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: 14-0032 Worksheet S Peri od: From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 1/24/2024 1:12 pm use only] Manually prepared cost report Ilf 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
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR

number of times reopened = 0-9.

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

(3) Settled with Audit

(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. ANTHONYS MEMORIAL HOSPITAL (14-0032) 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 ADMINISTRATO	R CHECKBOX	ELECTRONI C	
	1	2	SI GNATURE 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	-111, 528	-35, 228	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	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	TOTAL	0	-111, 528	-35, 228	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.

Contractor use only

In Lieu of Form CMS-2552-10 Health Financial Systems ST. ANTHONYS MEMORIAL HOSPITAL

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0032 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 1:12 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 503 N MAPLE 1.00 PO Box: 1.00 2.00 City: EFFINGHAM State: IL Zip Code: 62401 County: EFFINGHAM 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ST. ANTHONYS MEMORIAL 140032 99914 07/01/1966 Ν 0 3.00 HOSPI TAL Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF ST. ANTHONYS MEMORIAL 14U032 99914 Р 0 12/02/2020 N 7 00 7.00 HOSPITAL SNF 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA ST. ANTHONYS MEMORIAL 147661 99914 02/17/1997 Ν Ρ Ν 12.00 HOSPITAL HHA 13.00 Separately Certified ASC 13.00 ST. ANTHONY MEMORIAL 99914 14.00 Hospi tal -Based Hospi ce 141658 10/14/2014 14.00 HOSPITAL HOSPIC 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 06/30/2023 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2022 20.00 21.00 Type of Control (see instructions) 1 21.00 1.00 2. 00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for 22. 00 N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be 22 02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N Ν N 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23 00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

Health Financial Systems ST. ANTHONYS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0032 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 1: 12 pm XVIII XIX 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N IMF Direct GME IME Direct GME 2. 00 3. 00 4.00 5.00 1 00 61.00 Did your hospital receive FTE slots under ACA Ν 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61 03 Enter the base line FTE count for primary care 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

during in this cost reporting period of HRSA THC program. (see instructions)

your hospital received HRSA PCRE funding (see instructions)

Teaching Hospitals that Claim Residents in Nonprovider Settings

Enter the number of FTE residents that your hospital trained in this cost reporting period for which

Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital

Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

0.00 62.00

0.00 62.01

63.00

62.00

62.01

Health Financial Systems		ST. ANTHON	NYS MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH	CARE COMPLE	EX IDENTIFICATION DA	TA Provider CC		eriod: fom 07/01/2022 0 06/30/2023	Worksheet S-2 Part I Date/Time Pre 1/24/2024 1:1	
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1. 00	2.00	3.00	
Section 5504 of the ACA				This base year	is your cost r	eporti ng	
period that begins on c 64.00 Enter in column 1, if I in the base year period resident FTEs attributa settings. Enter in col resident FTEs that trai of (column 1 divided by	ine 63 is do not be to rot umn 2 the ned in you	0.00	0. 00	0. 000000	64. 00		
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTEs Nannnavi dan	FTEs in	(col. 3 + col.	
				Nonprovi der Si te	Hospi tal	4))	
		1. 00	2.00	3. 00	4. 00	5.00	
65.00 Enter in column 1, if is yes, or your facilit trained residents in the year period, the program associated with primary FTEs for each primary of program in which you the residents. Enter in column 3, the number of unweighted primary care residents attributable rotations occurring in non-provider settings. column 4, the number of unweighted primary care resident FTEs that train your hospital. Enter in 5, the ratio of (column divided by (column 3 + 4)). (see instructions)	ty ne base am name y care care carined umn 2, in e FTE to all Enter in ned in n column n 3 column	1.00	2.00	Unweighted FTEs Nonprovider Site	Unwei ghted FTEs in Hospi tal		65. 00
				1, 00	2. 00	3.00	
Section 5504 of the ACA	A Current Y	ear FTE Residents in	n Nonprovider Setting				
beginning on or after s	Jul y 1, 201	0					
66.00 Enter in column 1 the r FTEs attributable to ro Enter in column 2 the r FTEs that trained in yo (column 1 divided by (column 1 di	otations oc number of u our hospita	curring in all nonpr nweighted non-primar I. Enter in column 3	rovider settings. Ty care resident B the ratio of	0.00	0. 00	0. 000000	66. 00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
47 ap le 1		1. 00	2.00	3. 00	4.00	5.00	.= -
67.00 Enter in column 1, the name associated with earn your primary care progry which you trained residenter in column 2, the code. Enter in column 3 number of unweighted procare FTE residents attratorotations occurring non-provider settings. column 4, the number of unweighted primary care resident FTEs that train your hospital. Enter in 5, the ratio of (column divided by (column 3 + 4)). (see instructions)	ach of rams in dents. program 8, the rimary ributable in all Enter in e ned in n column a 3 column			0.00	0.00	0. 000000	67.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	MORIAL HOSPITAL Provider CC	N: 14-0032	Period: From 07/01/ To 06/30/	2022	wof Form (Worksheet Part I Date/Time 1/24/2024	S-2 Prepare	
					1.00		
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 3.00 For a cost reporting period beginning prior to October 1, 2 MAC to apply the new DGME formula in accordance with the FY (August 10, 2022)?	2022, did you ob	tain permiss	ion from you		N	68.	
				1. 00	2.00 3	. 00	
Inpatient Psychiatric Facility PPS				N.1		7.0	
Is this facility an Inpatient Psychiatric Facility (IPF), of Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approrecent cost report filed on or before November 15, 2004? E 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility is program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? E Column 3: If column 2 is Y, indicate which program year beginstructions)	oved GME teachir Enter "Y" for ye train residents Enter "Y" for ye	ng program ir es or "N" for in a new tea es or "N" for	n the most n no. (see aching no.	N		70. 0 71.	
Inpatient Rehabilitation Facility PPS 5.00 Is this facility an Inpatient Rehabilitation Facility (IRF)	N		75.				
subprovider? Enter "Y" for yes and "N" for no. 1f line 75 is yes: Column 1: Did the facility have an appropriate cost reporting period ending on or before November 1 no. Column 2: Did this facility train residents in a new to CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no	15, 2004? Enter eaching program	"Y" for yes in accordance	or "N" for ce with 42			0 76.	
indicate which program year began during this cost reporting	ng period. (see	instructions	5)				
T 0 H 14 1 PPC					1.00		
Long Term Care Hospital PPS 1.00 Is this a long term care hospital (LTCH)? Enter "Y" for years 1.00 Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.			ng period? Er	nter	N N	80. 81.	
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i 6.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				no.	N	85. 86.	
7.00 Is this hospital an extended neoplastic disease care hospit 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	tal classified ι	ınder sectior	1		N	87.	
			Approved Permane Adjustm (Y/N) 1.00	nt ent	Number of Approve Permaner Adjustmer 2.00	d nt	
3.00 Column 1: Is this hospital approved for a permanent adjustr amount per discharge? Enter "Y" for yes or "N" for no. If y 89. (see instructions)	yes, complete co		ne			0 88.	
Column 2: Enter the number of approved permanent adjustment	ts.	Wkst. A Lir	e Effective	Date	Approve	d	
		No.			Permaner Adjustme Amount P Discharq	nt er	
0.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A	Line number	1. 00	2.00		3.00	0 89.	
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 to per discharge.	as based. ng period target amount	0.				0 07.	
Column 3: Enter the amount of the approved permanent adjust TEFRA target amount per discharge.	tilletti to the						
			V 1. 00		XI X 2. 00		
Title V and XIX Services .00 Does this facility have title V and/or XIX inpatient hospit	tal sarvices? Fr	tor "V" for	N		Y	90.	
yes or "N" for no in the applicable column.			N N		r N	90.	
	full or in part? Enter "Y" for yes or "N" for no in the applicable column.						
instructions) Enter "Y" for yes or "N" for no in the applications. OD Does this facility operate an ICF/IID facility for purposes.	cable column.		N		N N	92.	
"Y" for yes or "N" for no in the applicable column. 1.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,			N		N	94.	
4. 00 DOCS title V OF ATA TENDED CAPITAL COST: Efficit T TOF VCS,			1				
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the ap			0.00		0.00	95.	
applicable column.	es or "N" for no	in the	0. 00 N 0. 00		0. 00 N 0. 00	95. 96. 97.	

Health Financial Systems ST. ANTHONYS MEMO	RIAL HOSPITAL	=	In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 14-0032	Peri od:	Worksheet S-2	
			From 07/01/2022 To 06/30/2023		epared:
			.,	1/24/2024 1:	12 pm
			V 1. 00	2. 00	_
98.00 Does title V or XIX follow Medicare (title XVIII) for the in	terns and res	sidents post	1.00 Y	2.00 Y	98. 00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f column 1 for title V, and in column 2 for title XIX.	or yes or "N"	for no in			
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 title XIX.				Y	98. 01
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			Y	Y	98. 02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye			N	98. 03	
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in	N	N	98. 04		
<pre>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</pre>		Y	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			Y	Y	98. 06
column 2 for title XIX. Rural Providers					
105.00 Does this hospital qualify as a CAH? 106.00 of this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of paymen	N N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for co training 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	1. (see ins you train I&F	structions) Rs in an			107. 00
Enter "Y" for yes or "N" for no in column 2. (see instructi 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		edul e? See 42	. N		108. 00
on the distriction of the first field of the first field of the field	Physi cal	Occupati ona	Il Speech	Respi ratory	
400 001 0 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1.00	2.00	3.00	4.00	100.00
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	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 Wor	Y" for yes or	"N" for no.	If yes,	N N	110. 00
appl i cabl e.					
			1.00	2.00	
111.00 f this facility qualifies as a CAH, did it participate in t	he Frontier (Community	1. 00 N	2.00	111. 00
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 lumn 1 is Y, ticipating ir	period? Enter enter the ocolumn 2.			
1.5. Core mear the services.					
		1. 00	2. 00	3.00	
112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If co	porting	N			112. 00

period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information

115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no N 0115.00 in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on 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" for no. 116. 00 117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. 117. 00 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 118. 00 if the policy is claim-made. Enter 2 if the policy is occurrence.

ealth Financial Systems ST. ANTHONYS MEMORI IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO	CN: 14-0032	Peri od:	Worksheet S	
			From 07/01/2022 To 06/30/2023	Part I	repared:
		Premi ums	Losses	Insurance	,,,,,,
		1.00	2.00	3.00	
18.01 List amounts of malpractice premiums and paid losses:		359, 86	96, 000	2, 267, 1	30 118. 0
10.00			1.00	2.00	110.0
18.02 Are malpractice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein. 19.00 DO NOT USE THIS LINE			N		118. C
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold F §3121 and applicable amendments? (see instructions) Enter in a "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	olumn 1, "Y' ifies for th	for yes or ne Outpatient	N	N	120. 0
21.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	able devices	s charged to	Y		121. (
22.00 Does the cost report contain healthcare related taxes as defin Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i			N		122. 0
the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purch services, e.g., legal, accounting, tax preparation, bookkeepin management/consulting services, from an unrelated organization	ig, payroll,	and/or			123. 0
for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., g professional services expenses, for services purchased from un located in a CBSA outside of the main hospital CBSA? In column "N" for no.	reater than related orga	50% of total anizations			
Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant cer	iter? Enter '	'Y" for ves	N		125. 0
and "N" for no. If yes, enter certification date(s) (mm/dd/yyy	y) below.	,			
26.00 f this is a Medicare-certified kidney transplant program, ent in column 1 and termination date, if applicable, in column 2.	er the certi	fication date	9		126. 0
27.00 of this is a Medicare-certified heart transplant program, ente in column 1 and termination date, if applicable, in column 2.	r the certif	ication date			127. 0
28.00 If this is a Medicare-certified liver transplant program, ente	r the certif	cation date			128. 0
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare-certified lung transplant program, enter in column 1 and termination date, if applicable, in column 2.	the certifi	cation date			129. (
30.00 If this is a Medicare-certified pancreas transplant program, educate in column 1 and termination date, if applicable, in colum		ti fi cati on			130. (
31.00 If this is a Medicare-certified intestinal transplant program, date in column 1 and termination date, if applicable, in colum	enter the one in 2.				131. (
32.00 If this is a Medicare-certified islet transplant program, enter in column 1 and termination date, if applicable, in column 2.	er the certif	fication date			132. (
33.00 Removed and reserved 34.00 If this is a hospital-based organ procurement organization (OF in column 1 and termination date, if applicable, in column 2.	0), enter th	ne OPO number			133. (134. (
All Providers					
40.00 Are there any related organization or home office costs as def chapter 10? Enter "Y" for yes or "N" for no in column 1. If ye are claimed, enter in column 2 the home office chain number. (es, and home	$of fice\ costs$	Y		140. 0
1.00 2.00 If this facility is part of a chain organization, enter on lir home office and enter the home office contractor name and contractor nam			3.00 ame and address	of the	
11.00 Name: HOSPITAL SISTERS HEALTH SYSTEM Contractor's Name: NGS			or's Number: 0013	31	141. (
12.00 Street: 4936 LAVERNA ROAD PO Box: 13.00 City: SPRINGFIELD State: I L		Zi p Code:	6270)7	142. (143. (
				1.00	
44.00 Are provider based physicians' costs included in Worksheet A?				1.00 Y	144. (
			1.00	2.00	
45.00 If costs for renal services are claimed on Wkst. A, line 74, a inpatient services only? Enter "Y" for yes or "N" for no in cono, does the dialysis facility include Medicare utilization for	olumn 1. If o	column 1 is	1.00	2.00	145. (
period? Enter "Y" for yes or "N" for no in column 2. 46.00Has the cost allocation methodology changed from the previousl			N		146. 0

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	ST. ANTHONYS	MEMORIA	AL HOSPITAL Provider CC	N: 14-0022	Peri		u of Form CMS Worksheet S-	
HUSELIAL AND HUSELIAL HEALIH CAKE CUMPLE	A IDENTIFICATION DATA		FLOVIDEL CC	IN. 14-UU32		07/01/2022 06/30/2023	Part I Date/Time Pr	epared:
							1/24/2024 1:	12 pm
							1.00	-
147.00 Was there a change in the statisti	cal basis? Enter "Y" 1	for yes	or "N" for	no.			N	147. 00
148.00 Was there a change in the order of	allocation? Enter "Y'	" for ye	es or "N" fo	r no.			N	148. 00
149.00 Was there a change to the simplifi	ed cost finding method	d? Enter					N	149. 00
			Part A	Part B	3	Title V	Title XIX	
D 11: 6 :1:1	1 11 1 1:6:		1.00	2.00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '								
155. 00 Hospi tal	N TOT TIO TOT EACT CO	iliporterri	N N	N	. (See	N N	N N	155. 00
156. 00 Subprovi der - IPF			N I	N		N	N N	156. 00
157. 00 Subprovi der – IRF			N	N		N	N N	157. 00
158. 00 SUBPROVI DER								158. 00
159. 00 SNF			N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY			N	N		N	N	160. 00
161. 00 CMHC				N		N	N	161. 00
							1. 00	_
Multicampus							1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has	s one or	r more campu	ses in dif	ferent	CBSAs?	N	165. 00
	Name	(County	State	Zip Cod	le CBSA	FTE/Campus	
	0		1. 00	2. 00	3.00	4. 00	5. 00	
166.00 f 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	\dashv
Health Information Technology (HI) incentive in the Am	eri can	Recovery and	Reinvestm	nent Act	t	1.00	
167.00 Is this provider a meaningful user	under §1886(n)? Ente	er "Y" 1	for yes or "	N" for no.			Υ	167. 00
168.00 If this provider is a CAH (line 10	05 is "Y") and is a mea	ani ngful	l user (line	167 is "Y	"), ent	er the		168. 00
reasonable cost incurred for the H	•	,						
168.01 If this provider is a CAH and is r						ardshi p		168. 01
exception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful under transition factor. (see instruction	ser (line 167 is "Y")					enter the	9. 9	99169. 00
transition ractor. (see mistruction	113)					Begi nni ng	Endi ng	
						1. 00	2.00	_
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	eginning date and endi	ing date	e for the re	porting				170. 00
						1. 00	2. 00	_
171.00 fline 167 is "Y", does this prov	ider have any days for	r indivi	i dual s encol	Led in		N. N.	2.00	0 171, 00
section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	eported on Wkst. S-3, umn 1. If column 1 is y	Pt. I,	line 2, col	. 6? Enter		14		171.00

Heal th	Financial Systems ST. ANTHONYS MEM	ORIAL HOSPITAL		In Li∈	eu of Form CMS-	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 14-0032	Peri od:	Worksheet S-2	
				From 07/01/2022 To 06/30/2023		epared:
) / /N	1/24/2024 1:	
				Y/N 1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT OUESTIONN	IAI RF	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N			er all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the			N		1. 00
	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instructions Y/N) Date	V/I	
			1.00	2.00	3. 00	
2.00	Has the provider terminated participation in the Medicare P		N			2. 00
	yes, enter in column 2 the date of termination and in column yelluntary or "I" for involuntary	n 3, "V" for				
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includin	g management	Y			3.00
0.00	contracts, with individuals or entities (e.g., chain home o					0.00
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members o					
	of directors through ownership, control, or family and othe relationships? (see instructions)	i Similai				
	The actions in per- (edec the citations)		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert	ified Dublic	У	A	10/20/2023	4.00
4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C" f		Y Y	A	10/20/2023	4.00
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
5. 00	Are the cost report total expenses and total revenues diffe		Y			5. 00
	those on the filed financial statements? If yes, submit rec	Onci i i ati on.		Y/N	Legal Oper.	
				1. 00	2.00	
	Approved Educational Activities				ı	
6.00	Column 1: Are costs claimed for a nursing program? Column the Legal operator of the program?	2: If yes, is	the provide	r N		6. 00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see in	N		7.00		
8.00	Were nursing programs and/or allied health programs approve		ved during th	e N		8. 00
0.00	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	•	cai education	N		9.00
10. 00	Was an approved Intern and Resident GME program initiated o		he current	N		10.00
	cost reporting period? If yes, see instructions.					
11. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes				Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	orrey change o	during this c	ost reporting	N	13.00
14. 00		nce amounts wa	nived? If yes	, see	N	14.00
	instructions.			•		
15 00	Bed Complement Did total beds available change from the prior cost reporti	na nonioda le	voc coo i no	tructions	l N	15 00
15.00	Total beds available change from the prior cost reporti		yes, see ms t A		N N	15. 00
		Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
1/ 00	PS&R Data		11 (01 (2022	V	11 /01 /2022	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	Υ	11/01/2023	Y	11/01/2023	16. 00
	date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N	1	N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.		I		I	1

OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	CN: 14-0032	Peri od: From 07/01/2022 To 06/30/2023	Worksheet S Part II Date/Time P 1/24/2024 1	repared:				
	Descri	pti on	Y/N	Y/N	. 12 piii				
)	1. 00	3. 00					
0.00 If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20. 00				
Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date					
	1.00	2. 00	3. 00	4. 00					
1.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 0				
				1. 00					
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)		1.00					
Capital Related Cost		,							
2.00 Have assets been relifed for Medicare purposes? If yes, see					22. 0				
3.00 Have changes occurred in the Medicare depreciation expense	due to apprais	als made du	ring the cost		23. 0				
reporting period? If yes, see instructions. 4.00 Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost r	eporting period?		24. 0				
5.00 Have there been new capitalized leases entered into during	the cost repor	ting period	? If yes, see		25. 0				
i nstructi ons.	•	0 .							
6.00 Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period?	If yes, see		26. 0				
7.00 Has the provider's capitalization policy changed during the	e cost reportin	a period? L	f ves. submit		27. 0				
сору.		9	. 900, 000						
Interest Expense									
8.00 Were new Loans, mortgage agreements or Letters of credit er period? If yes, see instructions.	ntered into dur	ing the cos	t reporting		28. 0				
9.00 Did the provider have a funded depreciation account and/or	bond funds (De	bt Service	Reserve Fund)		29. 0				
treated as a funded depreciation account? If yes, see instr	ructi ons		,						
DO Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see									
instructions. 1.00 Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If ye	s, see		31. 0				
Purchased Services									
2.00 Have changes or new agreements occurred in patient care ser		d through c	ontractual		32. 0				
arrangements with suppliers of services? If yes, see instru		_ +	: 4:		22.0				
3.00 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	biled pertainin	g to compet	itive bidding? IT		33. 0				
Provi der-Based Physi ci ans									
4.00 Were services furnished at the provider facility under an a	arrangement wit	h provider-	based physicians?		34.0				
If yes, see instructions.									
5.00 If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ts with the	provi der-based		35. 0				
physicians during the cost reporting period: 11 yes, see it	istructions.		Y/N	Date					
			1. 00	2. 00					
Home Office Costs									
6.00 Were home office costs claimed on the cost report? 7.00 If line 36 is yes, has a home office cost statement been pr	ropared by the	homo offico	2		36. 0 37. 0				
If yes, see instructions.	epared by the	nome office	f		37.0				
8.00 If line 36 is yes, was the fiscal year end of the home off	fice different	from that o	f		38. 0				
the provider? If yes, enter in column 2 the fiscal year end									
9.00 If line 36 is yes, did the provider render services to other	er chain compon	ents? If ye	S,		39. 0				
see instructions. O.00 If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 0				
THISTI DOLLOUS.									
	1.	00	2.	00					
Cost Report Preparer Contact Information	b. Th. a. :		DA QUEL :						
·	PATRI CI A		RACHELL		41.0				
held by the cost report preparer in columns 1, 2, and 3,									
respectively. 2.00 Enter the employer/company name of the cost report	FORVI S				42. 0				
respectively. 2.00 Enter the employer/company name of the cost report preparer.	FORVI S 314. 231. 5544		PATTY. RACHELL@F		42. 0 43. 0				

Heal th	Financial Systems ST. AN	NTHONYS MEN	ORIAL HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provider CCN: 14-0032	Peri od:	Worksheet S-2		
				From 07/01/2022 To 06/30/2023			
			3. 00				
ļ	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/pos	si ti on	MANAGING DIRECTOR			41.00	
ļ	held by the cost report preparer in columns 1, 2,	and 3,					
ļ	respecti vel y.						
42. 00	Enter the employer/company name of the cost repor	rt				42.00	
ļ	preparer.						
43.00	Enter the telephone number and email address of t	the cost				43.00	
ļ	report preparer in columns 1 and 2, respectively.						

| Period: | Worksheet S-3 | From 07/01/2022 | Part | To 06/30/2023 | Date/Time Prepared: Health Financial Systems ST. ANTHOM HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-0032

