (column 1 divided by (column 2)	0.00	0. 000000	64.00			
or (cordiiir r drvrded by (cordi	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 6 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 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)	n		0.00	0.00	0.000000	65. 00
			FTEs Nonprovider	FTEs in Hospital	1/ (col . 1 + col . 2))	
			Si te 1.00	2. 00	3. 00	
Section 5504 of the ACA Curre		n Nonprovider Setting				
beginning on or after July 1, 66.00 Enter in column 1 the number		arv care resident	0.00	0.00	0. 000000	66 00
FTEs attributable to rotation: Enter in column 2 the number of FTEs that trained in your hos	occurring in all nong of unweighted non-prima	provider settings. ary care resident	5. 33	0.00	0.00000	00.00
(column 1 divided by (column	+ column 2)). (see ir Program Name	nstructions) Program Code	Unweighted	Unwei ghted	Ratio (col.	
	i i ogi alli Nallie	1 Togram code	FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col . 3 + col . 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
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 attributab to rotations occurring in all non-provider settings. Enter 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)	e n		0.00	0.00	0.000000	67.00

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	CN: 14-1336	Period: From 07/01/20 To 06/30/20	022 F 023 D	Workshee Part I Date/Tin 1/24/202	ne Pre	pared:
						1. 00)	
68. 00 F	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 8 For a cost reporting period beginning prior to October 1, 20 MAC to apply the new DGME formula in accordance with the FY : (August 10, 2022)?	22, did you o	btain permis	sion from you		N		68. 00
				1	1.00	2. 00	3. 00	
	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or	does it cont	ain an IPF s	ubprovi der?	N			70.00
71. 00 	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approve recent cost report filed on or before November 15, 2004? En: 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility traprogram in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? En: Column 3: If column 2 is Y, indicate which program year began (see instructions) Inpatient Rehabilitation Facility PPS	ter "Y" for y ain residents ter "Y" for y	es or "N" fo in a new te es or "N" fo	r no. (see eachi ng er no.			0	71. 00
75. 00 lī	Is this facility an Inpatient Rehabilitation Facility (IRF),	or does it c	ontain an IR	F	N			75. 00
76. 00 I r r (subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approvence to the conting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teac CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Indicate which program year began during this cost reporting	, 2004? Enter ching program Column 3: If	"Y" for yes in accordan column 2 is	or "N" for ce with 42 Y,			0	76. 00
						1. 00)	
80. 00 I 81. 00 I	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part of 'Y" for yes and "N" for no.			ng period? En	ter	N N		80. 00 81. 00
85. 00 I	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (excluder §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				no.	N		85. 00 86. 00
37. 00 li	Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l classified	under sectio	n		N		87. 00
	1000(d) (1) (b) (vi) . Enter 1 101 yes 01 N 101 ho.			Approved f Permanent Adjustmen (Y/N) 1.00	t t	Number Approv Perman Adjustm	ved ent ents	
						2.00	J	
8	Column 1: Is this hospital approved for a permanent adjustmen amount per discharge? Enter "Y" for yes or "N" for no. If ye: 39. (see instructions)	s, complete c		ne N		2. 00		88. 00
8	amount per discharge? Enter "Y" for yes or "N" for no. If yes	s, complete c		ne	e	2.00	0	88. 00
8	amount per discharge? Enter "Y" for yes or "N" for no. If ye: 89. (see instructions)	s, complete c	ol. 2 and li	ne)		ved ent ment Per	88.00
8	amount per discharge? Enter "Y" for yes or "N" for no. If ye 39. (see instructions) Column 2: Enter the number of approved permanent adjustments	s, complete c	ol. 2 and li Wkst. A Lir No.	ne Effective Date	9	Approv Perman Adjustr Amount	ved ent ment Per rge	
89. 00 ((((amount per discharge? Enter "Y" for yes or "N" for no. If yes 39. (see instructions) Column 2: Enter the number of approved permanent adjustments. Column 1: If line 88, column 1 is Y, enter the Worksheet A library on which the per discharge permanent adjustment approval was column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA target of the permanent adjustment to the TEFRA target.	ine number based. period rget amount	ol. 2 and li Wkst. A Lir No.	ne Effective Date	9	Approv Perman Adjustr Amount Discha	ved ent ment Per rge	88. 00
89. 00 C	amount per discharge? Enter "Y" for yes or "N" for no. If yes 39. (see instructions) Column 2: Enter the number of approved permanent adjustments. Column 1: If line 88, column 1 is Y, enter the Worksheet A library on which the per discharge permanent adjustment approval was column 2: Enter the effective date (i.e., the cost reporting peginning date) for the permanent adjustment to the TEFRA tax	ine number based. period rget amount	ol. 2 and li Wkst. A Lir No.	ne Effective Date	9	Approv Perman Adjustr Amount Discha	ved ent ment Per rge	
89. 00 (C) (L) (L) (L) (L) (L) (L) (L) (L) (L) (L	amount per discharge? Enter "Y" for yes or "N" for no. If yes 39. (see instructions) Column 2: Enter the number of approved permanent adjustments. Column 1: If line 88, column 1 is Y, enter the Worksheet A I on which the per discharge permanent adjustment approval was column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment target amount per discharge.	ine number based. period rget amount	ol. 2 and li Wkst. A Lir No.	ne Effective Date	9	Approv Perman Adjustr Amount Discha	ved ent ment Per rge	
39. OO (C) L	amount per discharge? Enter "Y" for yes or "N" for no. If yes 39. (see instructions) Column 2: Enter the number of approved permanent adjustments. Column 1: If line 88, column 1 is Y, enter the Worksheet A liber which the per discharge permanent adjustment approval was column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA tables of the permanent adjustment approved permanent adjustment. Column 3: Enter the amount of the approved permanent adjustment.	ine number based. period rget amount	Wkst. A Lir No.	ne Effective Date 2.00 V 1.00	9	Approv Perman Adjustr Amount Discha 3.00	ved ent ment Per rge	
39. 00 ((((((((((((((((((amount per discharge? Enter "Y" for yes or "N" for no. If yes 39. (see instructions) Column 2: Enter the number of approved permanent adjustments. Column 1: If line 88, column 1 is Y, enter the Worksheet A library on which the per discharge permanent adjustment approval was column 2: Enter the effective date (i.e., the cost reporting peginning date) for the permanent adjustment to the TEFRA table of discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	ine number based. period rget amount ent to the	ol. 2 and li Wkst. A Lir No. 1.00 0.	ne Effective Date 2.00 V 1.00	9	Approv Perman Adjustr Amount Discha 3.00	ved ent ment Per rge	89.00
39. 00 (C)	amount per discharge? Enter "Y" for yes or "N" for no. If yes 39. (see instructions) Column 2: Enter the number of approved permanent adjustments. Column 1: If line 88, column 1 is Y, enter the Worksheet A I on which the per discharge permanent adjustment approval was column 2: Enter the effective date (i.e., the cost reporting peginning date) for the permanent adjustment to the TEFRA table of discharge. Column 3: Enter the amount of the approved permanent adjustment approved pe	ine number based. period rget amount ent to the	Wkst. A Lir No. 1.00 0. nter "Y" for t either in	ne Effective Date 2.00 V 1.00	9	Approv Perman Adjustr Amount Discha 3.00	ved ent ment Per rge	89.00
90. 00 [] 91. 00 [] 92. 00 [] 93. 00 []	amount per discharge? Enter "Y" for yes or "N" for no. If yes 39. (see instructions) Column 2: Enter the number of approved permanent adjustments. Column 2: Enter the number of approved permanent adjustments. Column 3: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA target discharge. Column 3: Enter the amount of the approved permanent adjustment terra that arget amount per discharge. Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual ones this facility operate an ICF/IID facility for purposes of the structions) Enter "Y" for yes or "N" for no in the applications of the applications of the structions and content to the applications of the applicati	ine number based. period rget amount ent to the I services? E he cost repor i cable column al certificat ble column.	Wkst. A Lir No. 1.00 0. t either in ion)? (see	ne Effective Date 2.00 V 1.00 N N	9	Approv Perman Adjustr Amount Discha 3.00 XIX 2.00	ved ent ment Per rge	90. 00 91. 00
39. 00 (c) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d	amount per discharge? Enter "Y" for yes or "N" for no. If yes 39. (see instructions) Column 2: Enter the number of approved permanent adjustments. Column 1: If line 88, column 1 is Y, enter the Worksheet A licen which the per discharge permanent adjustment approval was column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA table of discharge. Column 3: Enter the amount of the approved permanent adjustment approved p	ine number based. period rget amount ent to the I services? Ene cost report cable column al certificat ble column. of title V an	Nkst. A Lir No. 1.00 0. otherwise the state of the sta	ne Effective Date 2.00 V 1.00 N N	9	Approv Perman Adjustr Amount Discha 3.00 XIX 2.00 Y	ved ent ment Per rge	90. 00 91. 00 92. 00
99. 00 (0 (0 (0 (0 (0 (0 (0 (0 (0 (0 (0 (0	amount per discharge? Enter "Y" for yes or "N" for no. If yes 39. (see instructions) Column 1: If line 88, column 1 is Y, enter the Worksheet A II on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA target discharge. Column 3: Enter the amount of the approved permanent adjustment TEFRA target amount per discharge. Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable column. To yes or "N" for no in the applicable column.	ine number based. period rget amount ent to the services? Ene cost report cable column of title V and and "N" for nulicable column.	Nkst. A Lir No. 1.00 0. 1.00 0. t either in ion)? (see d XIX? Enter o in the n.	ne Effective Date 2.00 V 1.00 N N	9	Approv Perman Adjustr Amount Discha 3.00 XIX 2.00 Y	ved ent ment Per rge)	90. 00 91. 00 92. 00 93. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 14-1336		ri od: om 07/01/2022 06/30/2023	Worksheet Part I Date/Time 1/24/2024	Prepared:
				V	XIX	
98.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f	terns and res or yes or "N"	sidents post for no in		1. 00 N	2. 00 Y	98.00
column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti				N	Υ	98. 01
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o				N	Υ	98. 02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye				N	N	98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			d	N	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				N	Υ	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.				N	Y	98.06
Rural Providers						
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive met	hod of payme	nt	Y N		105. 00 106. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IP Enter "Y" for yes or "N" for no in column 2. (see instructions)	1. (see ins you train I&F F and/or IRF	structions) Rs in an		N		107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche			N		108. 0
	Physi cal 1. 00	0ccupationa 2.00	ıl	Speech 3. 00	Respirato 4.00	ry
109.00 f 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.	N	Y		N N	N	109.00
					1. 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.	lf	yes,	N 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 ad for tele-health services.	st reporting Iumn 1 is Y, ticipating ir	period? Ente enter the column 2.	r	N		111.00
		1.00		2. 00	3. 00	
(PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the demonstration. In column 3, enter the date the hospital began participation in the demonstration, if applicable.	porting lumn 1 is ating in the	N				112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub 15-1, chapter 22, 82208 1	, or E only) 3" percent includes	N				0115.00
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
	-	1	1			1
"N" for no. 117.00 s this facility legally-required to carry malpractice insur	ance? Enter	Y	- }			117. 0

117. 00 118. 00

117.00 Is this facility legally-required to carry malpractice insurance? Enter
"Y" for yes or "N" for no.

118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems ST. JOSEPHS HOSPITA	AL-HIGHLAND II	L	In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	CN: 14-1336	Peri od: From 07/01/2022	Worksheet S- Part I	
			To 06/30/2023	Date/Time Pr	
		Premi ums	Losses	1/24/2024 11 Insurance	: 48 am
		1.00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		61, 25	54 460	385, 89	94 118. 01
			1. 00	2. 00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched			N		118. 02
and amounts contained therein.	ure risting c	ost centers			
119.00 DO NOT USE THIS LINE	Harmlace pro	vision in ACA	A N	N	119. 00 120. 00
120.00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in				IN IN	120.00
"N" for no. Is this a rural hospital with < 100 beds that qu			t		
Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	ts? (see inst	ructions)			
121.00 Did this facility incur and report costs for high cost impla	ntable device	s charged to	Υ		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as def	ined in §1903	(w)(3) of the	e Y	5. 06	122. 00
Act?Enter "Y" for yes or "N" for no in column 1. If column 1				0.00	122.00
the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) pur	chasa profess	ional			123. 00
services, e.g., legal, accounting, tax preparation, bookkeep					123.00
management/consulting services, from an unrelated organizati	on? In column	1, enter "Y"	1		
for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e.,	greater than	50% of total			
professional services expenses, for services purchased from	unrelated org	ani zati ons			
located in a CBSA outside of the main hospital CBSA? In colu "N" for no.	mn 2, enter "	Y" for yes or			
Certified Transplant Center Information					
125.00 Does this facility operate a Medicare-certified transplant c and "N" for no. If yes, enter certification date(s) (mm/dd/y		"Y" for yes	N		125. 00
126.00 If this is a Medicare-certified kidney transplant program, e		ification dat	te		126. 00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare-certified heart transplant program, en		fication date			127. 00
in column 1 and termination date, if applicable, in column 2		ircation date			127.00
128.00 If this is a Medicare-certified liver transplant program, en		fication date	9		128. 00
in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare-certified lung transplant program, ent		ication date			129. 00
in column 1 and termination date, if applicable, in column 2					100.00
130.00 If this is a Medicare-certified pancreas transplant program, date in column 1 and termination date, if applicable, in col		rtification			130. 00
131.00 If this is a Medicare-certified intestinal transplant progra	m, enter the	certi fi cati or	۱		131. 00
date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare-certified islet transplant program, en		fication date	2		132.00
in column 1 and termination date, if applicable, in column 2		dat. o date			
133.00 Removed and reserved 134.00 If this is a hospital-based organ procurement organization (OPO) enter t	he OPO number	-		133. 00 134. 00
in column 1 and termination date, if applicable, in column 2		The of o frumber			134.00
All Providers 140.00 Are there any related organization or home office costs as d	ofined in CMS	Dub 1E 1	Y	14H005	140.00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If				1411005	140.00
are claimed, enter in column 2 the home office chain number. 1.00 2.00		tions)	3. 00		
1.00 2.00 If this facility is part of a chain organization, enter on I		ough 143 the i		of the home	
office and enter the home office contractor name and contract	tor number.				141 00
141.00 Name: HOSPITAL SISTERS HEALTH SYSTEM Contractor's Name: NAT SER'	TUNAL GOVERNMI VICES	ENT CONTracto	or s Number: 0013	i I	141. 00
142.00 Street: 4936 LAVERNA ROAD PO Box:				_	142.00
143. 00 Ci ty: SPRI NGFI ELD State: I L		Zi p Code:	6270)	143.00
				1. 00	
144.00 Are provider based physicians' costs included in Worksheet A	?			Y	144. 00
			1. 00	2. 00	
145.00 If costs for renal services are claimed on Wkst. A, line 74,					145. 00
inpatient services only? Enter "Y" for yes or "N" for no in no, does the dialysis facility include Medicare utilization					
period? Enter "Y" for yes or "N" for no in column 2.					144 22
146.00 Has the cost allocation methodology changed from the previou Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1			N		146. 00
yes, enter the approval date (mm/dd/yyyy) in column 2.		. 3,			

Health Financial Systems	ST. JOSEPHS	HOSPI TA	AL-HIGHLAND IL			In Lie	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI			Provi der CC			riod: com 07/01/2022	Worksheet S- Part I	-2 repared:
							1.00	_
147.00 Was there a change in the statist	ical basis? Enter "Y"	for v	es or "N" for	no			1.00 N	147. 00
148.00 Was there a change in the order of							N N	148. 00
149.00 Was there a change to the simplif					for r	10.	N	149.00
			Part A	Part	В	Title V	Title XIX	
			1. 00	2. 00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or								
155.00 Hospi tal			N	N		N	N	155. 00
156.00 Subprovi der - IPF			N	N		N	N	156. 00
157.00 Subprovi der - I RF			N	N		N	N	157. 00
158. 00 SUBPROVI DER								158. 00
159. 00 SNF			N I	N		N	N	159.00
160.00 HOME HEALTH AGENCY 161.00 CMHC			N	N N		N N	N N	160. 00 161. 00
101. OO CMHC				IN		IN	IN	161.00
							1.00	
Multicampus 165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that h	nas one	or more campu	uses in di	i ffere	ent CBSAs?	N	165. 00
period i voi you oi ii voi iioi	Name		County	State	Zip (Code CBSA	FTE/Campus	
	0		1. 00	2.00	3. (00 4.00	5. 00	
166.00 If line 165 is yes, for each 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)							0. (00 166. 00
							1.00	
Health Information Technology (HI	T) incentive in the A	Ameri ca	n Recovery an	d Rei nves	tment	Act	1	
167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 1	05 is "Y") and ís a m	neani ng	ful user (line			enter the	Y	167. 00 168. 00
reasonable cost incurred for the 168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user	, does	this provide			a hardshi p		168. 01
169.00 If this provider is a meaningful transition factor. (see instructi	user (line 167 is "Y"					N"), enter the	0.0	00169.00
						Begi nni ng	Endi ng	
170 00 Enter in column 1 and 2 th 500	bool ppi pa data and in	adin- '	ata far the	onost!		1. 00	2. 00	170.00
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and er	nding d	ate for the re	eporting				170.00
						1. 00	2.00	
171.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3 umn 1. If column 1 is	3, Pt.	I, line 2, col	I. 6? Ente		N		0171.00

Heal th	Financial Systems ST. JOSEPHS HOSPI	TAL-HIGHLAND I	1	In lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 14-1336	Peri od:	Worksheet S-2	
				From 07/01/2022 To 06/30/2023		epared:
				V/ /NI	1/24/2024 11:	
				Y/N 1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURS					
	General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format.	N for all NO r	esponses. Ente	er all dates in	the	
	COMPLETED BY ALL HOSPITALS					1
	Provider Organization and Operation			1	ı	
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in			N		1.00
	perfecting period. It yes, enter the date of the enange in	201 dilli1 2. (300	Y/N	Date	V/I	
0.00			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu	9	N			2.00
	voluntary or "I" for involuntary.					
3. 00	Is the provider involved in business transactions, includicontracts, with individuals or entities (e.g., chain home		N			3. 00
	or medical supply companies) that are related to the provi					
	officers, medical staff, management personnel, or members	of the board				
	of directors through ownership, control, or family and oth relationships? (see instructions)	er similar				
	relationships: (see mistractions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer	tified Public	Υ	A	I	4.00
4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C"	for Compiled,				4.00
	or "R" for Reviewed. Submit complete copy or enter date av	ailable in				
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diff	erent from	l N			5.00
	those on the filed financial statements? If yes, submit re					
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provide	r N		6. 00
7 00	the legal operator of the program?	netrueti one		N		7 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see i Were nursing programs and/or allied health programs approv		wed durina the	e N		7. 00 8. 00
	cost reporting period? If yes, see instructions.		· ·			
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00
10.00	Was an approved Intern and Resident GME program initiated		the current	N		10.00
	cost reporting period? If yes, see instructions.					
11. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N		11.00
	Treaching Trogram on worksheet A: Tr yes, see Thistructions.				Y/N	
					1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If ye	e soo instruc	ti one		Y	12.00
	If line 12 is yes, did the provider's bad debt collection	•		ost reporting	N N	13. 00
44.00	period? If yes, submit copy.			, ,		1
14.00	If line 12 is yes, were patient deductibles and/or coinsur instructions.	ance amounts w	arved? If yes,	, see	N	14.00
	Bed Complement					
15. 00	Did total beds available change from the prior cost report				N N	15. 00
		Y/N	t A Date	Y/N	t B Date	
		1. 00	2.00	3.00	4. 00	
1/ 00	PS&R Data	l N	1	N.	ı	1, 00
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16.00
	date of the PS&R Report used in columns 2 and 4 (see					
17. 00	instructions) Was the cost report prepared using the PS&R Report for	Y	11/01/2023	Y	11/01/2023	17. 00
17.00	totals and the provider's records for allocation? If	'	11/01/2023	'	11/01/2023	17.00
	either column 1 or 3 is yes, enter the paid-through date					
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
10.00	Report data for additional claims that have been billed	14		IN		10.00
	but are not included on the PS&R Report used to file this					
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
17.00	Report data for corrections of other PS&R Report	1		14		17.00
	information? If yes, see instructions.		1		l	

	Financial Systems ST. JOSEPHS HOSPI			In Lie	u of Form CMS-		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 14-1336	Peri od: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Pro 1/24/2024 11:	epared:	
		Descr	ipti on	Y/N	Y/N	10 4111	
)	1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
	The period and a control of the control and actinonics.	Y/N	Date	Y/N	Date		
04 00	lw. d	1.00	2.00	3.00	4. 00	04.00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)				
	Capital Related Cost						
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	Y N	22. 00 23. 00				
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost re	eporting period?	N	24. 00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period′	? If yes, see	N	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	he cost report	ing period?	f yes, see	N	26. 00	
27. 00	Has the provider's capitalization policy changed during th copy.	ne cost reporti	ng period? I	f yes, submit	N	27. 00	
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit e	entered into du	ring the cos	t reporting	N	28. 00	
29. 00							
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat instructions.		debt? If yes	s, see	N	30.00	
31. 00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes	s, see	N	31. 00	
32. 00	<u>Purchased Services</u> Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ed through co	ontractual	Υ	32. 00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competi	tive bidding? If	Y	33.00	
	Provi der-Based Physi ci ans						
34. 00	Were services furnished at the provider facility under an If yes, see instructions.	arrangement wi	th provider-l	pased physicians?	Υ	34.00	
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i	isting agreeme nstructions.	nts with the	provi der-based	Υ	35.00	
				Y/N	Date		
	11 0.55 0			1. 00	2. 00		
36 00	Home Office Costs Were home office costs claimed on the cost report?			Y		36.00	
	If line 36 is yes, has a home office cost statement been p	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 of the provider? If yes, enter in column 2 the fiscal year en			F N		38.00	
39. 00	If line 36 is yes, did the provider render services to oth see instructions.			s, Y		39.00	
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40.00	
		1.	00	2.	00		
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRI CI A		RACHELL		41.00	
42. 00	respectively. Enter the employer/company name of the cost report preparer.	FORVI S				42.00	
43. 00	• • •	314-231-5544		PATTY. RACHELL@	FORVIS. COM	43.00	

Heal th	Financial Systems	ST. JOSEPHS HOSPI	TAL-HI GHLAND I	L	In Lie	u of Form C	MS-2	552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der C	CN: 14-1336	7/01/2022	Worksheet Part II Date/Time 1/24/2024	Prep	oared:
		-	3.	00				
_	Cost Report Preparer Contact Information							
	Enter the first name, last name and the t held by the cost report preparer in colum respectively.		MANAGING DIREC	CTOR				41.00
42. 00	Enter the employer/company name of the compression.	st report						42.00
43. 00	Enter the telephone number and email addrer report preparer in columns 1 and 2, respe							43.00

| Period: | Worksheet S-3 | From 07/01/2022 | Part | To 06/30/2023 | Date/Time Prepared: Heal th Fi nancial SystemsST. JOSEPHSHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 14-1336

				Т	o 06/30/2023	Date/Time Pre 1/24/2024 11:	
						I/P Days /	10 a
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.		Avai I abl e			
	DADT I CTATICTICAL DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	PART I - STATISTICAL DATA	20.00	٥٦	0.105	02 227 70	0	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30. 00	25	9, 125	83, 327. 70	0	1. 00
	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		25	9, 125	83, 327. 70	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9, 125	83, 327. 70	0	14.00
15. 00	CAH visits					0	15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE						20. 00 21. 00
21.00	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)	30. 00					24. 10
25. 00	CMHC - CMHC	55. 55					25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	
27. 00	Total (sum of lines 14-26)		25				27. 00
28.00	Observation Bed Days					0	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)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges		_				33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0		0	34.00

Health Financial SystemsST. JOSEPHSHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

					1	1/24/2024 11:	48 am
		I/P Days	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns		
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	,		,	ı		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 458	54	3, 451			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	1, 322	153	•			2.00
3. 00	HMO IPF Subprovi der	0	0	1			3.00
4. 00	HMO I RF Subprovi der	0	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	1, 254	0				5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0				6. 00
7. 00	Total Adults and Peds. (exclude observation	2, 712	54	6, 141			7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNI T						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14.00	Total (see instructions)	2, 712	54	1	0. 00	162. 88	1
15. 00	CAH visits	0	0	0			15.00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - IRF						17.00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSI NG FACI LI TY						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)			59			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	_	_	_			26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0.00	ł
27. 00	Total (sum of lines 14-26)		_		0. 00	162. 88	ł
28. 00	Observation Bed Days	_	1	527			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			35			30.00
31. 00	Employee discount days - IRF	_	_	0			31.00
32. 00	Labor & delivery days (see instructions)	0	0				32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)	_					
33.00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0	_				33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0	l		34.00

Heal th Fi nancial SystemsST. JOSEPHSHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 14-1336

				10	06/30/2023	1/24/2024 11:	
		Full Time		Di sch	arges	172472024 11.	to alli
		Equi val ents		5. 56.	a. 900		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	404	16	999	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)			352	44		2.00
3.00	HMO IPF Subprovider				o		3.00
4.00	HMO IRF Subprovider				o		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	404	16	999	14. 00
15. 00	CAH visits	0.00	· ·			,,,	15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						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)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF					l	31.00
32. 00	Labor & delivery days (see instructions)					l	32.00
32. 01	Total ancillary labor & delivery room						32. 01
52. 51	outpatient days (see instructions)						02.01
33. 00	, , , , , , , , , , , , , , , , , , , ,			l			33.00
33. 01	LTCH site neutral days and discharges					ļ	33. 01
	Temporary Expansion COVID-19 PHE Acute Care					ļ	34.00
						'	

HUSDIT	Financial Systems ST. JOSEPHS HOSPITAL-HIO TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 14-1336	Period:	u of Form CMS-2 Worksheet S-10					
10321	AL UNCOMPENSATED AND INDIGENT CARE DATA	OVI dei CCN. 14-1330	From 07/01/2022	WOLKSHEET 3-10	U				
			To 06/30/2023	Date/Time Pre 1/24/2024 11:	pared: 48 am				
				1. 00					
	Uncompensated and indigent care cost computation								
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided Medicaid (see instructions for each line)	ded by line 202 colu	ımn 8)	0. 245097	1.00				
2. 00	Net revenue from Medicaid			3, 148, 338	2.00				
3. 00	Did you receive DSH or supplemental payments from Medicaid?			Υ	3.00				
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental		cai d?	Υ	4.00				
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from	n Medicaid		0					
6. 00 7. 00	Medicaid charges Medicaid cost (line 1 times line 6)			13, 779, 716 3, 377, 367					
7. 00 3. 00	Difference between net revenue and costs for Medicaid program (li	ne 7 minus sum of L	ines 2 and 5: if	229, 029	•				
	< zero then enter zero)								
	Children's Health Insurance Program (CHIP) (see instructions for	each line)							
9.00	Net revenue from stand-alone CHIP			0					
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)			0					
12.00	, , ,	ne 11 minus line 9	if < zero then	0					
12.00	enter zero)	ne ii minas iine 7,	11 (2010 then	Ü	12.00				
	Other state or local government indigent care program (see instru								
13. 00	Net revenue from state or local indigent care program (Not include				13.00				
14. 00	Charges for patients covered under state or local indigent care p 10)	orogram (Not include	d in lines 6 or	0	14.00				
15. 00	State or local indigent care program cost (line 1 times line 14)			o	15.00				
16. 00	Difference between net revenue and costs for state or local indig	gent care program (I	ine 15 minus line	0	16.00				
	13; if < zero then enter zero)				1				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and state/local ind	igent care progra	ms (see					
	Private grants, donations, or endowment income restricted to fund	9			17.00				
18.00	1 1 1		(-	0					
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)	ndigent care progra	illis (suill of fiftes	229, 029	19.00				
	,	Uni nsured	Insured	Total (col. 1					
		patients		+ col . 2)					
	Uncompensated Care (see instructions for each line)	1.00	2. 00	3. 00					
20. 00	Charity care charges and uninsured discounts for the entire facil	i ty 968, 3	313 291, 995	1, 260, 308	20. 00				
21 00	(see instructions)	227 /	221 201 005	E20, 224	21 00				
21. 00	Cost of patients approved for charity care and uninsured discount instructions)	s (see 237, 3	331 291, 995	529, 326	21.00				
22. 00	Payments received from patients for amounts previously written of	f as	0 0	0	22.00				
23. 00	charity care Cost of charity care (line 21 minus line 22)	237, 3	331 291, 995	529, 326	23.00				
24 00	Does the amount on line 20 column 2 include charges for national	daya bayand a Langt	b of otov limit	1.00	24.00				
24. 00	Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr		n or Stay IImit	N	24.00				
25. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit	•	am's length of	0	25. 00				
26. 00	Total bad debt expense for the entire hospital complex (see instr	ructions)		2, 299, 821	26.00				
27. 00	Medicare reimbursable bad debts for the entire hospital complex (•		283, 267	27.00				
	· · ·			435, 795	1				
27. 01									
27. 01 28. 00	Non-Medicare bad debt expense (see instructions)				1				
27. 01 28. 00 29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exper	nse (see instruction	ıs)	609, 395	29. 00				
27. 01 28. 00 29. 00 30. 00		`	s)		29. 00 30. 00				

		JOSEPHS HOSPITA				u of Form CMS-2	2552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C)F EXPENSES	Provi der C		Period: From 07/01/2022	Worksheet A	
					To 06/30/2023		
	Cook Cooks Decorated as	C-1	0+1	T-+-1 (1 1	D1: 6:+	1/24/2024 11:	48 am
	Cost Center Description	Sal ari es	Other	+ col . 2)	Reclassificat ions (See	Reclassified Trial Balance	
				+ (01. 2)	A-6)	(col. 3 +-	
					,, 0)	col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		2, 141, 919	2, 141, 91	9 1, 950, 080	4, 091, 999	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0		1, 197, 824	1, 197, 824	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 789, 852	3, 789, 85	2 0	3, 789, 852	4. 00
5. 01	01160 COMMUNI CATI ONS	0	8, 411	8, 41		10, 093	5. 01
5. 02	00550 DATA PROCESSING	0	1, 223, 963			1, 223, 963	5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	123, 226	131, 773			168, 417	5.03
5. 04	00570 ADMITTING	0	1, 517			1, 517	5.04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	440 424	2, 220, 660			2, 220, 660	5. 05
5. 06	00590 OTHER ADMIN & GENERAL	440, 424	8, 953, 725		9 -1, 096, 354 0 0	8, 297, 795	5.06
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	234, 079	941, 634		9	0 1, 175, 355	6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	234, 079	137, 815			1, 175, 355	8.00
9. 00	00900 HOUSEKEEPI NG	336, 303	157, 614			493, 917	9.00
10.00	01000 DI ETARY	302, 687	462, 354			765, 041	1
11. 00	01100 CAFETERI A	0	102, 334		0	703, 041	11.00
13. 00	01300 NURSING ADMINISTRATION	780, 828	28, 713		-	809, 541	
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	007,01	0	0	16.00
17. 00		o	0		0	0	1
19. 00	1 1	o	0		0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			•			1
30.00		2, 491, 357	1, 418, 465	3, 909, 82	2 -244, 053	3, 665, 769	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 248, 609	2, 351, 902				
53. 00	05300 ANESTHESI OLOGY	0	436, 237			419, 122	
54.00	05400 RADI OLOGY-DI AGNOSTI C	963, 244	753, 139			1, 537, 939	
60.00	06000 LABORATORY	805, 731	1, 146, 165			1, 395, 434	1
64. 00	06400 I NTRAVENOUS THERAPY	97, 420	76, 394			130, 903	1
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	146, 177	81, 676 55, 808			177, 154 194, 789	
66. 00	06600 PHYSI CAL THERAPY	169, 202 975, 931	23, 669		· ·	970, 481	
67. 00	06700 OCCUPATI ONAL THERAPY	175, 961	14, 845			209, 934	
68. 00	06800 SPEECH PATHOLOGY	44, 534	111			48, 428	
68. 01	03040 AUDI OLOGY	57	-1, 166			0, 420	68. 01
71. 00	1	l ő	18, 890				1
72. 00		l ol	0		990, 632	990, 632	
73. 00	1 1	578, 227	1, 975, 560	2, 553, 78		2, 556, 930	
76. 97	07697 CARDIAC REHABILITATION	217, 897	10, 738			225, 308	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	283, 143	1, 268, 402	1, 551, 54	-733, 617	817, 928	76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	1	0	0	l .	0		90.00
91. 00		1, 389, 182	1, 374, 007	2, 763, 18	9 -176, 131	2, 587, 058	
92.00							92.00
93. 00		218, 429	22, 411	240, 84	-523	240, 317	93.00
100.0	OTHER REIMBURSABLE COST CENTERS					-	100.00
102.0	0 10200 OPIOID TREATMENT PROGRAM	0	0		0 0	U	102.00
112 0	SPECIAL PURPOSE COST CENTERS 0 11300 NTEREST EXPENSE		1, 568, 611	1, 568, 61	1 -1, 568, 611	^	113.00
118.0		12, 022, 648	32, 795, 814			45, 021, 006	
110.0	NONREIMBURSABLE COST CENTERS	12,022,048	32, 193, 014	1 44,010,40	2 202, 544	45, 021, 000	1110.00
190 0	19000 GIFT FLOWER COFFEE SHOP & CAN	0	25, 434	25, 43	4 0	25 434	190. 00
192 0	19200 PHYSICIANS PRIVATE OFFICES	78, 089	237, 503			113, 695	
194 0	07950 TRANSPORTATION	34, 115	17, 129				194.00
	1 07951 FUND DEVELOPMENT	-677	0				194. 01
200. 0	1 1	12, 134, 175	33, 075, 880				
	· · ·						

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 14-1336 Peri

Peri od: Worksheet A From 07/01/2022 To 06/30/2023 Date/Time Prepared:

1/24/2024 11:48 am Cost Center Description Adjustments Net Expenses (See A-8) For Allocati on 6. 00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 2, 352, 321 6, 444, 320 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 718, 414 1, 916, 238 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT -2, 173, 078 1, 616, 774 4 00 4 00 5.01 01160 COMMUNI CATI ONS 10, 093 5.01 00550 DATA PROCESSING 779, 294 2,003,257 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES -78, 947 89, 470 5.03 00570 ADMITTING 170, 133 5.04 168, 616 5 04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE -1, 552, 455 668, 205 5.05 5.06 00590 OTHER ADMIN & GENERAL -5, 248, 347 3,049,448 5.06 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT -27, 627 1, 147, 728 7 00 7.00 1, 997 8.00 00800 LAUNDRY & LINEN SERVICE 139, 812 8.00 9.00 00900 HOUSEKEEPI NG -20, 293 473, 624 9.00 01000 DI ETARY 10.00 706, 409 10.00 -58.63211.00 01100 CAFETERI A -76, 626 -76, 626 11.00 01300 NURSING ADMINISTRATION 13.00 -362 809, 179 13.00 01600 MEDICAL RECORDS & LIBRARY 16,00 456, 448 456, 448 16.00 01700 SOCIAL SERVICE 17 00 0 Λ 17 00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 -1, 062, 254 2, 603, 515 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 -254, 925 1, 463, 208 50.00 53.00 05300 ANESTHESI OLOGY -409, 928 9, 194 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 -5,6321,532,307 54 00 60.00 06000 LABORATORY -891 1, 394, 543 60.00 06400 I NTRAVENOUS THERAPY 130, 903 64.00 64.00 65.00 06500 RESPIRATORY THERAPY -25, 493 151, 661 65.00 06501 SLEEP LAB 65.01 194, 789 65.01 66.00 06600 PHYSI CAL THERAPY -55, 821 914,660 66.00 06700 OCCUPATI ONAL THERAPY 67.00 209, 934 67.00 0 68 00 06800 SPEECH PATHOLOGY 0 48, 428 68 00 03040 AUDI OLOGY 68.01 0 68.01 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 2, 750, 958 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 990, 632 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS -48, 045 2, 508, 885 73 00 07697 CARDIAC REHABILITATION 76.97 0 225, 308 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 817, 928 76.98 76.98 77 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 91.00 09100 EMERGENCY -719, 205 1,867,853 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 92 00 92 00 93.00 04950 0/P GERIATRIC PSYCH CENTER -250 240,067 93.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) -7, 341, 721 37, 679, 285 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 25.434 190 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 113, 695 192.00 194. 00 07950 TRANSPORTATION 0 49, 920 194.00 194. 01 07951 FUND DEVELOPMENT 194.01 0 37, 868, 334 200.00 TOTAL (SUM OF LINES 118 through 199) -7.341.721 200.00

Health Financial Systems RECLASSIFICATIONS Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 1/24/2024 11:48 am Provider CCN: 14-1336

					1/24/2024 11	1:48 am
	2001.000100	Increases	0.1	0.11		
	Cost Center	Li ne #	Sal ary	Other E 00		
	2.00 A - CAPITAL RELATED COSTS -	3. 00	4. 00	5. 00		
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 232, 062		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	Ö	285, 730		2.00
3. 00		0.00	o	0		3.00
4. 00		0.00	o	0		4. 00
5.00		0.00	o	0		5. 00
6.00		0.00	o	0		6. 00
7.00		0.00	0	0		7. 00
8.00	L	0.00	0	0		8. 00
	0		0	1, 517, 792		
	B - TELEPHONE					
1. 00	COMMUNI CATI ONS	5. 01	0	1, 682		1.00
2. 00		0.00		0		2. 00
	0		0	1, 682		_
1 00	C - POSTAGE OTHER ADMIN & GENERAL	5. 06	ol	0.247		1 00
1. 00 2. 00	OTHER ADMIN & GENERAL	0.00	0	8, 347		1. 00 2. 00
2.00				$\frac{0}{8,347}$		2.00
	D - INTEREST		<u> </u>	0, 347		
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	1, 568, 611		1.00
	0	 		1, 568, 611		1
	E - MED SUPPLIES - IMPLANTS		-	,		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	2, 730, 305		1.00
	PAT					
2.00	IMPL. DEV. CHARGED TO	72. 00	0	990, 632		2. 00
	PATI ENTS					
3.00	DRUGS CHARGED TO PATIENTS	73. 00	0	2, 534		3. 00
4.00	AUDI OLOGY	68. 01	0	1, 178		4.00
5. 00		0.00	0	0		5. 00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0. 00 0. 00	0	0		8.00
9. 00 10. 00		0.00	0	0		9. 00 10. 00
11. 00		0.00	0	0		11.00
12. 00		0.00	0	0		12.00
13. 00		0.00	0	0		13. 00
14. 00		0.00	Ö	0		14. 00
		 		3, 724, 649		
	F - DRUGS CHARGED TO PATIENT	S	-,			
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	73, 235		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5. 00		0.00	0	0		5. 00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7. 00
8. 00		0.00		0	4	8. 00
	G - PROPERTY INSURANCE		0	73, 235		-
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	ol	50, 785		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	10, 716		2. 00
2.00	0	 	 	61, 501		2.00
	I - DEPRECIATION		<u> </u>	0.700.		
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	901, 378		1.00
	0 — — — — —			901, 378		
	K - REHAB ADMIN					
1.00	OCCUPATI ONAL THERAPY	67.00	17, 821	1, 307		1.00
2.00	SPEECH PATHOLOGY	6800	3, 628	<u> </u>		2. 00
	0		21, 449	1, 573		
	L - HEALTH CRISIS RECLASS					
1. 00	ADULTS & PEDIATRICS	30.00	4	0		1.00
2. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 763		2. 00
	PAT	++	+			
	O TO DECLASS CLOSED AUDIOL	OCV DEDT	4	1, 763		-
1. 00	O - TO RECLASS CLOSED AUDIOL PHYSICAL THERAPY	66. 00	57	12		1.00
1.00	TOTALS		5/	1 <u>2</u> 12		1.00
	P - INFUSION RECLASS		37	12		-
1. 00	INTRAVENOUS THERAPY	64. 00	20, 163	n		1.00
	0	 	20, 163	0		1
	•	, !	,	-	•	•

Heal th	Financial Systems	ST	. JOSEPHS HOSP	I TAL-HI GHLAND	l L	In Lieu	of Form CMS-	2552-10
RECLASS	SI FI CATI ONS			Provi der (CCN: 14-1336	Peri od:	Worksheet A-	6
						From 07/01/2022		
						To 06/30/2023	Date/Time Pro	
						l .	1/24/2024 11:	48 am
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	Q - NEGATIVE SALARY RECLASS							
1.00	FUND_DEVELOPMENT	19401	<u>6</u> 77	0				1.00
	TOTALS		677	0				
500.00	Grand Total: Increases		42, 350	7, 860, 543				500.00

RECLASSI FI CATI ONS

Provi der CCN: 14-1336

Peri od: Worksheet A-6 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

1/24/2024 11:48 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 A - CAPITAL RELATED COSTS -BUI LDI NGS 1.00 PURCHASING RECEIVING AND 5.03 78. 270 10 1.00 STORES. 1,041,433 2 00 OTHER ADMIN & GENERAL 5 06 0 10 2 00 3.00 ADULTS & PEDIATRICS 30.00 0 21, 473 0 3.00 4.00 OPERATING ROOM 50.00 0 94, 058 0 4.00 5.00 LABORATORY 60.00 0 3,802 0 5.00 0 6.00 DRUGS CHARGED TO PATIENTS 73.00 0 6.00 72,626 7.00 SLEEP LAB 65.01 0 4, 233 0 7.00 PHYSICIANS PRIVATE OFFICES 201, 897 8.00 192.00 0 8.00 0 1, 517, 792 B - TELEPHONE 1.00 OPERATION OF PLANT 7.00 0 358 0 1.00 2.00 TRANSPORTATI ON 194.00 0 1, 324 0 2.00 ō 1, 682 - POSTAGE 1.00 PURCHASING RECEIVING AND 5.03 0 8, 312 0 1.00 2.00 CARDIAC REHABILITATION 76. 97 35 0 2.00 8, 347 D - INTEREST 1.00 INTEREST EXPENSE 113. 00 1, 568, 611 1.00 1, 568, 611 E - MED SUPPLIES - IMPLANTS 1.00 ADULTS & PEDIATRICS 30.00 0 201, 074 0 1.00 OPERATING ROOM 2.00 50.00 0 1, 777, 495 0 2.00 0 3 00 ANESTHESI OLOGY 53.00 0 3 00 17, 115 RADI OLOGY-DI AGNOSTI C 4.00 54.00 0 118, 691 0 4.00 5.00 LABORATORY 60.00 0 552, 620 0 5.00 0 6.00 RESPIRATORY THERAPY 65.00 0 6.00 50, 691 INTRAVENOUS THERAPY 0 0 7.00 64.00 63,060 7.00 8.00 SLEEP LAB 65.01 0 25, 988 0 8.00 0 0 9.00 PHYSI CAL THERAPY 66.00 6, 166 9.00 CARDIAC REHABILITATION 0 10 00 76.97 3 292 0 10 00 0 0 11.00 HYPERBARIC OXYGEN THERAPY 76.98 733, 612 11.00 12.00 EMERGENCY 91.00 0 174, 211 0 12.00 13.00 O/P GERIATRIC PSYCH CENTER 93.00 0 523 0 13.00 SPEECH PATHOLOGY 0 14.00 14 00 68.00 0 111 0 3, 724, 649 - DRUGS CHARGED TO PATIENTS 1.00 ADULTS & PEDIATRICS 30.00 0 670 0 1.00 0 OPERATING ROOM 10, 825 2.00 50.00 0 2 00 3.00 RADI OLOGY-DI AGNOSTI C 54.00 0 59, 753 0 3.00 4.00 LABORATORY 60.00 0 40 0 4.00 RESPIRATORY THERAPY 0 0 5.00 65.00 5.00 8 76. 98 6.00 HYPERBARIC OXYGEN THERAPY 5 0 6.00 1, 920 7.00 EMERGENCY 91.00 0 0 7.00 8.00 INTRAVENOUS THERAPY 64.00 0 8.00 14 ō 73, 235 PROPERTY INSURANCE 1.00 OTHER ADMIN & GENERAL 5.06 0 12 61, 501 1.00 2.00 0.00 0 12 2.00 ō 61.501 - DEPRECIATION 1.00 CAP REL COSTS-BLDG & FIXT 1. 00 901, 378 1.00 901, 378 K - REHAB ADMIN 1.00 PHYSI CAL THERAPY 66.00 0 21, 449 1,573 1.00 2.00 0.00 0 2.00 21, 449 1, 573 - HEALTH CRISIS RECLASS 1.00 OTHER ADMIN & GENERAL 5.06 1, 763 0 1.00 0 2.00 0.00 0 2.00 1, 763 O - TO RECLASS CLOSED AUDIOLOGY DEPT 1.00 AUDI OLOGY 68. 01 57 12 0 1.00 TOTALS 57 12 P - INFUSION RECLASS 1.00 ADULTS & PEDIATRICS 30. 00 20, 163 0 0 1.00 20, 163 ō Q - NEGATIVE SALARY RECLASS 1.00 ADULTS & PEDIATRICS 30.00 677 0 0 1.00 677 TOTALS 500.00 Grand Total: Decreases 42, 350 7, 860, 543 500.00

5.00

6.00

7.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 14-1336 Peri od: Worksheet A-7 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 11:48 am Acqui si ti ons Begi nni ng Purchases Disposals and Donati on Total Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2, 034, 874 1.00 Land 0 Land Improvements 1, 469, 318 0 2.00 15, 500 15, 500 Ω 2.00 0 3.00 39, 696, 510 3.00 Buildings and Fixtures 131, 622 131, 622 0 0 4.00 Building Improvements 139, 133 0 4.00 Fi xed Equi pment 0 5.00 0 5.00 0 6.00 Movable Equipment 10, 831, 916 665, 663 665, 663 Ω 6.00 0 7.00 HIT designated Assets 9, 193, 721 0 7.00 8.00 Subtotal (sum of lines 1-7) 63, 365, 472 812, 785 0 812, 785 0 8.00 7, 079, 116 9.00 Reconciling Items -56, 597 0 -56, 597 358, 799 9.00 Total (line 8 minus line 9) 869, 382 869, 382 -358, 799 10.00 10.00 56, 286, 356 0 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 034, 874 1.00 2.00 1, 484, 818 0 2.00 Land Improvements 39, 828, 132 3.00 Buildings and Fixtures 0 3.00 4.00 Building Improvements 139, 133 0 4.00

11, 497, 579

9, 193, 721

6, 663, 720

64, 178, 257

57, 514, 537

0

0

0

0

0

0

5.00

6.00

7.00

8.00

9.00

Fixed Equipment

Movable Equipment

Reconciling Items

HIT designated Assets

10.00 Total (line 8 minus line 9)

Subtotal (sum of lines 1-7)

Heal th	Financial Systems ST	. JOSEPHS HOSPI	TAL-HIGHLAND I	I	In lie	eu of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od: From 07/01/2022	Worksheet A-7 Part II	,
					To 06/30/2023	Date/Time Pre 1/24/2024 11:	pared: 48 am
			SL	JMMARY OF CAF	PLTAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLUI	MN 2, LINES 1 a	and 2			1
1.00	CAP REL COSTS-BLDG & FIXT	2, 141, 919	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)	2, 141, 919	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1)				
	•	Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLUI	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 141, 919				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
2 00	Total (sum of lines 1 2)		2 1/1 010	I			2 00

0 0 0

2, 141, 919

2.00

3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems ST.	JOSEPHS HOSPI	TAL-HIGHLAND I	L	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 07/01/2022 Fo 06/30/2023	Worksheet A-7 Part III Date/Time Pre 1/24/2024 11:	pared:
		COMF	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
				col . 2)			
	DART III DECONOLITATION OF CARLTAL COCTO O	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT			42 40/ 05:	0 (7750)	0	1.00
1. 00 2. 00	CAP REL COSTS-BLUG & FIXT	43, 486, 957 20, 691, 300	l .	43, 486, 95 20, 691, 300			2.00
3. 00	Total (sum of lines 1-2)	64, 178, 257		64, 178, 25			3.00
3.00	Total (suii of Titles 1-2)	· · · · · · · · · · · · · · · · · · ·	TION OF OTHER (F CAPI TAL	3.00
		ALLUCA	IION OF OTHER (CAPITAL	SUMMART	IF CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed 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 & FIXT	0	0		3, 677, 938		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		1, 619, 792	· ·	2.00
3.00	Total (sum of lines 1-2)	0	0	(5, 297, 730	1, 517, 792	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at	`	
			instructions)		ed Costs (see	9 through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	DART III DECONCILIATION OF CARLTAL COCTO	11. 00	12. 00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT		E0 705	1		4 444 220	1 00
1. 00 2. 00	CAP REL COSTS-BLUG & FIXI	1, 483, 535 0	50, 785 10, 716		0	6, 444, 320 1, 916, 238	1. 00 2. 00
2. 00 3. 00	Total (sum of lines 1-2)	1, 483, 535		•		8, 360, 558	
3.00	Tiotal (Suil Of TITIES 1-2)	1, 400, 535	01,501	1	اح	0, 300, 558	3.00

| Period: | Worksheet A-8 | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: Provi der CCN: 14-1336