Component Worksheet A No. of Beds Bed Days Available CAH/REH Hours Title V Line No.						-	To 06/30/2023	Date/Time Prep 1/24/2024 1:1:	
Component Worksheet A No. of Beds Bed Days Available CAH/REH Hours Title V									E pin
Line No. Available									
PART - STATISTICAL DATA		Component	Worksheet A	No	of Beds	Bed Days			
PART I - STATISTICAL DATA		·	Line No.			Avai I abl e			
1.00 Hospit tal Adult is & Peds. (columns 5, 6, 7 and 8 8 exclude Swing Bed. (Diservation Bed and Hospic ed days) (see instructions for col. 2 7 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 2.00 MB0 10 F Subprovi der 2.00 MB0 10 F Subprovi der 3.30 0.00 MB0 10 F Subprovi der 3.30 0.00 MB0 10 F Subprovi der 3.30 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00			1. 00		2. 00	3. 00	4. 00	5. 00	
8 exclude Swing Bed, Observation Bed and Hospice days) (See instructions for col. 2 for the portion of LDP room available beds)		PART I - STATISTICAL DATA							
Hospice days)(see instructions for col. 2	1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		123	44, 89	0.00	0	1.00
For the portion of LDP room available beds) 2.00 Number 3.00 3.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1									
2.00 HMO and other (see instructions) 3.00 HMO IPF Subprovi der 4.00 4.00 HS IRF Subprovi der 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.00 INTENSIVE CARE UNIT 9.00 OWNARY CARE UNIT 11.00 SUBROVI CARE (SPECIFY) 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAR Visits 15.00 CAR Visits 15.00 CAR Visits 15.00 CAR SILLED NURSING FACILITY 10.00 SUBPROVI DER - IRF 18.00 ON HOSPICE 10.00 ON HOSPICE 10.00 CARC CARE (SPECIFY) 10.00 ON HOSPICE 10.00 CARC CARE (SPECIFY) 10.00 CARC CARE (SPECIFY) 10.00 CARC CARE (SPECIFY) 10.00 SUBPROVI DER - IRF 18.00 SUBPROVI DER - I									
3.00 HMO IPF Subprovi der									
4.00									
5.00		•							
6.00 Hospital Adults & Peds. Swing Bed NF 123 44,895 0.00 0 7.00 7.00 Total Adults and Peds. (exclude observation beds) (see Instructions) 123 44,895 0.00 0 7.00 8.00 INTENSIVE CARE UNIT 31.00 10 3,650 0.00 0 8.00 9.00 CORONARY CARE UNIT 10.00 10.00 BURN INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 INTERSIVE CARE UNIT 11.00 14.00 Total (see instructions) 43.00 133 48,545 0.00 14.00 15.00 CAH visits 15.10 15.00 16.00 SUBPROVIDER - IPF 16.00 18.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVIDER - IRF 16.00 19.00 NURSING FACILITY 20.00 10.00 OTHER LONG TERM CARE		•							
Total Adults and Peds. (exclude observation beds) See instructions) Section Se									
beds) (see instructions)								l	
8. 00 INTENSIVE CARE UNIT 31. 00 10 3,650 0.00 0 8. 00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0	7. 00				123	44, 89!	0.00	0	7. 00
9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 TOTALI (see instructions) 13.00 NURSERY 15.00 TOTALI (see instructions) 15.10 REH hours and visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 NURSING FACILITY 20.00 NURSING FACILITY 20.00 NURSING FACILITY 20.00 NURSING FACILITY 20.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE (non-distinct part) 25.00 CMR -		, ,							
10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 12.00 11.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00			31. 00		10	3, 650	0.00	0	
11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 13.00 14.00 14.00 15.00 15.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00									
12. 00 13. 00 14. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15		1							
13. 00 NURSERY		1							
14. 00 Total (see instructions) 15. 00 CAH visits 15. 10 REH hours and visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 LTCH non-covered days 33. 00 LTCH site neutral days and discharges 133 48, 545 0.00 0 14. 00 0 15. 00 0 16. 00 0 16. 00 0 17. 00 0 18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			40.00						
15. 00 CAH visits 15. 10 REH hours and visits 15. 10 REH hours and visits 16. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER - I RF 19. 00 SKI LLED NURSI NG FACILITY 20. 00 NURSI NG FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 00 HOSPI CE 24. 00 HOSPI CE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee di scount days (see instruction) 31. 00 Employee di scount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH site neutral days and discharges 33. 00 LTCH site neutral days and discharges			43.00		400	40.54			
15. 10 REH hours and visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 WINSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Empl oyee di scount days (see instruction) 31. 00 Empl oyee di scount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days and discharges		,			133	48, 54	0.00		
16. 00 SUBPROVIDER - IPF 16. 00 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00								0	
17. 00 SUBPROVI DER - IRF 17. 00 18. 00 SUBPROVI DER 18. 00 SUBPROVI DER 18. 00 18. 00 SUBPROVI DER 19. 00 SUBLED NURSI NG FACILITY 19. 00 20. 00 NURSI NG FACILITY 20. 00 21. 00 22. 00 OTHER LONG TERM CARE 21. 00 22. 00 OTHER LONG TERM CARE 21. 00 22. 00 OTHER LONG TERM CARE 22. 00 OTHER LONG TERM CARE 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 23. 00 24. 00 OTHER LONG TERM CARE 25. 00 OTHER LONG TERM CARE OTHER LONG TERM CARE									
18. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACILITY 20. 00 NURSI NG FACILITY 20. 00 NURSI NG FACILITY 20. 00 OTHER LONG TERM CARE 20. 00 22. 00 22. 00 HOME HEALTH AGENCY 23. 00 24. 00 HOSPI CE 24. 00 HOSPI CE 24. 00 24. 10 25. 00 24. 10 25. 00 24. 10 25. 00 26. 25 27. 00 28. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00									
19. 00		1							
20.00 NURSING FACILITY 20.00 21.00 21.00 22.00 22.00 40ME HALTH AGENCY 101.00 22.00 23.00 40MBULATORY SURGICAL CENTER (D.P.) 23.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00									
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D. P.) 24.00 HOSPICE 24.00 HOSPICE 30.00 CMHC - CMHC 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.00 Labor & delivery days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges									
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPI CE 24. 00 CMHC - CMHC 25. 00 CMHC - CMHC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Observation Bed Days 29. 00 Ambul ance Tri ps 29. 00 Ambul ance Tri ps 30. 00 31. 00 Employee discount days (see instruction) 32. 00 Labor & delivery days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH site neutral days and discharges									
23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE			101 00						
24. 00 HOSPICE			101.00					U	
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH site neutral days and discharges			116 00		0	,			
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 33. 01 LTCH site neutral days and discharges					Ü	'l	1		
26. 00			30.00						
26. 25 FEDERALLY QUALIFIED HEALTH CENTER									
27.00 Total (sum of lines 14-26) 133 27.00 28.00 29.00 Ambulance Trips 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 2			89 00					0	
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges			07.00		133				
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 29.00 30.00 30.00 30.00 31.00 32.00 33.00 33.01		· ·			133	1		0	
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges 30.00 O 0 O 0 O 32.01 32.01 33.00 Signature days (see instructions)								Ŭ	
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 31.00 0 0 0 32.01 32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges									
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 32.01 33.01					0				
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 33.01					· ·	1			
33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 33.00 ag. 01	32. 31								-2.0.
33.01 LTCH site neutral days and discharges 33.01	33.00								33.00
	33. 01	,							33. 01
	34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0)		0	34. 00

Health Financial Systems ST. ANTHONYS MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO

Provider CCN: 14-0032

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 07/01/2022 Part I

To 06/30/2023 Date/Time Prepared:
1/24/2024 1:12 pm

						1/24/2024 1:1:	2 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		/ 00	7.00	Pati ents	& Residents	Payrol I	
	DADT I CTATICTICAL DATA	6. 00	7. 00	8. 00	9. 00	10. 00	
1 00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and	4 (25	217	0 147			1. 00
1. 00	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	4, 625	217	9, 147			1.00
2.00	HMO and other (see instructions)	1, 943	1, 641				2. 00
3.00	HMO IPF Subprovider	.,,	.,				3. 00
4. 00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	o	Ō			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	J	0	Ö	1		6. 00
7. 00	Total Adults and Peds. (exclude observation	4, 625	217	9, 147			7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	817	13	1, 437			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		181	1, 308			13.00
14.00	Total (see instructions)	5, 442	411	11, 892	0.00	375. 89	14. 00
15. 00	CAH vi si ts	0	o	· C			15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - IRF						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	42, 620	o	102, 885	0.00	136. 83	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0	0	C	0.00	60. 10	24. 00
24. 10	HOSPICE (non-distinct part)			54			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	572.82	27. 00
28. 00	Observation Bed Days		16	1, 729			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			99			30.00
31.00	Employee discount days - IRF			C			31.00
32.00	Labor & delivery days (see instructions)	0	79	172			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			C			32. 01
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01
	Temporary Expansi on COVID-19 PHE Acute Care	0	o	C			34. 00
	· · · · · · · · · · · · · · · · · · ·		'		· '	'	

31 00

32.00

32.01

33.00

33.01

34.00

0

0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-0032 Peri od: Worksheet S-3 From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: To 1/24/2024 1:12 pm Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 14.00 12.00 13.00 15.00 11.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 55 1.00 1, 494 3, 492 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) 566 2.00 3.00 HMO IPF Subprovider 0 3.00 4.00 HMO IRF Subprovider ol 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 5 00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 0.00 1, 494 3, 492 14.00 14.00 55 CAH visits 15.00 15.00 REH hours and visits 15. 10 15. 10 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 0.00 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24. 00 HOSPI CE 0.00 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 CMHC - CMHC 25.00 25 00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26.25 Total (sum of lines 14-26) 27.00 27.00 0.00 28 00 Observation Bed Days 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00

Employee discount days - IRF

LTCH non-covered days

Labor & delivery days (see instructions)

Total ancillary labor & delivery room

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

outpatient days (see instructions)

31.00 32.00

32.01

33.00

33. 01

Provider CCN: 14-0032

						0 06/30/2023	Date/lime Pre 1/24/2024 1:1	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	Salaries (col.2 ± col.	Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2.00	A-6) 3.00	3) 4.00	col . 4 5.00	6. 00	
	PART II - WAGE DATA		2.00	0.00	11.00	0.00	0,00	
1. 00	SALARIES Total salaries (see	200. 00	46, 023, 349	18, 406	46, 041, 755	1, 181, 461. 86	38. 97	1.00
2. 00	instructions) Non-physician anesthetist Part	200.00	0			0.00		
3. 00	A Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
4. 00	B Physician-Part A -		0	0	0	0.00	0. 00	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0. 00 0. 00	l e	
5. 00 6. 00	Physician and Non Physician-Part B Non-physician-Part B for		0	0	0			
0.00	hospi tal -based RHC and FQHC services		· ·	Š		0.00	0.00	0.00
7. 00	Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		0	0	0	0. 00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 16, 450, 623	0 18, 406	0 16, 469, 029	0. 00 409, 620. 98	•	
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient Care		3, 196, 755	0	3, 196, 755	26, 346. 96	121. 33	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		75, 430	0	75, 430	572. 00	131. 87	13. 00
14. 00	Home office and/or related organization salaries and		0	0	0	0.00	0. 00	14. 00
14. 01 14. 02 15. 00	wage-related costs Home office salaries Related organization salaries Home office: Physician Part A		8, 066, 758 0 0	0 0	0	210, 116. 76 0. 00 0. 00	0. 00	1
16. 00	- Administrative Home office and Contract		0	0	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0. 00	16. 01
16. 02	- Teaching Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0.00	0. 00	16. 02
17. 00	Wage-related costs (core) (see instructions)		11, 454, 936	0	11, 454, 936			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		6, 079, 209 0	0	6, 079, 209 0			19. 00 20. 00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	1	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		3, 375, 751	0	3, 375, 751			25. 50
25. 51	(core) Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: 1/24/2024 1:12 pm Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION ST. ANTHONYS MEMORIAL HOSPITAL Provider CCN: 14-0032

							172772027 1.12	<u> Pili</u>
		Wkst. A Line		Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4.00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26.00	Employee Benefits Department	4. 00	0	0	0	0. 00	0. 00	26.00
27.00	Administrative & General	5. 00	1, 225, 686	-6, 938	1, 218, 748	44, 347. 00	27. 48	27.00
28.00	Administrative & General under		648, 025	0	648, 025	6, 702. 04	96. 69	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	194, 365	0	194, 365	4, 505. 57	43. 14	29.00
30.00	Operation of Plant	7. 00	639, 976	0	639, 976	18, 590. 07	34. 43	30.00
31.00	Laundry & Linen Service	8. 00	0	6, 938	6, 938	401. 75	17. 27	31.00
32.00	Housekeepi ng	9. 00	557, 095	0	557, 095	31, 602. 42	17. 63	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10.00	545, 953	-428, 137	117, 816	3, 081. 89	38. 23	34.00
35.00	Di etary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	428, 137	428, 137	25, 805. 88	16. 59	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	1, 497, 060	0	1, 497, 060	30, 489. 66	49. 10	38.00
39.00	Central Services and Supply	14. 00	179, 138	0	179, 138	7, 915. 83	22. 63	39.00
40.00	Pharmacy	15. 00	1, 185, 624	l .	1, 185, 624			40.00
41. 00	Medical Records & Medical	16. 00	449, 277	l .	449, 277			
	Records Library		,		,	2,0,2,00		
42.00	Social Service	17. 00	0	0	0	0.00	0.00	42.00
	Other General Service	18. 00	0	l o	o o	0. 00		43. 00
.0.00	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		Ü		١	3.00	3.00	.0.00

Total overhead cost (see

instructions)

7.00

35. 48

7.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 14-0032 Worksheet S-3 Peri od: From 07/01/2022 To 06/30/2023 Part III Date/Time Prepared: 1/24/2024 1:12 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Worksheet A-6) 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 46, 671, 374 18, 406 46, 689, 780 1, 188, 163. 90 39. 30 1.00 instructions) 2.00 16, 450, 623 18, 406 16, 469, 029 409, 620. 98 40. 21 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 30, 220, 751 30, 220, 751 778, 542. 92 38.82 3.00 minus line 2) 4.00 Subtotal other wages & related 11, 338, 943 11, 338, 943 237, 035. 72 47.84 4.00 costs (see inst.) Subtotal wage-related costs 49. 07 5.00 14, 830, 687 0 14, 830, 687 0.00 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 56, 390, 381 0 56, 390, 381 1, 015, 578. 64 55 53

7, 122, 199

0

7, 122, 199

200, 745. 21

	To 06/30/2		pared: 2 pm
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1. 00	401K Employer Contributions	880, 362	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	2, 896, 099	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	9, 524, 770	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10. 00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	664, 183	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	. 0	16. 00
	Noncumul ati ve porti on)		
	TAXES		
17. 00	FICA-Employers Portion Only	2, 746, 885	17. 00
18. 00	Medicare Taxes - Employers Portion Only	667, 605	
19. 00	Unempl oyment Insurance	41, 813	
20.00		0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	112, 428	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	17, 534, 145	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	ST. ANTHONYS MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 14-0032	Period: Worksheet S-3 From 07/01/2022 Part V To 06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm			

		0 00/30/2023	1/24/2024 1: 12	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	3, 196, 755	17, 516, 710	1.00
2.00	Hospi tal	3, 196, 755	17, 516, 710	2. 00
3.00	SUBPROVI DER - I PF			3. 00
4.00	SUBPROVI DER - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY			8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	RENAL DIALYSIS I	0	0	17.00
18. 00	0ther	0	0	18. 00

	Financial Systems S HEALTH AGENCY STATISTICAL DATA	T. ANTHONYS MEM	Provi der Co	CN: 14-0032 P	eriod: rom 07/01/2022	eu of Form CMS-2 Worksheet S-4	
			Component	CCN: 14-7661 T	o 06/30/2023 Home Health	Date/Time Pre 1/24/2024 1:1	
					Agency I		
	To a second	-				00	
0.00	County	Title V	Title XVIII	Title XIX	EFFINGHAM Other	Total	0.00
	HOME HEALTH AGENOV CTATICTION DATA	1.00	2.00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	5, 513	0	3, 868	9, 381	1.00
2.00	Unduplicated Census Count (see instructions)	0. 00		0.00	3, 456. 00	5, 449. 00	2. 00
				Number of Empi	oyees (Full Ti	me Equivalent)	
		Enter the numb		Staff	Contract	Total	
		your normal	work week				
		C)	1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40. 00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		40.00	0.00	0.00	0.00	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			0. 00 0. 00	11. 25 76. 51	11. 25 76. 51	1
7.00	Nursi ng Supervi sor			0.00	0.00	0.00	7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			0. 00 0. 00	30. 13 0. 00	l	
10.00	Occupational Therapy Service			0.00		•	1
11. 00	Occupational Therapy Supervisor			0.00	0.00	l e	
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. 00 0. 00	2. 16 0. 00		1
14.00	Medical Social Service			0.00	0.00	0.00	14. 00
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0. 00 0. 00	0. 00 4. 51	0. 00 4. 51	15. 00 16. 00
17. 00	Home Health Aide Supervisor			0.00	0.00	0.00	17. 00
18. 00	Other (specify)			0.00	0.00	0.00 CBSA Data	18. 00
	THOUSE HIS HOST HOST AND ADDRESS.					1. 00	
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where	you provided se	ervices during	the cost repor	ting period.	6	19. 00
20. 00	List those CBSA code(s) in column 1 serviced first code).	during this co	st reporting p	period (line 20	contains the	16060	20. 00
20. 01	Titist code).					16580	20. 01
20. 02 20. 03						19500 41180	20. 02 20. 03
20. 04						44100	20. 04
20. 05		Full Ep	oi sodes			99914	20. 05
		Wi thout		LUPA Epi sodes	PEP Only	Total (cols.	
		Outliers 1.00	2. 00	3.00	Epi sodes 4. 00	1-4) 5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	18, 514	5, 012	548	164	24, 238	21. 00
22. 00	Skilled Nursing Visit Charges	4, 017, 538		1		l	
23. 00	Physical Therapy Visits	6, 464	3, 967	1			
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	1, 493, 184 1, 423	916, 377 2, 224			2, 455, 068 3, 701	1
26. 00	Occupational Therapy Visit Charges	328, 713	513, 744	4, 158	8, 316	854, 931	26. 00
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	341 78, 771	342 79, 002	1	0	689 159, 159	
29. 00	Medical Social Service Visits	103	55	2	4	164	29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	29, 458 2, 084		1	1, 144 15	l	
32.00	Home Health Aide Visit Charges	218, 820	115, 395	210	1, 575	336, 000	32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	28, 929	12, 699	699	293	42, 620	33. 00
34.00	Other Charges	0	0 707 050	1	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28,	6, 166, 484	2, 727, 852	153, 655	63, 717	9, 111, 708	35. 00
33. 00	30, 32, and 34)						
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	3, 603		429	29	4, 061	36. 00
	30, 32, and 34)	3, 603 169, 616	676		8	684	37. 00

Heal th	Financial Systems	S ^T	Γ. ANTHONYS MEN	MORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	AL-BASED HOSPICE IDENTIFICATION	DATA		Provi der Co		Peri od: From 07/01/2022 To 06/30/2023		GH IV
				·			1/24/2024 1:1	2 pm
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled Nursing	Nursing Facility		cols. 1, 2 & 5)	
				Facility	Facility		5)	
		1.00	2.00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING F	PERI ODS BEGINNI	NG BEFORE OCTO	BER 1, 2015	<u>'</u>		
1.00	Hospice Continuous Home Care							1. 00
2.00	Hospice Routine Home Care							2. 00
3.00	Hospice Inpatient Respite Care							3. 00
4.00	Hospice General Inpatient Care							4. 00
5.00	Total Hospice Days				L			5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			,
6. 00	Number of patients receiving hospice care							6. 00
7. 00	Total number of unduplicated							7. 00
7.00	Continuous Care hours billable							7.00
	to Medicare							
8.00	Average Length of Stay (line 5							8. 00
	/ line 6)							
9.00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
				1.00	0.00	0.00	through 3)	
	PART III - ENROLLMENT DAYS FOR	COST DEDODTING	C DEDIANG BECLA	1.00	2.00	3. 00	4. 00	
10. 00	Hospice Continuous Home Care	COST REPORTING	PERIODS DEGIN	INTING ON OR AFT	ER OCTOBER I	0 0	0	10.00
11. 00	Hospice Routine Home Care			28, 073	1	57 4, 201	32, 431	
12. 00	Hospice Inpatient Respite Care			53	1	0 4, 201	70	1
13. 00	Hospice General Inpatient Care			547		15 299	861	
	Total Hospice Days			28, 673	1	72 4, 517	33, 362	
50	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	ST REPORTING PE					1 55
15. 00	Hospice Inpatient Respite Care			0		0 0		15. 00
16.00	Hospice General Inpatient Care			0		0 0		16. 00
				•	•	*		-

Heal th	Financial Systems ST. ANTHONYS MEMORIA	AL HOSPITAL	In Li∈	eu of Form CMS-2	2552-10			
		Provider CCN: 14-0032	Peri od:	Worksheet S-1				
			From 07/01/2022 To 06/30/2023	Data/Time Dro	narod:			
			To 06/30/2023	Date/Time Pre 1/24/2024 1:1				
				1.00				
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by line 202 colu	mn 8)	0. 293380	1. 00			
	Medicaid (see instructions for each line)			7 000 000				
2. 00 3. 00	Net revenue from Medicaid		7, 320, 222 Y	2.00				
4. 00								
5. 00	If line 4 is no, then enter DSH and/or supplemental payments fi	. 3	sar a.	Y	4. 00 5. 00			
6.00	Medi cai d charges			58, 988, 063	6. 00			
7.00	Medicaid cost (line 1 times line 6)			17, 305, 918				
8. 00	Difference between net revenue and costs for Medicaid program	(line 7 minus sum of l	ines 2 and 5; if	9, 985, 696	8. 00			
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for</pre>	or each line)			-			
9. 00	Net revenue from stand-alone CHIP	n each time)		0	9. 00			
10.00	Stand-alone CHIP charges			Ö				
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11. 00			
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 minus line 9;	if < zero then	0	12. 00			
	enter zero)		-)					
13. 00	Other state or local government indigent care program (see inst			0	13. 00			
14. 00	Charges for patients covered under state or local indigent care		•					
00	10)	5 p. og. a (1						
15.00								
16.00	Difference between net revenue and costs for state or local inc	digent care program (I	ne 15 minus line	0	16. 00			
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see							
	instructions for each line)	P and State/Tocal Thu	gent care program	iis (see				
17. 00	Private grants, donations, or endowment income restricted to fu	unding charity care		0	17. 00			
18. 00	Government grants, appropriations or transfers for support of h			0				
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent care progra	ms (sum of lines	9, 985, 696	19. 00			
		Uni nsured		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 fac	cility 5,077,	852 848, 245	5, 926, 097	20.00			
	(see instructions)	2, 3,	2.0, 2.0	2, 122, 211				
21. 00	Cost of patients approved for charity care and uninsured discou	unts (see 1, 489,	740 848, 245	2, 337, 985	21. 00			
22.00	instructions)	off on			22.00			
22. 00	Payments received from patients for amounts previously written charity care	orr as	0 0	0	22. 00			
23. 00	1	1, 489,	740 848, 245	2, 337, 985	23. 00			
		<u>.</u>						
0.4.00			6 1 1: :1	1.00	04.00			
24. 00	Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care		n of stay limit	N	24. 00			
25. 00	imposed on patients covered by Medicaid or other indigent care 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 ins	structions)		5, 256, 940	26. 00			
27. 00	Medicare reimbursable bad debts for the entire hospital complex			468, 217				
27. 01	Medicare allowable bad debts for the entire hospital complex (s	see instructions)		720, 334	27. 01			
28. 00	1			4, 536, 606	1			
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	bense (see instruction	S)	1, 583, 066	1			
30. 00 31. 00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)		3, 921, 051 13, 906, 747	1			
51.00	1.0 ta. a.m. or mour sour and anodispondated early cost (11110-17 plus 11	50)		10,700,747	1 51.00			

Heal th	Financial Systems	ST. ANTHONYS MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der Co		Peri od:	Worksheet A	
					From 07/01/2022 To 06/30/2023	Date/Time Pre	pared.
					10 00/00/2020	1/24/2024 1:1	2 pm
	Cost Center Description	Sal ari es	Other		Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		10, 171, 588				1.00
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		0	•	0 5, 158, 797 0 0	5, 158, 797 0	2. 00 3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	15, 999, 230	1	-	16, 075, 645	
5.00	00500 ADMINISTRATIVE & GENERAL	1, 225, 686	38, 769, 229			38, 893, 573	5. 00
6.00	00600 MAINTENANCE & REPAIRS	194, 365	11, 927			206, 292	6. 00
7.00	00700 OPERATION OF PLANT	639, 976	2, 271, 016			2, 910, 992	
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING	0 557, 095	383, 774 279, 901			390, 712 836, 996	
10. 00	01000 DI ETARY	545, 953	577, 570			176, 606	
11. 00	01100 CAFETERI A	0	3, 583			950, 500	
13.00	01300 NURSING ADMINISTRATION	1, 497, 060	313, 953				1
14.00	01400 CENTRAL SERVICES & SUPPLY	179, 138	429, 883	1			1
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 185, 624 449, 277	5, 449, 609 86, 178			1, 591, 228 529, 012	
17. 00	01700 SOCIAL SERVICE	449, 277	00, 170		0 -0, 443	0 329,012	1
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			<u> </u>		17.00
30.00	03000 ADULTS & PEDIATRICS	6, 882, 817	1, 718, 168	8, 600, 98	5 -1, 404, 020	7, 196, 965	30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 675, 443	200, 501				1
43. 00	04300 NURSERY	42, 512	42, 893	85, 40	5 512, 961	598, 366	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	3, 334, 528	5, 445, 820	8, 780, 34	8 -4, 076, 424	4, 703, 924	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 334, 328	122, 877				
53. 00	05300 ANESTHESI OLOGY	5, 645	6, 084, 019				
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 908, 020	1, 660, 932	3, 568, 95	2 -188, 942	3, 380, 010	
54. 01	03630 ULTRA SOUND	228, 144	97, 832				
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	109, 571	233, 044				
54. 06 57. 00	05404	0 482, 924	105, 125 384, 918			105, 125 864, 485	
58. 00	05800 MRI	203, 619	231, 940				
59.00	05900 CARDI AC CATHETERI ZATI ON	120, 420	280, 829				
60.00	06000 LABORATORY	1, 252, 734	3, 789, 542	5, 042, 27	6 -1, 849, 338	3, 192, 938	
62. 30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		0	0	62. 30
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	636, 422 1, 372, 508	117, 764 250, 985				
67. 00	06700 OCCUPATI ONAL THERAPY	364, 688	36, 567		· ·		1
68. 00	06800 SPEECH PATHOLOGY	304, 449	263			304, 712	
69. 00	06900 ELECTROCARDI OLOGY	501, 556	254, 869				
70. 00	07000 ELECTROENCEPHALOGRAPHY	171, 349	23, 310			'	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 7, 652, 136 0 1, 555, 378		
	07300 DRUGS CHARGED TO PATIENTS		0		0 5, 561, 844	5, 561, 844	1
74. 00	07400 RENAL DIALYSIS	0	0		0 0,001,011	0,001,011	1
76.00	03050 BACTERI OLOGY & MI CROBI OLOGY	0	0		0	0	76. 00
76. 01	03650 VASCULAR LAB	226, 893	11, 343			238, 236	
76. 02	03952 TELEMEDICINE	59, 986	74, 600			134, 163	
76. 03	03950 WOUND CARE 07697 CARDI AC REHABI LI TATI ON	504, 472 94, 581	1, 050, 253 2, 611			1, 327, 995 95, 192	
	07700 ALLOGENEIC HSCT ACQUISITION	94, 381	2,011		0 -2,000	93, 192	1
,,,,,,	OUTPATIENT SERVICE COST CENTERS				<u> </u>		77.00
90.00	09000 CLI NI C	196, 791	17, 461	•			
91. 00	09100 EMERGENCY	2, 418, 480	2, 795, 297	5, 213, 77	7 -408, 875	4, 804, 902	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	11, 697, 634	2, 984, 122	14, 681, 75	6 -865, 633	13, 816, 123	101 00
	10200 OPI OI D TREATMENT PROGRAM	0	0		0 0		102.00
	SPECIAL PURPOSE COST CENTERS	1		•	1		
	11300 INTEREST EXPENSE		382, 961				113. 00
	11600 HOSPI CE	4, 771, 395	3, 167, 001				
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	46, 041, 755	106, 315, 288	152, 357, 04	3 1, 138	152, 358, 181	1118.00
190. 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	l ol	49, 836	49, 83	6 0	49, 836	190. 00
194.00	07950 PHI LANTHROPY DEVELOPMENT	-18, 406	4, 122, 392				1
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	194. 01
	07952 MEALS ON WHEELS	0	0	1	0		194. 02
194. 03 200. 00	O7953 OTHER NONREIMBURSABLE COST CENTERS TOTAL (SUM OF LINES 118 through 199)	46, 023, 349	0 110, 487, 516	156, 510, 86	0 5 0		194. 03
200. UC	I TOTAL (SOM OF LINES 116 THEOUGH 199)	1 40, 023, 349	110,407,310	1 130, 310, 66	J ₁ 0	130, 310, 663	1200.00

Provi der CCN: 14-0032

| Period: | Worksheet A | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 1/24/2024 1:12 pm

				1/24/2024 1:	12 pm
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation	<u>1</u>	
	OFNEDAL CEDIU OF COCT OFNITEDO	6.00	7. 00		
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	108, 083	5, 713, 618	, i	1.00
2. 00	00200 CAP REL COSTS-BLDG & FTXT	523, 795	5, 713, 616		2.00
3.00	00300 OTHER CAP REL COSTS	0 323, 773	0,002,072		3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-7, 474, 921	8, 600, 724		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-9, 006, 637	29, 886, 936		5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	206, 292		6. 00
7.00	00700 OPERATION OF PLANT	-42, 033	2, 868, 959		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	-23, 031	367, 681		8. 00
9.00	00900 HOUSEKEEPI NG	0	836, 996		9. 00
10. 00	01000 DI ETARY	-4, 578	172, 028		10. 00
11. 00	01100 CAFETERI A	0	950, 500	l e e e e e e e e e e e e e e e e e e e	11. 00
13.00	1 1	-475	1, 798, 072	l e e e e e e e e e e e e e e e e e e e	13. 00
14. 00	I I	0	216, 087		14.00
15. 00	I I	1 442 024	1, 591, 228		15. 00
16. 00 17. 00	1 1	1, 463, 934 0	1, 992, 946 0	l e e e e e e e e e e e e e e e e e e e	16. 00 17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	J O	0	<i>y</i>	17.00
30. 00		-893, 512	6, 303, 453	3	30.00
31. 00		0,0,012	1, 780, 115		31.00
43. 00	+ +	0	598, 366		43. 00
	ANCILLARY SERVICE COST CENTERS			1	
50.00	05000 OPERATING ROOM	-1, 367	4, 702, 557	1	50.00
52.00		0	1, 454, 610		52. 00
53.00		-5, 869, 047	93, 103		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-336, 378	3, 043, 632		54. 00
54. 01	03630 ULTRA SOUND	0	285, 404		54. 01
54. 02	+ I	0	339, 462		54. 02
54. 06		0	105, 125		54.06
57. 00 58. 00		0	864, 485 414, 895		57. 00 58. 00
59. 00		0	180, 137		59.00
60. 00	06000 LABORATORY	-113, 750	3, 079, 188		60.00
62. 30	1	0	0, 0, 7, 100		62. 30
65. 00	06500 RESPI RATORY THERAPY	0	699, 430		65. 00
66.00		0	1, 604, 630		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	O	368, 200		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	304, 712		68. 00
69. 00		-108, 001	613, 004		69. 00
70. 00	I I	0	172, 946		70. 00
71. 00	+ I	0	7, 652, 136		71. 00
72. 00		0	1, 555, 378		72.00
73.00	1	0	5, 561, 844		73.00
74. 00 76. 00	1	0	0		74. 00 76. 00
76. 00	03650 VASCULAR LAB	0	238, 236		76. 00
76. 01	1 1	-71, 775	62, 388	i de la companya del companya de la companya de la companya del companya de la co	76. 02
	03950 WOUND CARE	-326, 428	1, 001, 567		76. 03
76. 97	1 1	0	95, 192	i de la companya del companya de la companya de la companya del companya de la co	76. 97
77. 00	1 1	0	0	1	77. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0	201, 704		90.00
91. 00	I I	-978, 537	3, 826, 365		91. 00
92. 00	· ·				92. 00
	OTHER REIMBURSABLE COST CENTERS	1			
	D 10100 HOME HEALTH AGENCY	-2, 023	13, 814, 100	l .	101.00
102.00	0 10200 OPI OI D TREATMENT PROGRAM	0	0)	102. 00
112 0	SPECIAL PURPOSE COST CENTERS D11300 INTEREST EXPENSE		0		112 00
	0 11600 HOSPI CE	-3, 266	7, 297, 211		113. 00 116. 00
118. 00		-23, 159, 947	129, 198, 234		118.00
110.00	NONREI MBURSABLE COST CENTERS	-23, 137, 747	127, 170, 234		110.00
190 0	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	n	49, 836		190. 00
	007950 PHI LANTHROPY DEVELOPMENT	0	4, 102, 848		194. 00
	1 07951 OTHER NONREIMBURSABLE COST CENTERS	o o	4, 102, 040	i e e e e e e e e e e e e e e e e e e e	194. 01
	2 07952 MEALS ON WHEELS	l o	0	1	194. 02
	3 07953 OTHER NONREIMBURSABLE COST CENTERS	l ol	0		194. 03
200.00	1 1	-23, 159, 947	133, 350, 918	3	200. 00

Provider CCN: 14-0032

| Period: | Worksheet A-6 | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 1/24/2024 1:12 pm

					1/24/2024 1:	12 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3. 00	4. 00	5. 00		
1 00	B - CAFETERIA COSTS	11 00	420 127	F10, 700		1 00
1. 00	CAFETERI A		42 <u>8, 1</u> 37 428, 137	51 <u>8, 7</u> 80 518, 780		1. 00
	C - PHARMACY DRUGS		420, 137	510, 700		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	5, 561, 844		1.00
2.00		0.00	o	0		2. 00
3.00		0.00	O	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	0		8. 00
9. 00 10. 00		0.00	0	0		9.00
11. 00	+	0. 00 0. 00	0	0		10. 00 11. 00
12. 00		0.00	o	0		12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	o	Ö		14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0. 00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20. 00			9	0		20. 00
	O D - CENTRAL SUPPLY		0	5, 561, 844		
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	7, 652, 136		1.00
1.00	PATI ENT	71.00		7,032,130		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	0		8. 00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	0	0		11. 00
12. 00		0.00	o	0		12. 00
13. 00		0.00	o	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20.00		0.00	0	0		20.00
21. 00 22. 00	+	0. 00 0. 00	0	0		21. 00 22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	O	Ö		24. 00
25. 00		0.00	0	0		25. 00
26.00		0.00	0	0		26. 00
27.00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00	<u> </u>	0.00	0	0		29. 00
	0 E - PROPERTY INSURANCE EXPENS):E	0	7, 652, 136		-
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	O	121, 695		1.00
2.00	CAP REL COSTS-BLDG & FIXT	2. 00	0	88, 088		2. 00
2.00	0		— — —	209, 783		2.00
	F - INTEREST EXPENSE		<u> </u>			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	382, 961		1. 00
	0			382, 961		
	G - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP		0	<u>5, 070, 7</u> 09		1. 00
	0		0	5, 070, 709		_
1 00	H - LABOR & DELIVERY	40.00	EEC 40.1	<u></u>		1 00
1.00	NURSERY	43.00	550, 484	0		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52.00	1, 44 <u>8, 7</u> 20 1, 999, 204	0		2. 00
	I ^C	I	1, 177, 204	U		1

Health Financial Systems ST. ANTHONYS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 14-0032 Period: Worksheet A-6

From 07/01/2022 To 06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm Increases Cost Center Sal ary 0ther Li ne # 2.00 3.00 4.00 5.00 - IMPLANT RECLASS 1.00 IMPL. DEV. CHARGED TO 72.00 1, 555, 378 1.00 PATI ENTS 2.00 0.00 0 0 2.00 0 3.00 0.00 0 3.00 4.00 0.00 0 0 4.00 5.00 0.00 0 5.00 6.00 0.00 0 6.00 1, 555, 378 J - LAUNDRY RECLASS 1.00 LAUNDRY & LINEN SERVICE 8.00 6, 938 1.00 6, 938 0 M - PHYSICIAN OVERHEAD COST CENTERS 1.00 ADULTS & PEDIATRICS 30.00 0 891, 012 1.00 2.00 0.00 0 2.00 89<u>1, 0</u>12 0 O - RECLASS NEG SALARY 1.00 PHI LANTHROPY DEVELOPMENT 194. 00 18, 406 1.00 18, 406 TOTALS P - TUITION REIMBURSEMENT 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 76, 083 1.00 2.00 0.00 0 0 2.00 0 3.00 0.00 0 3.00 4.00 0.00 0 4.00 5.00 0.00 0 0 5.00 0 0 6.00 0.00 6.00 7.00 0 0.00 0 7.00 8.00 0.00 0 8.00 TOTALS ō 76, 083

332

332

21, 919, 018

1.00

500.00

4. 00

2, 452, 685

Q - LAB BENEFITS

500.00 Grand Total: Increases

TOTALS

1.00

EMPLOYEE BENEFITS DEPARTMENT

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Provider CCN: 14-0032

					1		me Prepared:)24 1:12 pm
		Decreases		'		, 1721720	,2, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
4 00	B - CAFETERIA COSTS	40.00	400 407	540 700			
1. 00	DI ETARY	1000	42 <u>8, 1</u> 37 428, 137	51 <u>8, 7</u> 80			1.00
	C - PHARMACY DRUGS		420, 137	518, 780			
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	13, 549	0		1. 00
2.00	PHARMACY	15. 00	O	4, 948, 683	0		2. 00
3.00	ADULTS & PEDIATRICS	30.00	O	7, 949	0		3. 00
4.00	INTENSIVE CARE UNIT	31. 00	0	2, 834	0		4. 00
5.00	NURSERY	43. 00	0	257	0		5. 00
6.00	OPERATING ROOM	50.00	0	34, 673	0		6. 00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2, 898	0		7. 00
8. 00 9. 00	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	53. 00 54. 00	0	10, 562 4, 120	0		8. 00 9. 00
10.00	NUCLEAR MEDICINE -	54.00	0	1, 845	0		10.00
10.00	DI AGNOSTI C	34. 02		1, 043	J		10.00
11. 00	MRI	58. 00	O	460	0		11. 00
12.00	LABORATORY	60.00	0	107	0		12. 00
13.00	RESPIRATORY THERAPY	65.00	0	8	0		13. 00
14.00	OCCUPATI ONAL THERAPY	67. 00	0	54	0		14. 00
15. 00	ELECTROCARDI OLOGY	69. 00	0	1, 442	0		15. 00
16.00	WOUND CARE	76. 03	0	9, 455	0		16.00
17. 00	CLINIC	90.00	0	88	0		17. 00
18. 00 19. 00	EMERGENCY HOME HEALTH AGENCY	91. 00 101. 00	0	9, 165 14, 327	0		18. 00 19. 00
20. 00	HOSPI CE	116.00	0	499, 368			20.00
20.00	0	110.00	— — ŏ	5, 561, 844	— — -		20.00
	D - CENTRAL SUPPLY		<u> </u>	0,001,011			
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	378, 899	0		1. 00
2.00	PHARMACY	15. 00	0	95, 322	0		2. 00
3.00	MEDICAL RECORDS & LIBRARY	16. 00	0	52	0		3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	267, 765	0		4. 00
5.00	INTENSIVE CARE UNIT	31.00	0	89, 970	0		5. 00
6. 00 7. 00	NURSERY OPERATING ROOM	43. 00 50. 00	0	37, 266 2, 709, 436	0		6. 00 7. 00
8. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	114, 089	0		8. 00
9. 00	ANESTHESI OLOGY	53.00	Ö	116, 952	0		9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	184, 822	0		10.00
11.00	ULTRA SOUND	54. 01	0	40, 572	0		11. 00
12.00	NUCLEAR MEDICINE -	54. 02	O	1, 308	0		12. 00
	DI AGNOSTI C						
13. 00	CT SCAN	57. 00	0	3, 357	0		13. 00
14. 00	MRI	58. 00	0	20, 204	0		14.00
15. 00 16. 00	CARDI AC CATHETERI ZATI ON LABORATORY	59. 00 60. 00	0	114, 489 1, 842, 668	0		15. 00 16. 00
17. 00	RESPIRATORY THERAPY	65.00	0	54, 748	0		17. 00
18. 00	PHYSI CAL THERAPY	66.00	Ö	18, 863	0		18. 00
19. 00	OCCUPATI ONAL THERAPY	67. 00	o	33, 001	0		19. 00
20.00	ELECTROCARDI OLOGY	69. 00	О	33, 978	0		20. 00
21.00	ELECTROENCEPHALOGRAPHY	70. 00	0	21, 713			21. 00
22. 00	TELEMEDI CI NE	76. 02	0	423	0		22. 00
23. 00	WOUND CARE	76. 03	0	91, 614	0		23. 00
24. 00	CARDIAC REHABILITATION	76. 97	0	2, 000	0		24. 00
25. 00	CLINIC	90.00	0	12, 460	0		25. 00
26. 00 27. 00	EMERGENCY HOME HEALTH AGENCY	91. 00 101. 00	0	393, 239 844, 254	0		26. 00 27. 00
28. 00	HOSPI CE	116.00	0	127, 534	0		28. 00
29. 00	PHI LANTHROPY DEVELOPMENT	194.00	0	1, 138			29. 00
	0		0	7, 652, 136			
	E - PROPERTY INSURANCE EXPENS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	209, 783			1. 00
2. 00		0.00	0	0	12		2. 00
	F - INTEREST EXPENSE		ΟĮ	209, 783			
1.00	INTEREST EXPENSE	113. 00	O	382, 961	11		1.00
1.00	0			382, 961	├ ' '		1.00
	G - DEPRECIATION EXPENSE		<u> </u>	302, 701			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	O	5, 070, 709	9		1. 00
	0 — — — — —			5, 070, 709			
	H - LABOR & DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	1, 999, 204	0	0		1. 00
2. 00		0.00	0	— — <u> </u>	9		2. 00
	0	I	1, 999, 204	0	ı		I

6.00

7.00

8.00

1.00

EMERGENCY

HOSPI CE

LABORATORY

TOTALS

TOTALS

HOME HEALTH AGENCY

Q - LAB BENEFITS

500.00 Grand Total: Decreases

In Lieu of Form CMS-2552-10 Health Financial Systems ST. ANTHONYS MEMORIAL HOSPITAL RECLASSI FI CATI ONS Provi der CCN: 14-0032 Peri od: Worksheet A-6 From 07/01/2022 06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm Decreases Cost Center 0ther Wkst. A-7 Ref. Li ne # Sal ary 10. 00 6.00 7.00 8.00 9.00 - IMPLANT RECLASS 1.00 CENTRAL SERVICES & SUPPLY 14.00 486 1.00 OPERATING ROOM 50.00 0 1, 321, 760 0 2.00 2.00 CARDIAC CATHETERIZATION 3.00 59.00 0 106, 623 0 3.00 0 4.00 LABORATORY 60.00 6, 231 0 4.00 5.00 WOUND CARE 76.03 0 120, 103 0 5.00 6.00 EMERGENCY 91.00 175 6.00 0 1, 555, 378 J - LAUNDRY RECLASS 6, 938 ADMINISTRATIVE & GENERAL 1.00 5. 00 0 0 1.00 6, 938 M - PHYSICIAN OVERHEAD COST CENTERS 1.00 ADMINISTRATIVE & GENERAL 5.00 884, 621 0 1.00 2.00 MEDICAL RECORDS & LIBRARY <u>16.</u>00 6, 391 0 2.00 0 ō 891, 012 O - RECLASS NEG SALARY 0 1.00 PHI LANTHROPY DEVELOPMENT 194.00 18, 406 0 1.00 TOTALS 18, 406 P - TUITION REIMBURSEMENT 1.00 NURSING ADMINISTRATION 13.00 12, 466 0 1.00 2.00 ADULTS & PEDIATRICS 30.00 0 20, 114 0 2.00 0 0 3.00 INTENSIVE CARE UNIT 31.00 3, 025 3.00 OPERATING ROOM 4.00 50.00 0 10, 555 0 4.00 5.00 WOUND CARE 76.03 0 5, 558 0 5.00

0

0

0

2, 434, 279

6, 296

7.052

1<u>1, 0</u>17

76, 083

21, 937, 424

332

332

0

0

0

0

6.00

7.00

8.00

1.00

500.00

91.00

101.00

116.00

60.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 14-0032 Peri od: Worksheet A-7 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 1:12 pm Acqui si ti ons Begi nni ng Total Di sposal s and Purchases Donati on Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2, 699, 574 0 1.00 3, 381, 484 0 2.00 Land Improvements 0 2.00 0 3.00 120, 595, 735 1, 018, 342 1, 018, 342 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 1, 169, 101 192, 785 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 89, 956, 122 3, 165, 005 3, 165, 005 0 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 217, 802, 016 4, 183, 347 4, 183, 347 192, 785 8.00 9.00 Reconciling Items 8, 519, 560 759, 641 0 759, 641 0 9.00 1<u>92, 785</u> Total (line 8 minus line 9) 209, 282, 456 3, 423, 706 10.00 0 3, 423, 706 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 699, 574 1.00 2.00 Land Improvements 3, 381, 484 0 2.00 3.00 Buildings and Fixtures 121, 614, 077 0 3.00 0 4.00 Building Improvements 976, 316 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 93, 121, 127 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 221, 792, 578 0 8.00 9.00 Reconciling Items 9, 279, 201 9.00 10.00 Total (line 8 minus line 9) 212, 513, 377 10.00

Heal th	n Financial Systems S	T. ANTHONYS MEM	ORIAL HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 14-0032	Peri od:	Worksheet A-7	
					From 07/01/2022		
					To 06/30/2023		
				JMMARY OF CAP	ΙΤΛΙ	1/24/2024 1: 1	Z piii
			30	DIVINIAR I OI CAF	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	, , , , , , , , , , , , , , , , , , ,					instructions)	
		9.00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	9, 788, 627	0	382, 9	61 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)	9, 788, 627	0	382, 9	61 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	10, 171, 588				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)			2. 00
	1	1	40 474 500	.1			

0 0 0

10, 171, 588

1. 00 2. 00 3. 00

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

Hoal th	n Financial Systems S	T. ANTHONYS MEN	INTIDONH INIDNI		Inlie	u of Form CMS-2	2552_10
	CILIATION OF CAPITAL COSTS CENTERS	II. ANTHONIS WEN	Provi der Co		Period:	Worksheet A-7	
KLCOW	CILIATION OF CALLIAL COSTS CENTERS		Trovider co		From 07/01/2022		
						Date/Time Pre	pared:
						1/24/2024 1:1	2 pm
		COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col			
				2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	128, 671, 451	0	128, 671, 45	0. 580143	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	93, 121, 127	0	93, 121, 12	7 0. 419857	0	2.00
3.00	Total (sum of lines 1-2)	221, 792, 578	0	221, 792, 57	1. 000000	0	3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5	·		
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 5, 535, 832	-34, 709	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 5, 594, 504	0	2.00
3.00	Total (sum of lines 1-2)	0	0)	0 11, 130, 336	-34, 709	3.00
	,		Sl	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	'		instructions)	instructions)			
			Í	ĺ	d Costs (see	through 14)	
					instructions)	,	
		11.00	12. 00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	382, 961	121, 695		0 -292, 161	5, 713, 618	1.00
2 00	CAD DEL COSTS MADLE FOLLID	002,701			0 2,2, .0.		

0 382, 961

121, 695 88, 088 209, 783

0 0 0

0 -292, 161

5, 713, 618 5, 682, 592 11, 396, 210

2. 00

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

Health Financial Systems ST. ANTHONYS MEMORIAL HOSPITAL ADJUSTMENTS TO EXPENSES Provider CCN: 14-0032 Peri od: Worksheet A-8 From 07/01/2022 06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL -382, 961 CAP REL COSTS-BLDG & FLXT 1. 00 В 1.00 11 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) 4 00 Trade, quantity, and time 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay -7, 379 CAP REL COSTS-MVBLE EQUIP 7.00 Α 2.00 7.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce 0 0.00 8.00 (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 -8 360 623 10.00 10.00 Provider-based physician A-8-2 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 -1, 189, 392 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests 0 0.00 14.00 Rental of quarters to employee 0 15.00 15.00 0.00 and others Sale of medical and surgical 16.00 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 0 17.00 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 00 education (tuition, fees, books, etc.) 20.00 Vending machines -4, 578 DI ETARY 10.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 22.00 Interest expense on Medicare 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) OPHYSICAL THERAPY 24.00 Adjustment for physical A-8-3 66.00 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 1.00 26.00 COSTS-BLDG & FLXT Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 27.00 2.00 27.00 COSTS-MVBLE EQUIP 28.00 0 *** Cost Center Deleted *** 19.00 28.00 Non-physician Anesthetist Physicians' assistant 29.00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 32.00 0.00 Depreciation and Interest

-292, 161 CAP REL COSTS-BLDG & FIXT

1.00

14 33.00

В

33. 00 MISC INCOME

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

				To	06/30/2023	Date/Time Prep 1/24/2024 1:1:	
				Expense Classification on	Worksheet A	172472024 1. 1.	Z piii
				To/From Which the Amount is			
				Toy I I om the fire famoure 10	to bo haj dotod		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
33. 01	MISC INCOME	В		ADMI NI STRATI VE & GENERAL	5. 00	0	33. 01
33. 02	MI SC I NCOME	В		OPERATION OF PLANT	7. 00	0	33. 02
33. 03	MI SC I NCOME	В	•	NURSING ADMINISTRATION	13. 00		33. 03
33. 04	MI SC I NCOME	В		MEDICAL RECORDS & LIBRARY	16. 00		33. 04
33. 05	MI SC I NCOME	B		RADI OLOGY-DI AGNOSTI C	54.00		33. 05
33. 06	MI SC I NCOME	В		HOME HEALTH AGENCY	101. 00		33. 06
33. 07	MI SC I NCOME	B		HOSPI CE	116. 00	0	33. 07
33. 08	TELEPHONE EMPLOYEE BENEFITS	A	•	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 08
33. 09	TELEPHONE A&G SALARIES	A	•	ADMINISTRATIVE & GENERAL	5. 00		33. 09
33. 10	TELEPHONE A&G OTHER EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00		33. 10
33. 11	TELEVISION EMPLOYEE BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00		33. 11
33. 12	TELEVISION SALARIES	A	•	OPERATION OF PLANT	7. 00		33. 12
33. 12	TELEVISION SALARTES TELEVISION A&G OTHER EXPENSE	Ä		OPERATION OF PLANT	7.00		33. 12
33. 14	TELEVISION A&G OTHER CABLE	Ä		OPERATION OF PLANT	7.00	l	33. 14
33. 14	EXPENSE	^	-30, 727	OF ERATION OF TEAM	7.00	l o	33. 14
33. 15	MEDICALD TAX ASSESSMENT	A	-5 775 960	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 16	SELF-INS TO HOSP/EMP CLAIMS	A		EMPLOYEE BENEFITS DEPARTMENT	4.00		33. 16
33. 17	LOBBYING EXPENSES	A		ADMINISTRATIVE & GENERAL	5. 00		33. 17
33. 18	ALCOHOL BEVERAGE COST	A		ADMINISTRATIVE & GENERAL	5. 00	o o	33. 18
33. 19	ALCOHOL BEVERAGE COST	A		MEDICAL RECORDS & LIBRARY	16. 00	0	33. 19
33. 20	DEFINED PENSION ADJUSTMENT	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	1	33. 20
33. 21	PUBLIC RELATIONS/MARKETING	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 21
33. 22	PUBLIC RELATIONS/MARKETING	Ä		MEDICAL RECORDS & LIBRARY	16. 00	0	33. 22
33. 23	BUILDING RE-LIFING	A		CAP REL COSTS-BLDG & FLXT	1. 00	0	33. 22
33. 24	EQUIPMENT RE-LIFING	A	•	CAP REL COSTS-BEDG & TTAT	2.00	7	33. 24
33. 25	GI FTS/DONATI ONS	A		ADMINISTRATIVE & GENERAL	5. 00		33. 25
33. 26	PROPERTY TAX	A		ADMINISTRATIVE & GENERAL	5.00	0	33. 26
33. 27	PROPERTY TAX	A	•	RADI OLOGY-DI AGNOSTI C	54.00	Ĭ	33. 27
33. 28	PROPERTY TAX	A		OPERATION OF PLANT	7. 00		33. 28
33. 29	RENTAL REVENUE	A		RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 29
	1	1	•	la de la companya de		1	
33. 30 33. 31	RENTAL REVENUE	A A		CAP REL COSTS-BLDG & FIXT	1.00	l	33. 30 33. 31
	-	1 '''	•	RADI OLOGY-DI AGNOSTI C	54.00	0	
33. 32	PHYSI CI AN RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5.00		33. 32
33. 33	GI FTS/DONATI ONS	A		ADULTS & PEDIATRICS	30. 00	0	33. 33
50. 00	TOTAL (sum of lines 1 thru 49)		-23, 159, 947				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)			0140 D. J. 45 4			

⁽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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0032 | Period: From 07/01/2022 | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 1/24/2024 1:13 pm

					1/24/2024 1: 1	
	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	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1. 00	•	EMPLOYEE BENEFITS DEPARTMENT		11, 487, 180		
2.00		l .	CONTRACTED SERVICES - ISC	6, 934, 378	5, 139, 420	2. 00
3.00	5. 00	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES - SSC	3, 318, 990	4, 175, 616	3. 00
3. 01	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES	271, 137	786, 504	3. 01
3.02	5. 00	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES -SBO	2, 814, 222	5, 827, 284	3. 02
3.03	16. 00	MEDICAL RECORDS & LIBRARY	CONTRACTED SERVICES -SBO	1, 594, 711	0	3. 03
3.04	8. 00	LAUNDRY & LINEN SERVICE	LAUNDRY	343, 464	366, 495	3. 04
3.05	5. 00	ADMINISTRATIVE & GENERAL	IL - LIBRARY	39, 714	35, 049	3. 05
4.00	5. 00	ADMINISTRATIVE & GENERAL	IL - A&G	1, 462, 532	1, 644, 603	4.00
5.00	TOTALS (sum of lines 1-4).			28, 266, 328	29, 455, 720	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.

	tablifet book pooted to not kenoot 11, our amile 1 and of 2, the amount arrowable choard be rid out of the parti						
				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.