Cost Center Description					To	06/30/2023	Date/Time Pre 1/24/2024 11:	
Cost Center Description							172472024 11.	40 alli
100 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 11 1.00 2.00 3.00 4.00 5.00 11 1.00 2.00 3					To/From Which the Amount is	to be Adjusted		
100 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 11 1.00 2.00 3.00 4.00 5.00 11 1.00 2.00 3								
100 Investment Income - CAP REL 1.000 2.000 3.000 4.000 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.000								
100 Investment Income - CAP REL 1.000 2.000 3.000 4.000 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.001 1.000 0.000								
1.00 Investment Income		Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		·		2.00	2.00	4.00		
Investment Income CAP REL OCAP REL COSTS-MYBLE EQUIP 2.00 0.20 0.30	1. 00	Investment income - CAP REL						1.00
COSTS-WRILE FOULP (Chapter 2)	0.00				CAR REL COCTC MARKE FOUND	2 22		0.00
Chapter 2)	2.00			U	CAP REL CUSTS-MVBLE EQUIP	2.00	Ü	2.00
1.00 1.00	3. 00	II I		0		0. 00	0	3. 00
Section Sect	4. 00			0		0.00	0	4. 00
expenses (chapter 8) 6. 00 Rental of provider space by suppliers (chapter 8) 7. 00 Telephone services (pay 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5 00			0		0.00	0	5 00
Suppliers (chapter 8)	5.00	expenses (chapter 8)		0		0.00	O	3.00
Telephone services (pay stations excluded) (chapter 21)	6. 00			0		0. 00	0	6. 00
210 8. 00 Television and radio service 0 0.00 0 8. 00 Chapter 21) 0 0 0 0.00 0 9. 00 0.00 0 9. 00 0.00 0 9. 00 0.00 0 9. 00 0.00	7. 00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
1.00 Parking 101 (chapter 21) 0 0 0 0 0 0 0 0 0								
9.00 Parking lot (chapter 21) 0 0.00 9.00 0.00 0.90 0.00	8. 00	Television and radio service		0		0. 00	0	8. 00
10.00 Provi der-based physician A-8-2 -2,061,877	9 00			0		0.00	0	9 00
11.00 Sale of scrap, waste, etc. 0 0.00 0 11.00		Provi der-based physician	A-8-2	-2, 061, 877		0.00	-	
Chapter 23 Chapter 23 Chapter 10	11 00			0		0.00	0	11 00
Transactions (chapter 10)		(chapter 23)		_		0.00		
13.00 Laundry and I nen service B OLAUNDRY & LINEN SERVICE 8.00 0 13.00 14.00 Cafteria-employees and guests B -76, 626 CAFETERIA 11.00 0 14.00 15.00 Rental of quarters to employee and others 0 0.00 0 15.00 16.00 Sale of medical and surgical supplies to other than patients 0 0.00 0 16.00 17.00 Sale of medical records and abstracts 0 0.00 0 17.00 18.00 Sale of medical records and abstracts 0 0.00 0 18.00 19.00 Wirsing and allied health education (tuition, fees, books, etc.) 0 0 0.00 0 19.00 10.00 Vending machines 0 0.00 0.00 0 21.00 10.00 Income from imposition of linterest, finance or penality charges (chapter 21) 0 0 0 0 10.00 Vending machines 0 0.00 0.00 0 21.00 10.00 Vending machines 0 0.00 0.00 0 22.00 20.00 Vending machines 0 0.00 0.00 0 22.00 21.00 Interest expense on Medicare overpayments 0 0.00 0.00 0 22.00 22.00 Interest expense on Medicare overpayments 0 0.00 0.00 0 22.00 23.00 Adjustment for prespiratory therapy costs in excess of limitation (chapter 14) 0 0 0 0 0 24.00 Algustment for physical therapy costs in excess of limitation (chapter 14) 0 0 0 0 0 0 25.00 0 0 0 0 0 0 0 0 0	12. 00		A-8-1	-12, 526			0	12. 00
15.00 Rental of quarters to employee 0 0.00 0 15.00 and others 0.00 0 16.00 0.00 0 16.00 0.00 0 16.00 0.00 0 16.00 0.00 0 17.00 0.00 0 17.00 0.00 0 17.00 0.00 0 17.00 0.00 0 17.00 0.00 0 17.00 0.00 0 18.00 0.00 0 18.00 0.00 0 18.00 0.00 0 18.00 0.00 0 18.00 0.00 0.00 0 19.00 0.00 0.00 0 19.00 0.00		Laundry and linen service			i i		-	
and others				-76,626 0	CAFETERIA		-	
Supplies to other than patients 17.00 Sale of drugs to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing and allied health education (tuition, fees, books, etc.) 19.00 Nursing and allied health education (tuition, fees, books, etc.) 19.00		and others						
17.00 Sale of drugs to other than patients 0 0.00 0 17.00	16.00			Ü		0.00	Ü	16.00
Patients Sale of medical records and abstracts Sale of medical stracts Sale of medical records Sale of Med	17 00	1.		0		0.00	0	17 00
abstracts Nursing and allied health education (tuition, fees, books, etc.)	17.00	pati ents		Ü		0.00	O	17.00
19.00 Nursing and allied health education (tuition, fees, books, etc.) 20.00 Vending machines 0 0 0 0 0 0 20.00	18. 00		В	-4, 189	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
Dooks, etc.	19. 00	1		0		0. 00	0	19. 00
20.00 Vending machines 0 0.00 0.00 0.20.00								
interest, finance or penal ty charges (chapter 21) 22. 00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings thereof overpayments and overpa		Vending machines		0			-	
charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT COSTS-BLDG & FIXT COSTS-BLDG & FIXT COSTS-BLDG & FIXT COSTS-MVBLE EQUIP 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist COSTS-MVBLE EQUIP 29.00 Non-physician Anesthetist OND-physicians' assistant OND-physicians' assistant OND-physical manesthetist OND-physicians' assistant ON	21. 00			0		0. 00	0	21. 00
overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physicians Anesthetist 29.00 Physicians' assistant Adjustment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Depreciation - CAP REL COSTS-BLDG & FIXT 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Old Justment for occupational therapy costs in excess of limitatio		charges (chapter 21)						
repay Medicare overpayments	22. 00			0		0. 00	0	22. 00
therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 28.00 Physicians' assistant 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see	00.00	repay Medicare overpayments			DECDI DATODY THEDADY	(5.00		00.00
I imitation (chapter 14) Adjustment for physical therapy costs in excess of limitation (chapter 14) A-8-3 OPHYSICAL THERAPY 66.00 24.00	23.00		A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	24.00		4.0.2	0	DUVCI CAL THEDADY	// 00		24.00
25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see	24.00		A-8-3	Ü	PHYSICAL THERAPY	66.00		24.00
physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	25 00			0	*** Cost Contor Doloted ***	114 00		25 00
26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 2.00 0 27. 00 28. 00 Non-physician Anesthetist 0 NONPHYSICIAN ANESTHETISTS 19. 00 28. 00 29. 00 Physicians' assistant 0 0 0 0 0 0 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0	25.00	II I		0	cost center bereted	114.00		25.00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see) OCAP REL COSTS-MVBLE EQUIP O	26 00			0	CAD DEL COSTS BLDC & ELVT	1 00	0	26 00
28. 00 COSTS-MVBLE EQUIP Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS 19. 00 28. 00 29. 00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see OADULTS & PEDIATRICS 30. 00 30. 99 30. 99 30. 99 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 90 30. 99 30. 90 30. 90 30. 99 30. 90		COSTS-BLDG & FLXT						
28.00 Non-physician Anesthetist 0 NONPHYSICIAN ANESTHETISTS 19.00 29.00 29.00 Physicians' assistant 0.00 0 0 29.00 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see 0 ADULTS & PEDIATRICS 30.00 30.99	27. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.00		Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS			
therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99		1 3	A-8-3	0	OCCUPATIONAL THERAPY		0	
30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99	55.00	therapy costs in excess of	,, 5 0	0	THE WILL	37.00		55.00
	30. 99			0	ADULTS & PEDIATRICS	30. 00		30. 99

Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 1/24/2024 11:48 am Provi der CCN: 14-1336 Peri od: Worksheet A-8

						1/24/2024 11:	48 am_
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					,		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0. 00	0	32.00
02.00	Depreciation and Interest		O		0.00	J	02.00
33. 00	MISCELLANEOUS INCOME	В	22 024	CASHI ERI NG/ACCOUNTS	5. 05	0	33. 00
33.00	WI SCLELANEOUS TNCOME	ь	23, 724	RECEI VABLE	5.05	U	33.00
22 01	MI COEL LANEOUG LINCOME	D	70 047		F 00	_	22 01
33. 01	MISCELLANEOUS INCOME	В	- 78, 947	PURCHASING RECEIVING AND	5. 03	0	33. 01
		_		STORES			
33. 02	MI SCELLANEOUS I NCOME	В		OTHER ADMIN & GENERAL	5. 06	0	33. 02
33. 03	MI SCELLANEOUS I NCOME	В	-20, 640	OPERATION OF PLANT	7. 00	0	33. 03
33.04	MISCELLANEOUS INCOME	В	-20, 293	HOUSEKEEPI NG	9. 00	0	33. 04
33.05	MI SCELLANEOUS I NCOME	В	-275	NURSING ADMINISTRATION	13. 00	0	33. 05
33. 06	ATHLETI CARE OTHER EXPENSE	Α		PHYSI CAL THERAPY	66. 00	0	33.06
33. 07	ADVERTISING EXPENSES	A		OTHER ADMIN & GENERAL	5. 06	0	33. 07
33. 08	MEDICALD TAX ASSESSMENT	A		OTHER ADMIN & GENERAL	5. 06	0	33. 08
						_	
33. 09	CRNA-CONTRACT LABOR	A		ANESTHESI OLOGY	53.00	0	33.09
33. 10	PENSI ON ADJUSTMENT	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 10
33. 11	HSHS MED GROUP ADMIN	A		OTHER ADMIN & GENERAL	5. 06	0	33. 11
33. 12	USEFUL LIVES CARRYFORWARD	A	111, 756	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 12
	ADJUSTMEN						
33. 13	LOBBYING EXPENSE	Α	-15, 725	OTHER ADMIN & GENERAL	5. 06	0	33. 13
33. 14	COMMUNITY RELATIONS BENEFITS	A	-612	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 14
33. 15	COMMUNITY RELATIONS SALARY	A	-4. 168	OTHER ADMIN & GENERAL	5. 06	0	33. 15
33. 16	COMMUNITY RELATIONS OTHER	A		OTHER ADMIN & GENERAL	5. 06	0	33. 16
00. 10	EXPENSE	, ,	12,000	OTTIER ABINITY & GENERALE	0.00	J	00.10
33. 17	SELF-INSURANCE ADJUSTMENT	Α	1 624 077	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 17
	II .		· · ·	1		0	
33. 18	PROPERTY TAX NOT RELATED TO	A	-0, 987	OPERATION OF PLANT	7. 00	U	33. 18
00.40	PATIENT		0 005 / 44	ALD DEL COOTO DIDO A FLYT	4 00		
33. 19	BUILDING RELIFING	Α		CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 19
33. 20	EQUIPMENT RELIFING	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 20
33. 21	MARKETING OTHER EXPENSE	A	-75, 710	OTHER ADMIN & GENERAL	5. 06	0	33. 21
33. 22	ALCOHOL	Α	-10, 789	OTHER ADMIN & GENERAL	5. 06	0	33. 22
33. 23	ATHLETI CARE BENEFITS	A	-8, 092	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 23
33. 24	ATHLETI CARE SALARI ES	Α	-55, 120	PHYSI CAL THERAPY	66. 00	0	33. 24
33. 25	MEALS ON WHEEL REVENUE	В		DI ETARY	10. 00	0	33. 25
33. 26	MI SCELLANEOUS I NCOME	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 26
33. 27	4	В	·	ł .		_	33. 27
	MI SCELLANEOUS I NCOME	В		PHYSI CAL THERAPY	66. 00	0	
33. 28	MISCELLANEOUS INCOME			O/P GERIATRIC PSYCH CENTER	93.00	0	33. 28
33. 29	GIFTS OR DONATIONS MADE	A		NURSI NG ADMINI STRATI ON	13. 00	0	33. 29
33. 30	HEALTH FAIR	A		LABORATORY	60. 00	0	33. 30
50.00	TOTAL (sum of lines 1 thru 49)		-7, 341, 721				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) De	scription - all chapter referen	cas in this co	lumn nertain t	o CMS Pub 15-1			

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

⁽²⁾ Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

OFFICE COSTS

Provider CCN: 14-1336

Worksheet A-8-1

From 07/01/2022 06/30/2023 Date/Time Prepared:

					1/24/2024 11:	48 am_
	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 ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH & DENTAL PREMIUM	2, 464, 036	2, 467, 537	1.00
2.00	5. 02	DATA PROCESSING	CONTRACTED SERVICES - ISC	2, 003, 018	1, 223, 724	2.00
3.00	5. 05	CASHI ERI NG/ACCOUNTS RECEI VAB	SBO FEE	644, 281	2, 220, 660	3.00
4.00	5. 04	ADMITTI NG	SBO FEE	168, 616	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	SBO FEE	460, 637	0	4. 01
4. 02	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HR FEE	71, 486	223, 608	4. 02
4.03	5. 06	OTHER ADMIN & GENERAL	CONTRACTED SERVICES - SSC	1, 354, 379	805, 032	4.03
4.04	5. 06	OTHER ADMIN & GENERAL	PURCHASED SERVICES	O	95, 584	4.04
4.05	5. 06	OTHER ADMIN & GENERAL	IL - A&G	422, 458	518, 218	4. 05
4.06	73. 00	DRUGS CHARGED TO PATIENTS	IL - SHARED PHARMACIST	50, 292	98, 337	4.06
4.07	8. 00	LAUNDRY & LINEN SERVICE	LAUNDRY	139, 812	137, 815	4. 07
4.08	5. 06	OTHER ADMIN & GENERAL	IL - LIBRARY	11, 472	12, 498	4. 08
5.00	TOTALS (sum of lines 1-4).			7, 790, 487	7, 803, 013	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.

The first been posted to her keneet A, our amount of the amount of the beat a section and the control of the beat the						
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	В	HSHS	100.00	0.00	6.00
7.00			0.00	0.00	7. 00
8.00			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. JOSEPHS HOSPITA	AL-HIGHLAND IL	In Lieu	of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provi der CCN: 14-1336	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 07/01/2022	D-+- /T: D	
					To 06/30/2023	Date/Time Pro 1/24/2024 11:	
	Net	Wkst. A-7 Ref.				1,21,202111	10 4
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
		RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF T	RANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:						
1.00	-3, 501	0					1.00
2.00	779, 294	0					2.00
3.00	-1, 576, 379						3.00
4.00	168, 616	0					4.00
4.01	460, 637	0					4.01
4.02	-152, 122	0					4. 02
4.03	549, 347	0					4.03
4.04	-95, 584	0					4.04
4.05	-95, 760	0					4.05
4.06	-48, 045	0					4.06
4.07	1, 997	0					4.07
4. 08	-1, 026	0					4. 08

5.00 -12, 526 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.

5.00

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

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

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

To this discontinuo and the trong that the state of the s						
6. 00		6.00				
7. 00		7.00				
8. 00		8.00				
7. 00 8. 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:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Peri od: Worksheet A-8-2 From 07/01/2022 Date/Time Prepared: 1/24/2024 11:48 am

						To 06/30/2023	3 Date/Time Pro 1/24/2024 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6.00	7. 00	
1.00	30. 00	ADULTS & PEDIATRICS	1, 062, 254		0	C	0	1.00
2.00	91. 00	EMERGENCY	1, 020, 562	719, 205	301, 357	C	0	2.00
3.00	91. 00	EMERGENCY	96, 000	0	96, 000	C	0	3.00
4.00	76. 98	HYPERBARIC OXYGEN THERAPY	25, 000	0	25, 000	C	0	4. 00
5.00	64. 00	INTRAVENOUS THERAPY	5, 788	0	5, 788	C	0	5.00
6.00	50.00	OPERATING ROOM	254, 925	254, 925	0	C	0	6. 00
7. 00	93. 00	O/P GERIATRIC PSYCH CENTER	19, 750	0	19, 750	C	0	7. 00
8. 00	60. 00	LABORATORY	55, 158	0	55, 158	C	0	8. 00
9. 00	65. 00 l	RESPI RATORY THERAPY	28, 693	25, 493	3, 200	l c	0	9. 00
10.00	76. 97	CARDIAC REHABILITATION	3, 313	0	3, 313	l c	0	10.00
200.00	1		2, 571, 443	2, 061, 877	509, 566		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12.00	13. 00	14.00	
1. 00		ADULTS & PEDIATRICS	0		_			
2.00		EMERGENCY	0	0	0	C	_	
3. 00		EMERGENCY	0	0	0	C	0	
4. 00		HYPERBARIC OXYGEN THERAPY	0	0	0	C	0	
5. 00	1	INTRAVENOUS THERAPY	0	0	0	C	0	
6. 00		OPERATING ROOM	0	0	0	C	0	
7. 00	1	O/P GERIATRIC PSYCH CENTER	0	0	0	C	0	,
8. 00		LABORATORY	0	0	0	C	0	
9. 00	1	RESPIRATORY THERAPY	0	0	0	C	0	
10. 00	76. 97	CARDIAC REHABILITATION	0	0	0	C	0	
200.00			0	C	0	C	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15. 00	16. 00	17. 00	18. 00	-	
1. 00		ADULTS & PEDIATRICS	15.00					1. 00
2.00		EMERGENCY			_	719, 205		2.00
3.00		EMERGENCY				/ 17, 203		3.00
4. 00		HYPERBARIC OXYGEN THERAPY						4.00
5. 00		INTRAVENOUS THERAPY			0			5.00
6. 00		OPERATING ROOM			0	254, 925		6.00
7. 00		O/P GERIATRIC PSYCH CENTER			0	234, 923		7.00
8. 00		LABORATORY						8.00
				i o		25 403		
9. 00 10. 00		RESPIRATORY THERAPY		l o	_	25, 493		9. 00 10. 00
	/6. 9/	CARDIAC REHABILITATION			_	2 041 077		
200. 00	1		1	1	ı _l 0	2, 061, 877	I	200.00

REASON	Financial Systems ST ABLE COST DETERMINATION FOR THERAPY SERVICES FIELD SUPPLIERS	JOSEPHS HOSPITA JRNISHED BY	AL-HIGHLAND II Provider CC		In Lie Period: From 07/01/2022 To 06/30/2023	w of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 1/24/2024 11: Cost	-3 pared:
	Therapy						
	DADT I CENEDAL INFODMATION					1. 00	
1. 00 2. 00 3. 00 4. 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides) Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervise Number of unduplicated days in which therapy a nor therapist was on provider site (see instru	or or therapist assistant was o	was on provi			19 285 0 0	1. 00 2. 00 3. 00 4. 00
5. 00 6. 00							5. 00 6. 00
7. 00 8. 00	Standard travel expense rate Optional travel expense rate per mile					5. 62 0. 00	
		Supervi sors	Therapi sts	Assi stants		Trai nees	
9. 00 10. 00 11. 00	Total hours worked AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	1. 00 0. 00 0. 00 45. 10	2. 00 470. 00 90. 20 45. 10	3. 00 0. 0. 0.	0. 00	5. 00 0. 00 0. 00	
12. 00 12. 01 13. 00 13. 01	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site) Number of miles driven (offsite)	0 0 0 0	0 0 0 0		0 0 0 0		12. 00 12. 01 13. 00 13. 01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14. 00 15. 00 16. 00 17. 00	.00 Therapists (column 2, line 9 times column 2, line 10) .00 Assistants (column 3, line 9 times column 3, line10)					0 42, 394 0 42, 394	16. 00
18. 00 19. 00 20. 00	00 Trainees (column 5, line 9 times column 5, line 10) 0 Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 42,394					18. 00 19. 00 20. 00	
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21. 00	Weighted average rate excluding aides and trai for respiratory therapy or columns 1 thru 3, 1	nees (line 17		um of columns	s 1 and 2, line 9	0.00	21.00
22. 00 23. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions)					0 42, 394	22. 00 23. 00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWA	NCE AND TRAVEL	EXPENSE COMP	PUTATION - PI	ROVIDER SITE	, ,	
24. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					0	24. 00
25. 00	Assistants (line 4 times column 3, line 11)					0	25. 00
26. 00 27. 00	Subtotal (line 24 for respiratory therapy or s Standard travel expense (line 7 times line 3 f				3 and 4 for all	0	26. 00 27. 00
28. 00	others) Total standard travel allowance and standard 1	. ,	. ,				28. 00
	27) Optional Travel Allowance and Optional Travel	<u> </u>	•	•			
29. 00	Therapists (column 2, line 10 times the sum of		I 2, line 12))		0	29. 00
30.00	Assistants (column 3, line 10 times column 3,					0	30.00
31. 00 32. 00	Subtotal (line 29 for respiratory therapy or soptional travel expose (line 8 times columns				oy or sum of	0	31. 00 32. 00
33. 00	columns 1-3, line 13 for all others) Standard travel allowance and standard travel	expense (line	28)			0	33.00
34.00	Optional travel allowance and standard travel	expense (sum o	of lines 27 ar			0	34.00
35. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWAN				RVICES OUTSIDE PR	OVIDER SITE	35.00
36. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36. 00
37. 00	Assistants (line 6 times column 3, line 11)					0	37. 00
38. 00 39. 00						38. 00 39. 00	
	Optional Travel Allowance and Optional Travel Expense						
40. 00 41. 00							
42.00	00 Subtotal (sum of lines 40 and 41)					42.00	
43. 00	Optional travel expense (line 8 times the sum Total Travel Allowance and Travel Expense - Of				lowing three lin	0 les 44, 45, or	43.00
44. 00	46, as appropriate. Standard travel allowance and standard travel	expense (sum o	of lines 38 ar	nd 39 - see i	nstructions)	0	44.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der CO	JN: 14-1336	Peri od: From 07/01/2022 To 06/30/2023 Occupati onal	Worksheet A-8 Parts I-VI Date/Time Pre 1/24/2024 11: Cost	pared
					Therapy	0031	
						1. 00	
00	Optional travel allowance and standard travel	expense (sum	of lines 39 ar	nd 42 - see i	nstructions)	0	45.0
00	Optional travel allowance and optional trave					0	46. (
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1. 00	2. 00	3. 00	4. 00	5. 00	
	Overtime hours worked during reporting	0.00	0.00	0. 0	0.00	0.00	47.
	period (if column 5, line 47, is zero or						
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each						
	column of line 56)	0.00	0.00		0.00		40
	Overtime rate (see instructions) Total overtime (including base and overtime	0. 00 0. 00	0. 00 0. 00				48. 49.
00	allowance) (multiply line 47 times line 48)	0.00	0.00	0. 0	0.00		47.
	CALCULATION OF LIMIT	L					
	Percentage of overtime hours by category	0.00	0.00	O. C	0.00	0.00	50.
	(divide the hours in each column on line 47						
	by the total overtime worked - column 5,						
00	line 47) Allocation of provider's standard work year	0.00	0. 00	0. 0	0.00	0. 00	F1
00	for one full-time employee times the	0.00	0.00	0. 0	0.00	0.00	51.
	percentages on line 50) (see instructions)						
Ì	DETERMINATION OF OVERTIME ALLOWANCE						
00	Adjusted hourly salary equivalency amount	90. 20	0.00	O. C	0.00		52.
	(see instructions)	_	_				
00	Overtime cost limitation (line 51 times line	0	0		0 0		53.
00	52) Maximum overtime cost (enter the lesser of	0	0		o		54.
	line 49 or line 53)	Ĭ	O .				54.
00	Portion of overtime already included in	0	0		0 0		55.
	hourly computation at the AHSEA (multiply						
	line 47 times line 52)					0	
00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	U	0		0 0	0	56.
	the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
						1.00	
П	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	AD HISTMENT			1. 00	
	Salary equivalency amount (from line 23)	IND EXCESS COST	ADSOSTMENT			42, 394	57.
	Travel allowance and expense - provider site	(from lines 33	, 34, or 35))			0	58.
	Travel allowance and expense - Offsite service	ces (from lines	44, 45, or 46	5)		0	59.
	Overtime allowance (from column 5, line 56)					0	60.
	Equipment cost (see instructions)					0	
	Supplies (see instructions)					0 42, 394	
	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from	n vour records)				14, 326	
	Excess over limitation (line 64 minus line 63		. enter zero)				65
	LINE 33 CALCULATION		,				
0. 00	Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	all others			100.
	Line 27 = line 7 times line 3 for respirator	y therapy or su	m of lines 3 a	and 4 for all	others	-	100.
	Line 33 = line 28 = sum of lines 26 and 27					0	100.
	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respirator	, thorany or su	m of lines 2	and 4 for all	othors	0	101.
	Line 31 = line 29 for respiratory therapy or				OTHELS		101.
	Line 34 = sum of lines 27 and 31	Sam 01 111103 Z	, 3114 00 101 6	0011013			101.
	LINE 35 CALCULATION						1
	Line 31 = line 29 for respiratory therapy or	sum of lines 2	9 and 30 for a	all others			102
- 1	line 22 line 0 times columns 1 and 2 line	13 for respira	tory therany o	or sum of col	umns 1_3 line	0	102.
. 01	Line 32 = line 8 times columns 1 and 2, line 13 for all others	15 TOT TESPITA	tory therapy t	51 3 4 111 01 001	umins 1 5, 1111c	٥	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 14-1336