	Comonic undor the tro mining					
6.00	G	HSHS	100.00	HSHS	100. 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 organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Syste	ems	ST. ANTHONY	'S MEMORI	AL HOSPITAL		In Lieu	u of Form CMS-	2552-10
STATEME OFFICE		SERVICES FROM	RELATED ORGANIZATIONS AN	D HOME	Provider CCN:	14-0032	Peri od: From 07/01/2022	Worksheet A-	3-1
OITICL	C0313						To 06/30/2023	Date/Time Pro 1/24/2024 1:	
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESUL	T OF TRAI	NSACTIONS WITH	H RELATED O	RGANIZATIONS OR C	CLAI MED	
	HOME OFFICE CO	STS:							
1.00	6, 431	0							1.00
2.00	1, 794, 958	0							2. 00
3.00	-856, 626	0							3. 00
3. 01	-515, 367	0							3. 01
3.02	-3, 013, 062	0							3. 02
3. 03	1, 594, 711	0							3. 03
3. 04	-23, 031	0							3. 04
3. 05	4, 665	0							3. 05
4.00	-182, 071	0							4.00

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

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.

6.00	CORPORATE OFFICE	6.00						
7.00		7.00						
8.00		8.00						
9.00		9.00						
10.00		10.00						
100.00		100.00						

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

5.00

-1, 189, 392

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT In Lieu of Form CMS-2552-10
Worksheet A-8-2 Peri od: From 07/01/2022 Provider CCN: 14-0032

						To 06/30/2023		epared:
	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	
				i i	·		Hours	
	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00	30. 00	ADULTS & PEDIATRICS	891, 012	891, 012	0	0	0	1. 00
2.00		OPERATING ROOM	1, 367	1, 367	0	0	0	2. 00
3.00	53. 00	ANESTHESI OLOGY	5, 869, 047	5, 869, 047	0	0	0	3. 00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	22, 275	0	22, 275	271, 900	165	4.00
5.00	60.00	LABORATORY	113, 750	113, 750	0	0	0	5. 00
6.00	69. 00	ELECTROCARDI OLOGY	108, 001	108, 001	0	0	0	6.00
7.00	76. 02	TELEMEDI CI NE	71, 775			0	0	7. 00
8.00		WOUND CARE	367, 813	314, 658	53, 155	211, 500	407	8. 00
9. 00	91. 00	EMERGENCY	978, 537	978, 537	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00			8, 423, 577					200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	4 00		0.00		Educati on	12	44.00	
1 00	1.00	2.00 ADULTS & PEDIATRICS	8.00	9.00	12.00	13.00	14. 00	1 00
1.00		OPERATING ROOM	0	0	_	0		1.00
2. 00 3. 00		ANESTHESI OLOGY	0	0	0	0	0	2. 00 3. 00
4. 00		RADI OLOGY-DI AGNOSTI C	21, 569	1, 078	0	0	0	4. 00
5. 00		LABORATORY	21, 309	1,0/6		0	0	5. 00
6. 00		ELECTROCARDI OLOGY			0	0	0	6. 00
7. 00		TELEMEDI CI NE			0	0	0	7. 00
8.00		WOUND CARE	41, 385	2, 069	0	0	0	8. 00
9. 00		EMERGENCY	1 41, 303			0	0	9. 00
10. 00	0.00	EMERGENCI			0	0	0	10. 00
200.00	0.00		62, 954	3, 147	0	0	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	J	200.00
		I denti fi er	Component	Limit	Di sal I owance	,		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	0	0	0	,		1.00
2. 00		OPERATING ROOM	0	·	0	1,00,		2. 00
3. 00		ANESTHESI OLOGY	0	_	0	-,,		3. 00
4. 00		RADI OLOGY-DI AGNOSTI C	0	21, 569		l e		4. 00
5. 00		LABORATORY	0	0	0	113, 750		5. 00
6.00		ELECTROCARDI OLOGY	0	0	0	108, 001		6. 00
7. 00		TELEMEDI CI NE	0	0	0	71, 775		7. 00
8. 00		WOUND CARE	0	41, 385	11, 770			8. 00
9. 00		EMERGENCY	0	0	0	978, 537		9. 00
10. 00	0. 00		0	0	0	0		10. 00
200. 00			0	62, 954	12, 476	8, 360, 623		200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0032 Peri od: Worksheet B From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 5, 713, 618 5, 713, 618 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 5, 682, 592 5, 682, 592 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 8,600,724 11, 271 8, 611, 995 4.00 00500 ADMINISTRATIVE & GENERAL 1, 000, 287 5 00 29, 886, 936 1, 653, 494 227, 963 32, 768, 680 5 00 6.00 00600 MAINTENANCE & REPAIRS 206, 292 1, 355 36, 355 244, 002 6.00 7.00 00700 OPERATION OF PLANT 2, 868, 959 977, 360 477, 167 119, 706 4, 443, 192 7.00 26, 332 8.00 00800 LAUNDRY & LINEN SERVICE 367, 681 1,024 1, 298 396, 335 8.00 836, 996 942, 504 00900 HOUSEKEEPI NG 104, 203 9 00 9 00 1.305 10.00 01000 DI ETARY 172,028 92, 041 27,075 22, 037 313, 181 10.00 01100 CAFETERI A 950, 500 25, 993 80, 082 1, 056, 575 11.00 11.00 01300 NURSING ADMINISTRATION 1, 798, 072 50, 664 280, 021 2, 245, 138 13.00 13.00 116, 381 01400 CENTRAL SERVICES & SUPPLY 41, 441 14.00 216, 087 33, 507 291, 035 14.00 15.00 01500 PHARMACY 1, 591, 228 60, 565 69, 161 221, 767 1, 942, 721 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 992, 946 64,628 84, 036 2, 141, 610 16.00 01700 SOCIAL SERVICE 0 17.00 17.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 303, 453 592, 556 264, 885 913, 465 8, 074, 359 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 780, 115 70, 998 54, 770 313, 387 2, 219, 270 31.00 04300 NURSERY 110, 918 43.00 598, 366 12,852 722, 136 43.00 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 4, 702, 557 502, 451 964, 473 623, 713 6, 793, 194 50.00 50.00 05200 DELIVERY ROOM & LABOR ROOM 1, 797, 635 52.00 72,046 270, 979 52.00 1, 454, 610 53.00 05300 ANESTHESI OLOGY 93, 103 3, 160 19.847 1, 056 117, 166 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3,043,632 536, 135 1, 507, 761 356, 889 5, 444, 417 54.00 03630 ULTRA SOUND 397, 326 54.01 285, 404 8, 836 60, 412 42,674 54.01 39, 200 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 339, 462 204 20, 495 399, 361 54.02 54.06 05404 PET SCAN 105, 125 r C 105, 125 54.06 05700 CT SCAN 864, 485 22, 591 99, 043 90, 329 1,076,448 57.00 57.00 58.00 05800 MRI 414, 895 26, 912 258, 714 38, 086 738, 607 58.00 05900 CARDIAC CATHETERIZATION 180.137 29, 863 38, 291 59 00 22, 524 270, 815 59 00 60.00 06000 LABORATORY 3, 079, 188 84, 559 171, 873 234, 320 3, 569, 940 60.00 06250 BLOOD CLOTTING FACTORS FOR HEMOPH. 62.30 0 62.30 06500 RESPIRATORY THERAPY 699, 430 11, 771 19, 893 119, 041 850, 135 65.00 65.00 06600 PHYSI CAL THERAPY 1, 961, 818 1, 604, 630 66.00 75, 222 25, 242 256, 724 66.00 67.00 06700 OCCUPATI ONAL THERAPY 368, 200 42, 554 C 68, 214 478, 968 67.00 68.00 06800 SPEECH PATHOLOGY 304, 712 11, 223 56, 946 372, 881 68.00 921, 327 06900 ELECTROCARDI OLOGY 613.004 65, 064 93. 815 69 00 149 444 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 172, 946 11, 013 22, 819 32,050 238, 828 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 7, 652, 136 0 7, 652, 136 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 1, 555, 378 0 0 0 1, 555, 378 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73 00 5, 561, 844 5, 561, 844 73 00 Ω 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 03050 BACTERI OLOGY & MI CROBI OLOGY 76.00 76.00 0 0 0 76.01 03650 VASCULAR LAB 238, 236 15, 851 578 42, 440 297, 105 76.01 76.02 03952 TELEMEDI CI NE 62, 388 11, 220 76, 02 14, 786 0 88, 394 76.03 03950 WOUND CARE 1,001,567 55, 744 15, 572 94, 360 1, 167, 243 76.03 07697 CARDIAC REHABILITATION 76.97 95, 192 10, 642 1,884 17, 691 125, 409 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 201, 704 20, 849 10, 995 36, 809 270, 357 90.00 09100 EMERGENCY 91 00 3, 826, 365 218, 701 248, 088 452, 369 4, 745, 523 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 16, 129, 834 101. 00 13, 814, 100 79, 044 48, 659 2, 188, 031 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 5, 390 7, 297, 211 892, 475 8, 195, 076 116. 00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 129, 198, 234 5, 638, 412 5, 682, <u>5</u>92 8, 611, 995 129, 123, 028 118. 00 118.00 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 49, 836 58, 350 190. 00 8, 514 194. 00 07950 PHI LANTHROPY DEVELOPMENT 0 4, 102, 848 66, 692 0 4, 169, 540 194. 00 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 194, 01 0 0 0 C 0 194. 02 0 194.02 07952 MEALS ON WHEELS 0 C 0 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 03 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201, 00 202.00 TOTAL (sum lines 118 through 201) 133, 350, 918 5, 713, 618 5, 682, 592 8, 611, 995 133, 350, 918 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0032

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

1/24/2024 1:12 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS **PLANT** LINEN SERVICE 7.00 9.00 5.00 6.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 32, 768, 680 5 00 6.00 00600 MAINTENANCE & REPAIRS 79, 493 323, 495 6.00 00700 OPERATION OF PLANT 1, 447, 548 78, 105 5, 968, 845 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 129, 122 2, 115 51, 171 578, 743 8.00 1, 249, 562 00900 HOUSEKEEPI NG 307.058 9.00 9 00 10.00 01000 DI ETARY 102, 031 7, 356 178, 863 3,872 37, 768 10.00 11.00 01100 CAFETERI A 344, 222 2,084 50, 513 10,666 11.00 01300 NURSING ADMINISTRATION 20, 790 731, 444 4.046 98, 456 13 00 13 00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 94,816 3, 310 80, 532 1,084 17,005 14.00 117, 696 15.00 01500 PHARMACY 632, 919 4,843 0 24, 852 15.00 01600 MEDICAL RECORDS & LIBRARY 16, 00 697, 715 5, 149 125, 593 26, 520 16, 00 0 01700 SOCIAL SERVICE 17.00 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30.00 2, 630, 545 47, 356 1, 151, 515 178 111 243, 152 03100 INTENSIVE CARE UNIT 5, 671 27, 271 29, 133 31.00 723,016 137.970 31.00 04300 NURSERY 43.00 235, 265 1, 011 24, 974 5, 274 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 2, 213, 155 40, 153 976, 414 112, 444 206, 177 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 585, 652 5, 762 140,007 50,832 29, 564 52.00 53.00 05300 ANESTHESI OLOGY 38, 172 245 6, 142 1, 297 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 773, 737 42, 820 1, 041, 873 13, 627 220,000 54.00 03630 ULTRA SOUND 129, 445 705 17, 172 1, 993 54.01 3.626 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 130, 108 3, 126 76, 177 857 16, 085 54.02 54.06 05404 PET SCAN 34, 249 54.06 0 05700 CT SCAN 350, 696 43, 901 9, 270 57.00 1,808 12, 160 57.00 58.00 05800 MRI 240, 631 2, 146 52, 299 31, 205 11,043 58.00 05900 CARDIAC CATHETERIZATION 59.00 88, 229 2, 39 58, 033 110 12, 254 59 00 34, 698 60.00 06000 LABORATORY 1, 163, 051 6,743 164, 323 0 60.00 06250 BLOOD CLOTTING FACTORS FOR HEMOPH. 62.30 0 0 62.30 65 00 06500 RESPIRATORY THERAPY 276, 965 950 22.875 5 089 4 830 65 00 06600 PHYSI CAL THERAPY 66.00 639, 141 6,008 146, 180 1, 600 30, 867 66.00 06700 OCCUPATIONAL THERAPY 156, 043 3, 402 82, 694 67.00 67.00 645 17, 462 68.00 06800 SPEECH PATHOLOGY 121, 481 889 21, 809 4, 605 68.00 0 06900 ELECTROCARDI OLOGY 69.00 300, 159 5, 211 126, 439 5, 406 26, 698 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 77,808 889 21, 402 284 4,519 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 492, 989 C 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 506 727 0 0 72 00 C 0 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 811, 993 C 0 0 0 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 0 76.00 03050 BACTERI OLOGY & MI CROBI OLOGY 76.00 0 C C 0 0 03650 VASCULAR LAB 96, 794 30 803 1.257 8.946 6.504 76 01 76 01 76.02 03952 TELEMEDI CI NE 28, 798 1, 195 28, 735 6,068 76.02 76.03 03950 WOUND CARE 380, 276 4.444 108, 327 8.745 22, 874 76.03 07697 CARDIAC REHABILITATION 40, 857 76. 97 858 20, 681 849 4, 367 76. 97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 0 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 88.080 1,655 40, 517 287 8,555 90.00 09100 EMERGENCY 1, 546, 044 91.00 17, 471 425,003 110, 119 89, 743 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 5, 254, 928 6, 314 153, 607 0 32, 435 101. 00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 2, 669, 874 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 317, 488 118.00 31, 391, 276 5, 822, 696 575, 536 1, 218, 701 118. 00 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19, 010 674 16, 545 3, 494 190. 00 194. 00 07950 PHI LANTHROPY DEVELOPMENT 1, 358, 394 129, 604 3, 207 27, 367 194. 00 5, 333 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 194. 01 0 C C 0 194.02 07952 MEALS ON WHEELS 0 194. 02 0 0 0 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 C 0 0 0 194. 03 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 5, 968, 845 578, 743 1, 249, 562 202. 00 202.00 32, 768, 680 323, 495

Provider CCN: 14-0032

			To		1/24/2024 1:1	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	10.00	11. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS						4 00
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 00600 MAI NTENANCE & REPAI RS						6. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	643, 071					10.00
11. 00 01100 CAFETERI A	0	1, 464, 060	1			11.00
13.00 O1300 NURSI NG ADMINI STRATI ON 14.00 O1400 CENTRAL SERVI CES & SUPPLY		42, 282 10, 989		498, 771		13. 00 14. 00
15. 00 01500 PHARMACY		26, 679		12, 427	2, 918, 733	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	o	14, 911		3	0	16. 00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	494, 931	171, 752		13, 627	34, 431	30. 00
31. 00 03100 NTENSI VE CARE UNIT	77, 705	46, 291	271, 858	4, 581	12, 156	31.00
43.00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	70, 435	18, 545	108, 919	1, 890	1, 023	43. 00
50. 00 05000 OPERATING ROOM	0	106, 080	623, 011	205, 711	18, 103	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	o	45, 310		5, 927	0, 103	52.00
53. 00 05300 ANESTHESI OLOGY	o	29		5, 922	55, 150	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	82, 602	0	9, 595	21, 424	54.00
54. 01 03630 ULTRA SOUND	0	7, 095		2, 054	5	54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	3, 576	1	8, 155	9, 634	54. 02
54. 06 05404 PET SCAN	0	17.2(2	0	0	0	54.06
57. 00 05700 CT SCAN 58. 00 05800 MRI	0	17, 363		5, 678	0	57.00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON		7, 210 3, 836		2, 806 11, 205	2, 402 0	58. 00 59. 00
60. 00 06000 LABORATORY	o	53, 357	0	116, 609	0	60.00
62. 30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	o	0	Ö	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	o	26, 332	154, 576	6, 247	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	51, 194	0	955	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	13, 238		1, 674	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	9, 345		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	16, 901	0	1, 721	7, 514	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		6, 403	0	1, 099	0	70. 00 71. 00
72. 00 07100 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	0	Ö	o	0	73. 00
74. 00 07400 RENAL DI ALYSI S	o	0	0	0	0	74.00
76. 00 03050 BACTERI OLOGY & MI CROBI OLOGY	0	0	0	0	0	76. 00
76. 01 03650 VASCULAR LAB	0	6, 432		0	0	76. 01
76. 02 03952 TELEMEDI CI NE	0	2, 452		21	0	76. 02
76. 03 03950 WOUND CARE 76. 97 07697 CARDI AC REHABI LI TATI ON	0	17, 305		10, 722 101	49, 193 0	76. 03 76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUISITION	0	2, 913	0	101	0	77.00
OUTPATIENT SERVICE COST CENTERS	o o		<u> </u>	<u> </u>		77.00
90. 00 09000 CLI NI C	0	6, 489	0	635	0	90.00
91. 00 09100 EMERGENCY	o	79, 170	464, 893	20, 138	25, 513	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	394, 641	0	42, 752	74, 705	101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	173, 338	0	6, 458	2, 607, 480	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	643, 071	1, 464, 060		498, 713	2, 918, 733	
NONREI MBURSABLE COST CENTERS				, ,	, , , , , ,	
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
194. 00 07950 PHI LANTHROPY DEVELOPMENT	0	0	0	58		194. 00
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 01
194. 02 07952 MEALS ON WHEELS	0	0	0	0		194. 02
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS		0	0	O	0	194. 03
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		^			0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	643, 071	1, 464, 060	3, 142, 156	498, 771	2, 918, 733	

Health Financial Systems ST. ANTHONYS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0032 Peri od: Worksheet B From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 1:12 pm Cost Center Description MEDI CAL SOCIAL SERVICE Intern & Subtotal Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 17.00 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 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 3, 099, 029 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 121, 425 14, 169, 886 14, 169, 886 30.00 03100 INTENSIVE CARE UNIT 22, 487 0 3, 577, 409 0 3, 577, 409 31.00 31.00 43.00 04300 NURSERY 11, 394 0 1, 200, 866 1, 200, 866 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 322, 914 11, 617, 356 11, 617, 356 50.00 05200 DELIVERY ROOM & LABOR ROOM 39, 665 2, 966, 447 0 2, 966, 447 52.00 52.00 53.00 05300 ANESTHESI OLOGY 69, 487 0 293, 610 0 293, 610 53.00 05400 RADI OLOGY-DI AGNOSTI C 173, 184 0 8.823.279 8, 823, 279 54 00 54 00 54.01 03630 ULTRA SOUND 31, 402 590, 823 590, 823 54.01 694, 286 694, 286 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 47.207 0 0 0 0 0 0 0 0 0 54.02 05404 PET SCAN 148, 770 148, 770 54.06 9.396 54.06 2, 015, 731 05700 CT SCAN 2, 015, 731 57.00 498, 407 57.00 58.00 05800 MRI 143, 665 1, 232, 014 1, 232, 014 58.00 05900 CARDIAC CATHETERIZATION 59 00 9,627 456, 500 456, 500 59 00 60.00 06000 LABORATORY 273, 084 0 5, 381, 805 5, 381, 805 60.00 06250 BLOOD CLOTTING FACTORS FOR HEMOPH. 62.30 62.30 06500 RESPIRATORY THERAPY 18,092 1, 366, 091 1, 366, 091 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 66, 339 2, 904, 102 2, 904, 102 66.00 06700 OCCUPATIONAL THERAPY 791, 627 37, 501 791, 627 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 9,879 540, 889 540, 889 68.00 69.00 06900 ELECTROCARDI OLOGY 111,616 1, 522, 992 0 1, 522, 992 69.00 07000 ELECTROENCEPHALOGRAPHY 16, 983 368, 215 368, 215 70.00 70.00 10, 202, 785 10, 202, 785 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 57, 660 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 51, 264 2, 113, 369 0 0 0 2, 113, 369 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 367, 579 7, 741, 416 7, 741, 416 73.00 07400 RENAL DIALYSIS 0 74.00 0 0 0 74.00 76.00 03050 BACTERI OLOGY & MI CROBI OLOGY 0 0 0 Ω 76.00 76.01 03650 VASCULAR LAB 24, 467 472, 308 472, 308 76.01 0 03952 TELEMEDI CI NE 0 155, 806 155, 806 76.02 76.02 143 03950 WOUND CARE 0 1.817.143 1, 817, 143 76.03 48 014 76.03 76.97 07697 CARDIAC REHABILITATION 4, 262 C 200, 297 200, 297 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3, 230 419, 805 419, 805 90.00 91.00 09100 EMERGENCY 270, 611 C 7, 794, 228 0 7, 794, 228 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 152, 682 0 22, 241, 898 0 22, 241, 898 101. 00 102.00 10200 OPI OID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113 00 11300 INTEREST EXPENSE 113 00 13, 737, 589 116. 00 116. 00 11600 HOSPI CE 85, 363 13, 737, 589 SUBTOTALS (SUM OF LINES 1 through 117) 3,099,029 127, 559, 342 127, 559, 342 118. 00 118.00 0 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 98, 073 190. 00 98 073 194. 00 07950 PHI LANTHROPY DEVELOPMENT 0 0 5, 693, 503 0 5, 693, 503 194. 00 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 01 C 0 194. 02 07952 MEALS ON WHEELS 0 0 0 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194, 03 200.00 Cross Foot Adjustments 0 0 200. 00 201.00 Negative Cost Centers n 0 0 201.00

3, 099, 029

133, 350, 918

133, 350, 918 202. 00

TOTAL (sum lines 118 through 201)