					Fr To	com 07/01/2022 06/30/2023	Part I Date/Time Pre	pared:
				CAPI TAL REI	_ATED COSTS		1/24/2024 11:	48 alli
		Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ON	
			for Cost Allocation			BENEFITS DEPARTMENT	S	
			(from Wkst A			DEPARTMENT		
			col . 7)	1.00	2.00	4.00	F 04	
	GENER	AL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	5. 01	
1. 00	00100	CAP REL COSTS-BLDG & FIXT	6, 444, 320					1.00
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	1, 916, 238 1, 616, 774	38, 903	1, 916, 238 1, 622	1, 657, 299		2.00 4.00
5. 01		COMMUNI CATI ONS	1, 010, 774			1, 037, 299	50, 240	5. 01
5. 02		DATA PROCESSING	2, 003, 257	99, 044		0	5, 712	5. 02
5. 03 5. 04	1	PURCHASING RECEIVING AND STORES ADMITTING	89, 470 170, 133	179, 733 57, 071	4, 478 1, 353	16, 830 0	1, 166 2, 331	5. 03 5. 04
5. 05	1	CASHI ERI NG/ACCOUNTS RECEI VABLE	668, 205	85, 199		0	583	5. 05
5.06		OTHER ADMIN & GENERAL	3, 049, 448	502, 613		60, 153	9, 671	5.06
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	0 1, 147, 728	0 318, 119	_	0 31, 971	0 816	6. 00 7. 00
8. 00		LAUNDRY & LINEN SERVICE	139, 812	6, 265		0	0	8. 00
9.00		HOUSEKEEPI NG	473, 624	128, 300		45, 933	117	9.00
10. 00 11. 00	1	DI ETARY CAFETERI A	706, 409 -76, 626	164, 572 151, 605		41, 341 0	233	10. 00 11. 00
13. 00		NURSI NG ADMI NI STRATI ON	809, 179	46, 484		106, 646	117	13. 00
16.00		MEDICAL RECORDS & LIBRARY	456, 448	75, 614		0	1, 632	16.00
17. 00 19. 00		SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS	0	19, 295 0		0	117	17. 00 19. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						17.00
30. 00		ADULTS & PEDIATRICS LARY SERVICE COST CENTERS	2, 603, 515	1, 091, 054	89, 396	337, 427	7, 577	30. 00
50. 00		OPERATING ROOM	1, 463, 208	663, 802	860, 427	170, 536	4, 313	50. 00
53.00		ANESTHESI OLOGY	9, 194	0		0	0	53.00
54. 00 60. 00		RADI OLOGY-DI AGNOSTI C LABORATORY	1, 532, 307 1, 394, 543	510, 506 196, 647	46, 915 37, 525	131, 561 110, 048	2, 215 2, 914	54. 00 60. 00
64. 00	1	INTRAVENOUS THERAPY	130, 903	60, 955		16, 060	2, 714	64.00
65.00	1	RESPI RATORY THERAPY	151, 661	53, 813		19, 965	0	65. 00
65. 01 66. 00		SLEEP LAB PHYSI CAL THERAPY	194, 789 914, 660	76, 303 322, 880		23, 110 130, 372	933 2, 098	65. 01 66. 00
67.00		OCCUPATI ONAL THERAPY	209, 934	60, 955		26, 467	117	67.00
68.00		SPEECH PATHOLOGY	48, 428			6, 578	0	68.00
68. 01 71. 00	1	AUDIOLOGY MEDICAL SUPPLIES CHARGED TO PAT	0 2, 750, 958	0 105, 309	_	0	0	68. 01 71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	990, 632	0		0	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	2, 508, 885	73, 672		78, 975	1, 049	73. 00 76. 97
76. 97 76. 98		CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	225, 308 817, 928	·		29, 761 38, 672	1, 166 1, 166	
77. 00		ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
90 00		TIENT SERVICE COST CENTERS	0	0	O	0	0	90.00
91.00		EMERGENCY	1, 867, 853	_		189, 736	2, 331	
92.00		OBSERVATION BEDS (NON-DISTINCT						92.00
93. 00		O/P GERIATRIC PSYCH CENTER REIMBURSABLE COST CENTERS	240, 067	155, 050	41, 182	29, 833	933	93. 00
102.00		OPLOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
440.00		AL PURPOSE COST CENTERS						440.00
113.00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	37, 679, 285	6, 010, 117	1, 900, 614	1, 641, 975	49, 307	113. 00 118. 00
110.00	_	IMBURSABLE COST CENTERS	07, 077, 200	0,010,117	1, 700, 011	1,011,770	17,007	110.00
	1	GIFT FLOWER COFFEE SHOP & CAN	25, 434			0		190.00
		PHYSICIANS PRIVATE OFFICES TRANSPORTATION	113, 695 49, 920	·		10, 665 4, 659		192. 00 194. 00
194. 01	1 07951	FUND DEVELOPMENT	0	29, 632		0		194. 01
200.00		Cross Foot Adjustments		_			_	200.00
201. 00 202. 00		Negative Cost Centers TOTAL (sum lines 118 through 201)	37, 868, 334	0 6, 444, 320	_	0 1, 657, 299		201. 00 202. 00
	1		,	,			,	

				1	0 06/30/2023	1/24/2024 11:	
	Cost Center Description	DATA	PURCHASI NG	ADMITTING	CASHI ERI NG/AC	Subtotal	10 diii
	5551 551151 25551 Pt 1511	PROCESSI NG	RECEIVING AND	7.5	COUNTS	oub to tu.	
			STORES		RECEI VABLE		
		5. 02	5. 03	5. 04	5. 05	5A. 05	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	00550 DATA PROCESSING	2, 517, 968					5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	70, 903	362, 580				5. 03
5.04	00570 ADMI TTI NG	319, 973		553, 402			5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	16, 362	0	0	770, 737		5. 05
5.06	00590 OTHER ADMIN & GENERAL	279, 976	26, 963	0	O	3, 958, 556	5.06
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	O	0	6.00
7.00	00700 OPERATION OF PLANT	27, 270	95, 099	0	0	1, 681, 913	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	146, 077	8. 00
9.00	00900 HOUSEKEEPI NG	3, 636	25, 243	0	0	678, 337	9. 00
10.00	01000 DI ETARY	0	1, 363	0	0	918, 833	10.00
11.00	01100 CAFETERI A	0	0	0	0	74, 979	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 818	117	0	0	1, 064, 171	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	43, 633	0	0	0	577, 968	16.00
17.00	01700 SOCI AL SERVI CE	12, 726	0	0	0	32, 138	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	245, 434	43, 946	127, 415	33, 593	4, 579, 357	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	98, 173	,			3, 361, 643	
53.00	05300 ANESTHESI OLOGY	0	.,			39, 618	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	185, 439	1			2, 715, 380	
60.00	06000 LABORATORY	67, 267	1			2, 087, 516	1
64. 00	06400 I NTRAVENOUS THERAPY	52, 723	1		4, 576	275, 354	
65. 00	06500 RESPI RATORY THERAPY	16, 362	l .			340, 615	
65. 01	06501 SLEEP LAB	0	22, 610			344, 798	
66. 00	06600 PHYSI CAL THERAPY	90, 901	13, 085			1, 537, 718	
67.00	06700 OCCUPATI ONAL THERAPY	10, 908		10, 595		324, 879	
68.00	06800 SPEECH PATHOLOGY	3, 636	0	876	I	60, 903	
68. 01	03040 AUDI OLOGY	0	0	0	0	0	68. 01
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PAT	0	0			2, 897, 495	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	F20 040	0	-,		1, 012, 566	
73.00	07300 DRUGS CHARGED TO PATIENTS	529, 048				3, 351, 592	
76. 97	07697 CARDI AC REHABI LI TATI ON	5, 454			2, 662	373, 806	
76. 98	07700 ALLOCENEL CUSCE ACQUISITION	32, 724		2, 775		1, 143, 127	1
77. 00	O7700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	l ol	0	77. 00
90.00	09000 CLINIC	0	0	0	ol	0	90.00
91.00	09100 EMERGENCY	279, 976	_			2, 999, 756	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	217, 710	20, 730	15, 120	62,001	2, 777, 730	92.00
93. 00	04950 O/P GERIATRIC PSYCH CENTER	123, 626	1, 446	0	2, 420	594, 557	
73.00	OTHER REIMBURSABLE COST CENTERS	123, 020	1, 440		2, 420	374, 337	73.00
102.00	10200 OPLOLD TREATMENT PROGRAM	0	0	0	ol	0	102.00
102.00	SPECIAL PURPOSE COST CENTERS		0		<u> </u>		1102.00
113 00	11300 I NTEREST EXPENSE						113.00
118.00		2, 517, 968	323, 031	553, 402	770, 737	37, 173, 652	
110.00	NONREI MBURSABLE COST CENTERS	2,317,700	323,031	333, 402	770,737	37, 173, 032	1110.00
190 00	19000 GIFT FLOWER COFFEE SHOP & CAN	0	31, 499	0	ol	109, 751	190 00
	19200 PHYSICIANS PRIVATE OFFICES	0				498, 193	
	07950 TRANSPORTATION	n	23		1		194.00
	07951 FUND DEVELOPMENT	n	0			29, 632	
200.00		Ö					200.00
201.00		0	0	0	o		201.00
202.00	1 1 0	2, 517, 968	362, 580	553, 402	770, 737	37, 868, 334	
	, , , , , , , , , , , , , , , , , , , ,	•	,			•	•

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1336

Peri od: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared:

1/24/2024 11:48 am Cost Center Description OTHER ADMIN & MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG **GENERAL REPAIRS PLANT** LINEN SERVICE 9. 00 5.06 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 01160 COMMUNI CATI ONS 5.01 5.01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5 04 00570 ADMITTING 5 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.05 3, 958, 556 00590 OTHER ADMIN & GENERAL 5.06 5.06 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 196 343 1, 878, 256 7 00 0 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 17,053 2, 281 165, 411 8.00 46, 719 9.00 00900 HOUSEKEEPI NG 79, 188 804, 244 9.00 01000 DI ETARY 107, 263 0 59, 927 21 15, 390 10.00 10.00 55, 205 01100 CAFETERI A 0 11.00 8.753 0 0 11.00 13.00 01300 NURSING ADMINISTRATION 124, 229 0 16, 927 0 0 13.00 01600 MEDICAL RECORDS & LIBRARY 67, 471 0 16.00 0 27, 534 674 16.00 01700 SOCIAL SERVICE 3, 752 17.00 0 7,026 0 786 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 C C 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 ADULTS & PEDIATRICS 534, 582 397, 297 97, 663 342, 052 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 392, 431 \cap 241, 717 7.200 3, 763 50.00 53.00 05300 ANESTHESI OLOGY 4,625 C 53.00 05400 RADI OLOGY-DI AGNOSTI C 316, 988 185, 896 60,716 54.00 0 14, 742 54.00 60.00 06000 LABORATORY 243, 692 Ω 71,607 21,062 60.00 06400 I NTRAVENOUS THERAPY 32, 144 0 22, 196 10, 680 72,848 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 39, 763 0 19, 596 189 5, 223 65.00 27, 785 40, 251 65.01 06501 SLEEP LAB 0 41 0 65.01 06600 PHYSI CAL THERAPY 66.00 179, 510 C 117, 573 7,531 29, 937 66.00 67.00 06700 OCCUPATI ONAL THERAPY 37, 926 22, 196 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 68.00 7.110 0 0 03040 AUDI OLOGY 0 68.01 \cap 0 0 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 338, 248 C 38, 347 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 118, 205 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 391, 258 0 26, 827 7.976 73.00 0 07697 CARDIAC REHABILITATION 0 76.97 43, 637 34, 309 0 25, 106 76.97 76. 98 133, 446 07698 HYPERBARIC OXYGEN THERAPY 0 78, 519 3, 427 21, 175 76.98 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 0 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 91.00 09100 EMERGENCY 350, 186 0 164, 201 23, 917 89, 248 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 04950 0/P GERLATRIC PSYCH CENTER 11, 739 93 00 69, 407 0 56, 460 93.00 0 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 877, 461 0 1, 720, 145 165, 411 707, 695 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 8, 537 190. 00 Ω 17 771 12 812 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 58, 158 C 129, 550 0 88, 012 192. 00 194. 00 07950 TRANSPORTATI ON 0 0 194.00 6,666 194. 01 07951 FUND DEVELOPMENT 3, 459 0 10, 790 ol 0 194. 01 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201.00 3, 958, 556 202.00 TOTAL (sum lines 118 through 201) 1, 878, 256 165, 411 804, 244 202. 00

Provider CCN: 14-1336

						1/24/2024 11:	<u>48 am</u>
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	MEDI CAL	SOCI AL	
				ADMI NI STRATI O	RECORDS &	SERVI CE	
				N	LI BRARY		
		10. 00	11. 00	13.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04	00570 ADMITTING						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06	00590 OTHER ADMIN & GENERAL						5.06
6. 00	00600 MAINTENANCE & REPAIRS						6.00
	1 1						1
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG	4 404 404					9.00
10.00	01000 DI ETARY	1, 101, 434					10.00
11. 00	01100 CAFETERI A	516, 811	655, 748				11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	36, 657	1, 241, 984			13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	673, 647		16. 00
17.00	01700 SOCI AL SERVI CE	0	0	0	0	43, 702	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	507, 303	169, 331	625, 061	668, 923	43, 702	30.00
	ANCILLARY SERVICE COST CENTERS			,			1
50.00	05000 OPERATING ROOM	0	76, 606	134, 313	1, 181	0	50.00
53.00	05300 ANESTHESI OLOGY	ol	. 0	0	ol	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	59, 064	23, 708	0	0	54.00
60.00	06000 LABORATORY	o	59, 310		ol	0	
64. 00	06400 I NTRAVENOUS THERAPY	27, 347	6, 388	661	0	0	1
65. 00	06500 RESPIRATORY THERAPY	27,017	11, 891	0		0	1
65. 01	06501 SLEEP LAB	o	12, 432	l ĭ	1, 417	0	1
66. 00	06600 PHYSI CAL THERAPY	0	62, 897	42, 333	1, 417	0	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	11, 547	0	0	0	1
68. 00	06800 SPEECH PATHOLOGY	0		0	0	0	1
	1 1	0	3, 194 0	0	0		
68. 01	03040 AUDI OLOGY	U O	0	0	0	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PAT	0	0	000 001	0	0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	200, 831	0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	22, 161	56, 488	0	0	1
	07697 CARDI AC REHABI LI TATI ON	0	12, 137	0	0	0	1
	07698 HYPERBARI C OXYGEN THERAPY	0	17, 591	0	236	0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						4
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91. 00	09100 EMERGENCY	49, 973	68, 449	85, 598	1, 890	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	0	13, 071	69, 345	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						1
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS	- 1			-1		
113 00	11300 I NTEREST EXPENSE						113. 00
118.00		1, 101, 434	642, 726	1, 241, 255	673, 647	43 702	118.00
110.00	NONREI MBURSABLE COST CENTERS	1, 101, 101	012,720	1,211,200	070,017	10, 702	1110.00
100 00	19000 GIFT FLOWER COFFEE SHOP & CAN	٥	0	0	n	0	190. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	8, 010		0		192.00
	07950 TRANSPORTATION		5, 012				194.00
			5,012	1			
	07951 FUND DEVELOPMENT	٩	0	ا	٩	U	194. 01
200.00			^			^	200.00
201.00		1 101 101	0 4 F F 7 4 0		470 (47		201.00
202.00	TOTAL (sum lines 118 through 201)	1, 101, 434	655, 748	1, 241, 984	673, 647	43, 702	202. 00

Health Financial Systems	ST. JOSEPHS HOSPITAL-HIGHLAND IL	In Lieu of Form CMS-2552-10
COST ALLOCATION CENEDAL SERVICE COSTS	Dravi dan CCN: 14 1224	Daniad Wantahaat D

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1336 Period: From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 1/24/2024 11:48 am Cost Center Description NONPHYSI CI AN Total Subtotal Intern & **ANESTHETISTS** Resi dents Cost & Post Stepdown Adjustments 19. 00 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 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 01160 COMMUNI CATI ONS 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00590 OTHER ADMIN & GENERAL 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 00900 HOUSEKEEPING 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 7, 965, 271 0 7, 965, 271 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 4, 218, 854 0 4, 218, 854 50.00 0 0 53.00 05300 ANESTHESI OLOGY 44, 243 44, 243 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 376, 494 0 3, 376, 494 54.00 60.00 06000 LABORATORY 000000000000 2, 486, 082 0 2, 486, 082 60.00 06400 I NTRAVENOUS THERAPY 0 64 00 447, 618 447, 618 64 00 0 65.00 06500 RESPIRATORY THERAPY 417, 277 417, 277 65.00 06501 SLEEP LAB 469, 079 469, 079 65.01 65.01 06600 PHYSI CAL THERAPY 66.00 1, 935, 166 1, 935, 166 66.00 06700 OCCUPATI ONAL THERAPY 0 67 00 396, 548 396, 548 67.00 0 68.00 06800 SPEECH PATHOLOGY 71, 207 71, 207 68.00 03040 AUDI OLOGY 68.01 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 3, 274, 090 0 3, 274, 090 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1, 331, 602 72.00 72 00 1, 331, 602 0 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 856, 302 3, 856, 302 73.00 488, 995 76 97 07697 CARDIAC REHABILITATION 0 0 488, 995 76.97 0 07698 HYPERBARIC OXYGEN THERAPY 0 1, 397, 521 76.98 76.98 1, 397, 521 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0 0 0 91.00 09100 EMERGENCY 0 3, 833, 218 3, 833, 218 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 0 92.00 93.00 04950 0/P GERIATRIC PSYCH CENTER 0 814, 579 0 814, 579 93.00 OTHER REIMBURSABLE COST CENTERS 0 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 118.00 0 36, 824, 146 36, 824, 146 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CAN 148, 871 148.871 190.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 782, 652 0 782, 652 192.00 0 194. 00 07950 TRANSPORTATION 68, 784 0 68. 784 194 00 0 194. 01 07951 FUND DEVELOPMENT 43, 881 43,881 194.01 0 200.00 Cross Foot Adjustments 0 0 200.00 0 201.00 0 201.00 Negative Cost Centers 0 202.00 TOTAL (sum lines 118 through 201) 37, 868, 334 37, 868, 334 202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Period: Worksheet B From 07/01/2022 Part II Provi der CCN: 14-1336

			To	06/30/2023	Date/Time Pre 1/24/2024 11:	pared:
		CAPI TAL REI	_ATED COSTS		1/24/2024 11:	48 am
Cook Cooker Doors' at an	D:+1	DIDC & FLVT	MVDLE FOULD	Culatatal	EMDL OVEE	
Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs 0	1. 00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT		38. 903	1, 622	40, 525	40, 525	2.00 4.00
5. 01 01160 COMMUNI CATI ONS	0	5, 576	, , ,	40, 323	40, 525	5. 01
5. 02 00550 DATA PROCESSING	460, 352	99, 044	· ·	969, 351	0	5. 02
5.03 OO560 PURCHASING RECEIVING AND STORES	0	179, 733		184, 211	412	5. 03
5. 04 00570 ADMITTING 5. 05 00580 CASHIERING/ACCOUNTS RECEIVABLE	0 13, 614	57, 071 85, 199	· ·	58, 424 99, 201	0	5. 04 5. 05
5. 06 00590 OTHER ADMI N & GENERAL	29, 479	502, 613		561, 824	1, 471	5. 06
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7. 00 00700 OPERATION OF PLANT	0	318, 119		379, 029	782	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	8, 319	6, 265 128, 300		14, 584 129, 784	0 1, 123	8. 00 9. 00
10. 00 01000 DI ETARY	0	164, 572		169, 487	1, 011	10.00
11. 00 01100 CAFETERI A	0	151, 605	0	151, 605	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	46, 484		146, 294	2, 608	13.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	0	75, 614 19, 295		76, 255 19, 295	0	16. 00 17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0		0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	0	1, 091, 054	89, 396	1, 180, 450	8, 248	30.00
50. 00 05000 OPERATING ROOM	0	663, 802	860, 427	1, 524, 229	4, 170	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		1, 308	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	510, 506		557, 421	3, 217	54.00
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	0	196, 647 60, 955		234, 172 64, 428	2, 691 393	60. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	0	53, 813		75, 174	488	65.00
65. 01 06501 SLEEP LAB	0	76, 303	16, 063	92, 366	565	65. 01
66. 00 06600 PHYSI CAL THERAPY	0	322, 880		338, 928	3, 188	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	60, 955 0		62, 373 465	647 161	67. 00 68. 00
68. 01 03040 AUDI OLOGY	0	0		0	0	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	105, 309	6, 078	111, 387	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	72 (72	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDI AC REHABILITATION	0	73, 672 94, 220		76, 068 105, 790	1, 931 728	73. 00 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	215, 629		219, 887	946	76. 98
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
90. 00 O9000 CLINIC	0	0	l ol	ol	0	90.00
91. 00 09100 EMERGENCY	0	450, 929		541, 801		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT			·	0		92.00
93. 00 04950 O/P GERIATRIC PSYCH CENTER	0	155, 050	41, 182	196, 232	730	93. 00
OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 0I D TREATMENT PROGRAM	0	0	0	o	0	102. 00
SPECIAL PURPOSE COST CENTERS			<u> </u>	<u> </u>		102.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	511, 764	6, 010, 117	1, 900, 614	8, 422, 495	40, 150	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	48, 802	4, 016	52, 818	0	190. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES		355, 769		364, 873		192. 00
194. 00 07950 TRANSPORTATI ON	0	0	2, 504	2, 504		194. 00
194. 01 07951 FUND DEVELOPMENT	0	29, 632	0	29, 632		194. 01
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0	o	0		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	511, 764	_	_	8, 872, 322	40, 525	
	· ·		·	•		

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1336

				То	06/30/2023	Date/Time Pre 1/24/2024 11:	
	Cost Center Description	COMMUNI CATI ON	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	40 alli
	oost center bescription	S	PROCESSI NG	RECEIVING AND	7,0,111110	COUNTS	
				STORES		RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS	40, 147	070 045				5. 01
	00550 DATA PROCESSING	4, 564	973, 915	1			5.02
	OO560 PURCHASING RECEIVING AND STORES OO570 ADMITTING	931 1, 863	27, 424		105 541		5. 03 5. 04
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	466	123, 761 6, 329		185, 541 0	105, 996	5.04
5. 06	00590 OTHER ADMIN & GENERAL	7, 734	108, 291	1	0	103, 440	5.06
	00600 MAI NTENANCE & REPAI RS	7,734	100, 271		0	Ö	6.00
	00700 OPERATION OF PLANT	652	10, 548		0	Ö	7. 00
	00800 LAUNDRY & LINEN SERVICE	0	0	0	Ö	0	8.00
9. 00	00900 HOUSEKEEPI NG	93	1, 406	14, 827	0	0	9.00
10.00	01000 DI ETARY	186	0	801	0	0	10.00
11.00	01100 CAFETERI A	o	0	O	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	93	703	69	0	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 304	16, 877	0	0	0	16.00
	01700 SOCIAL SERVICE	93	4, 922	0	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		0.4.000	05.04	40 740		
30. 00	03000 ADULTS & PEDIATRICS	6, 055	94, 930	25, 814	42, 719	4, 617	30.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	3, 446	37, 972	12, 350	7, 853	7, 797	50.00
	05300 ANESTHESI OLOGY	3, 440	37, 472	1	3, 136		53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 770	71, 725		25, 077	30, 987	54.00
60.00	06000 LABORATORY	2, 329	26, 018	1	38, 992	19, 633	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	20, 392		912	629	64.00
65.00	06500 RESPI RATORY THERAPY	o	6, 329	95	17, 355	3, 508	65.00
65. 01	06501 SLEEP LAB	745	0	13, 281	0	1, 510	65. 01
	06600 PHYSI CAL THERAPY	1, 677	35, 159	1	7, 682	3, 403	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	93	4, 219	1	3, 552	616	67.00
	06800 SPEECH PATHOLOGY	0	1, 406		294	126	68.00
68. 01	03040 AUDI OLOGY	0	0	-	0	0	68. 01
	07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6, 984 2, 263	1, 968 2, 087	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	838	204, 629		22, 723	12, 254	73.00
	07697 CARDI AC REHABI LI TATI ON	931	2, 110		22, 723		1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	931	12, 657		930		76. 98
	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
	09100 EMERGENCY	1, 863	108, 291	12, 299	5, 069	11, 269	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
93. 00	04950 0/P GERIATRIC PSYCH CENTER	745	47, 817	849	0	333	93.00
100.00	OTHER REIMBURSABLE COST CENTERS						100.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	O	0	0	0	102. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
118. 00	l I	39, 402	973, 915	189, 747	185, 541		1
	NONREI MBURSABLE COST CENTERS	07, 102	770,710	107,717	100, 011	100, 770	1110.00
	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	18, 502	0	0	190. 00
	19200 PHYSICIANS PRIVATE OFFICES	745	0	1	0	0	192.00
	07950 TRANSPORTATI ON	0	0	14	0		194. 00
	07951 FUND DEVELOPMENT	0	0	0	0		194. 01
200.00							200.00
201.00		0	0	0	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	40, 147	973, 915	212, 978	185, 541	105, 996	J202.00