202.00

| 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: 14-0032

Cost Center Description						То	06/30/2023	Date/Time Pre 1/24/2024 1:1:	
Company Comp					CAPI TAL REI	LATED COSTS		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, p
Company Comp			Cost Center Description	Directly	RIDG & FLYT	MVRLE FOLLE	Subtotal	EMPL OVEE	
			oost center bescription		DEDO & TIXI	MARCE EGOLI	Subtotal		
DEBERAL SERVICE COST CENTERS 1,000 2,000 2A 4,000								DEPARTMENT	
CHERRAL SERVICE COST CENTERS					1 00	2 00	2A	4 00	
DOCIDIO CAP RIL COSTS MULL FOULP		GENER	AL SERVICE COST CENTERS			2.00	271		
4.00 GOODQ IMPLICATE INFELLIS DEPARTMENT 0 11,277 0 11,277 1,271 4.00									
5.00 DODOD JAZIMI IN STRATIVE & EFRIPAIS 1,805,866 1,603,494 1,000,787 4,539,447 299 5,00 7.00 DODOD JORGATION OF PLANT 19,800 977,867 17,157 1,474,325 157 7,00 7.00 DODOD JORGATION OF PLANT 19,800 977,807 1,714,325 157 7,00 7.00 DODOD JORGATION OF PLANT 1,00 1,00 1,00 1,00 1,00 7.00 DODOD JORGATION OF PLANT 1,00 1,00 1,00 1,00 1,00 7.00 DODOD JORGATION OF PLANT 1,00 1,00 1,00 1,00 1,00 7.00 DODOD JORGATION OF PLANT 1,00 1,00 1,00 1,00 1,00 7.00 DODOD JORGATION OF PLANT 1,00 1,00 1,00 1,00 1,00 7.00 DODOD JORGATION OF PLANT 1,00 1,00 1,00 1,00 7.00 DODOD JORGATION OF PLANT 1,00 1,00 1,00 1,00 7.00 DODOD JORGATION OF PLANT 1,00 1,00 1,00 1,00 7.00 DODOD JORGATION OF PLANT 1,00 1,00 1,00 1,00 7.00 DODOD JORGATION OF PLANT 1,00 1,00 1,00 1,00 7.00 DODOD JORGATION OF PLANT 1,00 1,00 7.00 DODOD JORGATION OF PLANTSTIC OF PLANT 1,00 1,00 7.00 DODOD JORGATION OF PLANTSTIC OF PLANT 1,00 1,00 7.00 DODOD JORGATION OF PLANTSTIC OF PLANT 1,00 1,00 7.00 DODOD JORGATION OF PLANTSTIC OF PLANT 1,00 1,00 7.00 DODOD JORGATION OF PLANTSTIC OF PLANT 1,00 1,00 7.00 DODOD JORGATION OF PLANTSTIC OF PLANTSTIC OF PLANT 1,00 1,00 7.00 DODOD JORGATION OF PLANTSTIC OF PLANT 1,00 1,00 7.00 DODOD JORGATION OF PLANTSTIC				0	11, 271	0	11, 271	11. 271	
0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.0000000 0.00000000				1, 885, 866					
8.00 0.0800 LAURDRY & LINEN SERVICE 0 26, 332 1, 0.02 27, 556 2 8, 0.0 0.0000 CONTROL SEEPTING 0 0 0 1, 305 1, 305 3, 0.0 10.00 10.001 10.1007 10.1007 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001 10.001				0	_				
0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000				19, 800					
11.00 0 1000 CAFETERIA 0 25, 993 0 25, 993 105 11.00 13.00 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.		1	•	o					
13.00 01300 NIRES INC. ADMINI STRATION 0 50, 664 116, 381 167, 045 367 13.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00		1	•	o		·			
14.00 01400 CENTRAL SERVICES & SUPPLY 0 41, 441 0 41, 441 44 0.0 16.00 01600 MFBICAL RECORDS & LIBRARY 0 0 64,628 0 0 64,628 110 16.00 17.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00				0					
15.00 0 1500 PARABIACY 199, 034 60, 565 69, 161 328, 760 200 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 1				0					
17.00				199, 034					
IMPATT ENT ROUTH IN: SERVICE COST CENTERS 1.104 30,0 30.0 30.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000000		1	•	0					
30.00	17.00			0	0	0	0	0	17.00
A3.00 0.4300 NURSERY 0 12,852 0 12,852 145 43,00	30. 00			257	592, 556	264, 885	857, 698	1, 196	30. 00
MAILLARY SERVICE COST CENTERS 50.00 DS000 DEPRATING ROM DOPERATING ROM 185, 460 502, 451 964, 473 7,652, 384 817 50.00 520.00 DEPRATING ROM 180, 460 502, 451 964, 473 72, 046 355 52.00 350, 300 3500, 00 SERVICE STORM 180, 461 57 1 53.00 30.00 DELIVERY ROM & LABDR ROM 25, 450 3,160 19, 847 48, 457 1 53.00 30.00 DEPRATING ROM 180, 461 19, 847 48, 457 1 53.00 30.00 DEPRATING ROM 180, 461 19, 847 48, 457 1 53.00 30.00 DEPRATING ROM 180, 461 19, 847 48, 457 1 53.00 30.00 DEPRATING ROM 180, 461 19, 847 48, 457 1 53.00 30.00 DEPRATING ROM 180, 461 19, 847 48, 457 1 53.00 30.00 DEPRATING ROM 180, 461 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19, 847 19				1					
50.00	43. 00		·	0	12, 852	0	12, 852	145	43. 00
52 00 05200 DELIVERY ROOM & LABOR ROOM 0 72, 046 0 72, 046 355 52, 00 53.00 05300 ABSTHESIOLOGY 25, 450 3, 160 19, 847 48, 457 153, 00 540, 00 05400 RADIOLOGY-DI AGNOSTI C 447, 473 536, 135 1,507, 761 69, 248 55, 65, 51, 51 51, 00 03450 NULTEA SOUND 0 0 0 0 0 0 0 0 0	50. 00			185, 460	502, 451	964, 473	1, 652, 384	817	50.00
54. 00 05400 RADIOLOGY-DI ACMOSTIC 447, 473 5.56, 135 1, 507, 761 2, 491, 369 467 54. 00 54. 00 03450 ULTRA SOUND 0 0 0 0 0 0 0 0 0	52.00	05200	DELIVERY ROOM & LABOR ROOM	0					52. 00
54. 01 03630 ULTERA SOUND 0 8, 83 6 60, 412 69, 248 55 54. 01				1					
54. Q2 03450 NUCLEAR MEDICINE - DI ACNOSTIC 0 39, 200 204 39, 404 27 54. 02 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0				447, 473					
54,00 05404 PET SCAN				l o					
58.00 OSBOO MRI 0 26.912 258,714 285,626 50 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50. 50.		05404	PET SCAN	o	_	_	0		
59.00 05900 CARDIA C CATHETERI ZATION 0 29, 863 38, 291 68, 154 30 59.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 0				0					
60 00 06000 LABORATORY 0 84, 559 171, 873 256, 422 307 80 . 00 20 . 30 0650 08 050 08 050 08 050 08 050 08 08				0					
65 00 0.0500 RESPI RATORY THERAPY 95 099 75, 222 2, 22 2, 24 195, 563 336 66, 00	60.00	06000	LABORATORY	0					60. 00
66.00 06600 PHYSI CAL THERAPY 95,099 75,222 25,242 195,563 336 66,000 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 68.00 68.00 68.00 69.00 ELECTROCARDI OLOCY 0 0 65.064 149,444 214,508 123 69.00 69.00 ELECTROCARDI OLOCY 0 0 65.064 149,444 214,508 123 69.00 71.00 72.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.0		1	•	0	_	-	0		
67:00 06700 0CCUPATIONAL THERAPY 0 42,554 0 42,554 89 67,00 68:00 06800 SPECH PATHOLOGY 0 0 11,223 75 68,00 69:00 06900 ELECTROCARDIOLOGY 0 65,064 149,444 214,508 123 69,00 70:00 07000 ELECTROENCEPHALOGRAPHY 398 11,013 22,819 34,230 42 70,00 70:00 07000 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 72:00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 73:00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 74:00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 76:00 03650 BACTERIOLOGY & MICROBIOLOGY 0 0 0 0 0 0 76:00 03650 VASCULAR LAB 0 15,851 578 16,429 56 76.01 76:03 03950 WONDO CARE 0 0 57.74 0 76:03 03950 WONDO CARE 0 0 57.74 15,572 71,316 124 76.03 76:97 07697 CARDIA CREHABILITATION 0 10,642 1,884 12,526 23 76.97 76:00 07000 ALCUSTRUE CHISCT ACQUISITION 0 0 0 0 0 0 76:00 09000 CLINIC 0 0 0 0 0 0 0 77:00 07700 07700 07700 00700 0		1	•	95,099					
69.00				0					
170.00 07000 Common Co		1	•	o					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 74.00 07400 RENAL DIALYSI S 0 0 0 0 0 0 0 76.00 03050 BACTERIOLOGY & MICROBIOLOGY 0 0 0 0 0 0 76.01 03650 VASCULAR LAB 0 15, 851 578 16, 429 56 76.01 76.02 03952 TELEMBUICINE 0 14, 786 15 76.02 76.03 03950 WOUND CARE 0 55, 744 15, 572 71, 316 124 76.03 76.04 07697 CARDI AC REHABI LITATI ON 0 10, 642 1, 884 12, 526 23 76.97 77.00 07700 ALLOGENEI C HISCT ACQUISITION 0 0 0 0 0 0 77.00 00000 00000 0 0 0 0 77.00 00000 00000 0 0 0 78.00 09000 00000 00000 0 0 78.00 09000 00000 00000 0 0 78.00 09000 00000 00000 0 78.00 00000 00000 0 0 0 78.00 000000 00000 0 0 0 78.00 000000 00000 0 0 0 78.00 000000 000000 0 0 0 78.00 000000 000000 0 0 0 0 78.00 0000000 000000 0 0 0 78.00 000000000000000000000000000000000				0					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 75. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 76. 01 03650 VASCULAR LOB LAYSIS 0 0 0 0 0 0 0 76. 01 03650 VASCULAR LAB 0 15, 851 578 16, 429 56 76, 01 76. 02 03952 TELEMEDICINE 0 14, 786 0 14, 786 15 76, 02 76. 03 03952 TELEMEDICINE 0 14, 786 0 14, 786 15 76, 02 76. 03 03952 TELEMEDICINE 0 55, 744 15, 572 71, 316 124 76, 03 77. 00 07697 CARDIA CREHABILITATION 0 10, 642 1, 884 12, 526 23 76, 97 77. 00 07700 ALLOGENEIC HISCT ACQUISITION 0 0 0 0 0 0 77. 00 00000 CILINIC ECOST CENTERS 0 79. 00 09000 CILINIC CECOST CENTERS 0 0 20, 849 10, 995 31, 844 48 90, 00 79. 00 09000 EMERGENCY 1, 363 218, 701 248, 088 468, 152 593 91, 00 79. 00 09100 EMERGENCY 0 0 0 0 0 0 0 70 09200 095ERVANTION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 70 09200 09100 EMERGENCY 68, 739 79, 044 48, 659 196, 442 2, 856 101, 00 70 102. 00 102. 00 09101 TEREATMENT PROGRAM 0 0 0 0 0 0 70 00 102. 00 09101 TEREATMENT PROGRAM 0 0 5, 390 396, 728 1, 169 116, 00 70 102. 00 10300 INTEREST EXPENSE 113, 00 1300 INTEREST EXPENSE 113, 00 1300 INTEREST EXPENSE 114, 644, 951 112, 271 118, 00 70 104, 00 10900 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 09100 0910				398					
74. 00 07400 RENAL DIALYSIS 0 0 00 0 0 0 74. 00 76. 00 03050 BACTERI OLOGY & MICROBI OLOGY 0 0 0 0 0 0 76. 00 76. 01 03650 VASCULAR LAB 0 15,851 578 16,429 56 76. 01 76. 01 03650 VASCULAR LAB 0 15,851 578 16,429 56 76. 01 76. 02 03952 TELEMEDI CINE 0 14,786 0 14,786 15 76. 02 76. 03 03950 WOUND CARE 0 0 14,786 0 14,786 15 76. 02 76. 07 07697 CARDI AC REHABI LI TATI ON 0 10,642 1,884 12,526 23 76. 97 77. 00 07700 ALLOGENEI C. HSCT ACQUI SI TION 0 0 0 0 0 0 0 77. 00 DUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0,849 10,995 31,844 48 90. 00 91. 00 09000 GLI NI C 0 0,849 10,995 31,844 48 90. 00 91. 00 09000 BERRGENCY 1,363 218,701 248,088 468,152 593 91. 00 92. 00 09000 BERRGENCY 1,363 218,701 248,088 468,152 593 91. 00 92. 00 09000 BERRGENCY 68,739 79,044 48,659 196,442 2,856 101. 00 102. 00 10200 OP1010 TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0		-	Ō		
76. 00 03050 BACTERI OLOGY & MI CROBI OLOGY 0 0 0 0 0 0 76. 00 76. 01 03650 VASCULAR LAB 0 15,851 578 16,429 56 76. 01 76. 02 03952 TELEMEDI CI NE 0 14,786 0 14,786 15 76. 02 76. 03 03950 WOUND CARE 0 55,744 15,572 71,316 124 76. 03 76. 97 07697 CARDI AC REHABI LITATI ON 0 0 0 0 0 0 0 77. 00 OTOTOO ALLOGENEI C HSCT ACQUI SITI ON 0 0 0 0 0 0 0 OTOTOO OTO				0	0	0	0		
76. 01 03650 VASCULAR LAB				0	0	0	0		
76. 03 03950 WOUND CARE				l o	15, 851	578	16, 429		
76. 97 07697 CARDI AC REHABILITATION 0 10, 642 1, 884 12, 526 23 76. 97 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0				0					
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0				0					
90. 00				0					
91. 00									
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 0THER REI MBURSABLE COST CENTERS 101. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00		1	•	1 262					
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 68,739 79,044 48,659 196,442 2,856 101.00 102.00 102.00 102.00 10 10 TREATMENT PROGRAM 0 0 0 0 0 0 102.00 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPI CE 391,338 0 5,390 396,728 1,169 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3,323,947 5,638,412 5,682,592 14,644,951 11,271 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 8,514 0 8,514 0 190.00 194.01 194.01 107951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194.01 194.02 194.03 07952 MEALS ON WHEELS 0 0 0 0 0 194.02 194.03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194.02 194.03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194.02 194.03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194.02 194.03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194.03 194.03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0				1, 303	218, 701	240, 000		573	
102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O		OTHER	REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11600 HOSPI CE 391,338 0 5,390 396,728 1,169 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3,323,947 5,638,412 5,682,592 14,644,951 11,271 118.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 1				1					
116. 00	102.00			٩	0	<u> </u>	<u> </u>	0	102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3,323,947 5,638,412 5,682,592 14,644,951 11,271 118.00									
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN 0 8, 514 0 190. 00 194. 00 07950 PHI LANTHROPY DEVELOPMENT 0 66, 692 0 66, 692 0 194. 00 194. 01 07951 07951 07951 07951 07951 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952 07952					0 5 620 412			·	
190. 00 19000 GFT FLOWER COFFEE SHOP & CANTEEN 0 8, 514 0 190. 00 194. 00 07950 PHI LANTHROPY DEVELOPMENT 0 66, 692 0 66, 692 0 194. 00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 01 194. 02 07952 MEALS 0N WHEELS 0 0 0 0 0 0 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 03 200. 00 0 0 0 0 194. 03 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	110.00			3, 323, 947	5, 030, 412	5, 002, 592	14, 644, 951	11, 271	110.00
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 01 194. 02 07952 MEALS ON WHEELS 0 0 0 0 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 03 200. 00 0 0 0 194. 03 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0					
194. 02 07952 MEALS ON WHEELS 0 0 0 0 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 201. 00				0					
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 03 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00					U		ol Ol		
201.00 Negative Cost Centers 0 0 0 0 201.00			OTHER NONREIMBURSABLE COST CENTERS	0	Ö	O	ő	0	194. 03
201.00 Negative Cost Centers 0 0 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 3,323,947 5,713,618 5,682,592 14,720,157 11,271 202.00							О		
202.00 10 miz (30m 11103 110 till 00gh 201) 3,020,747 3,713,010 3,002,372 14,720,137 11,271 202.00				3 323 047	0 5 712 61Ω	5 682 502	0 14 720 157	0 11 271	201.00 202.00
	202.00	1	1.5 (3am 111165 110 till dagn 201)	0,020,747	5, 715, 516	0, 502, 572	11, 720, 107	11,2/1	1-02.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared:
1/24/2024 1:12 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0032

					00/30/2023	1/24/2024 1:1	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL 5.00	REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					l	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4 520 044				l	4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	4, 539, 946 11, 014	l e			l	5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	200, 552	12, 417 2, 997	1		I	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	17, 889			59, 714	I	8.00
9. 00	00900 HOUSEKEEPI NG	42, 542		1	0	43, 983	1
10.00	01000 DI ETARY	14, 136	282	50, 284	400	1, 329	1
11. 00	01100 CAFETERI A	47, 691	80	14, 201	0	375	11. 00
13.00	01300 NURSING ADMINISTRATION	101, 339	155	27, 679	0	732	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	13, 136	l e	l	112	599	1
15. 00	01500 PHARMACY	87, 689	186		0	875	1
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	96, 666 0	198 	l	0	933 0	1
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U		<u> </u>	U	0	17.00
30. 00	03000 ADULTS & PEDI ATRI CS	364, 452	1, 818	323, 726	18, 375	8, 558	30.00
31. 00	03100 INTENSIVE CARE UNIT	100, 171	218	1		1, 025	1
43.00	04300 NURSERY	32, 595	39	7, 021	0	186	43. 00
	ANCI LLARY SERVI CE COST CENTERS		Ī				
50.00	05000 OPERATING ROOM	306, 624	1, 541		11, 602	7, 257	50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	81, 140 5, 289		39, 360	5, 245	1, 041	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	245, 745	l .	1, 121	0 1, 406	46 7, 744	1
54. 01	03630 ULTRA SOUND	17, 934	27	1		128	1
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	18, 026	120		88	566	1
54.06	05404 PET SCAN	4, 745	O	1	0	0	1
57.00	05700 CT SCAN	48, 588	69	12, 342	1, 255	326	57. 00
58. 00	05800 MRI	33, 339	82	l	3, 220	389	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	12, 224	92	1		431	1
60.00	06000 LABORATORY	161, 136	259	1	0	1, 221	1
62. 30 65. 00	06250 BLOOD CLOTTI NG FACTORS FOR HEMOPH. 06500 RESPI RATORY THERAPY	38, 373	36		525	0 170	1
66. 00	06600 PHYSI CAL THERAPY	88, 551	231		165	1, 086	1
67. 00	06700 OCCUPATI ONAL THERAPY	21, 619	l .			615	1
68. 00	06800 SPEECH PATHOLOGY	16, 831	34		0	162	68. 00
69.00	06900 ELECTROCARDI OLOGY	41, 586	200	35, 546	558	940	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	10, 780	34	1	29	159	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	345, 394	0		0	0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	70, 205	0		0	0	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	251, 045 0			0	0	1
76. 00	03050 BACTERI OLOGY & MI CROBI OLOGY	0			0	0	1
76. 01	03650 VASCULAR LAB	13, 410	1	_	923	229	
76. 02	03952 TELEMEDI CI NE	3, 990	46	1	0	214	1
	03950 WOUND CARE	52, 686	171			805	
	07697 CARDI AC REHABI LI TATI ON	5, 661	33				76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	12 202	L 4	11 201	20	201	90.00
90.00	09100 EMERGENCY	12, 203 214, 199	l e		30 11, 362		90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	214, 177	0/1	117, 402	11, 302	3, 139	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	728, 015	242	43, 184	0		101. 00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE		_	_	_	_	113. 00
	11600 HOSPI CE	369, 901	12.100	1 (2) 04(50, 202		116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	4, 349, 111	12, 186	1, 636, 946	59, 383	42, 897	118. 00
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 634	26	4, 651	0	123	190. 00
	07950 PHI LANTHROPY DEVELOPMENT	188, 201	205		-		194. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS	0		0	0		194. 01
194. 02	07952 MEALS ON WHEELS	0	0	0	О		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 03
200.00						I	200.00
201.00		4 530 044	10 417	1 (70 000	0		201. 00 202. 00
202.00	TOTAL (sum lines 118 through 201)	4, 539, 946	12, 417	1, 678, 033	59, 714	43, 983	1202.00

Provider CCN: 14-0032

			10	06/30/2023	Date/lime Pre 1/24/2024 1:1	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	2 piii
	10.00	11. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
6. 00 00600 MAINTENANCE & REPAIRS						6.00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	185, 576					10. 00
11. 00 01100 CAFETERI A	0	88, 445				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	2, 554	299, 871	70 7/2		13.00
14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY	0	664 1, 612	14, 945	78, 763 1, 962	469, 407	14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY		901	8, 353	1, 902	469, 407	16.00
17. 00 01700 SOCIAL SERVICE		0	0, 333	0	0	17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		<u> </u>	<u>~</u> 1		
30. 00 03000 ADULTS & PEDI ATRI CS	142, 826	10, 376	96, 263	2, 152	5, 537	30.00
31.00 03100 INTENSIVE CARE UNIT	22, 424	2, 796	25, 945	723	1, 955	31.00
43. 00 04300 NURSERY	20, 326	1, 120	10, 395	298	165	43. 00
ANCI LLARY SERVI CE COST CENTERS			F0 457	22 422	0.044	
50. 00 05000 OPERATING ROOM	0	6, 408	59, 457	32, 489	2, 911	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	2, 737	25, 394 0	936 935	0 8, 870	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		4, 990	0	1, 515	3, 446	54.00
54. 01 03630 ULTRA SOUND		429	l o	324	1	54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	216	Ö	1, 288	1, 549	54. 02
54.06 05404 PET SCAN	0	0	0	0	0	54. 06
57.00 05700 CT SCAN	0	1, 049	0	897	0	57. 00
58. 00 05800 MRI	0	436	0	443	386	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	232	0	1, 769	0	59. 00
60. 00 06000 LABORATORY	0	3, 223	0	18, 413	0	60.00
62. 30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH. 65. 00 06500 RESPIRATORY THERAPY	0	0 1, 591	14, 752	986	0	62. 30 65. 00
66. 00 06600 PHYSI CAL THERAPY		3, 093	14, 732	151	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		800	0	264	0	67.00
68. 00 06800 SPEECH PATHOLOGY		565	Ö	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 021	O	272	1, 208	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	387	0	174	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03050 BACTERI OLOGY & MI CROBI OLOGY	0	0	0	0	0	74. 00 76. 00
76. 00 03050 BACTERI OLOGY & MI CROBI OLOGY 76. 01 03650 VASCULAR LAB		389	0	0	0	76. 00
76. 02 03952 TELEMEDI CI NE		148	0	3	0	76. 02
76. 03 03950 WOUND CARE		1, 045		1, 693	7, 911	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	176		16	. 0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	392		100	0	90.00
91. 00 09100 EMERGENCY	0	4, 783	44, 367	3, 180	4, 103	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	0	23, 838	0	6, 751	12, 015	101 00
102. 00 10200 OPI OI D TREATMENT PROGRAM		23, 030	0	0, 731		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		102.00
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	10, 472	О	1, 020	419, 350	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	185, 576	88, 445	299, 871	78, 754	469, 407	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194. 00 07950 PHI LANTHROPY DEVELOPMENT	0	0	0	9		194.00
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 194. 02 07952 MEALS ON WHEELS		0	0	O		194. 01 194. 02
194.02 07952 MEALS ON WHEELS 194.03 07953 OTHER NONREIMBURSABLE COST CENTERS		0	0	0		194. 02
200.00 Cross Foot Adjustments		U		٩	U	200.00
201.00 Negative Cost Centers		Ω	n	o	n	201.00
202.00 TOTAL (sum lines 118 through 201)	185, 576	88, 445	299, 871	78, 763	469, 407	
		•		,	•	-

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0032 Peri od: Worksheet B From 07/01/2022 Part II 06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm Cost Center Description MEDI CAL SOCIAL SERVICE Intern & Subtotal Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 17.00 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 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 207, 097 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8, 109 1,841,086 1,841,086 30.00 03100 INTENSIVE CARE UNIT 1,502 0 328, 209 0 328, 209 31.00 31.00 43.00 04300 NURSERY 761 0 85, 903 85, 903 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 21, 564 0 2, 377, 555 0 2, 377, 555 50.00 05200 DELIVERY ROOM & LABOR ROOM 231, 124 0 231, 124 52.00 2,649 52.00 53.00 05300 ANESTHESI OLOGY 4,640 0 69, 976 0 69, 976 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 3, 062, 795 3, 062, 795 54 00 11, 565 54 00 54.01 03630 ULTRA SOUND 2,097 0 95, 278 95, 278 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 85, 852 54.02 3, 152 0 0 0 0 0 85, 852 54.02 05404 PET SCAN 54.06 627 5. 372 5. 372 54.06 219, 709 05700 CT SCAN 0 219, 709 57.00 33 431 57.00 58.00 05800 MRI 9,594 0 348, 268 348, 268 58.00 05900 CARDIAC CATHETERIZATION 99, 901 59 00 643 99, 901 59 00 60.00 06000 LABORATORY 0 505, 424 505, 424 60.00 18, 236 06250 BLOOD CLOTTING FACTORS FOR HEMOPH. 0 62.30 Λ 62.30 06500 RESPIRATORY THERAPY 1, 208 95, 892 0 0 0 95, 892 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 4, 430 334, 702 334, 702 66.00 06700 OCCUPATIONAL THERAPY 91, 891 2,504 91.891 67.00 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 660 35, 681 35, 681 68.00 69.00 06900 ELECTROCARDI OLOGY 7, 454 303, 416 0 303, 416 69.00 07000 ELECTROENCEPHALOGRAPHY 52, 986 52, 986 70.00 70.00 1.134 349, 244 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 850 0 349, 244 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 423 73, 628 0 0 0 73, 628 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 24, 546 275, 591 275, 591 73.00 07400 RENAL DIALYSIS 0 74.00 0 0 0 74.00 03050 BACTERI OLOGY & MI CROBI OLOGY 76.00 0 0 0 Ω 76.00 76.01 03650 VASCULAR LAB 1,634 41, 778 41,778 76.01 0 0 03952 TELEMEDI CI NE 27, 290 27, 290 76.02 76.02 10 03950 WOUND CARE 0 170, 313 76.03 3.206 170.313 76.03 76.97 07697 CARDIAC REHABILITATION 285 C 24, 776 0 24, 776 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 216 56, 589 56, 589 90.00 91.00 09100 EMERGENCY 18,071 C 892, 122 0 892, 122 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 10, 196 0 1,024,681 0 1, 024, 681 101. 00 102.00 10200 OPI OID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113 00 11300 INTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 5,700 1, 204, 340 1, 204, 340 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 207, 097 14, 411, 372 14, 411, 372 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 15, 948 190. 00 15 948 194. 00 07950 PHI LANTHROPY DEVELOPMENT 292, 837 194. 00 0 0 292, 837 0 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 01 C 194. 02 07952 MEALS ON WHEELS 0 0 0 0 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194, 03 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 0 C 0 0 201.00 14, 720, 157 14, 720, 157 202. 00 207.097 202.00 TOTAL (sum lines 118 through 201) 0

COST /	n Financial Systems S' ALLOCATION - STATISTICAL BASIS	T. ANTHONYS MEMO	Provider CC	:N: 14-0032 F	Peri od:	worksheet B-1	
					rom 07/01/2022 o 06/30/2023	Date/Time Pre 1/24/2024 1:1	
		CAPITAL RELA	ATED COSTS	,			
	Cost Center Description	BLDG & FIXT (SQUARE FEET) (MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2. 00	4. 00	5A	5. 00	
1 00	GENERAL SERVI CE COST CENTERS	254 224					1 00
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	354, 336 699 102, 543 0 60, 612 1, 633 0 5, 708 1, 612 3, 142 2, 570 3, 756 4, 008 0	3, 479, 925 0 612, 559 830 292, 209 627 799 16, 580 0 71, 270 0 42, 353 0	46, 041, 755 1, 218, 748 194, 365 639, 976 6, 938 557, 095 117, 816 428, 137 1, 497, 060 179, 138 1, 185, 624 449, 277	-32, 768, 680 0 0 0 0 0 0 0 0 0 0 0 0 0 0	244, 002 4, 443, 192 396, 335 942, 504 313, 181 1, 056, 575 2, 245, 138 291, 035 1, 942, 721 2, 141, 610	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
30. 00		36, 748	162, 211	4, 883, 613	0	8, 074, 359	30.00
31.00		4, 403	33, 540	1, 675, 443		1	1
43. 00		797	0	592, 996	0	722, 136	43.00
50. 00 52. 00 53. 00 54. 00 54. 01 54. 02 54. 06 57. 00 58. 00 60. 00 62. 30 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 01 76. 01 76. 02 76. 03 76. 97	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADIOLOGY-DI AGNOSTIC 03630 ULTRA SOUND 03450 NUCLEAR MEDICINE - DI AGNOSTIC 05404 PET SCAN 05700 CT SCAN 05800 MRI 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06250 BLOOD CLOTTING FACTORS FOR HEMOPH. 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03050 BACTERIOLOGY & MICROBIOLOGY 03650 VASCULAR LAB 03952 TELEMEDICINE	31, 160 4, 468 196 33, 249 548 2, 431 0 1, 401 1, 669 1, 852 5, 244 0 730 4, 665 2, 639 696 4, 035 683 0 0 0 0 0 0 0 0 0 0 0 0 0	590, 627 0 12, 154 923, 329 36, 995 125 0 60, 652 158, 432 23, 449 105, 252 0 12, 182 15, 458 0 0 91, 517 13, 974 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 334, 528 1, 448, 720 5, 645 1, 908, 020 228, 144 109, 571 482, 924 203, 619 120, 420 1, 252, 734 0 636, 422 1, 372, 508 364, 688 304, 449 501, 556 171, 349 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		6, 793, 194 1, 797, 635 117, 166 5, 444, 417 397, 326 399, 361 105, 125 1, 076, 448 738, 607 270, 815 3, 569, 940 850, 135 1, 961, 818 478, 968 372, 881 921, 327 238, 828 7, 652, 136 1, 555, 378 5, 561, 844 0 297, 105 88, 394 1, 167, 243 125, 409	50. 00 52. 00 53. 00 54. 00 54. 02 54. 06 57. 00 58. 00 60. 00 62. 33 65. 00 66. 00 67. 00 69. 00 71. 00 72. 00 74. 00 76. 00 76. 01 76. 02 76. 03 76. 97
90. 00 91. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 293 13, 563	6, 733 151, 925	196, 791 2, 418, 480			
	OTHER REIMBURSABLE COST CENTERS D 10100 HOME HEALTH AGENCY D 10200 OPIOLD TREATMENT PROGRAM	4, 902	29, 798 0	11, 697, 634 0			101.00
116. 00 118. 00	NONREI MBURSABLE COST CENTERS	349, 672	3, 301 3, 479, 925	4, 771, 395 46, 041, 755	-32, 768, 680		118. 00
194. 00 194. 00 194. 02		528 4,136 0 0	0 0 0 0	C C C	0 0	0	

Health Fina	ncial Systems S	T. ANTHONYS MEN	MORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 07/01/2022 To 06/30/2023		
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
				(GROSS SALARI ES)		, , , , , , , , , , , , , , , , , , ,	
		1.00	2. 00	4.00	5A	5. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 713, 618	5, 682, 592	8, 611, 995	5	32, 768, 680	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	16. 124859	1. 632964	0. 187047	7	0. 325790	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			11, 27	1	4, 539, 946	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000245	5	0. 045137	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:1 1/24/2024 1:	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 13. 00 15. 00 16. 00 17. 00 30. 00 31. 00 43. 00
GENERAL SERVICE COST CENTERS 1.00	2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 30. 00 31. 00
1. 00	2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 30. 00 31. 00
5. 00	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 17. 00 30. 00 31. 00
10. 00	10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 30. 00 31. 00
14. 00	14. 00 15. 00 16. 00 17. 00 30. 00 31. 00
INPATIENT ROUTINE SERVICE COST CENTERS	30. 00 31. 00
31. 00 03100 INTENSIVE CARE UNIT 185 4, 403 21, 607 4, 403 1, 443 43. 00 04300 NURSERY 33 797 0 797 1, 308 ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATING ROOM	50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY 8 196 0 196 0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 397 33, 249 10, 797 33, 249 0 54. 01 03630 ULTRA SOUND 23 548 1, 579 548 0	54. 00 54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 102 2, 431 679 2, 431 0	54. 02
54. 06 05404 PET SCAN	54. 06 57. 00
57. 00 05700 CT SCAN 59 1, 401 9, 634 1, 401 0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 78 1, 852 87 1, 852 0	59. 00
60. 00 06000 LABORATORY 220 5, 244 0 5, 244 0 62. 30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH. 0 0 0 0	60. 00 62. 30
65. 00 06500 RESPIRATORY THERAPY 31 730 4, 032 730 0	65. 00
66. 00 06600 PHYSI CAL THERAPY 196 4, 665 1, 268 4, 665 0	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY 170 4, 035 4, 283 4, 035 0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 29 683 225 683 0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	73. 00
74. 00 07400 RENAL DIALYSIS 0 0 0 0 0	74. 00
76. 00 03050 BACTERI OLOGY & MI CROBI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76. 00 76. 01
76. 02 03952 TELEMEDI CI NE 39 917 0 917 0	76. 01
76. 03 03950 WOUND CARE 145 3, 457 6, 929 3, 457 0	76. 03
76. 97 07697 CARDI AC REHABI LI TATI ON 28 660 673 660 0 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0	76. 97 77. 00
OUTPATIENT SERVICE COST CENTERS	77.00
90. 00 09000 CLI NI C 54 1, 293 227 1, 293 0	90. 00
91. 00 09100 EMERGENCY 570 13, 563 87, 247 13, 563 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS	91. 00 92. 00
101.00 10100 HOME HEALTH AGENCY 206 4, 902 0 4, 902 0	101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE	102. 00 113. 00
116. 00 11600 HOSPI CE 0 0 0 0 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 10, 358 185, 818 455, 995 184, 185 11, 942	116. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN 22 528 0 528 0 528 0	190. 00
194. 00 07950 PHI LANTHROPY DEVELOPMENT 174 4, 136 2, 541 4, 136 0	194. 00
	194. 01
	194. 02 194. 03
200.00 Cross Foot Adjustments	200. 00
201.00 Negative Cost Centers	201. 00
202.00 Cost to be allocated (per Wkst. B, 323, 495 5, 968, 845 578, 743 1, 249, 562 643, 071	202. UU
203.00 Unit cost multiplier (Wkst. B, Part I) 30.651412 31.335481 1.262154 6.616726 53.849523	203. 00

Health Finar	cial Systems S	T. ANTHONYS MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	FION - STATISTICAL BASIS		Provider CO		Period: From 07/01/2022 To 06/30/2023	Worksheet B-1 Date/Time Pre 1/24/2024 1:1	
	Cost Center Description	MAINTENANCE & REPAIRS (HOURS OF SERVICE)		LAUNDRY & LINEN SERVICI (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
		6.00	7. 00	8. 00	9. 00	10.00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	12, 417	1, 678, 033	59, 71	4 43, 983	185, 576	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	1. 176521	8. 809405	0. 13022	8 0. 232900	15. 539776	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	ALLOCATION - STATISTICAL BASIS	I. ANTHONIS WEN	Provi der CC	N: 14-0032 P	eri od:	Worksheet B-1	
				F	rom 07/01/2022 o 06/30/2023	Date/Time Pre	
				1	00/30/2023	1/24/2024 1:1	2 pm
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(FTES)	ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	
			(DIRECT NRSING	(COSTED	KEQUIU.)	(GROSS CHAR	
			HRS)	REQUIS.)		GES)	
	GENERAL SERVICE COST CENTERS	11. 00	13.00	14. 00	15. 00	16. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11. 00	01100 CAFETERI A	50, 762					11. 00
13.00	01300 NURSING ADMINISTRATION	1, 466	1				13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	381		9, 849, 898			14.00
15. 00 16. 00	O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY	925 517		245, 412 52		434, 792, 363	15.00
	01700 SOCIAL SERVICE	0		0		0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 NTENSIVE CARE UNIT	5, 955		·		17, 034, 926	1
43. 00	04300 NURSERY	1, 605 643		90, 477 37, 328		3, 154, 731 1, 598, 529	
.0. 00	ANCILLARY SERVICE COST CENTERS	0 10	1.07.07.0	077 020	.,,	1, 0, 0, 02,]
50.00	05000 OPERATI NG ROOM	3, 678		4, 062, 399		45, 302, 185	1
52. 00 53. 00	O5200 DELIVERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	1, 571 1		117, 040 116, 951		5, 564, 647 9, 748, 462	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 864		189, 481		24, 296, 302	1
54. 01	03630 ULTRA SOUND	246	o o	40, 572	1	4, 405, 425	1
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	124	1	161, 053		6, 622, 732	1
54. 06 57. 00	05404 PET SCAN	602	1	0 112, 125	0	1, 318, 248 69, 946, 480	1
58. 00	05800 MRI	250		55, 421	460	20, 155, 029	1
59.00	05900 CARDI AC CATHETERI ZATI ON	133	1	221, 282		1, 350, 614	1
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	1, 850	1	2, 302, 835 0		38, 311, 476 0	1
65. 00	06500 RESPIRATORY THERAPY	913	1	123, 374	-1	2, 538, 216	1
66. 00	06600 PHYSI CAL THERAPY	1, 775		18, 864		9, 306, 879	1
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	459 324		33, 056 0		5, 261, 048	1
69. 00	06900 ELECTROCARDI OLOGY	586		33, 980	-1	1, 385, 912 15, 658, 741	1
70.00	07000 ELECTROENCEPHALOGRAPHY	222		21, 713		2, 382, 568	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	_	0	0	8, 089, 166	1
72.00	O7200 IMPL. DEV. CHARGED TO PATIENTS O7300 DRUGS CHARGED TO PATIENTS	0		0	0 0	7, 191, 896 51, 568, 257	1
	07400 RENAL DIALYSIS			0	0	0 0 0 0 0	1
76. 00	03050 BACTERI OLOGY & MI CROBI OLOGY	0		0	o	0	76. 00
76. 01	03650 VASCULAR LAB 03952 TELEMEDI CI NE	223		0	0	3, 432, 493	
76. 02 76. 03	03952 TELEMEDICT NE 03950 WOUND CARE	85 600		423 211, 751	9, 421	20, 113 6, 735, 942	
76. 97	07697 CARDI AC REHABI LI TATI ON	101		2, 000		597, 922	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	225	ol ol	12, 548	ol	453, 191	90.00
91.00	09100 EMERGENCY	2, 745		397, 692	l	37, 964, 483	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
101 00	OTHER REIMBURSABLE COST CENTERS	12 (02	ا ما	044 274	14 207	21 420 007	101 00
	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM	13, 683	1	844, 274 0	l l	21, 420, 006 0	102.00
	SPECIAL PURPOSE COST CENTERS	_	-	·	-	<u> </u>]
	11300 I NTEREST EXPENSE	,		407 507	100.015	44 075 744	113.00
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	6, 010 50, 762		127, 537 9, 848, 760		11, 975, 744 434, 792, 363	
110.00	NONREI MBURSABLE COST CENTERS	30, 702	303, 070	7, 040, 700	330, 774	434, 772, 303	1110.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0			190. 00
	07950 PHI LANTHROPY DEVELOPMENT	0		1, 138	0		194. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS 07952 MEALS ON WHEELS			0	0		194. 01 194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS		ol ol	0	o		194. 03
200.00	1 1						200.00
201. 00 202. 00		1, 464, 060	3, 142, 156	498, 771	2, 918, 733	3, 099, 029	201. 00
202. U	Part I)	1,404,000	3, 142, 130	470, //1	2,710,733	3, 077, 029	202.00
203.00		28. 841653	8. 142874	0. 050637	5. 221590	0. 007128	203. 00

Health Fina	ancial Systems S	T. ANTHONYS MEN	MORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 07/01/2022 To 06/30/2023	Date/Time Pre 1/24/2024 1:1	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(FTES)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
				SUPPLY	REQUIS.)	LI BRARY	
			(DIRECT NRSING	(COSTED		(GROSS CHAR	
			HRS)	REQUI S.)		GES)	
		11. 00	13.00	14.00	15.00	16.00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	88, 445	299, 871	78, 76	3 469, 407	207, 097	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	1. 742347	0. 777113	0. 00799	0. 839765	0. 000476	205. 00
206. 00	II) NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems ST. ANTHONYS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0032 Peri od: Worksheet B-1 From 07/01/2022 06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm Cost Center Description SOCIAL SERVICE (PATIENT DA YS) 17.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 11, 942 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 9 191 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 443 31.00 43.00 04300 NURSERY 1, 308 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 50 00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05300 ANESTHESI OLOGY 53.00 000000000000000000000000000 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 54 00 54.01 03630 ULTRA SOUND 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 54.06 05404 PET SCAN 54.06 05700 CT SCAN 57 00 57 00 58.00 05800 MRI 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 60.00 06000 LABORATORY 60.00 62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH. 62 30 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 74.00 07400 RENAL DIALYSIS 74.00 03050 BACTERI OLOGY & MI CROBI OLOGY 76.00 76.00 76. 01 03650 VASCULAR LAB 76.01 76. 02 03952 TELEMEDI CI NE 76.02 76. 03 03950 WOUND CARE 76.03 07697 CARDIAC REHABILITATION 76.97 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 90.00 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 101.00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 11, 942 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GLFT FLOWER COFFEE SHOP & CANTEEN 0 190 00 194. 00 194. 00 07950 PHI LANTHROPY DEVELOPMENT 0 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 194. 01 194.02 07952 MEALS ON WHEELS 0 194.02 0 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 194 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 0 202.00 Part I) 203.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000

Heal th Fina	ncial Systems	ST. ANTHONYS MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CCN: 14-0032	Peri od: From 07/01/2022 To 06/30/2023	Worksheet B-1 Date/Time Pre	
	·			L	1/24/2024 1:1:	2 pm
	Cost Center Description	SOCI AL SERVI CE				
		(PATIENT DA				
		YS)				
		17. 00				
204. 00	Cost to be allocated (per Wkst. B,	0				204. 00
	Part II)					
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000				205. 00
206. 00	NAHE adjustment amount to be allocated	1				206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207. 00

near the Financial Systems S	I. ANTHUNTS WEN	URIAL HUSPITAL		III LI E	u OI FOI III CW3	2332-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	F	Period: From 07/01/2022 To 06/30/2023	Date/Time Pre	pared:
		Ti +Lo	XVIII	Hospi tal	1/24/2024 1:1 PPS	2 pm
		l little	AVIII	Costs	PF3	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
cost center bescription	(from Wkst. B,	Adj.	TOTAL COSTS	Di sal I owance	TOTAL COSTS	
	Part I, col.	Auj .		DI Sai i Owalice		
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS	14, 169, 886		14, 169, 886	ol ol	14, 169, 886	30.00
31. 00 03100 NTENSI VE CARE UNI T	3, 577, 409		3, 577, 409		3, 577, 409	
43. 00 04300 NURSERY	1, 200, 866		1, 200, 866		1, 200, 866	
ANCI LLARY SERVI CE COST CENTERS	1, 200, 800		1, 200, 800	<u> </u>	1, 200, 800	43.00
50. 00 05000 OPERATING ROOM	11, 617, 356		11, 617, 356	0	11, 617, 356	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 966, 447		2, 966, 447		2, 966, 447	52. 00
53. 00 05300 ANESTHESI OLOGY	2, 700, 447		293, 610		293, 610	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 823, 279		8, 823, 279		8, 823, 985	
54. 00 03400 RADI OLOGI - DI AGNOSTI C 54. 01 03630 ULTRA SOUND	590, 823		590, 823		590, 823	54. 00
54. 07 03636 OLTRA SOUND 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	694, 286		694, 286		694, 286	
54. 02 05450 NOCLEAR MEDICINE - DIAGNOSTIC 54. 06 05404 PET SCAN	148, 770		148, 770		148, 770	1
57. 00 05700 CT SCAN 58. 00 05800 MRI	2, 015, 731		2, 015, 731		2, 015, 731	57. 00 58. 00
	1, 232, 014		1, 232, 014		1, 232, 014	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	456, 500		456, 500		456, 500	
60. 00 06000 LABORATORY	5, 381, 805		5, 381, 805		5, 381, 805	60.00
62. 30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	1 2// 001		1 2// 002	1 4	1 2// 001	62. 30
65. 00 06500 RESPIRATORY THERAPY	1, 366, 091	0	,		1, 366, 091	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 904, 102	0	2, 904, 102		2, 904, 102	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	791, 627	0	,		791, 627	67. 00
68. 00 06800 SPEECH PATHOLOGY	540, 889				540, 889	
69. 00 06900 ELECTROCARDI OLOGY	1, 522, 992		1, 522, 992		1, 522, 992	
70. 00 07000 ELECTROENCEPHALOGRAPHY	368, 215		368, 215		368, 215	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 202, 785		10, 202, 785		10, 202, 785	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	2, 113, 369		2, 113, 369		2, 113, 369	
73. 00 07300 DRUGS CHARGED TO PATIENTS	7, 741, 416		7, 741, 416		7, 741, 416	
74. 00 07400 RENAL DI ALYSI S	0		(-	0	74. 00
76. 00 03050 BACTERI OLOGY & MI CROBI OLOGY	0		(-	0	
76. 01 03650 VASCULAR LAB	472, 308		472, 308		472, 308	
76. 02 03952 TELEMEDI CI NE	155, 806		155, 806		155, 806	
76. 03 03950 WOUND CARE	1, 817, 143		1, 817, 143		1, 828, 913	
76. 97 O7697 CARDI AC REHABI LI TATI ON	200, 297		200, 297		200, 297	76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON	0		(0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	110.005	I		-1 -1	440.005	
90. 00 09000 CLI NI C	419, 805		419, 805		419, 805	
91. 00 09100 EMERGENCY	7, 794, 228		7, 794, 228		7, 794, 228	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 252, 645		2, 252, 645		2, 252, 645	92.00
OTHER REIMBURSABLE COST CENTERS	T	T		. T		
101. 00 10100 HOME HEALTH AGENCY	22, 241, 898		22, 241, 898		22, 241, 898	
102. 00 10200 OPI OI D TREATMENT PROGRAM	0		()	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	13, 737, 589		13, 737, 589		13, 737, 589	
200.00 Subtotal (see instructions)	129, 811, 987	0			129, 824, 463	
201.00 Less Observation Beds	2, 252, 645		2, 252, 645		2, 252, 645	
202.00 Total (see instructions)	127, 559, 342	0	127, 559, 342	12, 476	127, 571, 818	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0032 Peri od: Worksheet C From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 1:12 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 13, 412, 153 13, 412, 153 03000 ADULTS & PEDIATRICS 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 3, 154, 731 3, 154, 731 31.00 04300 NURSERY 1, 598, 529 1, 598, 529 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 5, 778, 521 39, 523, 664 45, 302, 185 0 256441 0.000000 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 4, 964, 810 599, 837 5, 564, 647 0.533088 0.000000 52.00 53 00 05300 ANESTHESI OLOGY 2, 392, 838 7, 355, 624 9, 748, 462 0.030119 0.000000 53 00 05400 RADI OLOGY-DI AGNOSTI C 1.803.231 22, 493, 071 24, 296, 302 0.363153 0.000000 54.00 54.00 03630 ULTRA SOUND 4, 405, 425 0.000000 54.01 392.877 4, 012, 548 0.134113 54 01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 115, 452 6, 507, 280 6, 622, 732 0.104834 0.000000 54.02 54.06 05404 PET SCAN 1, 318, 248 1, 318, 248 0.112854 0.000000 54.06 58, 499, 038 69, 946, 480 05700 CT SCAN 11, 447, 442 0.028818 0.000000 57.00 57.00 58.00 05800 MRI 1, 186, 905 18, 968, 124 20, 155, 029 0.061127 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 95, 871 1, 254, 743 1, 350, 614 0. 337994 0.000000 59.00 60.00 06000 LABORATORY 10, 484, 463 27, 827, 013 38, 311, 476 0.140475 0.000000 60.00 06250 BLOOD CLOTTING FACTORS FOR HEMOPH. 0.000000 0.000000 62.30 62.30 2, 093, 812 65.00 06500 RESPIRATORY THERAPY 444, 404 2, 538, 216 0.538209 0.000000 65.00 06600 PHYSI CAL THERAPY 1, 951, 510 7, 355, 369 9, 306, 879 0. 312038 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 1, 392, 936 3, 868, 112 5, 261, 048 0.150469 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 1, 257, 802 68.00 128, 110 1, 385, 912 0.390277 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 2, 286, 179 13, 372, 562 15, 658, 741 0.097261 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 14,079 2, 368, 489 2, 382, 568 0.154545 0.000000 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 256, 755 4 832 411 8, 089, 166 0.000000 71 00 1 261290 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 1,647,343 5, 544, 553 7, 191, 896 0.293854 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 16, 056, 435 35, 511, 822 51, 568, 257 0. 150120 0.000000 73.00 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 0 03050 BACTERI OLOGY & MI CROBI OLOGY 0.000000 76.00 0 \cap 0.000000 76.00 76.01 03650 VASCULAR LAB 197, 095 3, 235, 398 3, 432, 493 0. 137599 0.000000 76.01 03952 TELEMEDI CI NE 76.02 92 20, 021 20, 113 7.746532 0.000000 76.02 76 03 03950 WOUND CARE 43 130 6, 692, 812 6, 735, 942 0 269768 0.000000 76 03 07697 CARDIAC REHABILITATION 76.97 645 597, 277 597, 922 0.334989 0.000000 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0.000000 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 90 00 0 926331 452, 541 453 191 0.000000 90 00 09000 CLI NI C 650 0.205303 91.00 09100 EMERGENCY 6, 765, 534 31, 198, 949 37, 964, 483 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1,060,227 2, 562, 546 3, 622, 773 0.621801 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 21, 420, 006 101.00 0 21, 420, 006 102.00 10200 OPIOID TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 11, 975, 744 116. 00 11600 HOSPI CE 11, 975, 744 116. 00 200.00 Subtotal (see instructions) 93, 722, 355 341, 070, 008 434, 792, 363 200.00 201.00 Less Observation Beds 201. 00