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1336

COST Center Description					1	o 06/30/2023	Date/Time Pre 1/24/2024 11:	
SENERAL SERVICE COST CRUTERS		Cost Center Description	OTHER ADMIN &	MAINTENANCE &	OPERATION OF	LAUNDRY &		40 alli
SERIERAL SERVICE COST CENTERS		oost denter beschiptron					11000EREEL THO	
BINEMAL SERVICE COST CENTERS							9. 00	
1.00 20.00		GENERAL SERVICE COST CENTERS		<u> </u>				
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
5.01 011-00 COMMINICATIONS	2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
5. 02 00550 DATA PROCESSI NG 5. 03 00550 PRICHASIAN RECEIVABLE 5. 04 00550 CASHEL RING-ACCOUNTS RECEIVABLE 5. 06 00550 CONTROL CASH LERING-ACCOUNTS RECEIVABLE 6. 00 00550 CONTROL CASH LERING-ACCOUNTS RECEIVABLE 7. 00 00 00550 CONTR	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
D. 03 00660 PURCHASI NG RECELVING AND STORES	5. 01	01160 COMMUNI CATI ONS						5. 01
5.04 00570 ARMITTING	5.02	00550 DATA PROCESSING						5. 02
5.05 OBSRQ CASHIER INC/ACCOUNTS RECEI VABLE 5.06 COSQ OTHER ADMIN IS GENERAL 695, 158 6.00 0000 OTHER ADMIN IS GENERAL 695, 158 6.00 6.0	5.03	00560 PURCHASING RECEIVING AND STORES						5. 03
5.06 0.0590 OTHER ADMIN N. GENERAL 695, 158 0 0 0 0 0 0 0 0 0	5.04	00570 ADMITTING						5. 04
6.00 00000 MAINTENNINCE & REPAIRS 0 0 481, 351 7.00 7.00 00700 OPERATION OF PLANT 34,479 0 481, 351 7.00 7.00 00700 OPERATION OF PLANT 34,479 0 481, 351 7.00 173, 112 9.00 10.00 10000 HUSEKEEPINE 13,906 0 11,973 0 173, 112 9.00 10.00 10000 HUSEKEEPINE 18,836 0 15,358 2 3,313 10.00 10.00 10100 CAFETERIA 1,537 0 14,148 0 0 11.00 1100 CAFETERIA 15,537 0 14,148 0 0 11.00 1100 CAFETERIA 15,537 0 14,148 0 0 0 10.00 1000 MEDICAL RECORDS & LIBRARY 11,848 0 7,056 0 145 16.00 10.00 1000 MEDICAL SERVICE 659 0 1,801 0 169 17.00 10700 MEDICAL SERVICE 659 0 1,801 0 169 17.00 10700 MONPHYSICIAN MAESTHETISTS 0 0 0 0 0 0 0 0 0	5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
2.00 007000 OPERATI LON OF PLANT 34, 479 0 481, 351 8, 164 8. 00 00800 LANIDRY & LINEN SERVICE 2,995 0 585 18, 164 8. 00 00800 LANIDRY & LINEN SERVICE 2,995 0 585 18, 164 8. 00 00900 HOUSEKEEPI NG 13, 906 0 11, 973 0 173, 112 9, 00 1.00 10000 DI ETARY 18, 836 0 15, 558 2 3, 313 10, 00 11. 00 10000 DI ETARY 18, 836 0 15, 558 2 3, 313 10, 00 11. 00 10100 CAFETERI A 1, 537 0 14, 148 0 0 11. 00 160 00 160 00 160 00 160 00 160 00 160 00 0	5.06	00590 OTHER ADMIN & GENERAL	695, 158					5. 06
8.00 00800 LAUNDRY & LINEN SERVICE 2,995 0 585 18,164 8,00 10,000 10,000 10,000 10,000 17,000 173,12 9,00 10,000 10,000 10,000 10,000 12,000 13,000 10,000	6.00	00600 MAINTENANCE & REPAIRS	0	0				6.00
0.00 000000 00JEKEREPI NG	7.00	00700 OPERATION OF PLANT	34, 479	0	481, 351			7. 00
10.00 010000 015ARY 18,836	8.00	00800 LAUNDRY & LINEN SERVICE	2, 995	0	585	18, 164		8. 00
11.00 01100 CAPETERIA 1,537	9.00	00900 HOUSEKEEPI NG	13, 906	0	11, 973	0	173, 112	9. 00
13.00 01300 NURSING ADMINISTRATION 21,816 0 4,338 0 0 13.00	10.00	01000 DI ETARY	18, 836	0	15, 358	2	3, 313	10.00
16. 00 01-000 MEDICAL RECORDS & LIBRARY 11, 848 0 7, 056 0 145 16. 00 170 01-90	11. 00	01100 CAFETERI A	1, 537	0	14, 148	0	0	11.00
17. 00 01700 SOCIAL SERVICE 659 0 1,801 0 169 17. 00 19	13.00	1 1	21, 816	0	4, 338	0	0	13. 00
19, 00 01900 00190N 019 0 0 0 0 0 0 0 0 0	16.00	01600 MEDI CAL RECORDS & LI BRARY	11, 848	0	7, 056	0	145	16.00
IMPATI ENT ROUTI NE SERVICE COST CENTERS 93,883 0 101,817 10,724 73,625 30.00 200,000 20	17.00		659	0	1, 801	-	169	17. 00
30.00	19.00		0	0	0	0	0	19. 00
ANCILLARY SERVICE COST CENTERS								
SOLO 050000 050000 050000 050000 050000 050000 050000 05000000 0500000 0500000000	30.00		93, 883	0	101, 817	10, 724	73, 625	30.00
S3.00 05300 ARSTHESI OLOGY 812 0								
54.00 05400 RADIOLOCY-DIAGNOSTIC 55, 665 0 47, 641 1, 619 13, 069 54.00								1
60.00 06000 LABORATORY		1					_	•
64.00 06400 INTRAVENOUS THERAPY 5, 645 0 5, 688 1, 173 15, 680 64.00 65.00 06500 RESPIRATORY THERAPY 6, 983 0 5, 022 21 1, 124 65.00 65.01 06501 SLEEP LAB 7, 068 0 7, 121 5 0 65.01 66.00 06600 PHYSI CAL THERAPY 31, 523 0 30, 131 827 6, 444 66.00 67.00 06700 OCCUPATIONAL THERAPY 6, 660 0 5, 688 0 0 0 0 68.01 03040 AUDIOLOGY 1, 249 0 0 0 0 0 0 68.01 03040 AUDIOLOGY 1, 249 0 0 0 0 0 0 67.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 59, 399 0 9, 827 0 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 20, 758 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 68, 708 0 6, 875 0 1, 717 73.00 76.97 07697 CARDIAC REHABILITATION 7, 663 0 8, 793 0 5, 404 76, 97 76.98 07698 HYPERBARIC DAYGEN THERAPY 23, 434 0 20, 123 376 4, 558 76. 98 76.98 07698 HYPERBARIC CHARGED TO FAILENTS 0 0 0 0 0 77.00 07700 ALLOGENEIC HISC ACQUISITION 0 0 0 0 77.00 07700 ALLOGENEIC HISC ACQUISITION 0 0 0 0 79.00 09000 09000 CLINIC COST CENTERS 79.00 09000 09000 0 0 0 0 79.00 09000 0 0 0 79.00 09000 0 0 0 79.00 09000 0 0 0 79.00 09000 0 0 0 79.00 09000 0 0 0 79.00 09000 0 0 79.00 0 0 0 79.00		1 1		0		1, 619		1
65. 01 06500 RESPIRATORY THERAPY		1 1		0		_		1
65. 01 06501 SLEEP LAB				0				1
66. 00 06600 PHYSI CAL THERAPY 31,523 0 30,131 827 6,444 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 6,660 0 5,688 0 0 0 67. 00 68. 01 03040 AUDI OLOGY 0 0 0 0 0 0 68. 01 69. 01 03040 AUDI OLOGY 0 0 0 0 0 0 0 68. 01 69. 01 07100 MEDI CAL SUPPLIES CHARGED TO PAT 59,399 0 9,827 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 20,758 0 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 68,708 0 6,875 0 1,717 73. 00 74. 07 07 07 07 07 07 07 07		1 1		0				1
67. 00 06700 OCCUPATI ONAL THERAPY 6, 660 0 5, 688 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 1, 249 0 0 0 0 0 68. 01 30340 AUDI OLOGY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 59, 399 0 9, 827 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 20, 758 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 68, 708 0 6, 875 0 1, 717 73. 00 07300 DRUGS CHARGED TO PATI ENTS 68, 708 0 6, 875 0 1, 717 73. 00 07300 DRUGS CHARGED TO PATI ENTS 68, 708 0 6, 875 0 1, 717 74. 97 07697 CARDI AC REHABI LITATI ON 7, 663 0 8, 793 0 5, 404 76. 98 07698 HYPERBARI C OXYGEN THERAPY 23, 434 0 20, 123 376 4, 558 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TION 0 0 0 0 0 0 77. 00 OUTPATI ENT SERVI CE COST CENTERS 79. 00 09000 CLI NI C 0 0 0 0 0 0 79. 00 09000 EMERGENCY 61, 495 0 42, 081 2, 626 19, 210 79. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT 92. 00 79. 00 09200 095ERVATI ON BEDS (NON-DI STI NCT 92. 00 70 OTHER REI MBURSABLE COST CENTERS 70 010200 OPI OD I TREATMENT PROGRAM 0 0 0 0 0 71. 00 010200 OPI OD I TREATMENT PROGRAM 0 0 0 0 71. 00 010200 OPI OD I TREATMENT PROGRAM 0 0 0 0 71. 00 010200 OPI OD I TREATMENT PROGRAM 0 0 0 0 71. 00 010200 OPI OD I TREATMENT PROGRAM 0 0 0 0 71. 00 010200 OPI OD I TREATMENT PROGRAM 0 0 0 0 71. 00 010200 OPI OD I TREATMENT PROGRAM 0 0 0 0 71. 00 010200 OPI OD I TREATMENT PROGRAM 0 0 0 0 71. 00 010200 OPI OD I TREATMENT PROGRAM 0 0 0 0 71. 00 010200 OPI OD I TREATMENT PROGRAM 0 0 0 0 71. 00 010200 OPI OD I TREATMENT PROGRAM 0 0 0 0 71. 00 010200 OPI OD I TREATMENT PROGRAM 0 0 0 0 71. 00 010200 OPI OD I TREATMENT PROGRAM 0 0 0 0 0 71. 00 010200 OPI OD I TR								1
68.00 06800 SPEECH PATHOLOGY 1, 249 0 0 0 0 0 68.00 68.01 03040 AUDI OLOGY 0 0 0 0 0 0 0 0 68.01 03040 AUDI OLOGY 0 0 0 0 0 0 0 68.01 03040 AUDI OLOGY 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 59, 399 0 9, 827 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 20, 758 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 68, 708 0 6, 875 0 1,717 73.00 76.97 07697 CARDI AC REHABI LI TATI ON 7, 663 0 8, 793 0 5, 404 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 23, 434 0 20, 123 376 4,558 76.98 77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 77.00 07700 DEMERGENCY 61, 495 0 42, 081 2, 626 19, 210 91.00 79.00 09000 CLI NI C 0 0 0 0 0 0 0 79.00 09000 DEMERGENCY 61, 495 0 42, 081 2, 626 19, 210 91.00 79.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT 20, 00 0 0 0 0 0 70.00 0700 DEMERGENCY 50, 200 0 0 0 0 0 70.00 09100 OFFICIAL PURPOSE COST CENTERS 10, 200 0 70.00 09100 OFFICIAL PURPOSE COST CENTERS 113.00 13000 INTEREST EXPENSE 113.00 1000 0 0 0 0 0 0 0				1				1
68. 01 03040 AUDI OLOGY 0 0 0 0 0 0 68. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 59, 399 0 9,827 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 20,758 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 68,708 0 6,875 0 1,717 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 7,663 0 8,793 0 5,404 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 23,434 0 20,123 376 4,558 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 79. 00 09000 CLI NI C 0 0 0 0 0 0 79. 00 09000 DINCE MERGENCY 61,495 0 42,081 2,626 19,210 91,00 79. 00 09500 OBSERVATI ON BEDS (NON-DISTINCT 92.00 79. 00 09500 OBSERVATI ON BEDS (NON-DISTINCT 92.00 79. 00 009500 OPI GERI ATRIC PSYCH CENTER 12,188 0 14,469 0 2,527 70 01200 OPI OID TREATMENT PROGRAM 0 0 0 0 0 70 01200 OPI OID TREATMENT PROGRAM 0 0 0 0 0 70 000 ONDREI MEBURSABLE COST CENTERS 70 113. 00 11300 INTEREST EXPENSE 113. 00 71 1300 SPECI AL PURPOSE COST CENTERS 113. 00 71 1300 ONDREI MEBURSABLE COST CENTERS 113. 00 71 1300 ONDREI MEBURSABLE COST CENTERS 10, 213 0 33, 200 18, 838 90.00 71 1900 OT950 TREATMENT FOR COFFEE SHOP & CAN 2, 250 0 4, 554 0 1, 838 90.00 71 1900 OT950 TREANSPORTATI ON 1, 171 0 0 0 0 0 71 1900 ONDREI MEBURSABLE COST CENTERS 10, 213 0 0 0 0 71 1900 ONDREI MEBURSABLE COST CENTERS 10, 213 0 0 0 0 71 1900 ONDREI MEBURSABLE COST CENTERS 10, 213 0 0 0 0 71 1900 ONDREI MEBURSABLE COST CENTERS 10, 213 0 0 0 0 71 1900 ONDREI MEBURSABLE COST CENTERS 10, 213 0 0 0 0 71 1900 ONDREI MEBURSABLE COST CENTERS 10, 213 0 0 0 0 71 1900 ONDREI MEBURSABLE COST CENTERS 10, 213 0 0 0 0								1
71. 00				0	1	_	-	
72. 00		1 1	١	0	1	_	-	1
73. 00 07300 DRUGS CHARGED TO PATIENTS 68, 708 0 6, 875 0 1, 717 73. 00 76. 97 07697 O7697 CARDIA CR EHABI LITATION 7, 663 0 8, 793 0 5, 404 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 23, 434 0 20, 123 376 4, 558 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 90. 00 09000 CLINIC 0 0 0 0 0 0 91. 00 09100 DEBERGENCY 01, 469 0 2, 527 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 92. 00 93. 00 04950 O/P GERIATRIC PSYCH CENTER 12, 188 0 14, 469 0 2, 527 102. 00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 113. 00 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 680, 917 0 440, 832 18, 164 152, 329 118. 00 109. 00 19000 GIFT FLOWER COST CENTERS 10, 213 0 33, 200 0 18, 945 192. 00 194. 00 07950 TRANSPORTATION 1, 171 0 0 0 0 194. 00 194. 01 07951 FUND DEVELOPMENT 607 0 2, 765 0 0 194. 00 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00 00 00 0 0 0 0 0 0		1 1		0	1	_	-	1
76. 97 07697 CARDI AC REHABILITATION 7, 663 0 8, 793 0 5, 404 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 23, 434 0 20, 123 376 4, 558 76. 98 77. 00 0 0 0 0 0 0 0 0 0				0	1	_	-	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY 23, 434 0 20, 123 376 4, 558 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 0 0 77. 00 0 0 0 0 0 0 0 0 0				0				1
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION O O O O O O O O O				0				1
OUTPATIENT SERVICE COST CENTERS O		1 1						1
90. 00	77.00		0		0	U	0	17.00
91. 00	00 00			1 0	1 0	0	0	00.00
92. 00			_				-	
93. 00			01, 493	0	42, 081	2, 020	19, 210	1
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O 102.00			12 100	0	14 460	0	2 527	1
102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O	93.00		12, 100	0	14, 409	U	2, 327	93.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 11300 SUBTOTALS (SUM OF LINES 1 through 117) 680,917 0 440,832 18,164 152,329 118.00 118.00 119.	102.00					0		102.00
113. 00	102.00				0	U		102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 680, 917 0 440, 832 18, 164 152, 329 118.00	112 00							112 00
NONREL MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 2, 250 0 4, 554 0 1, 838 190. 00 192. 00 19200 PHYSI CI ANS PRI VATE OFFICES 10, 213 0 33, 200 0 18, 945 192. 00 194. 00 07950 TRANSPORTATI ON 1, 171 0 0 0 0 194. 00			690 017	0	140 022	10 16/	152 220	
190. 00	110.00		000, 717		440, 632	10, 104	152, 329	1118.00
192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 10, 213 0 33, 200 0 18, 945 192. 00 194. 00 07950 TRANSPORTATI ON 1, 171 0 0 0 0 0 194. 00 194. 00 194. 01 07951 FUND DEVELOPMENT 607 0 2, 765 0 0 194. 01 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	100 00		2 250		4 554	0	1 020	100 00
194. 00 07950 TRANSPORTATION 1, 171 0 0 0 194. 00 194. 01 07951 FUND DEVELOPMENT 607 0 2, 765 0 0 194. 01 200. 00 Cross Foot Adjustments 200. 00 Negative Cost Centers 0 0 0 0 0 0 0								
194. 01 07951 FUND DEVELOPMENT 607 0 2, 765 0 0 194. 01 200. 00 201. 00 Cross Foot Adjustments 200. 00 0 0 0 0 0 0 0								
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0<					_			
201.00 Negative Cost Centers 0 0 0 0 201.00			007	١	2, 700			
			_		_	_	_	
202.00 10 m. (30 11103 110 till 00g 201) 073, 130 0 401, 331 10, 104 1/3, 112 202.00		1 1 0	١	ł control de la control de				
	202.00	1. The (Sam Fines Fie through 201)	075, 150	, ,	1 401, 331	10, 104	175,112	1-02.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 14-1336

				To	06/30/2023	Date/Time Pre 1/24/2024 11:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	MEDI CAL	SOCI AL	40 aiii
	·			ADMI NI STRATI O	RECORDS &	SERVI CE	
		10.00	11 00	N 12.00	LI BRARY	17.00	
	GENERAL SERVICE COST CENTERS	10. 00	11. 00	13. 00	16. 00	17. 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	01160 COMMUNI CATI ONS						5. 01
5. 02 5. 03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES						5. 02 5. 03
5. 04	00570 ADMITTING						5.03
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMIN & GENERAL						5.06
6. 00	00600 MAINTENANCE & REPAIRS						6.00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY	208, 994					10.00
11. 00	01100 CAFETERI A	98, 064	237, 591				11.00
13.00	01300 NURSING ADMINISTRATION	o	13, 282	189, 203			13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0		113, 485		16. 00
17. 00	01700 SOCIAL SERVICE	0	0		0	26, 939	17.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	96, 259	61, 351	95, 222	112, 689	26, 939	30.00
00.00	ANCILLARY SERVICE COST CENTERS	70,207	0.7001	707222	1.2,007	20, 707	00.00
50.00	05000 OPERATING ROOM	0	27, 756		199	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0	_	0	0	53.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	21, 400		0	0	54. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY	5, 189	21, 489 2, 314		0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0, 10,	4, 309		o	0	65.00
65. 01	06501 SLEEP LAB	o	4, 504		239	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	0	22, 789		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	4, 184		0	0	67.00
68. 00 68. 01	06800 SPEECH PATHOLOGY 03040 AUDI OLOGY	0	1, 157 0	0	0	0	68. 00 68. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	ő	0		Ö	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	8, 029		0	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	4, 398		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	6, 374		40	0	76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	O	0	O	ol	0	90.00
91. 00	09100 EMERGENCY	9, 482	24, 801	13, 040	318	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
93. 00	04950 O/P GERIATRIC PSYCH CENTER	0	4, 736	10, 564	0	0	93. 00
102.00	OTHER REIMBURSABLE COST CENTERS	ما	0		ol	0	100 00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	9 /	208, 994	232, 873	189, 092	113, 485	26, 939	118. 00
100.00	NONREI MBURSABLE COST CENTERS	al			ما		100.00
	19000 GIFT FLOWER COFFEE SHOP & CAN 19200 PHYSICIANS PRIVATE OFFICES	0	0 2, 902		0		190. 00 192. 00
	07950 TRANSPORTATION	0	2, 902 1, 816		0		194. 00
	07951 FUND DEVELOPMENT	ő	0		o		194. 01
200.00	Cross Foot Adjustments						200. 00
201.00		0	27, 763		0		201.00
202.00	TOTAL (sum lines 118 through 201)	208, 994	265, 354	189, 203	113, 485	26, 939	202.00

Health Financial Systems	ST. JOSEPHS HOSPITAL-HIGHLAND IL	In Lieu of Form CMS-2552-10
ALLOCATION OF CARLTAL DELATED COSTS	Drovi don CCN, 14 1224	Doni od. Warkahaat D