434, 792, 363

202.00

341, 070, 008

93, 722, 355

202.00

Total (see instructions)

Heal th Financial Systems ST. ANTHONYS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0032 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 1/24/2024 1: 12 pm

					1/24/2024 1:12 pm
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	PATIENT ROUTINE SERVICE COST CENTERS				
1	000 ADULTS & PEDIATRICS				30.00
31. 00 03	100 INTENSIVE CARE UNIT				31.00
	300 NURSERY				43.00
	CILLARY SERVICE COST CENTERS				
50.00 05	000 OPERATING ROOM	0. 256441			50.00
52. 00 05:	200 DELIVERY ROOM & LABOR ROOM	0. 533088			52. 00
53. 00 05	300 ANESTHESI OLOGY	0. 030119			53.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	0. 363182			54.00
54. 01 03	630 ULTRA SOUND	0. 134113			54. O
54. 02 03	450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 104834			54. 02
	404 PET SCAN	0. 112854			54.00
	700 CT SCAN	0. 028818			57. 00
	800 MRI	0. 061127			58.00
	900 CARDI AC CATHETERI ZATI ON	0. 337994			59.00
	000 LABORATORY	0. 140475			60.00
4	250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0. 000000			62. 30
4	500 RESPIRATORY THERAPY	0. 538209			65. 00
	600 PHYSI CAL THERAPY	0. 312038			66. 00
	700 OCCUPATIONAL THERAPY	0. 312038			67. 00
	800 SPEECH PATHOLOGY	0. 130407			68.00
	900 ELECTROCARDI OLOGY	0. 390277			69.00
4	000 ELECTROCARDI OLOGI 000 ELECTROENCEPHALOGRAPHY	0. 097261			70.00
4	l				71.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 261290			
	200 I MPL. DEV. CHARGED TO PATIENTS	0. 293854			72. 00
	300 DRUGS CHARGED TO PATIENTS	0. 150120			73. 00
	400 RENAL DI ALYSI S	0.000000			74.00
	050 BACTERI OLOGY & MI CROBI OLOGY	0. 000000			76. 00
	650 VASCULAR LAB	0. 137599			76. 0
	952 TELEMEDI CI NE	7. 746532			76. 02
	950 WOUND CARE	0. 271516			76. 03
	697 CARDI AC REHABI LI TATI ON	0. 334989			76. 9
	700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
	TPATIENT SERVICE COST CENTERS				
	000 CLI NI C	0. 926331			90. 00
4	100 EMERGENCY	0. 205303			91. 00
92. 00 09:	200 OBSERVATION BEDS (NON-DISTINCT PART	0. 621801			92. 00
OTI	HER REIMBURSABLE COST CENTERS				
101.00 10	100 HOME HEALTH AGENCY				101. 00
102. 00 10	200 OPIOID TREATMENT PROGRAM				102. 00
SPI	ECIAL PURPOSE COST CENTERS				
	300 INTEREST EXPENSE				113. 00
	600 HOSPI CE				116. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00
1	1	1			1=32. 0.

Health Financial Systems	ST. ANTHONYS MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO	CN: 14-0032	Peri od:	Worksheet C	
				From 07/01/2022	Part I	
			-	To 06/30/2023		pared:
					1/24/2024 1:1	2 pm
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
0001 00111011 200011 pti 011	(from Wkst. B,	Adj .	.014. 00010	Di sal I owance	.014. 00010	
	Part I, col.	Auj .		Di Sai i Gwanee		
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						4
30. 00 03000 ADULTS & PEDIATRICS	14, 169, 886		14, 169, 88	6 0	14, 169, 886	30.00
31.00 03100 INTENSIVE CARE UNIT	3, 577, 409		3, 577, 40	9 0	3, 577, 409	31.00
43. 00 04300 NURSERY	1, 200, 866		1, 200, 86	6 ol	1, 200, 866	43.00
ANCILLARY SERVICE COST CENTERS	, , , , , , , , , ,		, , , , , , ,	- 1		
50. 00 05000 OPERATI NG ROOM	11, 617, 356		11, 617, 35	6 0	11, 617, 356	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 966, 447				2, 966, 447	
			2, 966, 44			
53. 00 05300 ANESTHESI OLOGY	293, 610		293, 610		293, 610	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 823, 279		8, 823, 27	706	8, 823, 985	54.00
54. 01 03630 ULTRA SOUND	590, 823		590, 82	3 0	590, 823	54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	694, 286		694, 28	6l ol	694, 286	54. 02
54.06 05404 PET SCAN	148, 770		148, 770		148, 770	
57. 00 05700 CT SCAN	2, 015, 731		2, 015, 73		2, 015, 731	•
58. 00 05800 MRI	1, 232, 014		1, 232, 01		1, 232, 014	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	456, 500		456, 500		456, 500	
60. 00 06000 LABORATORY	5, 381, 805		5, 381, 80	5 0	5, 381, 805	60.00
62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	o		(lo lc	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	1, 366, 091	0	1, 366, 09 ⁻	1 0	1, 366, 091	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 904, 102	0	2, 904, 10		2, 904, 102	
67. 00 06700 OCCUPATI ONAL THERAPY	791, 627	0	791, 62		791, 627	
· · · · · · · · · · · · · · · · · · ·		0				1
	540, 889	U	540, 88		540, 889	•
69. 00 06900 ELECTROCARDI OLOGY	1, 522, 992		1, 522, 99		1, 522, 992	
70. 00 07000 ELECTROENCEPHALOGRAPHY	368, 215		368, 21	5 0	368, 215	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 202, 785		10, 202, 78	5 0	10, 202, 785	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 113, 369		2, 113, 36	9 0	2, 113, 369	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 741, 416		7, 741, 41	6l ol	7, 741, 416	
74. 00 07400 RENAL DIALYSIS	0		., ,	ol ol	0	
76. 00 03050 BACTERI OLOGY & MI CROBI OLOGY					0	
	470 000		470.00	-		1
76. 01 03650 VASCULAR LAB	472, 308		472, 30		472, 308	
76. 02 03952 TELEMEDI CI NE	155, 806		155, 80		155, 806	
76. 03 03950 WOUND CARE	1, 817, 143		1, 817, 14	3 11, 770	1, 828, 913	76. 03
76. 97 07697 CARDI AC REHABI LI TATI ON	200, 297		200, 29	7 O	200, 297	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	l ol			ol ol	0	77. 00
OUTPATIENT SERVICE COST CENTERS				-1		
90. 00 09000 CLI NI C	419, 805		419, 80	5 ol	419, 805	90.00
91. 00 09100 EMERGENCY					-	
	7, 794, 228		7, 794, 22		7, 794, 228	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 252, 645		2, 252, 64	5	2, 252, 645	92. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	22, 241, 898		22, 241, 89	8	22, 241, 898	101.00
102.00 10200 OPIOLD TREATMENT PROGRAM	l ol		(0	102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	13, 737, 589		12 727 50		13, 737, 589	
		=	13, 737, 58			
200.00 Subtotal (see instructions)	129, 811, 987	0	129, 811, 98			
201.00 Less Observation Beds	2, 252, 645		2, 252, 64		2, 252, 645	
202.00 Total (see instructions)	127, 559, 342	0	127, 559, 342	2 12, 476	127, 571, 818	202.00
	,			. '		•

Heal th	Financial Systems S	T. ANTHONYS MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 14-0032	Peri od:	Worksheet C	
					From 07/01/2022	Part I	
					To 06/30/2023	Date/Time Pre	
						1/24/2024 1:1	2 pm
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col . 7)	Ratio	Inpati ent	
				'		Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30. 00	03000 ADULTS & PEDIATRICS	13, 412, 153		13, 412, 15	2		30.00
		1					1
31.00	03100 INTENSIVE CARE UNIT	3, 154, 731		3, 154, 73			31.00
43.00	04300 NURSERY	1, 598, 529		1, 598, 52	9		43. 00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	5, 778, 521	39, 523, 664			0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 964, 810	599, 837	5, 564, 64	7 0. 533088	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	2, 392, 838	7, 355, 624	9, 748, 46	2 0. 030119	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 803, 231	22, 493, 071	24, 296, 30	2 0. 363153	0.000000	54.00
54. 01	03630 ULTRA SOUND	392, 877	4, 012, 548	4, 405, 42	0. 134113	0.000000	54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	115, 452	6, 507, 280			0. 000000	
54. 06	05404 PET SCAN	0	1, 318, 248			0. 000000	
57. 00	05700 CT SCAN	1				0. 000000	
		11, 447, 442	58, 499, 038				
58. 00	05800 MRI	1, 186, 905	18, 968, 124			0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	95, 871	1, 254, 743			0. 000000	
60.00	06000 LABORATORY	10, 484, 463	27, 827, 013	38, 311, 47	6 0. 140475	0. 000000	
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		0. 000000	0.000000	62. 30
65.00	06500 RESPI RATORY THERAPY	2, 093, 812	444, 404	2, 538, 21	6 0. 538209	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 951, 510	7, 355, 369	9, 306, 87	9 0. 312038	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 392, 936	3, 868, 112			0.000000	
68. 00	06800 SPEECH PATHOLOGY	128, 110	1, 257, 802	1, 385, 91		0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	2, 286, 179	13, 372, 562			0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	14, 079	2, 368, 489			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 256, 755	4, 832, 411			0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 647, 343	5, 544, 553			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	16, 056, 435	35, 511, 822			0. 000000	
74.00	07400 RENAL DI ALYSI S	0	0	1	0. 000000	0. 000000	
76.00	03050 BACTERI OLOGY & MI CROBI OLOGY	0	0		0. 000000	0.000000	76. 00
76. 01	03650 VASCULAR LAB	197, 095	3, 235, 398	3, 432, 49	0. 137599	0.000000	76. 01
76.02	03952 TELEMEDI CI NE	92	20, 021	20, 11	7. 746532	0.000000	76. 02
76. 03	03950 WOUND CARE	43, 130	6, 692, 812	6, 735, 94		0.000000	76. 03
76. 97	07697 CARDI AC REHABI LI TATI ON	645	597, 277			0.000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000	0. 000000	
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u>'</u>	0. 000000	0.000000	77.00
90. 00	09000 CLINIC	650	452, 541	453, 19	1 0.02(221	0. 000000	90.00
		1		•			
91.00	09100 EMERGENCY	6, 765, 534	31, 198, 949			0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 060, 227	2, 562, 546	3, 622, 77	0. 621801	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	21, 420, 006	21, 420, 00	6		101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		0		102.00
	SPECIAL PURPOSE COST CENTERS	•					
113.00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	o	11, 975, 744	11, 975, 74	4		116.00
200.00		93, 722, 355	341, 070, 008				200.00
200.00		75, 722, 555	371,070,000	757, 772, 30	~		201.00
		02 722 255	341, 070, 008	424 702 24			201.00
202. 00	Total (see instructions)	93, 722, 355	341,070,008	434, 792, 36	ا ا		1202.00

Health Financial Systems

ST. ANTHONYS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0032
Form 07/01/2022
To 06/30/2023
Date/Time Prepared:

			10 06/30/2023	1/24/2024 1:12 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient	THE XIX	nospi tui	3031
oost conter bescription	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	11100			
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31. 00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				.0.00
50. 00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01 03630 ULTRA SOUND	0. 000000			54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000			54. 02
54. 06 05404 PET SCAN	0. 000000			54. 06
57. 00 05700 CT SCAN	0. 000000			57.00
58. 00 05800 MRI	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 000000			60.00
62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
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
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000			74. 00
76. 00 03050 BACTERI OLOGY & MI CROBI OLOGY	0. 000000			76.00
76. 01 03650 VASCULAR LAB	0. 000000			76. 01
76. 02 03952 TELEMEDICINE	0. 000000			76. 02
76. 03 03950 WOUND CARE	0. 000000			76. 03
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS	3. 333333			
90. 00 09000 CLINI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	0.00000			72.00
101. 00 10100 HOME HEALTH AGENCY				101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS				102.00
113. 00 11300 I NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200. 00
201. 00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
1.2.2. (222	1			1232.00

Health Financial Systems S	T. ANTHONYS MEM	ORIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 07/01/2022 To 06/30/2023		narod:
				10 00/30/2023	1/24/2024 1: 1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 841, 086	0	1, 841, 08	6 10, 876	169. 28	30.00
31.00 INTENSIVE CARE UNIT	328, 209		328, 20	9 1, 437	228. 40	31.00
43. 00 NURSERY	85, 903		85, 90	3 1, 308	65. 68	43.00
200.00 Total (lines 30 through 199)	2, 255, 198		2, 255, 19	8 13, 621		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	4, 625	782, 920				30.00
31.00 INTENSIVE CARE UNIT	817	186, 603				31. 00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	5, 442	969, 523				200. 00

Health Financial Systems	ST. ANTHONYS MEMORI	AL HOSPITAL		In Lieu of Form CMS-2552-10
ADDODTI ONMENT OF INDATIONS	ANCILLARY CERVICE CARLEAL COCTO	Drawi dan CCN, 14 0022	Donied.	Washabaat D

Heal th	Financial Systems S	T. ANTHONYS MEN	MORIAL HOSPITAL		In Li€	eu of Form CMS-	2552-10
APPORT	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 07/01/2022 To 06/30/2023	Date/Time Pre 1/24/2024 1:1	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges		Inpatient	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS		T	1	. T	T	
50. 00	05000 OPERATING ROOM	2, 377, 555					
52.00	05200 DELIVERY ROOM & LABOR ROOM	231, 124					
53. 00	05300 ANESTHESI OLOGY	69, 976			· ·		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 062, 795					
54. 01	03630 ULTRA SOUND	95, 278					
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	85, 852		1			
54. 06	05404 PET SCAN	5, 372				_	
57. 00	05700 CT SCAN	219, 709					
58. 00	05800 MRI	348, 268					58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	99, 901	1, 350, 614				
60.00	06000 LABORATORY	505, 424	38, 311, 476			66, 997	
62. 30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.00000		0	62. 30
65. 00	06500 RESPI RATORY THERAPY	95, 892			· ·	·	65.00
66.00	06600 PHYSI CAL THERAPY	334, 702					
67.00	06700 OCCUPATI ONAL THERAPY	91, 891	5, 261, 048				
68. 00	06800 SPEECH PATHOLOGY	35, 681	1, 385, 912				68. 00
69. 00	06900 ELECTROCARDI OLOGY	303, 416	15, 658, 741	0. 01937	7 1, 166, 170	22, 597	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	52, 986	2, 382, 568			198	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	349, 244	8, 089, 166	0. 04317	4 1, 648, 120	71, 156	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	73, 628	7, 191, 896	0. 01023	881, 197	9, 022	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	275, 591	51, 568, 257			41, 634	73. 00
74.00	07400 RENAL DI ALYSI S	0	0	0.00000	0 0	0	74. 00
76.00	03050 BACTERI OLOGY & MI CROBI OLOGY	0	0	0.00000	0 0	0	76. 00
76. 01	03650 VASCULAR LAB	41, 778	3, 432, 493	0. 01217	1 111, 102	1, 352	76. 01
76. 02	03952 TELEMEDI CI NE	27, 290	20, 113	1. 35683	4 0	0	76. 02
76.03	03950 WOUND CARE	170, 313	6, 735, 942	0. 02528	4 30, 366	768	76. 03
76. 97	07697 CARDI AC REHABI LI TATI ON	24, 776	597, 922	0. 04143	7 430	18	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	56, 589	453, 191	0. 12486	8 300	37	
91.00	09100 EMERGENCY	892, 122	37, 964, 483	0. 02349	9 3, 593, 463	84, 443	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	292, 684	3, 622, 773	0. 08079	0 564, 423	45, 600	92.00
200.00	Total (lines 50 through 199)	10, 219, 837	383, 231, 200)	35, 733, 783	761, 351	200. 00

Health Financial Systems	ST. ANTHONYS MEM	ORIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	ER PASS THROUGH COST		F	Period: From 07/01/2022 To 06/30/2023		pared: 2 pm
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
·	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown	3	Adjustments		Education Cost	
	Adjustments		,			
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	l ol	0		0	0	31.00
43. 00 04300 NURSERY	l ol	0		0	0	43.00
200.00 Total (lines 30 through 199)	l ol	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>		•	<u>'</u>		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	10, 876	0.00	4, 625	30.00
31.00 03100 INTENSIVE CARE UNIT		0	1, 437	0.00	817	31.00
43. 00 04300 NURSERY		0	1, 308	0.00	0	43.00
200.00 Total (lines 30 through 199)		0	13, 62	i	5, 442	200.00
Cost Center Description	I npati ent			<u>'</u>		
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	o					31.00
43. 00 04300 NURSERY	O					43.00
200.00 Total (lines 30 through 199)	0					200.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, -1					

THROUGH COSTS				From 07/01/2022 To 06/30/2023		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS			,			
50.00 05000 OPERATING ROOM	0	1	1	0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	
53. 00 05300 ANESTHESI OLOGY	0	0)	0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	
54. 01 03630 ULTRA SOUND	0	0)	0	0	
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0)	0	0	
54.06 05404 PET SCAN	0	0)	0	0	
57. 00 05700 CT SCAN	0	0)	0	0	
58. 00 05800 MRI	0	0)	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0	0	59. 00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0)	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0)	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0)	0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0)	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0)	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 0	0	73. 00
74. 00 07400 RENAL DIALYSIS	0	0	1	0 0	0	74. 00
76. 00 03050 BACTERI OLOGY & MI CROBI OLOGY	0	0	1	0 0	0	76. 00
76. 01 03650 VASCULAR LAB	0	0	1	0 0	0	76. 01
76. 02 03952 TELEMEDI CI NE	0	0)	0 0	0	76. 02
76. 03 03950 WOUND CARE	0	0)	0 0	0	76. 03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	l o)	0 0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	,	0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0	,[0 0	l o	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			o	Ō	
200.00 Total (lines 50 through 199)	0	0)	0 0	l o	200.00
, , , , , , , , , , , , , , , , , , , ,	-		•			

Health Financial Systems	ST. ANTHONYS MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-0032	Peri od:	Worksheet D
THROUGH COSTS			From 07/01/2022	Part IV

THROUGH COSTS				To 06/30/2023		
		Title	e XVIII	Hospi tal	PPS	z piii
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				-		
50. 00 05000 OPERATI NG ROOM	0	0		45, 302, 185	0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	5, 564, 647	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0	1	9, 748, 462	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	24, 296, 302	0. 000000	
54. 01 03630 ULTRA SOUND	0	0		4, 405, 425	0. 000000	
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0)	0 6, 622, 732	0. 000000	
54. 06 05404 PET SCAN	0	0	1	1, 318, 248	0.000000	
57.00 05700 CT SCAN	0	0	1	69, 946, 480	0.000000	
58. 00 05800 MRI	0	0	1	20, 155, 029	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1	1, 350, 614	0.000000	59. 00
60. 00 06000 LABORATORY	0	0	1	38, 311, 476	0.000000	
62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	1	0 0	0.000000	
65. 00 06500 RESPIRATORY THERAPY	0	0	1	2, 538, 216	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0		9, 306, 879	0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		5, 261, 048	0.000000	
68.00 06800 SPEECH PATHOLOGY	0	0		1, 385, 912	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		15, 658, 741	0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		2, 382, 568	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		8, 089, 166	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		7, 191, 896	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		51, 568, 257	0. 000000	
74. 00 07400 RENAL DI ALYSI S	0	0	1	0	0. 000000	
76. 00 03050 BACTERI OLOGY & MI CROBI OLOGY	0	0	1	0	0. 000000	1
76. 01 03650 VASCULAR LAB	0	0	1	3, 432, 493	0. 000000	
76. 02 03952 TELEMEDI CI NE	0	0	1	20, 113	0. 000000	
76. 03 03950 WOUND CARE	0	0	1	6, 735, 942	0. 000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	1	597, 922	0.000000	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.000000	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0		1	0 453, 191	0. 000000	
91. 00 09100 EMERGENCY	0			37, 964, 483		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1		3, 622, 773	0. 000000	
200.00 Total (lines 50 through 199)	0	0	1	383, 231, 200		200. 00

Health Financial Systems	ST. ANTHONYS MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 14-0032	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared: 1/24/2024 1:12 pm
		Ti +1 o V/// / /	Hospi tal	DDC

TIROUGH COSTS			Ť	06/30/2023	Date/Time Pre 1/24/2024 1:1	pared:
		Title	XVIII	Hospi tal	PPS	2 piii
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	2, 775, 033		13, 732, 541	0	00.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	4, 270		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	648, 809		2, 216, 118	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 025, 696		4, 512, 817	0	54. 00
54. 01 03630 ULTRA SOUND	0. 000000	190, 485	0	833, 176		54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000	47, 427	0	3, 010, 050		54. 02
54.06 05404 PET SCAN	0. 000000	0		623, 500		54.06
57. 00 05700 CT SCAN	0. 000000	6, 304, 801	0	20, 049, 329		57. 00
58. 00 05800 MRI	0. 000000	657, 527	0	7, 592, 548	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	42, 981	0	671, 224	0	59. 00
60. 00 06000 LABORATORY	0. 000000	5, 078, 619	0	4, 927, 363	0	60.00
62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0. 000000	0		0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 000000	983, 639	0	117, 602	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 230, 683	0	81, 613	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	865, 007	0	35, 848	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	83, 537	0	9, 544	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 166, 170	0	5, 472, 215	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	8, 898	0	948, 929	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 648, 120		1, 489, 677	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	881, 197	0	2, 500, 100	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	7, 790, 800	0	17, 098, 686	0	73. 00
74.00 07400 RENAL DI ALYSI S	0. 000000	0	0	0	0	74. 00
76. 00 03050 BACTERI OLOGY & MI CROBI OLOGY	0. 000000	0	0	0	0	76. 00
76. 01 03650 VASCULAR LAB	0. 000000	111, 102	0	1, 702, 022	0	76. 01
76. 02 03952 TELEMEDI CI NE	0. 000000	0	0	177	0	76. 02
76. 03 03950 WOUND CARE	0. 000000	30, 366		3, 421, 210	0	76. 03
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	430	0	329, 170	0	76. 97
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	300		6, 694	0	
91. 00 09100 EMERGENCY	0. 000000	3, 593, 463			0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	564, 423		1, 263, 197	0	1 ,2.00
200.00 Total (lines 50 through 199)		35, 733, 783	0	100, 594, 634	0	200. 00

Health Financial Systems S	T. ANTHONYS MEM	IORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 14-0032	Peri od:	Worksheet D	
				From 07/01/2022	Part V	
				To 06/30/2023	Date/Time Pre	pared:
		Ti +l c	xVIII	Hospi tal	1/24/2024 1:1 PPS	2 piii
		11116	Charges	HOSPI tai	Costs	
Cost Center Description	Cost to Charge	DDS Doi mburgod		Cost	PPS Services	
cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(366 11131.)	
	Part I, col. 9		Subject To	Subject To		
	Tart 1, Cor. 7		Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATI NG ROOM	0. 256441	13, 732, 541		0 0	3, 521, 587	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 533088			0 0	0, 021, 007	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 030119			0 0	66, 747	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 363153			0 0	1, 638, 843	1
54. 01 03630 ULTRA SOUND	0. 134113			0 0	111, 740	
				-		
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 104834			-	315, 556	
54. 06 05404 PET SCAN	0. 112854	623, 500		0	70, 364	
57. 00 05700 CT SCAN	0. 028818			0	577, 782	
58. 00 05800 MRI	0. 061127			0	464, 110	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 337994			0	226, 870	59. 00
60. 00 06000 LABORATORY	0. 140475			0	692, 171	
62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0. 000000			0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 538209			0	63, 294	
66. 00 06600 PHYSI CAL THERAPY	0. 312038			0	25, 466	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 150469			0	5, 394	
68.00 06800 SPEECH PATHOLOGY	0. 390277	9, 544		0	3, 725	
69. 00 06900 ELECTROCARDI OLOGY	0. 097261	5, 472, 215		0	532, 233	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 154545	948, 929		0	146, 652	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 261290	1, 489, 677		0	1, 878, 915	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 293854	2, 500, 100		0 0	734, 664	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 150120	17, 098, 686		0 45, 602	2, 566, 855	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
76. 00 03050 BACTERI OLOGY & MI CROBI OLOGY	0.000000	0		0 0	0	76. 00
76. 01 03650 VASCULAR LAB	0. 137599	1, 702, 022		0 0	234, 197	76. 01
76. 02 03952 TELEMEDI CI NE	7. 746532			0 0	1, 371	76. 02
76. 03 03950 WOUND CARE	0. 269768			0 0	922, 933	
76. 97 07697 CARDIAC REHABILITATION	0. 334989			0	110, 268	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	0.00000			<u> </u>		77.00
90. 00 09000 CLINIC	0. 926331	6, 694		0 0	6, 201	90.00
91. 00 09100 EMERGENCY	0. 205303			0 0	1, 632, 012	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 621801	1, 263, 197		0 0	785, 457	1
200.00 Subtotal (see instructions)	0. 02 1001	100, 594, 634		0 45, 602	17, 335, 407	
201.00 Less PBP Clinic Lab. Services-Program		100, 374, 034		0 43,002	17, 333, 407	201.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)		100, 594, 634		0 45, 602	17, 335, 407	202 00
202. 00 Net onarges (11116 200 11116 201)	1	100, 574, 034	I	اح ا	17, 333, 407	1202.00