Health Financial Systems S	T. JOSEPHS HOSPI	TAL-HI GHLAND I	L	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	1	Period: From 07/01/2022 Fo 06/30/2023	
Cost Center Description	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	19. 00	24. 00	25. 00	26.00	
GENERAL SERVICE COST CENTERS	1				
1.00 00100 CAP REL COSTS-BLDG & FLXT					1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 O1160 COMMUNI CATI ONS					4. 00 5. 01
5. 02 00550 DATA PROCESSING					5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES					5.03
5. 04 00570 ADMI TTI NG					5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 05
5. 06 00590 OTHER ADMIN & GENERAL					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 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13.00 O1300 NURSING ADMINISTRATION					13. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16.00
17. 00 01700 SOCI AL SERVI CE					17.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0				19. 00
I NPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	1	2 025 242	,	2, 035, 342	30.00
30. 00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS		2, 035, 342	<u> </u>	2, 035, 342	30.00
50. 00 05000 OPERATING ROOM		1, 778, 694	ıl (1, 778, 694	50.00
53. 00 05300 ANESTHESI OLOGY		9, 918	1	9, 918	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		837, 147	1	837, 147	54.00
60. 00 06000 LABORATORY		422, 845		422, 845	60.00
64.00 06400 INTRAVENOUS THERAPY		124, 860		124, 860	64.00
65. 00 06500 RESPIRATORY THERAPY		120, 408	3	120, 408	65.00
65. 01 06501 SLEEP LAB		133, 856	1	133, 856	65. 01
66. 00 06600 PHYSI CAL THERAPY		489, 437	1	489, 437	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		88, 032	1	88, 032	67. 00
68. 00 06800 SPEECH PATHOLOGY		4, 858		4, 858	68.00
68. 01 03040 AUDI OLOGY		100 5/5	1	0	68. 01
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PAT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		189, 565 55, 702	1	189, 565 55, 702	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		412, 745	1	412, 745	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		138, 336	1	138, 336	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		298, 789	1	298, 789	76. 98
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0		0	77. 00
OUTPATIENT SERVICE COST CENTERS			•	-,	
90. 00 09000 CLI NI C		0) (0	90.00
91. 00 09100 EMERGENCY		858, 285	5	858, 285	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT					92.00
93.00 04950 0/P GERIATRIC PSYCH CENTER		291, 190) (291, 190	93.00
OTHER REIMBURSABLE COST CENTERS					
102. 00 10200 OPI OI D TREATMENT PROGRAM		0) (0	102.00
SPECIAL PURPOSE COST CENTERS	1				112 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117		9 200 000		8, 290, 009	113. 00 118. 00
NONREI MBURSABLE COST CENTERS) 0	8, 290, 009	' '	0, 290, 009	118.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN		79, 962) (79, 962	190. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	1	435, 965	1	435, 965	192.00
194. 00 07950 TRANSPORTATION	1	5, 619	1	5, 619	194. 00
194. 01 07951 FUND DEVELOPMENT	1	33, 004	1	33, 004	194. 01
200.00 Cross Foot Adjustments	0	0		0	200.00
201.00 Negative Cost Centers	0	27, 763	8	27, 763	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	8, 872, 322	2 (8, 872, 322	202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1336 Peri od: Worksheet B-1 From 07/01/2022 06/30/2023 Date/Time Prepared: 1/24/2024 11:48 am CAPITAL RELATED COSTS COMMUNI CATI ON BLDG & FIXT MVBLE EQUIP **EMPLOYEE** DATA Cost Center Description (SQUARE FEET) (DOLLAR **BENEFITS PROCESSING** (TELEPHONES) DEPARTMENT (WORK ORDERS) VALUE) (GROSS SALARIES) 1. 00 2.00 4.00 5. 01 5. 02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 102.868 1 00 00200 CAP REL COSTS-MVBLE EQUIP 1, 619, 791 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 371 4.00 621 12, 134, 175 4.00 01160 COMMUNICATIONS 29, 223 5.01 89 431 5.01 5.02 00550 DATA PROCESSING 1,581 346, 534 C 49 1, 385 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 2,869 3, 785 123, 226 10 39 5.03 1, 144 00570 ADMITTING 911 5 04 20 176 5 04 0 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 1, 360 328 5.05 5.06 00590 OTHER ADMIN & GENERAL 8,023 25, 132 440, 420 83 154 5.06 6.00 00600 MAINTENANCE & REPAIRS 0 0 6.00 C 00700 OPERATION OF PLANT 7 5, 078 15 7 00 51, 487 234,079 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 100 0 0 8.00 00900 HOUSEKEEPI NG 2,048 1, 254 2 9.00 9.00 336, 303 01000 DI ETARY 4, 155 2 0 10.00 10.00 2.627 302, 687 0 11.00 11.00 01100 CAFETERI A 2, 420 0 0 13.00 01300 NURSING ADMINISTRATION 742 84, 369 780, 828 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 207 542 24 16.00 0 14 01700 SOCIAL SERVICE 7 O 17 00 17 00 308 Γ 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 17, 416 30.00 03000 ADULTS & PEDIATRICS 75, 566 2, 470, 521 65 135 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 10, 596 727, 316 1, 248, 609 37 54 50.00 05300 ANESTHESI OLOGY 0 53.00 1, 106 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 19 54.00 8.149 39, 657 963. 244 102 54.00 31, 720 805, 731 06000 LABORATORY 25 60.00 3.139 37 60.00 64.00 06400 I NTRAVENOUS THERAPY 973 2, 936 117, 583 0 29 64.00 06500 RESPIRATORY THERAPY 0 9 65.00 859 18,056 146, 177 65.00 06501 SLEEP LAB 1, 218 13, 578 169, 202 8 0 65.01 65.01 06600 PHYSI CAL THERAPY 66.00 5.154 13, 565 954, 539 18 50 66.00 1, 199 06700 OCCUPATI ONAL THERAPY 973 193, 782 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 393 48, 162 0 0 68.00 03040 AUDI OLOGY 68.01 68.01 0 0 0 07100 MEDICAL SUPPLIES CHARGED TO PAT 71.00 1, 681 5, 138 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS C 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 2,025 578, 227 291 73.00 73.00 1.176 07697 CARDIAC REHABILITATION 9, 780 217, 897 10 76.97 76.97 1,504 3 76. 98 07698 HYPERBARIC OXYGEN THERAPY 3, 442 3, 599 283, 143 10 18 76.98 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 Ω 91.00 09100 EMERGENCY 7, 198 76,814 1, 389, 182 20 154 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 04950 0/P GERLATRIC PSYCH CENTER 2, 475 218, 429 93.00 93.00 34, 811 8 68 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 95, 937 1,606,583 12, 021, 971 423 1, 385 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 3 395 0 190, 00 779 0 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 5,679 7,696 78,089 8 194. 00 07950 TRANSPORTATION 0 0 194.00 2, 117 34, 115 194. 01 07951 FUND DEVELOPMENT 473 0 0 0 194. 01 200 00 lana an Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 50, 240 2, 517, 968 202. 00 202.00 Cost to be allocated (per Wkst. B, 6, 444, 320 1, 916, 238 1, 657, 299 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 116. 566125 1, 818. 027437 203. 00 62.646498 1.183016 0.136581 204.00 Cost to be allocated (per Wkst. B, 40, 525 40, 147 973, 915 204. 00 Part II) 703. 187726 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 0.003340 93. 148492 II) 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems ST. JOSEPHS HOSPITAL-HIGHLAND IL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1336 Peri od: Worksheet B-1 From 07/01/2022 06/30/2023 Date/Time Prepared: 1/24/2024 11:48 am Cost Center Description PURCHASI NG ADMITTI NG CASHIERING/AC Reconciliatio OTHER ADMIN & COUNTS RECEIVING AND (INPATIENT **GENERAL** n STORES REVENUE) RECEI VABLE (ACCUM. COST) (SUPPLY EXP (GROSS CHARGES) ENSE) 5.03 5.04 5.05 5A. 06 5.06 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 01160 COMMUNI CATI ONS 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 216, 462 5.03 5.04 00570 ADMITTING 1,517 25, 566, 660 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 150, 243, 100 5.05 -3, 958, 556 00590 OTHER ADMIN & GENERAL 16, 097 33, 909, 778 5.06 5.06 Ω 6.00 00600 MAINTENANCE & REPAIRS C 0 6.00 7.00 00700 OPERATION OF PLANT 56, 774 1, 681, 913 7.00 00800 LAUNDRY & LINEN SERVICE 0 0 0 146, 077 8.00 8.00 0 00900 HOUSEKEEPING 0 0 9.00 15,070 C 678, 337 9.00 10.00 01000 DI ETARY 814 0 0 918, 833 10.00 0 11.00 01100 CAFETERI A 0 0 0 74, 979 11.00 01300 NURSING ADMINISTRATION 0 1.064.171 13 00 70 C 13 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ST. JOSEPHS HOSPITAL-HIGHLAND IL In Lieu of Form CMS-2552-10 Provider CCN: 14-1336

						Date/lime Pre 1/24/2024 11:	
	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (HOURS OF	DI ETARY (MEALS	
		(SQUARE FEET)		(POUNDS OF	SERVICE)	SERVED)	
		6. 00	7. 00	LAUNDRY) 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03 5. 04	00560 PURCHASING RECEIVING AND STORES						5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06	00590 OTHER ADMIN & GENERAL						5.06
6.00	00600 MAI NTENANCE & REPAI RS	87, 414	ł				6.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	5, 078 100	l '				7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	2, 048	ł		14, 319		9.00
10.00	01000 DI ETARY	2, 627	2, 627		274	52, 479	1
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	2, 420 742	2, 420 742		0	24, 624 0	11.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 207	1, 207	0	12	0	1
17. 00	01700 SOCIAL SERVICE	308	l '	0	14	0	1
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	17, 416	17, 416	163, 838	6, 090	24, 171	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	17,410	17,410	103, 030	0, 070	27, 171	30.00
50.00	05000 OPERATING ROOM	10, 596			67	0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 8. 149	0 8, 149		0 1, 081	0	53. 00 54. 00
60.00	06000 LABORATORY	3, 139			375	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	973	973		1, 297	1, 303	1
65.00	06500 RESPI RATORY THERAPY	859	l		93	0	1
65. 01 66. 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	1, 218 5, 154	1, 218 5, 154		0 533	0	65. 01 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	973	973		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	О	0	68. 00
68. 01	03040 AUDI OLOGY	0	0	-	0	0	68. 01
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 MPL. DEV. CHARGED TO PATIENTS	1, 681	1, 681 0		0 0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 176	1, 176	0	142	0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 504	1, 504	1	447	0	
76. 98 77. 00	07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC HSCT ACQUISITION	3, 442	3, 442		377 O	0	
77.00	OUTPATIENT SERVICE COST CENTERS		<u> </u>	<u> </u>	<u></u>	0	77.00
	09000 CLI NI C	0	0	0	0	0	
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT	7, 198	7, 198	40, 122	1, 589	2, 381	91. 00 92. 00
92.00	04950 O/P GERIATRIC PSYCH CENTER	2, 475	2, 475	0	209	0	1
	OTHER REIMBURSABLE COST CENTERS	_,	_,	-		-	
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
118.00		80, 483	75, 405	277, 489	12, 600	52, 479	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CAN 19200 PHYSICIANS PRIVATE OFFICES	779	l		152		190. 00 192. 00
	07950 TRANSPORTATION	5, 679 0	5,679	0	1, 567 0		194.00
	07951 FUND DEVELOPMENT	473	473	0	ō		194. 01
200.00	1 1						200.00
201. 00 202. 00		0	1, 878, 256	165, 411	804, 244	1, 101, 434	201.00
202.00	Part I)	0	1, 676, 230	105, 411	004, 244	1, 101, 434	202.00
203.00		0. 000000	l		56. 166213	20. 988090	1
204.00		0	481, 351	18, 164	173, 112	208, 994	204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000000	5. 846179	0. 065458	12. 089671	3. 982431	205.00
206.00							206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
30	Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1336 Peri od: Worksheet B-1 From 07/01/2022 06/30/2023 Date/Time Prepared: 1/24/2024 11:48 am Cost Center Description CAFETERI A NURSI NG MEDI CAL SOCI AL NONPHYSI CI AN ADMI NI STRATI O RECORDS & ANESTHETI STS (MEALS FTES) SERVI CE LI BRARY (TIME SPENT) (ASSI GNED Ν (DI RECT (TIME SPENT) TIME) NRSI NG HRS) 11. 00 13. 00 16.00 17.00 19.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 01160 COMMUNI CATI ONS 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00590 OTHER ADMIN & 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 HOUSEKEEPING 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 13, 345 11.00 01300 NURSING ADMINISTRATION 13 00 746 54, 483 13 00 16.00 01600 MEDICAL RECORDS & LIBRARY 2,852 16.00 0 01700 SOCIAL SERVICE 17.00 0 0 100 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 19.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 446 27, 420 2,832 100 0 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 1, 559 5, 892 0 n 50 00 5 0 0 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 202 1,040 0 0 0 54.00 0 60.00 06000 LABORATORY 1, 207 127 0 0 60.00 0 06400 I NTRAVENOUS THERAPY 64 00 0 64 00 130 29 0 0 65.00 06500 RESPIRATORY THERAPY 242 0 65.00 06501 SLEEP LAB 1, 858 6 0 65.01 65.01 253 0 0 0 0 06600 PHYSI CAL THERAPY 66.00 1.280 0 0 66,00 06700 OCCUPATI ONAL THERAPY 0 67.00 235 67.00 C 0 0 68.00 06800 SPEECH PATHOLOGY 65 C 0 68.00 03040 AUDI OLOGY 68.01 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 0 8.810 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 451 0 0 73.00 2,478 76 97 07697 CARDIAC REHABILITATION 247 C 0 0 0 76.97 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 76.98 358 1 0 C 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0 0 0 91.00 09100 EMERGENCY 1.393 3, 755 8 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 93.00 04950 0/P GERIATRIC PSYCH CENTER 266 3, 042 0 0 O 93.00 OTHER REIMBURSABLE COST CENTERS 0 0 0 102.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 13,080 2,852 118.00 54, 451 100 0 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CAN C 0 190.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 192.00 163 32 194. 00 07950 TRANSPORTATION 0 194.00 102 C 0 0 194. 01 07951 FUND DEVELOPMENT 0 C 0 0 0 194. 01 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201. 00 201.00 202.00 Cost to be allocated (per Wkst. B, 655, 748 1, 241, 984 673, 647 43, 702 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 49. 138104 22. 795808 236. 201613 437. 020000 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 265.354 189, 203 113, 485 26, 939 0 204.00 Part II) 39. 791374 269. 390000 0.000000 205.00 205.00 Unit cost multiplier (Wkst. B, Part 17 803747 3.472698 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 207 00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)

Health Financial Systems	ST. JOSEPHS HOSPI			In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C	
				From 07/01/2022	Part I	
				To 06/30/2023	Date/Time Pre 1/24/2024 11:	pared:
		Ti +Lo	XVIII	Hospi tal	Cost	40 alli
		i ii ti e	AVIII	Costs	COST	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
Cost Center Description	(from Wkst.	Adj.	lotal costs	Di sal I owance	TOTAL COSTS	
	B, Part I,	Auj .		Di Sai i Owance		
	col. 26)					
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	7, 965, 271		7, 965, 27	1 0	0	30.00
ANCI LLARY SERVI CE COST CENTERS	7,703,271		1, 703, 21	1 0		30.00
50. 00 05000 OPERATING ROOM	4, 218, 854		4, 218, 85	4 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	44, 243		44, 24		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 376, 494		3, 376, 49	~ ~	0	54.00
60. 00 06000 LABORATORY	2, 486, 082		2, 486, 08		0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	447, 618		447, 61		0	64.00
65. 00 06500 RESPIRATORY THERAPY	417, 277	0	417, 27		0	65.00
65. 01 06501 SLEEP LAB	469, 079	0	469, 07		0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 935, 166	0	1, 935, 16		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	396, 548	0	396, 54		0	67.00
68. 00 06800 SPEECH PATHOLOGY	71, 207	0	71, 20		0	68.00
68. 00 00800 SPEECH PATHOLOGY 68. 01 03040 AUDI OLOGY	71, 207	0		0	0	68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	١	U		9	0	71.00
72.00 07100 MEDICAL SUPPLIES CHARGED TO PATENTS	3, 274, 090 1, 331, 602		3, 274, 09 1, 331, 60		0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS					0	73.00
73. 00 07300 DRUGS CHARGED TO PATTENTS 76. 97 07697 CARDIAC REHABILITATION	3, 856, 302 488, 995		3, 856, 30 488, 99		ŭ	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY					0	76. 97
	1, 397, 521		1, 397, 52	0 0	0	77.00
77.00 O7700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	J U		l	U U	U	77.00
90. 00 09000 CLINI C	O		I	0 0	0	90.00
91. 00 09100 EMERGENCY	3, 833, 218		3, 833, 21		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	649, 491		649, 49		-	
93. 00 04950 0/P GERI ATRI C PSYCH CENTER	814, 579		814, 57		0	
	814, 579		814, 57	9 0	U	93.00
OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM					^] 102. 00
	0			0	0	102.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE						112 00
	27 472 (27	0	27 472 (2	7	^	113. 00 200. 00
200.00 Subtotal (see instructions) 201.00 Less Observation Beds	37, 473, 637 649, 491	0				200.00
202.00 Total (see instructions)	36, 824, 146	0	649, 49 36, 824, 14			201.00
ZUZ. UUI TUTAL (SEE TIISTI UCTI UIS)	j 30, 824, 146	U	ı 30, ö∠4, 14	·OI UI	U	12U2. UU

37, 473, 637 649, 491 36, 824, 146

37, 473, 637 649, 491 36, 824, 146

202.00

Total (see instructions)

Health Financial Systems	ST. JOSEPHS HOSPI	TAL-HIGHLAND I	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	F	Period: From 07/01/2022 To 06/30/2023		pared: 48 am
			XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent	
					Rati o	
	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			T			
30. 00 03000 ADULTS & PEDIATRICS	5, 803, 987		5, 803, 987	7		30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 082, 135	9, 977, 504			0. 000000	50.00
53. 00 05300 ANESTHESI OLOGY	432, 112	2, 576, 801			0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 455, 525	40, 391, 829			0. 000000	54.00
60. 00 06000 LABORATORY	5, 372, 956	22, 475, 699			0. 000000	60.00
64.00 06400 I NTRAVENOUS THERAPY	125, 702	766, 371	892, 073	0. 501773	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	2, 391, 541	2, 584, 235	4, 975, 776	0. 083862	0.000000	65.00
65. 01 06501 SLEEP LAB	o	2, 142, 339	2, 142, 339	0. 218956	0.000000	65.01
66. 00 06600 PHYSI CAL THERAPY	1, 058, 565	3, 768, 233	4, 826, 798	0. 400921	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	489, 478	384, 757	874, 235	0. 453594	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	40, 464	138, 862	179, 326	0. 397081	0.000000	68.00
68. 01 03040 AUDI OLOGY	ol	0		0. 000000	0.000000	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	962, 446	1, 828, 604	2, 791, 050	1. 173067	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	311, 775	2, 648, 430	2, 960, 205	0. 449834	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 131, 132	14, 250, 540	17, 381, 672	0. 221860	0. 000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	l ol	518, 880			0.000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	128, 199	3, 803, 249			0. 000000	76. 98
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0] -,,,,,,,,	0. 000000	0. 000000	77. 00
OUTPATIENT SERVICE COST CENTERS			I	., 21000000	27 000000	
an an analysis of the second s				0.00000	0.000000	00 00

0 698, 546

82, 097

25, 566, 660

25, 566, 660

0

15, 286, 145 662, 247 471, 715

124, 676, 440

124, 676, 440

0

15, 984, 691

150, 243, 100

150, 243, 100

744, 344 471, 715

0

0.000000

0. 239806

0. 872568

1. 726846

0.000000

0.000000

0.000000

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MCRI F32 - 21. 3. 178. 0

90.00

200.00

201.00

202.00

09000 CLI NI C

113. 00 11300 I NTEREST EXPENSE

92. 00 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200

SPECIAL PURPOSE COST CENTERS

OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

91. 00 09100 EMERGENCY

Health Financial Systems	ST. JOSEPHS HOSPITAL	HIGHLAND IL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 14-1336	Peri od: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared: 1/24/2024 11:48 am
		Ti +Lo VVIII	Uocni tal	Cost

				1/24/2024 11:48 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
65. 01 06501 SLEEP LAB	0. 000000			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00
68. 01 03040 AUDI OLOGY	0. 000000			68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000			92.00
93. 00 04950 0/P GERLATRIC PSYCH CENTER	0. 000000			93.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>			
102.00 10200 OPI OI D TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS	<u> </u>			
113. 00 11300 NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	ST. JOSEPHS HOSPI	Provider Co	CN: 14-1336	In Lie Period: From 07/01/2022 To 06/30/2023	wof Form CMS-2 Worksheet C Part I Date/Time Pre 1/24/2024 11:	pared:
		Ti tl	e XIX	Hospi tal	Cost	
				Costs	<u> </u>	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.		RCE Di sal I owance	Total Costs	
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDIATRICS	7, 965, 271		7, 965, 27	1 0	7, 965, 271	30.00
ANCILLARY SERVICE COST CENTERS	1 010 051				1 010 051	
50. 00 05000 OPERATING ROOM	4, 218, 854		4, 218, 85		4, 218, 854	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	44, 243		44, 24		44, 243	
ł ł	3, 376, 494		3, 376, 49		3, 376, 494	
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	2, 486, 082 447, 618		2, 486, 08 447, 61		2, 486, 082 447, 618	
65. 00 06500 RESPIRATORY THERAPY	417, 277		1		447, 018	65.00
65. 01 06501 SLEEP LAB	469, 079		469, 07		469, 079	
66. 00 06600 PHYSI CAL THERAPY	1, 935, 166		1, 935, 16		1, 935, 166	
67. 00 06700 OCCUPATI ONAL THERAPY	396, 548		396, 54		396, 548	
68. 00 06800 SPEECH PATHOLOGY	71, 207	l .	71, 20		71, 207	
68. 01 03040 AUDI OLOGY	71,207	l .		, o	0	68. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	3, 274, 090	_	3, 274, 09		3, 274, 090	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 331, 602		1, 331, 60		1, 331, 602	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 856, 302		3, 856, 30		3, 856, 302	
76. 97 07697 CARDI AC REHABI LI TATI ON	488, 995		488, 99		488, 995	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 397, 521		1, 397, 52	1 0	1, 397, 521	76. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	C			o o	0	77. 00
OUTPATIENT SERVICE COST CENTERS	·					
90. 00 09000 CLI NI C	C			0 0	0	90.00
91. 00 09100 EMERGENCY	3, 833, 218		3, 833, 21	8 0	3, 833, 218	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	649, 491		649, 49		649, 491	
93.00 04950 0/P GERLATRIC PSYCH CENTER	814, 579		814, 57	9 0	814, 579	93.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM	C			0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE		_				113.00
200.00 Subtotal (see instructions)	37, 473, 637		,,		37, 473, 637	
201.00 Less Observation Beds	649, 491		649, 49		649, 491	
202.00 Total (see instructions)	36, 824, 146	1 0	36, 824, 14	6 0	36, 824, 146	12U2. UU

37, 473, 637 649, 491 36, 824, 146

37, 473, 637 649, 491 36, 824, 146

37, 473, 637 649, 491 36, 824, 146 202. 00

202.00

Total (see instructions)

Health Financial Systems S	ST. JOSEPHS HOSPI	TAL-HI GHLAND I	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 1/24/2024 11:	pared: 48 am
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6. 00	7.00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	5, 803, 987		5, 803, 98	7		30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	1, 082, 135	9, 977, 504	11, 059, 63	9 0. 381464	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	432, 112	2, 576, 801	3, 008, 91	0. 014704	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 455, 525	40, 391, 829	43, 847, 35	4 0. 077006	0.000000	54.00
60. 00 06000 LABORATORY	5, 372, 956	22, 475, 699	27, 848, 65	5 0. 089271	0.000000	60.00
44 OO O44OO LNTDAVENOUS THEDADY	105 700	744 271	1 000 07	0 501770	0 000000	44 00

Health Financial Systems	ST. JOSEPHS HOSPITA	L-HIGHLAND IL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 14-1336	Peri od: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared: 1/24/2024 11:48 am
		Title XIX	Hospi tal	Cost

				1/24/2024 11:48 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
65. 01 06501 SLEEP LAB	0. 000000			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00
68. 01 03040 AUDI OLOGY	0. 000000			68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000			92.00
93.00 04950 0/P GERLATRIC PSYCH CENTER	0. 000000			93.00
OTHER REIMBURSABLE COST CENTERS				
102. 00 10200 OPI OI D TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00

Health Financial Systems	ST. JOSEPHS HOSPITAL	HIGHLAND IL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS	Provider CCN: 14-1336	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D Part II Date/Time Prepared

To O6/30/2023 Date/Time Prepared: To O6/30/2023 Date/Time Prepared: To Title XVIII Hospital Cost Cost Center Description Related Cost Related Cost (from Wkst. B. Part II, col. 26) Total Charges (col. 1 ÷ col. 2) Charges (col. 1 ÷ col. 2) Charges Col. 2m Charges Charges Col. 2m Charges	APPORTIONMENT OF INPATTENT ANCILLARY SERVICE CAPITAL		AL CUS13	Provider C		From 07/01/2022	Part II	
Title XVIII							Date/Time Pre	
Capital Related Cost (From Wkst. B, Part II, col. 26) C. Part III, col. 26, col. 27, col. 27, col. 27, col. 28, col. 27, col. 28, col. 28, col. 28, col. 28, col. 28, col. 28, col. 29, col. 29, col. 24, col. 29, col. 29, col. 24, col. 29, col. 29, col. 24, col. 29, col. 29, col. 26, col. 20, col. 24, col. 29, col. 26, col. 20, col. 26, col. 20, col. 26, col. 20, col. 26, col. 20, col. 27, col. 29, col. 29, col. 20, col. 27, col. 29, col. 29, col. 20, col. 20, col. 20, col. 27, col. 29, col. 29, col. 20, col. 20								48 am_
Related Cost (from Wkst. C, Part I, Col. 1 + Col. 1 + Col. 2) Charges (col umn 4) Related Cost (from Wkst. C, Part I, Col. 2)								
Crowned Reservation		Cost Center Description						
B, Part II, col. 26 Col. 20 Col. 20 Col. 20 Col. 26								
Col. 26 1.00 2.00 3.00 4.00 5.00						Charges	column 4)	
1.00 2.00 3.00 4.00 5.00				COL. 8)	COI. 2)			
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 1,778,694 11,059,639 0.160827 355,794 57,221 50.00 53.00 05300 ANESTHESI OLOGY 9,918 3,008,913 0.003296 118,633 391 53.00 65.00 05400 RADI OLOGY-DI AGNOSTI C 837,147 43,847,354 0.019092 956,372 18,259 54.00 65.00 06000 LABORATORY 422,845 27,848,655 0.015184 1,595,932 24,233 60.00 64.00 06400 INTRAVENOUS THERAPY 124,860 892,073 0.139966 23,744 3,323 64.00 65.00 06500 RESPI RATORY THERAPY 120,408 4,975,776 0.024199 616,786 14,926 65.00 65.01 06501 SLEEP LAB 133,856 2,142,339 0.062481 0 0 65.01 66.00 06600 PHYSI CAL THERAPY 489,437 4,826,798 0.101400 204,654 20,752 66.00 66.00 06700 0CCUPATI ONAL THERAPY 88,032 874,235 0.100696 71,181 7,168 67.00 68.01 03040 AUDI OLOGY 4,858 179,326 0.027090 21,950 595 68.00 68.01 03040 AUDI OLOGY 0 0.000000 0 0 68.01 07100 MEDI CAL SUPPLIES CHARGED TO PATI 189,565 2,791,050 0.067919 260,695 17,706 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 55,702 2,960,205 0.018817 84,600 1,592 72.00 76.97 07607 CARDI AC REHABI LI TATI ON 138,336 518,880 0.266605 0 0.7700 0.7700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0.000000 0 0 0.000000 0				2.00	2.00	4.00	F 00	
50. 00 05000 OPERATI NG ROOM 1,778,694 11,059,639 0.160827 355,794 57,221 50. 00 53. 00 05300 ANESTHESI OLOGY 9,918 3,008,913 0.003296 118,633 391 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 837,147 43,847,354 0.019092 956,372 18,259 54. 00 60. 00 06000 LABORATORY 422,845 27,848,655 0.015184 1,595,932 24,233 60. 00 64. 00 06400 INTRAVENOUS THERAPY 124,860 892,073 0.139966 23,744 3,323 64. 00 65. 01 06501 SLEEP LAB 133,856 2,142,339 0.062481 0 0 65.01 66. 00 06600 PHYSI CAL THERAPY 489,437 4,826,798 0.101400 204,654 20,752 65.00 67. 00 06700 OCCUPATI ONAL THERAPY 88,032 874,235 0.100696 71,181 7,168 67.00 68. 01 03040 AUDI OLOGY 4,858 179,326 0.027090 21,950 <		ANCILLARY CERVICE COCT CENTERS	1.00	2.00	3.00	4.00	5.00	
53. 00 05300 ANESTHESI OLOGY 9, 918 3, 008, 913 0. 003296 118, 633 391 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 837, 147 43, 847, 354 0. 019092 956, 372 18, 259 54. 00 60. 00 06000 LABDRATORY 422, 845 27, 848, 655 0. 015184 1, 595, 932 24, 233 60. 00 64. 00 06400 INTRAVENOUS THERAPY 124, 860 892, 073 0. 139966 23, 744 3, 323 64. 00 65. 01 06500 RESPI RATORY THERAPY 120, 408 4, 975, 776 0. 024199 616, 786 14, 926 65. 00 65. 01 06501 SLEEP LAB 133, 856 2, 142, 339 0. 062481 0 65. 01 66. 00 06600 PHYSI CAL THERAPY 489, 437 4, 826, 798 0. 101400 204, 654 20, 752 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 88, 032 874, 235 0. 100400 204, 654 20, 752 66. 00 68.	FO 00		1 770 (04	11 050 420	0.14000	255 704	E7 221	E0 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 837, 147 43, 847, 354 0. 019092 956, 372 18, 259 54. 00 60. 00 06000 LABORATORY 422, 845 27, 848, 655 0. 015184 1, 595, 932 24, 233 60. 00 64. 00 06400 I NTRAVENOUS THERAPY 124, 860 892, 073 0. 139966 23, 744 3, 323 64. 00 06500 RESPI RATORY THERAPY 120, 408 4, 975, 776 0. 024199 616, 786 14, 926 65. 00 06500 RESPI RATORY THERAPY 133, 856 2, 142, 339 0. 062481 0 0 0 65. 01 06501 SLEEP LAB 133, 856 2, 142, 339 0. 062481 0 0 0 65. 01 06600 PHYSI CAL THERAPY 489, 437 4, 826, 798 0. 101400 204, 654 20, 752 66. 00 06700 0CCUPATI ONAL THERAPY 88, 032 874, 235 0. 100696 71, 181 7, 168 67. 00 06800 SPEECH PATHOLOGY 4, 858 179, 326 0. 027090 21, 950 595 68. 00 0680. 0 06800 SPEECH PATHOLOGY 4, 858 179, 326 0. 027090 21, 950 595 68. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 189, 565 2, 791, 050 0. 067919 260, 695 17, 706 71. 00 07200 MEDI CAL SUPPLI ES CHARGED TO PAT 189, 565 2, 791, 050 0. 067919 260, 695 17, 706 71. 00 07300 DRUGS CHARGED TO PATI ENTS 55, 702 2, 960, 205 0. 018817 84, 600 1, 592 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 55, 702 2, 960, 205 0. 018817 84, 600 1, 592 72. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 138, 336 518, 880 0. 266605 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 298, 789 3, 931, 448 0. 076000 10, 152 772 76. 98 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0. 0000000 0 0 0 0 0 0 0 0 0 0 0					1			
60. 00 06000 LABORATORY 422, 845 27, 848, 655 0. 015184 1, 595, 932 24, 233 60. 00 64. 00 06400 INTRAVENOUS THERAPY 124, 860 892, 073 0. 139966 23, 744 3, 323 64. 00 65. 00 06500 RESPIRATORY THERAPY 120, 408 4, 975, 776 0. 024199 616, 786 14, 926 65. 00 65. 01 06501 SLEEP LAB 133, 856 2, 142, 339 0. 062481 0 0 65. 01 06501 SLEEP LAB 133, 856 2, 142, 339 0. 062481 0 0 65. 01 06500 OCCUPATI ONAL THERAPY 489, 437 4, 826, 798 0. 101400 204, 654 20, 752 66. 00 06800 SPEECH PATHOLOGY 88, 032 874, 235 0. 100696 71, 181 7, 168 67. 00 06800 SPEECH PATHOLOGY 4, 858 179, 326 0. 027090 21, 950 595 68. 00 68. 01 03040 AUDI OLOGY 0 0 0. 000000 0 0 68. 01 07100 MEDI CAL SUPPLIES CHARGED TO PAT 189, 565 2, 791, 050 0. 067919 260, 695 17, 706 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 55, 702 2, 960, 205 0. 018817 84, 600 1, 592 72. 00 73. 00 07300 RUGUS CHARGED TO PATI ENTS 412, 745 17, 381, 672 0. 023746 724, 821 17, 212 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 138, 336 518, 880 0. 266605 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 298, 789 3, 931, 448 0. 076000 10, 152 772 76. 98 77. 00 00TPATI ENT SERVICE COST CENTERS								
64. 00 06400 INTRAVENOUS THERAPY 124, 860 892, 073 0. 139966 23, 744 3, 323 64. 00 65. 00 65. 00 665. 01 665. 01 06501 SLEEP LAB 133, 856 2, 142, 339 0. 062481 0 0 65. 01 665. 01 06501 SLEEP LAB 133, 856 2, 142, 339 0. 062481 0 0 65. 01 665. 01 06501 SLEEP LAB 133, 856 2, 142, 339 0. 101400 204, 654 20, 752 66. 00 06700 0CCUPATI ONAL THERAPY 88, 032 874, 235 0. 100696 71, 181 7, 168 67. 00 06800 SPEECH PATHOLOGY 4, 858 179, 326 0. 027090 21, 950 595 68. 00 68. 01 03040 AUDI OLOGY 0 0. 000000 0 0. 000000 0 0								1
65. 00 06500 RESPIRATORY THERAPY 120, 408 4, 975, 776 0. 024199 616, 786 14, 926 65. 00 65. 01 06501 SLEEP LAB 133, 856 2, 142, 339 0. 062481 0 0 65. 01 06501 SLEEP LAB 133, 856 2, 142, 339 0. 062481 0 0 65. 01 06501 SLEEP LAB 133, 856 2, 142, 339 0. 062481 0 0 65. 01 06501 SLEEP LAB 133, 856 2, 142, 339 0. 101400 204, 654 20, 752 66. 00 06700 OCCUPATI ONAL THERAPY 88, 032 874, 235 0. 100696 71, 181 7, 168 67. 00 068. 00 SPEECH PATHOLOGY 4, 858 179, 326 0. 027090 21, 950 595 68. 00 03040 AUDI OLOGY 0 0. 000000 0 0. 68. 01 03040 AUDI OLOGY 0 0. 0000000 0 0. 68. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 189, 565 2, 791, 050 0. 067919 260, 695 17, 706 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 55, 702 2, 960, 205 0. 018817 84, 600 1, 592 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 412, 745 17, 381, 672 0. 023746 724, 821 17, 212 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 138, 336 518, 880 0. 266605 0 0. 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 298, 789 3, 931, 448 0. 076000 10, 152 772 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0. 000000 0 0 0. 000000 0					1			
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66. 00 06600 PHYSI CAL THERAPY 489, 437 4,826,798 0.101400 204,654 20,752 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 88,032 874,235 0.100696 71,181 7,168 67. 00 68. 00 06800 SPEECH PATHOLOGY 4,858 179,326 0.027090 21,950 595 68. 00 68. 01 03040 AUDI OLOGY 0 0 0.000000 0 0 68. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 189,565 2,791,050 0.067919 260,695 17,706 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 55,702 2,960,205 0.018817 84,600 1,592 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 412,745 17,381,672 0.023746 724,821 17,212 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 138,336 518,880 0.266605 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 298,789 3,931,448 0.076000 10,152 772 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0.000000 0 0 0 0 0 0 0 0 0 0 0			· ·		1			
67. 00 06700 0CCUPATI ONAL THERAPY 88, 032 874, 235 0. 100696 71, 181 7, 168 67. 00 68. 00 06800 SPEECH PATHOLOGY 4, 858 179, 326 0. 027090 21, 950 595 68. 00 68. 01 03040 AUDI OLOGY 0 0 0. 000000 0 0 68. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 189, 565 2, 791, 050 0. 067919 260, 695 17, 706 71. 00 72. 00 07300 MPL. DEV. CHARGED TO PATI ENTS 55, 702 2, 960, 205 0. 018817 84, 600 1, 592 72. 00 73. 00 07300 SUPPLIES CHARGED TO PATI ENTS 412, 745 17, 381, 672 0. 023746 724, 821 17, 212 73. 00 76. 97 76. 97 07697 CARDI AC REHABI LI TATI ON 138, 336 518, 880 0. 266605 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 298, 789 3, 931, 448 0. 076000 10, 152 772 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0.000000 0 0 0 0 0			· ·					
68. 00 06800 SPEECH PATHOLOGY 4,858 179,326 0.027090 21,950 595 68. 00 68. 01 03040 AUDI OLOGY 0 0 0.000000 0 0 68. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 189,565 2,791,050 0.067919 260,695 17,706 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 55,702 2,960,205 0.018817 84,600 1,592 72. 00 73. 00 07300 DRIGS CHARGED TO PATI ENTS 412,745 17,381,672 0.023746 724,821 17,212 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 138,336 518,880 0.266605 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 298,789 3,931,448 0.076000 10,152 772 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0.000000 0 0 0UTPATI ENT SERVI CE COST CENTERS			· ·		1	·		
68. 01			· ·					1
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 189, 565 2, 791, 050 0.067919 260, 695 17, 706 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 55, 702 2, 960, 205 0.018817 84, 600 1, 592 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 412, 745 17, 381, 672 0.023746 724, 821 17, 212 73. 00 76. 97 07697 CARDI AC REHABI LITATI ON 138, 336 518, 880 0.266605 0 0.76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 298, 789 3, 931, 448 0.076000 10, 152 772 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0.000000 0 0 0 0 0 0			4, 838					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 55, 702 2, 960, 205 0. 018817 84, 600 1, 592 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 412, 745 17, 381, 672 0. 023746 724, 821 17, 212 73. 00 76. 97 07697 CARDI AC REHABILITATION 138, 336 518, 880 0. 266605 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 298, 789 3, 931, 448 0. 076000 10, 152 772 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0. 000000 0 0 0 0 0			100 545	Ĭ	1			
73. 00 07300 DRUGS CHARGED TO PATIENTS 412, 745 17, 381, 672 0.023746 724, 821 17, 212 73. 00 76. 97 76. 98 77. 00 07697 CARDI AC REHABI LI TATI ON 138, 336 518, 880 0.266605 0 0 76. 97 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0.000000 0 0 0 0 0 0						·		
76. 97 07697 CARDI AC REHABI LI TATI ON 138, 336 518, 880 0. 266605 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 298, 789 3, 931, 448 0. 076000 10, 152 772 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0. 000000 0 0 0UTPATI ENT SERVI CE COST CENTERS								
76. 98 07698 HYPERBARI C OXYGEN THERAPY 298, 789 3, 931, 448 0. 076000 10, 152 77. 2 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0. 0000000 0 0 0 0 0								
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0.000000 0 0.77. 00 OUTPATIENT SERVICE COST CENTERS			· ·		1			
OUTPATIENT SERVICE COST CENTERS			298, 789	3, 931, 448	1	·		
	77.00		0		0.00000) 0	0	77.00
	90. 00	09000 CLINIC			0. 000000	0	0	90.00
91. 00 09100 EMERGENCY 858, 285 15, 984, 691 0. 053694 22, 512 1, 209 91. 00			050 205	15 004 401			_	
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT 165, 962 744, 344 0. 222964 6, 510 1, 451 92. 00					1			
93. 00 04950 0/P GERI ATRI C PSYCH CENTER 291, 190 471, 715 0. 617301 0 0 93. 00					1			
200.00 Total (lines 50 through 199) 6, 420, 629 144, 439, 113 5, 074, 336 186, 810 200.00					1		-	
200. 00	200.00	Tiotal (Titles 30 till ough 199)	0, 420, 029	144, 437, 113	1	0,074,330	100,810	200.00

| Peri od: | Worksheet D | From 07/01/2022 | Part IV | To 06/30/2023 | Date/Time Prepared: THROUGH COSTS

				10 00/30/2023	1/24/2024 11:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
1	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60. 00 06000 LABORATORY	0	0	,	0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	1	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0	1	0	0	65.00
65. 01 06501 SLEEP LAB	0	0	1	0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	(0	0	68.00
68. 01 03040 AUDI OLOGY	0	0	1	0	0	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	1	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	(0	0	76. 98
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
OUTPATIENT SERVICE COST CENTERS			Т		_	
90. 00 09000 CLI NI C	0	0	(0	0	90.00
91. 00 09100 EMERGENCY	0	0		0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0				0	92.00
93. 00 04950 0/P GERIATRIC PSYCH CENTER	0	0		0	0	93.00
200.00 Total (lines 50 through 199)	0	0		0 اد	۱ 0 ا	200. 00

Health Financial Systems	ST. JOSEPHS HOSPITAL	HIGHLAND IL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCLLLARY SERVICE OTHER PASS	Provider CCN: 14-1336	Peri od:	Worksheet D	

From 07/01/2022 Part IV
To 06/30/2023 Date/Time Prepared: THROUGH COSTS 1/24/2024 11:48 am Title XVIII Hospi tal Cost All Other Total Cost Total Charges Ratio of Cost Cost Center Description Total to Charges Medi cal (sum of cols. Outpati ent (from Wkst. C, Part I, Educati on 1, 2, 3, and Cost (sum of (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 4. 00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 11, 059, 639 0.000000 50.00 05300 ANESTHESI OLOGY 0 0 3, 008, 913 0.000000 53.00 53.00 0 0 0 0 0 0 0 0 0 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 0 43, 847, 354 0.000000 54.00 54.00 0 06000 LABORATORY 0 60.00 27, 848, 655 0.000000 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 892, 073 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 0 4, 975, 776 0.000000 65.00 65.01 06501 SLEEP LAB 0 0 2, 142, 339 0.000000 65.01 0 66.00 06600 PHYSI CAL THERAPY 0 4, 826, 798 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 874, 235 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 179, 326 0.000000 68.00 03040 AUDI OLOGY 0 0 0.000000 68.01 68.01 07100 MEDICAL SUPPLIES CHARGED TO PAT 71.00 0 2, 791, 050 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 2, 960, 205 0.000000 72.00 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 17, 381, 672 0.000000 Ω 73 00 0 76. 97 07697 CARDIAC REHABILITATION 0 518, 880 0.000000 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 3, 931, 448 0.000000 76.98 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 0.000000 90.00 09000 CLI NI C 0 0 90.00 0 0 0 0 91. 00 09100 EMERGENCY 0 15, 984, 691 0.000000 91.00 744, 344 471, 715 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 0 0 0.000000 92.00 0 93. 00 04950 0/P GERIATRIC PSYCH CENTER 0 0.000000 93.00

0

144, 439, 113

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	ST. JOSEPHS HOSPITAL	HIGHLAND IL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 14-1336	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared:

THROUGH COSTS		Ť	06/30/2023			
		Ti tl a	XVIII	Hospi tal	1/24/2024 11: Cost	48 am_
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
cost center bescription	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	onal ges	Costs (col. 8	onar gcs	Costs (col. 9	
	col. 7)		x col . 10)		x col . 12)	
	9. 00	10. 00	11.00	12. 00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	355, 794	0	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	118, 633	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	956, 372	0	0	0	54.00
60. 00 06000 LABORATORY	0. 000000	1, 595, 932	0	0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	23, 744	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	616, 786	0	0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0	0	0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	204, 654	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	71, 181	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	21, 950	0	0	0	68.00
68. 01 03040 AUDI OLOGY	0. 000000	0	0	0	0	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000	260, 695	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	84, 600	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	724, 821	0	0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	10, 152	0	0	0	76. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	22, 512	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000	6, 510	0	0	0	92.00
93.00 04950 0/P GERLATRIC PSYCH CENTER	0. 000000	0	0	0	0	93.00
200.00 Total (lines 50 through 199)		5, 074, 336	0	0	0	200. 00

Health Financial Systems	ST. JOSEPHS HOSPITAL	-HIGHLAND IL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1336	Peri od:	Worksheet D

From 07/01/2022 Part V 06/30/2023 Date/Time Prepared: 1/24/2024 11:48 am Title XVIII Hospi tal Cost Costs Charges PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 4. 00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 358, 873 50.00 0. 381464 05300 ANESTHESI OLOGY 53.00 0.014704 590, 592 0 0 0 0 0 0 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.077006 0 54.00 11, 168, 935 0 54.00 60.00 06000 LABORATORY 0.089271 5, 042, 240 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0.501773 263, 310 64.00 65. NO 06500 RESPIRATORY THERAPY 0.083862 726, 515 0 65.00 65.01 06501 SLEEP LAB 0. 218956 512, 226 0 65.01 66.00 06600 PHYSI CAL THERAPY 0. 400921 1, 232, 956 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0. 453594 145, 639 0 67.00 0. 397081 06800 SPEECH PATHOLOGY 68.00 68.00 6, 623 0 68.01 03040 AUDI OLOGY 0.000000 0 68.01 07100 MEDICAL SUPPLIES CHARGED TO PAT 438, 089 0 71.00 71.00 1.173067 0 07200 IMPL. DEV. CHARGED TO PATIENTS ol 0.449834 749, 760 72.00 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.221860 0 7, 140, 309 1, 109 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0. 942405 0 211, 873 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76. 98 0. 355472 0 1, 516, 635 0 0 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 ol 77.00 77 00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 90.00 0 1, 188 91.00 91.00 09100 EMERGENCY 0.239806 3, 540, 492 0 09200 OBSERVATION BEDS (NON-DISTINCT 298, 068 92.00 92 00 0.872568 0 0 Ω 93.00 04950 0/P GERIATRIC PSYCH CENTER 1.726846 0 306, 773 0 93.00 200.00 Subtotal (see instructions) 36, 249, 908 2, 297 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 0 202.00 202.00 Net Charges (line 200 - line 201) 36, 249, 908 2, 297

Health Financial Systems	ST. JOSEPHS HOSPITAL	L-HIGHLAND IL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERV	ICES AND VACCINE COST	Provider CCN: 14-1336	From 07/01/2022	Worksheet D Part V Date/Time Prepared: 1/24/2024 11:48 am
		Title XVIII	Hospi tal	Cost

					To 06/30/2023	Date/Time Pro 1/24/2024 11:	
			Title	XVIII	Hospi tal	Cost	
	·	Cos	sts		· · · · · · · · · · · · · · · · · · ·		
	Cost Center Description	Cost	Cost				
	'	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	899, 825	0				50.00
53.00	05300 ANESTHESI OLOGY	8, 684					53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	860, 075	0				54.00
60.00	06000 LABORATORY	450, 126	0				60.00
64.00	06400 I NTRAVENOUS THERAPY	132, 122	0				64.00
65. 00	06500 RESPI RATORY THERAPY	60, 927	0				65.00
65. 01	06501 SLEEP LAB	112, 155	0				65. 01
66. 00	06600 PHYSI CAL THERAPY	494, 318	0				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	66, 061	0				67.00
68. 00	06800 SPEECH PATHOLOGY	2, 630	0				68. 00
68. 01	03040 AUDI OLOGY	0	0				68. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	513, 908	0				71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	337, 268					72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 584, 149	246				73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	199, 670	0				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	539, 121	0				76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
Ī	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0				90.00
91. 00	09100 EMERGENCY	849, 031	285				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	260, 085	0				92.00
93. 00	04950 O/P GERIATRIC PSYCH CENTER	529, 750	0				93.00
200.00	Subtotal (see instructions)	7, 899, 905	531				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	7, 899, 905	531				202. 00

Health Financial Systems	ST. JOSEPHS HOSPITAL	. JOSEPHS HOSPITAL-HIGHLAND IL In Lieu			2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 14-1336	Peri od: From 07/01/2022	Worksheet D-1	
			To 06/30/2023	Date/Time Pre 1/24/2024 11:	pared: 48 am
		Title XVIII	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

	Cost Contan Description Title XVIII Hospital	Cost	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6, 668	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	3, 978 0	2. 00 3. 00
3. 00	do not complete this line.	O	3.00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	3, 451	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	1, 417	5.00
	reporting period		
5. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	1, 028	6.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	142	7.00
	reporting period		
3. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	103	8.00
	reporting period (if calendar year, enter 0 on this line)	4 450	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1, 458	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	727	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	527	11.00
12 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	12.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	U	12.00
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	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	15. 00 16. 00
16.00	SWING BED ADJUSTMENT	U	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17.00
	reporting period		
8. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18.00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	201. 56	19.00
7. 00	reporting period	201.30	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	201. 56	20.00
	reporting period	7 0/5 074	
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	7, 965, 271 0	21. 00 22. 00
2.00	5 x line 17)	U	22.00
23. 00	, and the second	0	23.00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	28, 622	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)	20, 761	25.00
20.00	x line 20)	20, 701	25.00
26. 00		3, 062, 674	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4, 902, 597	27.00
00 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	29.00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
2.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31)	0. 00 0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
8. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1, 232. 43	38.00
9. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 796, 883	
10.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
+0.00		1, 796, 883	

		JOSEPHS HOSPI			In Lie Period:	u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	F	rom 07/01/2022	Worksheet D-1	
					To 06/30/2023	1/24/2024 11:	
	Cost Center Description	Total	Total	Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient	I npati ent	Diem (col. 1	· · · · · · · · · · · · · · · · · · ·	(col. 3 x	
		1.00	Days 2.00	÷ col. 2)	4. 00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)						42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			T			43.00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					1, 059, 641	48. 00
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column 1)	0 2, 856, 524	
47.00	PASS THROUGH COST ADJUSTMENTS	+1 through +o.	01) (366 1113116	10 (1 0113)		2, 030, 324	47.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, sum	of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D, s	um of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclu	ding capital r	elated, non-ph	nysician anesth	etist, and	0	
	medical education costs (line 49 minus line	52)					
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	
	Target amount per discharge						55.00
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	•
56.00	Target amount (line 54 x sum of lines 55, 55)			0	1
57. 00 58. 00	Difference between adjusted inpatient operat	ing cost and t	arget amount ((line 56 minus	line 53)	0	
59.00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 fro	m the cost rep	orting period	ending 1996,	0.00	•
	updated and compounded by the market basket)						,,,,,,,
60.00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fr	om prior year	cost report, u	pdated by the	0.00	60.00
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of	the amount by	which operatin	g costs (line	0	61.00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.00
63. 00	1 1 7	ent (see instr	uctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	ne cost reporti	ng period (See	895, 977	64.00
/F 00	instructions)(title XVIII only)	t£t D	h 21 -E +h-			(40, 401	/F 00
65.00	<pre>Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	its after becem	ber 31 of the	cost reporting	period (see	649, 491	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only); for	1, 545, 468	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs throug	h December 31	of the cost re	porting period	0	67.00
49.00	(line 12 x line 19)	o costs often	Docombor 21 of	the cost rope	rting pariod	0	49 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs at tel	pecelliper 31 01	the cost repo	a criig perrou	0	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N		`	<u> </u>		0	69. 00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID ro	utine service	cost (line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		line 70 ÷ line	2)			71. 00 72. 00
73.00	Medically necessary private room cost applic	,	m (line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv	ice costs (lin	e 72 + line 73	3)			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine servic	e costs (from	Worksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		provi der recor	ds)			79.00
80.00	Total Program routine service costs for comp	arison to the	•		us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instructio					83. 00
84.00	Program inpatient ancillary services (see in		one)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	J//			- :	
	Total observation bed days (see instructions Adjusted general inpatient routine cost per		÷ line 2)			527 1, 232. 43	87. 00 88. 00
		/					

Health Financial Systems ST.	JOSEPHS HOSPI	TAL-HI GHLAND I	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			649, 491	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 035, 342	7, 965, 271	0. 25552	7 649, 491	165, 962	90.00
91.00 Nursing Program cost	0	7, 965, 271	0.00000	649, 491	0	91.00
92.00 Allied health cost	0	7, 965, 271	0.00000	649, 491	0	92.00
93.00 All other Medical Education	0	7, 965, 271	0. 00000	649, 491	0	93.00

	Financial Systems ST. JOSEPHS HOSPITAL- ENT ANCILLARY SERVICE COST APPORTIONMENT			Period:	u of Form CMS-2 Worksheet D-3	
INIAII	ENT ANGLEEART SERVICE COST ALLORITONNIENT	i i ovi dei c		From 07/01/2022	WOLKSHEET D-3	
				To 06/30/2023	Date/Time Pre 1/24/2024 11:	
		Titl∈	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1			
	03000 ADULTS & PEDI ATRI CS			1, 909, 621		30.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 38146		135, 723	
	05300 ANESTHESI OLOGY		0. 01470			
	05400 RADI OLOGY-DI AGNOSTI C		0. 07700		73, 646	
	06000 LABORATORY		0. 08927		142, 470	
	06400 I NTRAVENOUS THERAPY		0. 50177		11, 914	
	06500 RESPIRATORY THERAPY		0. 08386		51, 725	65.00
	06501 SLEEP LAB		0. 21895		0	
	06600 PHYSI CAL THERAPY		0. 40092		82, 050	
	06700 OCCUPATI ONAL THERAPY		0. 45359		32, 287	
	06800 SPEECH PATHOLOGY		0. 39708		8, 716	
	03040 AUDI OLOGY		0.00000		0	
	07100 MEDICAL SUPPLIES CHARGED TO PAT		1. 17306		305, 813	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 44983		38, 056	
	07300 DRUGS CHARGED TO PATIENTS		0. 22186		160, 809	
	07697 CARDI AC REHABI LI TATI ON		0. 94240		0	
	07698 HYPERBARI C OXYGEN THERAPY		0. 35547		3, 609	
	07700 ALLOGENEI C HSCT ACQUI SI TI ON		0.00000	00 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		0.00000	00	0	90.00
	09100 CET NT C		0. 23980		5, 399	
	09200 OBSERVATION BEDS (NON-DISTINCT		0. 23980		5, 399 5, 680	
	04950 O/P GERIATRIC PSYCH CENTER		1. 72684		5, 680	1
200.00			1. /2684		1, 059, 641	
200.00		(1:00 (1)		5, 074, 336		200.00
201.00		(Title 61)		E 074 224		
202.00	iner charges (Title 200 illinus Title 201)		l	5, 074, 336		202.00

Health Financial Systems ST. JOSEPHS HOSPITAL	-HIGHLAND I	L	In Li∈	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od:	Worksheet D-3	
	•	CCN: 14-Z336	From 07/01/2022 To 06/30/2023	Date/Time Pre 1/24/2024 11:	
	Title		Swing Beds - SNI		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		4 00	0.00	col . 2)	
INDATIONE CONTINUE CONTINUE CONTINUE CONTINUE		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 38146	4, 923	1, 878	50.00
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY		0. 38146	· ·		
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.01470			
60. 00 06000 LABORATORY		0.07700			
64. 00 06400 NTRAVENOUS THERAPY		0. 50177		1 41, 102	
65. 00 06500 RESPI RATORY THERAPY		0. 08386		1	
65. 01 06501 SLEEP LAB		0. 21895			65.01
66. 00 06600 PHYSI CAL THERAPY		0. 40092		1	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 45359		•	
68. 00 06800 SPEECH PATHOLOGY		0. 39708	4, 900		
68. 01 03040 AUDI OLOGY		0. 00000	00	0	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT		1. 17306	57 111, 397	130, 676	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 44983	34 C	0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 22186	414, 208	91, 896	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 94240		0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 35547			
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0. 00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 00000		0	
91. 00 09100 EMERGENCY		0. 23980		1	
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT		0. 87256		1	
93. 00 04950 0/P GERIATRIC PSYCH CENTER		1. 72684		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(1: (1)		2, 085, 733		
201.00 Less PBP Clinic Laboratory Services-Program only charges	(IINE 61)		2 005 722	•	201.00
202.00 Net charges (line 200 minus line 201)		I	2, 085, 733	1	202. 00

Health Financial Systems	ST. JOSEPHS HOSPITAL	HIGHLAND IL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 14-1336	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 1/24/2024 11:48 am

		1/24/2024 11:	48 am
	Title XVIII Hospital	Cost	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	7, 900, 436	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	
4.00	Outlier payment (see instructions)	0	
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)	0.000	4. 01 5. 00
6. 00	Line 2 times line 5	0.000	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	1
8.00	Transitional corridor payment (see instructions)	0	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	
10.00	Organ acqui si ti ons	0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	7, 900, 436	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges		ł
12. 00	Ancillary service charges	0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		
	Total reasonable charges (sum of lines 12 and 13)	0	•
	Customary charges		
	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
17 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0.00000	17. 00
17. 00 18. 00	Total customary charges (see instructions)	0.000000	18.00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see		•
171.00	instructions)		
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
	instructions)		1
	Lesser of cost or charges (see instructions)	7, 979, 440	
	Interns and residents (see instructions)	0	
	Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	0	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	70, 899	25. 00
	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6, 182, 223	1
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	1, 726, 318	27.00
	instructions)		1
	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
	REH facility payment amount ESRD direct medical education costs (from Wkst. E-4, line 36)	0	28. 50 29. 00
	Subtotal (sum of lines 27, 28, 28.50 and 29)	1, 726, 318	•
	Primary payer payments	348	1
	Subtotal (line 30 minus line 31)	1, 725, 970	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		l
	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
	Allowable bad debts (see instructions)	383, 144	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)	249, 044 207, 037	
	Subtotal (see instructions)	1, 975, 014	ı
38. 00		0	ı
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	1
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	39. 75
	Demonstration payment adjustment amount before sequestration	0	39. 97
	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)	0 1, 975, 014	39. 99 40. 00
40. 00	Sequestration adjustment (see instructions)	39, 500	1
	Demonstration payment adjustment amount after sequestration	0	1
	Sequestration adjustment-PARHM pass-throughs		40. 03
	Interim payments	2, 185, 625	41.00
41. 01	Interim payments-PARHM		41. 01
42.00	Tentative settlement (for contractors use only)	0	
	Tentative settlement-PARHM (for contractor use only)	050 444	42. 01
43.00	Balance due provider/program (see instructions)	-250, 111	1
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	43. 01 44. 00
44.00	§115. 2		44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
	Outlier reconciliation adjustment amount (see instructions)	0	
	The rate used to calculate the Time Value of Money	0.00	•
93.00		0	
94.00	Total (sum of lines 91 and 93)	0	94.00

Health Financial Systems	ST. JOSEPHS HOSPITAL	HIGHLAND IL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1336	Peri od:	Worksheet E	
			From 07/01/2022		
			To 06/30/2023	1/24/2024 11	
		T: 11 . \0.0111	11		. 40 alli
		Title XVIII	Hospi tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

Health Financial Systems ST. JOSE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 14-1336

				0 06/30/2023	1/24/2024 11:	
		Title	· XVIII	Hospi tal	Cost	10 4
	· .	Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider	1.00	2, 339, 743		2, 189, 415	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2, 337, 743		0	2.00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 00
0 01	Program to Provider ADJUSTMENTS TO PROVIDER	00 (07 (0000	100 (54	07 /45 /0000	41, 709	
3. 01 3. 02 3. 03 3. 04 3. 05	AUJUSIMENTS TO PROVIDER	02/27/2023 06/15/2023	100, 651 29, 816 0 0		0 0 0	3. 01 3. 02 3. 03 3. 04 3. 05
	Provider to Program					
3. 50 3. 51 3. 52 3. 53 3. 54	ADJUSTMENTS TO PROGRAM		0		45, 499 0 0 0	3. 50 3. 51 3. 52 3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		130, 467		-3, 790	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		2, 470, 210		2, 185, 625	4.00
5. 00	List separately each tentative settlement payment after	I	I		T	5.00
3.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5. 01 5. 02	TENTATIVE TO PROVIDER				0 0	5. 01 5. 02
5. 03			<u> </u>		0	5.03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 51
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		C		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		32, 561		250, 111	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 437, 649		1, 935, 514	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

		Component	CON: 14-Z336 10	0 06/30/2023	1/24/2024 11:	
		Title	XVIII Sv	ving Beds - SNF		10 01
		Inpatien	t Part A	Par	T B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
. 00	Total interim payments paid to provider	1.00	1, 759, 635	3.00	4.00	1.
. 00	Interim payments payable on individual bills, either		0,707,000		0	
	submitted or to be submitted to the contractor for				_	
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider ADJUSTMENTS TO PROVIDER	02/27/2023	102, 301		Ιο	3.
)2	ADJUSTMENTS TO PROVIDER	06/15/2023	5, 874			
3		00/15/2025	0,874			
)4			o o		0	
)5			ő		0	-
-	Provider to Program					1 ~
0	ADJUSTMENTS TO PROGRAM		0		0	3
1			0		0	3
2			0		0	3
3			0		0	
4			0		0	_
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines		108, 175		0	3
	3. 50-3. 98)		4 0/7 040			١.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 867, 810		0	4
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					1
00	List separately each tentative settlement payment after					1 5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
)1	TENTATI VE TO PROVI DER		0		0	
2			0		0	-
3	Describing to Describe		0		0	5
0	Provi der to Program TENTATI VE TO PROGRAM		0		0	5
1	TENTATI VE TO FROGRAM		0		0	
2			Ö			
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines		ő		0	
	5. 50-5. 98)					-
0	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
1	SETTLEMENT TO PROVIDER		152, 652		0	
)2	SETTLEMENT TO PROGRAM		0		0	1 -
0	Total Medicare program liability (see instructions)		2, 020, 462		0	7
				Contractor	NPR Date	
		,)	Number 1.00	(Mo/Day/Yr)	
00	Name of Contractor		J	1.00	2. 00	8

Health Financial Systems ST. JOSEPHS HOSPITAL-HIGHLAND IL In Lieu of Form					2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-1336 Period: W					
			From 07/01/2022 To 06/30/2023	Part II Date/Time Pre	enared.	
			10 00/ 30/ 2023	1/24/2024 11:		
		Title XVIII	Hospi tal	Cost		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	.1			+	
1. 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION Total hospital discharges as defined in AARA §4102 from Wkst.		0.14		1.00	
2. 00	Medicare days (see instructions)	. 3-3, Pt. 1 Col. 15 1111	E 14		2.00	
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00	
4. 00	Total inpatient days (see instructions)				4.00	
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	line 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of o	certified HIT technology	Wkst. S-2, Pt. I		7.00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9. 00	Sequestration adjustment amount (see instructions)				9. 00	
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00	
00.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH				30.00	
	30.00 Initial/interim HIT payment adjustment (see instructions)					
31.00	Other Adjustment (specify) Balance due provider (line 8 (or line 10) minus line 30 and l	lino 21) (soo instructio	ne)		31. 00 32. 00	
32.00	parance due provider (Title o (Of Title 10) militus Title 30 and 1	Title 31) (See This truction	1115)		32.00	

Health Financial Systems	ST. JOSEPHS HOSPITAL	HIGHLAND IL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 14-1336	Peri od:	Worksheet E-2
			From 07/01/2022	
		Component CCN: 14-Z336	To 06/30/2023	Date/Time Prepared:
				1/24/2024 11:48 am

		Component CCN: 14-Z336	To 06/30/2023	Date/Time Pre 1/24/2024 11:	
-		Title XVIII	Swing Beds - SNF		40 aiii
		,	Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1, 560, 923	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)	+ A and our of Wko+ D	E20 004	0	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi	t A, and Sum OT WKSt. D, na-bed pass-through see	529, 884	U	3.00
	instructions)	ng-bed pass-till odgil, see			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teach	ing program (see		0.00	1
	instructions)	31 3 (
5.00	Program days		1, 254	0	5.00
6.00	Interns and residents not in approved teaching program (see i			0	
7. 00	Utilization review - physician compensation - SNF optional me	thod only	0	_	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2, 090, 807	0	
9.00	Primary payer payments (see instructions)		2 000 907	0	
10. 00 11. 00	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts appli	cable to physician	2, 090, 807	0	
11.00	professional services)	cable to physician	0	U	11.00
12. 00	Subtotal (line 10 minus line 11)		2, 090, 807	0	12.00
13. 00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	30, 122	0	
	for physician professional services)		·		
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		2, 060, 685	0	
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
16. 50	Pioneer ACO demonstration payment adjustment (see instruction				16.50
16. 55	Rural community hospital demonstration project (§410A Demonst	ration) payment	0		16. 55
16. 99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		1, 556	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		1, 011	0	
18. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	
19.00	Total (see instructions)	,	2, 061, 696	0	19.00
19. 01	Sequestration adjustment (see instructions)		41, 234	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	, ,				19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	1
20.00	Interim payments		1, 867, 810	0	
20. 01 21. 00	Interim payments-PARHM		0	0	20.01
21.00	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)		U	U	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.0	2 19 25 20 and 21)	152, 652	0	1
22. 01	Balance due provider/program-PARHM (see instructions)	2, 17. 20, 20, and 21)	102,002		22. 01
23. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0	0	
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonst				
200.00	Is this the first year of the current 5-year demonstration pe	riod under the 21st			200.00
	Century Cures Act? Enter "Y" for yes or "N" for no.				-
201 00	Cost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from	Wkst D 1 Dt II line			201 00
201.00	66 (title XVIII hospital))	Wkst. D-1, Pt. II, line			201.00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst D-3 col 3 lin	e		202.00
202.00	200 (title XVIII swing-bed SNF))	Mat. B 0, 001. 0, 1111			202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons	trati on	1
	peri od)				
	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t				206. 00
207.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbur	sement	1		207 00
	Program reimbursement under the §410A Demonstration (see inst		1		207.00
∠∪8. U(Medicare swing-bed SNF inpatient service costs (from Wkst. E- and 3)	z, cor. i, sum or rines	'		208. 00
209 00	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
	Reserved for future use				210.00
2. 30	Comparision of PPS versus Cost Reimbursement				1
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line	209 plus line 210) (see			215. 00
	instructions)				

Health Financial Systems	ST. JOSEPHS HOSPITAL	HIGHLAND IL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 14-1336	From 07/01/2022	Worksheet E-3 Part V Date/Time Prepared: 1/24/2024 11:48 am
		Title XVIII	Hospi tal	Cost

				1/24/2024 11:	48 am_
		Title XVIII	Hospi tal	Cost	
				1, 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	RELMBURSEMENT		
1. 00	Inpatient services	TAIRT A SERVICES COST	TET IIIDONOLIIILIVI	2, 856, 524	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructi	one)		2, 030, 324	2.00
		0115)		0	
3.00	Organ acqui si ti on			-	3.00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			2, 856, 524	4. 00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 885, 089	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7.00	Routine service charges			0	7. 00
8.00	Ancillary service charges			o	8.00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
10.00	Customary charges			0	10.00
11. 00	Aggregate amount actually collected from patients liable for	nayment for services on	a chargo basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for				12.00
12.00	·	. 3	ni a charge basis	١	12.00
40.00	had such payment been made in accordance with 42 CFR 413.13(e	e)		0.000000	40.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14. 00	Total customary charges (see instructions)			0	14.00
15. 00	Excess of customary charges over reasonable cost (complete on	lly if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete on	ly if line 6 exceeds lir	ne 14) (see	0	16.00
	instructions)				
17.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 885, 089	19.00
20.00	Deductibles (exclude professional component)			430, 904	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			2, 454, 185	22.00
23. 00	Coinsurance			0	23. 00
24. 00	Subtotal (line 22 minus line 23)			2, 454, 185	
25. 00	Allowable bad debts (exclude bad debts for professional servi	cas) (saa instructions)		51, 095	
26. 00	Adjusted reimbursable bad debts (see instructions)	ces) (see mistractions)		33, 212	
27.00	Allowable bad debts for dual eligible beneficiaries (see inst	ruoti ana)			
		ructions)		37, 748	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			2, 487, 397	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	
30.00	Subtotal (see instructions)			2, 487, 397	30.00
30. 01	Sequestration adjustment (see instructions)			49, 748	30. 01
30.02	Demonstration payment adjustment amount after sequestration			0	30.02
30.03	Sequestration adjustment-PARHM				30. 03
31.00	Interim payments			2, 470, 210	31.00
31. 01	Interim payments-PARHM				31.01
	Tentative settlement (for contractor use only)			0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.0	12 31 and 32)		-32, 561	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m		and 32 01)	32, 301	33. 01
34. 00	Protested amounts (nonallowable cost report items) in accorda	·	,	o	
54.00	\$115. 2	mice with ows rub. 13-2,	chapter I,		34.00
	[3113. 2				

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

Provi der CCN: 14-1336

Peri od: Worksheet G
From 07/01/2022
To 06/30/2023 Date/Time Prepared: 1/24/2024 11: 48 am

——————————————————————————————————————			,		1/24/2024 11:	48 am_
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS		2.00	0.00	11.00	
1.00	Cash on hand in banks	354, 333	0	0	0	
2.00	Temporary investments	0	0	0		1
3. 00	Notes receivable	0	0	0		3.00
4.00	Accounts receivable	-60, 392	0	0	0	
5.00	Other receivable	(120 010	0	0	0	5.00
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable			0	0	6. 00 7. 00
8. 00	Inventory Prepai d expenses	742, 738 332, 810		0	0	
9. 00	Other current assets	7, 529, 921		0	0	
10.00	Due from other funds	0	ol ol	0	Ö	
11. 00	Total current assets (sum of lines 1-10)	15, 030, 320	o	0	l	11.00
	FIXED ASSETS					
12.00	Land	2, 034, 874	0	0	1	12.00
13. 00	Land improvements	1, 484, 818		0		13.00
14. 00	Accumulated depreciation	-1, 414, 606		0	1	14.00
15.00	Buildings	17, 322, 320		0	ı	15.00
16.00	Accumulated depreciation	-3, 879, 501		0	0	1
17. 00 18. 00	Leasehold improvements Accumulated depreciation	139, 133 -113, 592	1	0	0	17. 00 18. 00
19. 00	Fi xed equi pment	22, 865, 298		0	0	19.00
20. 00	Accumul ated depreciation	-9, 015, 056		0	0	20.00
21. 00	Automobiles and trucks	7,010,000		0	Ö	21.00
22. 00	Accumulated depreciation		o	0	Ō	22.00
23. 00	Major movable equipment	13, 668, 093	0	0	0	23. 00
24.00	Accumulated depreciation	-10, 535, 828	0	0	0	24.00
25.00	Mi nor equi pment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	00 555 050	0	0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	32, 555, 953	0	0	0	30.00
31. 00	Investments	8, 163, 625	ol ol	0	0	31.00
32. 00	Deposits on Leases	6, 663, 720		0	0	32.00
33. 00	Due from owners/officers	0,000,720		0	o o	33.00
34.00	Other assets	0	o	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14, 827, 345	0	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	62, 413, 618	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1, 424, 957		0		
38. 00	Salaries, wages, and fees payable	1, 613, 619	0	0		38.00
39. 00 40. 00	Payroll taxes payable Notes and Loans payable (short term)	4 422 024	0	0	0	
41. 00	Deferred income	6, 432, 934		0	0	41.00
42. 00	Accel erated payments			0	l o	42.00
43. 00	Due to other funds		o	0	0	43.00
44. 00	Other current liabilities	2, 361, 891	Ö	0	Ō	
45.00	Total current liabilities (sum of lines 37 thru 44)	11, 833, 401	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	1	
47.00	Notes payable	34, 627, 550		0	1	
48. 00	Unsecured Loans	0	0	0	1	1
49. 00	Other long term liabilities	0	0	0	1	
50.00	Total long term liabilities (sum of lines 46 thru 49)	34, 627, 550		0		50.00
51. 00	Total liabilities (sum of lines 45 and 50)	46, 460, 951	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	15, 952, 667	,			52.00
53. 00	Specific purpose fund	15, 752, 007	0			53.00
54. 00	Donor created - endowment fund balance - restricted	•		0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			· ·	0	
58.00	Plant fund balance - reserve for plant improvement,				0	
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	15, 952, 667		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	62, 413, 618	0	0	0	60.00
	[59]	I	1		l	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 14-1336

Peri od: Worksheet G-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

					То	06/30/2023	Date/Time Pre 1/24/2024 11:	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1. 00	2. 00	3. 00		4. 00	5. 00	
1. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	1.00	7, 832, 132 9, 499, 460			4.00	5.00	1.00
3. 00 4. 00	Total (sum of line 1 and line 2) NET ASSET RELEASED PPE	2, 767	17, 331, 592		0	0	0	3. 00 4. 00
5. 00 6. 00		0			0		0	5. 00 6. 00
7. 00 8. 00		0			0		0	7. 00 8. 00
9. 00 10. 00	Total additions (sum of line 4-9)	0	2, 767		0	0	0	9. 00 10. 00
11. 00 12. 00	Subtotal (line 3 plus line 10) AFS TRANSFER TO AFFILIATE	1, 381, 691	17, 334, 359		0	0	0	11. 00 12. 00
13. 00 14. 00	ROUNDI NG	1			0		0	13. 00 14. 00
15. 00 16. 00		0			0		0	15. 00 16. 00
17. 00 18. 00	Total deductions (sum of lines 12-17)	0	1, 381, 692		0	0	0	17. 00 18. 00
19. 00			15, 952, 667			0		19. 00
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0	7.00	0.00	0			1. 00 2. 00
3. 00 4. 00	Total (sum of line 1 and line 2) NET ASSET RELEASED PPE	0	0		0			3. 00 4. 00
5. 00 6. 00	NET 763ET RELEASES TTE		0					5. 00 6. 00
7. 00 8. 00			0					7. 00 8. 00
9. 00 10. 00	Total additions (sum of line 4-9)		0		0			9. 00 10. 00
11. 00 12. 00	Subtotal (line 3 plus line 10) AFS TRANSFER TO AFFILIATE	0	0		0			11. 00 12. 00
13. 00 14. 00	ROUNDI NG		0					13. 00 14. 00
15. 00 16. 00			0					15. 00 16. 00
17. 00	Total deductions (sum of lines 12.17)		0					17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			18. 00 19. 00

Health Financial Systems ST. J Provi der CCN: 14-1336

		Т	o 06/30/2023	Date/Time Pre 1/24/2024 11:	
	Cost Center Description	I npati ent	Outpati ent	Total	
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	4, 605, 625		4, 605, 625	1.00
2. 00	SUBPROVI DER - I PF				2.00
3. 00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVI DER				4.00
5. 00	Swing bed - SNF	1, 116, 488		1, 116, 488	5. 00
6.00	Swing bed - NF	111, 877		111, 877	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)	5, 833, 990		5, 833, 990	10. 00
44.00	Intensive Care Type Inpatient Hospital Services	T			44.00
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT				12.00
13.00					13. 00 14. 00
15. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	0		0	16.00
16.00	11-15)			U	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	5, 833, 990		5, 833, 990	17. 00
18. 00	Ancillary services	19, 223, 021	110, 963, 128	130, 186, 149	18.00
19. 00	Outpatient services	796, 152		17, 436, 713	
20.00	RURAL HEALTH CLINIC	770, 132	10, 040, 301	17, 430, 719	20.00
	FEDERALLY QUALIFIED HEALTH CENTER		-1	0	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
27. 00	PRO FEES	40, 817	179, 428	220, 245	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	25, 893, 980	127, 783, 117	153, 677, 097	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		45, 210, 055		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0	I I		31.00
32. 00		0			32.00
33.00		0			33.00
34. 00		0			34.00
35.00		0			35.00
36. 00	Total additions (sum of lines 30-35)		0		36.00
37. 00	DEDUCT (SPECIFY)	0			37.00
38. 00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00	Total deductions (sum of Lines 27 41)	0			41.00
42.00	Total deductions (sum of lines 37-41)		45 210 055		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		45, 210, 055		43.00
	10 mkst. 0-3, 1116 4)	1	ı I		l

TATEN	IENT OF REVENUES AND EXPENSES	Provi der CCN: 14-1336	Period: From 07/01/2022 To 06/30/2023	Worksheet G-3 Date/Time Pre 1/24/2024 11:	pared
			-	1. 00	
. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		153, 677, 097	1.0
. 00	Less contractual allowances and discounts on patients' accour			102, 806, 763	
. 00	Net patient revenues (line 1 minus line 2)	113		50, 870, 334	
. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		45, 210, 055	
. 00	Net income from service to patients (line 3 minus line 4)	10)		5, 660, 279	
	OTHER I NCOME			0,000,2,,	0.0
. 00	Contributions, donations, bequests, etc			0	6.0
. 00	Income from investments			85, 076	7. (
. 00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.
. 00	Revenue from television and radio service			0	
0.00	Purchase di scounts			0	10.
1.00	Rebates and refunds of expenses			0	11.
2. 00	Parking Lot receipts			0	12.
3. 00	Revenue from Laundry and Linen service			0	13.
4. 00	Revenue from meals sold to employees and guests			135, 258	14.
5. 00	Revenue from rental of living quarters			0	15.
5. 00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.
7.00	Revenue from sale of drugs to other than patients	•		0	17.
3. 00	Revenue from sale of medical records and abstracts			4, 189	18.
9. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.
0. 00	Revenue from gifts, flowers, coffee shops, and canteen			22, 024	20.
. 00	Rental of vending machines			0	21.
2. 00	Rental of hospital space			174, 706	22.
3. 00	Governmental appropriations			0	23.
1. 00	OTHER OPERATING REVENUE			225, 142	24.
1. 01	GRANTS			139, 360	24.
. 50	COVI D-19 PHE Fundi ng			0	24.
. 00	Total other income (sum of lines 6-24)			785, 755	25.
. 00	Total (line 5 plus line 25)			6, 446, 034	
7. 00	NON OPERATING EXPENSES			-3, 587, 072	27.
7. 01	NON OPERATING PENSION			533, 646	27.
3. 00	Total other expenses (sum of line 27 and subscripts)			-3, 053, 426	28
0 00	Net income (or loss) for the period (line 26 minus line 28)			9, 499, 460	29