06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7.00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 00000000000000000000000000000000 0 52.00 53. 00 05300 ANESTHESI OLOGY 0 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.01 03630 ULTRA SOUND 0 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 54.02 05404 PET SCAN 0 54.06 54.06 57. 00 05700 CT SCAN 0 57.00 05800 MRI 0 58.00 58.00 05900 CARDIAC CATHETERIZATION 0 59 00 59 00 60.00 06000 LABORATORY 0 60.00 62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH. 0 62.30 06500 RESPIRATORY THERAPY 65.00 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 6,846 73.00 07400 RENAL DIALYSIS 74.00 Ω 74 00 76.00 03050 BACTERI OLOGY & MI CROBI OLOGY 0 76.00 03650 VASCULAR LAB 76.01 0 76.01 03952 TELEMEDI CI NE 0 76.02 76.02 76.03 03950 WOUND CARE 0 76.03 76. 97 07697 CARDIAC REHABILITATION 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09100 EMERGENCY 91.00 0 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 200.00 Subtotal (see instructions) 6,846 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges

0

6, 846

202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	ST. ANTHONYS MEMORI	AL HOSPITAL	In Lieu of Form CMS-2552-		
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0032	Peri od: From 07/01/2022	Worksheet D-1	
				Date/Time Prepared: 1/24/2024 1:12 pm	
		Title XVIII	Hospi tal	PPS	

			10 00/30/2023	1/24/2024 1: 12	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
	DADT I ALL DROWLDED COMPONENTS			1. 00	
-	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		10, 876	1.00
2. 00	Inpatient days (including private room days, excluding swing-led days)			10, 876	2.00
3. 00	Private room days (excluding swing-bed and observation bed day		ivate room days	0	3.00
3.00	do not complete this line.	ys). It you have only pr	rvate room days,	J	0.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		9, 147	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5.00
	reporting period	3 , 3			
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7.00
	reporting period				
3. 00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	4, 625	9. 00
10 00	newborn days) (see instructions)	alv (i polydi po pojvoto p	aam dayaa	0	10 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-		oolii days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		nom dave) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, en		dom days) arter	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	through December 31 of the cost reporting period	(instanting privat	o . oo dayo,	ŭ.	.2. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye				
	Medically necessary private room days applicable to the Progra			0	14.00
15. 00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17.00
	reporting period			0.00	
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost				18.00
10 00	reporting period				10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ha cost	0. 00	20.00
20.00	reporting period	3 di tei becember 31 di t	110 0031	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	s)		14, 169, 886	21.00
22. 00	Swing-bed cost applicable to SNF type services through December		ina period (line	0	22.00
	5 x line 17)		3 1		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23.00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 3	37 of the cost reporting	period (line 8	0	25. 00
,, ,,,	x line 20)				24 00
26. 00 27. 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		0 14, 169, 886	26. 00 27. 00
	General inpatient routine service cost net of swing-bed cost	(TITIE 21 IIITIUS TITIE 26)		14, 109, 880	J 27. UC
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had ch	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	d and observation bed cir	ai yes)	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
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. True 20)		0. 00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34. 00					34.00
35. 00					35. 0
					36.00
36. 00	Private room cost differential adjustment (line 3 x line 35)		1	0	
36. 00 37. 00		and private room cost di	fferential (line	14, 169, 886	
	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fferential (line		
37. 00	Private room cost differential adjustment (line 3×1 ine 35) General inpatient routine service cost net of swing-bed cost 3×1	and private room cost di	fferential (line		
37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	·	fferential (line		
37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	JSTMENTS	fferential (line		37.00
37. 00 38. 00 39. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	JSTMENTS instructions) 38)	fferential (line	14, 169, 886 1, 302. 86 6, 025, 728	37. 00 38. 00 39. 00
37. 00 38. 00 39. 00 40. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see	JSTMENTS instructions) 38) am (line 14 x line 35)	fferential (line	14, 169, 886	37. 00 38. 00 39. 00 40. 00

	Financial Systems ST ATION OF INPATIENT OPERATING COST	T. ANTHONYS MEMO		- CN: 14-0032	In Lie	worksheet D-1	
COMPUT	ATTON OF INPATTENT OPERATING COST		Provider C	CN: 14-0032	From 07/01/2022 To 06/30/2023		
			Ti +l e	e XVIII	Hospi tal	1/24/2024 1: 1: PPS	2 pm
	Cost Center Description	Total	Total	Average Pei	Program Days	Program Cost	
		Inpatient Cost	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	C	0.	00 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	3, 577, 409	1, 437	2, 489.	50 817	2, 033, 922	43. 00
44. 00	CORONARY CARE UNIT	3, 377, 107	1, 107	2, 107.	017	2,000,722	44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description	<u> </u>		•			
48. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	line 200)			1. 00 7, 897, 212	48. 00
48. 01	Program inpatient cellular therapy acquisition			III, line 10	, column 1)	7, 077, 212	1
49. 00	Total Program inpatient costs (sum of lines	11 through 48.0	1)(see instruc	ctions)		15, 956, 862	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst D su	m of Parts L and	969, 523] 50. 00
	111)		•				
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	761, 351	51.00
52. 00	Total Program excludable cost (sum of lines !					1, 730, 874	
53.00	Total Program inpatient operating cost exclud		lated, non-phy	/sician anest	hetist, and	14, 225, 988	53.00
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	JZ)					
54.00	Program di scharges					0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0.00	55. 00 55. 01
55. 02	Adjustment amount per discharge (contractor u	use only)				0.00	
56.00	Target amount (line 54 x sum of lines 55, 55.		ract amount (ino E4 minus	lino E2)	0 0	56. 00 57. 00
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	rget amount (i	The so minus	11 ne 53)	0	58.00
59. 00	0 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,						59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						60.00
	market basket)						
61. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	61. 00
	53) are less than expected costs (lines 54 x						
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63.00
(4.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ha dhaarah Daar	21 -6 +1-		!!! (C	0	
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through bece	mber 31 of the	e cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the d	cost reportin	g period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing</pre>	ne costs (line	64 plus line 6	55)(title XVI	II onlv): for	0	66.00
	CAH, see instructions				•		
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (coutine costs (line 67 + line	- 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NU						07.00
70.00	Skilled nursing facility/other nursing facili	•		•)		70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 1		THE 70 - TITLE	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applica		•				73. 00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient i	,			Part II column		74. 00 75. 00
70.00	26, line 45)		00313 (1101111	ioi Raneet B,	rare ir, coramir		
76.00	Per diem capital related costs (line 75 ÷ lin						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p		*.	I i - 70`		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ust iimitation	ı (ııne /8 mi	nus iine 79)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (li	ne 9 x line 81					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		s)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					1, 729	87. 00
88. 00	Adjusted general inpatient routine cost per d	diem (line 27 ÷	line 2)			1, 302. 86	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see					2, 252, 645	

Health Financial Systems	ST. ANTHONYS MEN	MORIAL HOSPITAL		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	Date/Time Pre 1/24/2024 1:1:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 841, 086	14, 169, 886	0. 12992	9 2, 252, 645	292, 684	90.00
91.00 Nursing Program cost	0	14, 169, 886	0. 000000	2, 252, 645	0	91.00
92.00 Allied health cost	0	14, 169, 886	0. 000000	2, 252, 645	0	92. 00
93.00 All other Medical Education	0	14, 169, 886	0. 000000	2, 252, 645	0	93. 00

Heal th	Financial Systems	ST. ANTHONYS MEMORIAL HOSPITAL		In Li∈	eu of Form CMS-:	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 14-0032	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D-3	pared:
		Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	T		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				1	
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY			5, 944, 477 1, 805, 285		30. 00 31. 00 43. 00
	ANCILLARY SERVICE COST CENTERS					
50.00			0. 25644	· · · · · ·		
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 53308			
53.00	05300 ANESTHESI OLOGY		0. 03011			
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 36318	· · · · · ·		
54. 01	03630 ULTRA SOUND		0. 13411			
54. 02			0. 10483			
54. 06	05404 PET SCAN		0. 11285		-	
	05700 CT SCAN		0. 02881			1
58. 00	05800 MRI		0. 06112			
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 33799			
60.00	06000 LABORATORY		0. 14047			
62. 30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.		0.00000		0	62. 30
65. 00	06500 RESPI RATORY THERAPY		0. 53820			
66. 00	06600 PHYSI CAL THERAPY		0. 31203			
67. 00	06700 OCCUPATI ONAL THERAPY		0. 15046			
68. 00	06800 SPEECH PATHOLOGY		0. 39027	· ·		
69. 00	06900 ELECTROCARDI OLOGY		0. 09726			
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 15454			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 26129	· · · · · ·		
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 29385			
	07300 DRUGS CHARGED TO PATIENTS		0. 15012			
74.00	07400 RENAL DI ALYSI S		0.00000			
			0.00000		-	
76. 01	03650 VASCULAR LAB		0. 13759	· ·		
76. 02	03952 TELEMEDI CI NE		7. 74653		-	
76. 03	03950 WOUND CARE		0. 27151			
76. 97 77. 00	07697 CARDI AC REHABI LI TATI ON		0. 33498		1	
11.00	07700 ALLOGENEIC HSCT ACQUISITION		0.00000	00 0	1 0	1 / / . 00

0. 926331

0. 205303

0. 621801

300

3, 593, 463

35, 733, 783

35, 733, 783

564, 423

90.00

91.00

92.00

201.00

202. 00

278

7, 897, 212 200. 00

737, 749

350, 959

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

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

90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY

200.00

201.00

202.00

Health Financial Systems	ST. ANTHONYS MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der Co	CN: 14-0032	Peri od:	Worksheet D-3	
				From 07/01/2022		
		Component (CCN: 14-U032	To 06/30/2023		
		·			1/24/2024 1: 1	2 pm
		Ti tl	e XIX	Swing Beds - SNF	Cost	
Cost Center Description			Ratio of Cos	st Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				, and the second	2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						

Cost Center	Description	Ratio of Cost	Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
	SERVI CE COST CENTERS				
30.00 03000 ADULTS & PEI					30. 00
31. 00 03100 I NTENSI VE CA	ARE UNIT				31. 00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE		, ,			
50. 00 05000 OPERATING RO		0. 256441	(1	50. 00
52. 00 05200 DELI VERY ROO		0. 533088	(0	52. 00
53. 00 05300 ANESTHESI OLO		0. 030119	(0	53. 00
54. 00 05400 RADI OLOGY-DI	AGNOSTI C	0. 363153	(0	54.00
54. 01 03630 ULTRA SOUND		0. 134113	(0	54. 01
54. 02 03450 NUCLEAR MEDI	CINE - DIAGNOSTIC	0. 104834	(0	54. 02
54.06 05404 PET SCAN		0. 112854	(0	54. 06
57.00 05700 CT SCAN		0. 028818	(0	57. 00
58. 00 05800 MRI		0. 061127	(0	58. 00
59. 00 05900 CARDI AC CATI	HETERI ZATI ON	0. 337994	(0	59. 00
60. 00 06000 LABORATORY		0. 140475	(0	60.00
62. 30 06250 BL00D CL0TTI	NG FACTORS FOR HEMOPH.	0.000000	(0	62. 30
65. 00 06500 RESPI RATORY	THERAPY	0. 538209	(0	65.00
66.00 06600 PHYSI CAL THE	ERAPY	0. 312038	(0	66. 00
67. 00 06700 OCCUPATI ONAL	_ THERAPY	0. 150469	(0	67. 00
68.00 06800 SPEECH PATH	DLOGY	0. 390277	(0	68. 00
69. 00 06900 ELECTROCARDI	OLOGY	0. 097261	(0	69. 00
70. 00 07000 ELECTROENCE	PHALOGRAPHY	0. 154545	(0	70. 00
71.00 07100 MEDICAL SUPP	PLIES CHARGED TO PATIENT	1. 261290	(0	71. 00
72.00 07200 I MPL. DEV. (CHARGED TO PATIENTS	0. 293854	(0	72. 00
73. 00 07300 DRUGS CHARGE		0. 150120	C		73. 00
74.00 07400 RENAL DIALYS		0. 000000	C		74. 00
76. 00 03050 BACTERI OLOGY		0.000000	C		76. 00
76. 01 03650 VASCULAR LA		0. 137599	(76. 01
76. 02 03952 TELEMEDICINE		7. 746532	(ol o	76. 02
76. 03 03950 WOUND CARE	-	0. 269768	(76. 03
76. 97 07697 CARDI AC REHA	ABILITATION	0. 334989	(1	76. 97
77. 00 07700 ALLOGENEI C H		0. 000000	(77. 00
OUTPATIENT SERVICE		0.00000		,	77.00
90. 00 09000 CLINIC	2 OUT CENTENO	0. 926331	(0	90.00
91. 00 09100 EMERGENCY		0. 205303	(1	91. 00
	BEDS (NON-DISTINCT PART	0. 621801	(92. 00
	of lines 50 through 94 and 96 through 98)	3. 32 100 1	(1	200. 00
	nic Laboratory Services-Program only charges (line 61)		(201. 00
	(line 200 minus line 201)		(202.00
202.00	(255 251)	1	,	1	1202.00

Health Financial Systems	ST. ANTHONYS MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14	From 07/01/2022 P To 06/30/2023 D	Worksheet E Part A Date/Time Prepared: 1/24/2024 1:12 pm

			10 00/00/2020	1/24/2024 1:1:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0	
1. 01	DRG amounts other than outlier payments for discharges occurri	ing prior to October 1 (s	see	0	1. 01
1 00	instructions)	ing on an after October :	1 (000	10 045 400	1 00
1. 02	DRG amounts other than outlier payments for discharges occurriinstructions)	ing on or after october	i (see	12, 245, 483	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring i	orior to October	0	1. 03
1.03	1 (see instructions)	or discharges occurring p	orror to october	U	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring o	on or after	0	1. 04
1.01	October 1 (see instructions)	or ar serial ges occurring t	on arter	١	1.01
2.00	Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1	•		0	2. 03
2.04	Outlier payments for discharges occurring on or after October			30, 540	2. 04
3.00	Managed Care Simulated Payments	,		0	3. 00
4.00	Bed days available divided by number of days in the cost report	rtina period (see instru	ctions)	128. 12	4. 00
	Indirect Medical Education Adjustment	<u> </u>			
5.00	FTE count for allopathic and osteopathic programs for the most	t recent cost reporting i	period ending on	0.00	5.00
	or before 12/31/1996. (see instructions)	3 1			
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the (CAA 2021 (see instruction	ns)	0.00	5. 01
6.00	FTE count for allopathic and osteopathic programs that meet the			0.00	•
	new programs in accordance with 42 CFR 413.79(e)				
6. 26	Rural track program FTE cap limitation adjustment after the ca	ap-building window closed	d under §127 of	0.00	6. 26
	the CAA 2021 (see instructions)		-		
7.00	MMA Section 422 reduction amount to the IME cap as specified u	under 42 CFR §412.105(f)	(1) (i v) (B) (1)	0.00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under	42 CFR §412.105(f)(1)(i)	/)(B)(2) If the	0.00	7. 01
	cost report straddles July 1, 2011 then see instructions.		, , , , ,		
7. 02	Adjustment (increase or decrease) to the hospital's rural trad	ck program FTE limitation	n(s) for rural	0.00	7. 02
	track programs with a rural track for Medicare GME affiliated	programs in accordance	vi th 413.75(b)		
	and 87 FR 49075 (August 10, 2022) (see instructions)				
8.00	Adjustment (increase or decrease) to the FTE count for allopations	thic and osteopathic pro	grams for	0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.7	79(c)(2)(iv), 64 FR 26340) (May 12,		
	1998), and 67 FR 50069 (August 1, 2002).				
8. 01	The amount of increase if the hospital was awarded FTE cap slo	ots under § 5503 of the A	ACA. If the cost	0.00	8. 01
	report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachi	ng hospital	0.00	8. 02
	under § 5506 of ACA. (see instructions)			ļ	
8. 21	The amount of increase if the hospital was awarded FTE cap slo	ots under §126 of the CA	A 2021 (see	0. 00	8. 21
	instructions)				
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through		7.01, plus or	0. 00	9. 00
40.00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.			0.00	40.00
10.00	FTE count for allopathic and osteopathic programs in the curre	ent year from your record	as	0.00	1
11. 00	FTE count for residents in dental and podiatric programs.				11.00
12. 00	Current year allowable FTE (see instructions)			0. 00	1
13. 00	Total allowable FTE count for the prior year.			0. 00	1
14. 00	Total allowable FTE count for the penultimate year if that year	ar ended on or after Sep	tember 30, 1997,	0. 00	14. 00
45.00	otherwise enter zero.				45.00
15. 00	Sum of lines 12 through 14 divided by 3.				15. 00
16. 00	Adjustment for residents in initial years of the program (see				16. 00
17. 00	Adjustment for residents displaced by program or hospital clos	sure		0. 00	1
18. 00	Adjusted rolling average FTE count			0. 00	1
19. 00	Current year resident to bed ratio (line 18 divided by line 4)).		0.000000	1
20.00	Prior year resident to bed ratio (see instructions)			0. 000000	1
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	1
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422	2 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE reside	ent cap slots under 42 Cl	FR 412. 105	0.00	23. 00
	(f)(1)(iv)(C).			ļ	
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
25.00	If the amount on line 24 is greater than -O-, then enter the I	lower of line 23 or line	24 (see	0.00	25. 00
	instructions)				
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions))		0	28. 01
29.00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.07	1)		0	29. 01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	2. 23	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)			17. 52	1
32.00	Sum of lines 30 and 31			19. 75	1
33. 00	Allowable disproportionate share percentage (see instructions))		5. 59	1
	Disproportionate share adjustment (see instructions)			171, 131	1
	· · · · · · · · · · · · · · · · · · ·				

llool +b	Financial Cystems CT ANTHONYS MEMOR	NI AL LIOCDI TAL	المانا	u of Form CMC (DEED 10
	Financial Systems ST. ANTHONYS MEMOR ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0032	Peri od: From 07/01/2022 To 06/30/2023		pared:
		Title XVIII	Hospi tal	1/24/2024 1: 1: PPS	2 pm
		TI LI E XVIII	Prior to 10/1		
			1. 00	2. 00	
25 00	Uncompensated Care Payment Adjustment Total uncompensated care amount (see instructions)		7 102 009 710	4 974 402 450	35. 00
35. 00 35. 01	· · · · · · · · · · · · · · · · · · ·		0. 000104674	6, 874, 403, 459 0. 000121193	
35. 02	,	enter zero on this line			
05.00	(see instructions)		100 754	, , , , , , , ,	05.00
35. 03	Pro rata share of the hospital UCP, including supplemental UC Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	CP (see instructions)	189, 751 812, 886	623, 135	35. 03 36. 00
30.00	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throu			30.00
40.00	Total Medicare discharges (see instructions)		0		40. 00
			Before 1/1	On/After 1/1	
41.00	Total ESPD Modicare discharges (see instructions)		1.00	1. 01	41.00
41. 00 41. 01	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instruct	tions)		0	
42. 00	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42. 00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instructions	5)	0.00	0.00	45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41		0		46. 00
47. 00	Subtotal (see instructions)		13, 260, 040		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	15, 675, 659		48. 00
	only. (see instructions)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instructions			15, 675, 659	•
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt.			915, 016 0	
52. 00	Direct graduate medical education payment (from Wkst. E-4, li			Ö	52. 00
53.00	Nursing and Allied Health Managed Care payment	•		0	
54.00	Special add-on payments for new technologies			39, 996	
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	59)		0	54. 01 55. 00
55. 01	Cellular therapy acquisition cost (see instructions)	,,,		Ö	55. 01
56.00	Cost of physicians' services in a teaching hospital (see intr	ructi ons)		0	56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	0	57. 00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	IV, col. II line 200)		0 16, 630, 671	
60. 00	Primary payer payments			13, 413	
61. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		16, 617, 258	61. 00
62.00	Deductibles billed to program beneficiaries			1, 648, 916	•
63. 00 64. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			19, 890 338, 641	1
	Adjusted reimbursable bad debts (see instructions)			220, 117	
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		287, 135	1
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			15, 168, 569	67. 00
68. 00 69. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).		,	0	68. 00 69. 00
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(101 3011 see This truction	3)	0	70.00
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see	instructions)	0	70. 50
70. 75	N95 respirator payment adjustment amount (see instructions)			0	70. 75
70. 87 70. 88	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0	70. 87 70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see inst	tructions)			70. 88
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)	,		0	•
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70. 92 70. 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 0	70. 92 70. 93
	HRR adjustment amount (see instructions)			-78, 263	•
	Recovery of accelerated depreciation			0	

Health Financial Systems	ST. ANTHONYS MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0032	Peri od: Worksheet E From 07/01/2022 Part A To 06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C		Period: From 07/01/2022 To 06/30/2023	1/24/2024 1: 12	
	<u> </u>	Title	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
70.01				0	1. 00	70.01
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		0	0	70. 96
70 07	the corresponding federal year for the period prior to 10/1)	1 0		0		70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
70.00	the corresponding federal year for the period ending on or after Valume Payment 2	ter 10/1)		0	0	70.00
70. 98 70. 99	Low Volume Payment-3			0	-	
	HAC adjustment amount (see instructions)	(0 0 70)			15 000 304	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	09 & 70)			15, 090, 306	1
71. 01 71. 02	Sequestration adjustment (see instructions)				301, 806	1
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs				0	
71. 03	, , , , , , , , , , , , , , , , , , , ,				14 000 020	71. 03
	Interim payments				14, 900, 028	1
	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				0	
73. 01	Tentative settlement-PARHM (for contractor use only)	2 72			111 500	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			-111, 528	74. 00
74 01	73)					74 01
74. 01	Balance due provider/program-PARHM (see instructions)				000 410	74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			923, 412	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					1
00 00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2 02			0	90.00
90. 00		01 2.03			١	90.00
91. 00	plus 2.04 (see instructions)				0	91.00
	Capital outlier from Wkst. L, Pt. I, line 2	uati ana)			0	
92.00	Operating outlier reconciliation adjustment amount (see instruction and until or reconciliation adjustment amount (see instruction)	,			0	
93.00	Capital outlier reconciliation adjustment amount (see instruct				-	
94.00	The rate used to calculate the time value of money (see instructions)	uctions)			0. 00 0	1
95.00	Time value of money for operating expenses (see instructions)	+:)			-	
96. 00	Time value of money for capital related expenses (see instruc-	LI ONS)		Prior to 10/1	0 0n/After 10/1	96. 00
				1.00	2.00	
	HSP Bonus Payment Amount			1.00	2.00	
100 00	HSP bonus amount (see instructions)			0	0	100. 00
100.00	HVBP Adjustment for HSP Bonus Payment			J O	0	100.00
101 00	HVBP adjustment factor (see instructions)			0.0000000000	0.0000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instructions	e)		0.0000000000		102.00
102.00	HRR Adjustment for HSP Bonus Payment	3)		<u> </u>		1102.00
103 00	HRR adjustment factor (see instructions)			0.0000	0.0000	103 00
	HRR adjustment amount for HSP bonus payment (see instructions)	`		0.0000		104.00
104.00	Rural Community Hospital Demonstration Project (§410A Demonstr		ctmont	<u> </u>		104.00
200 00	Is this the first year of the current 5-year demonstration per					200 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	i i od under t	THE ZIST			200. 00
	Cost Reimbursement					ł
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	2 40)				201. 00
	Medicare discharges (see instructions)	C 47)				202.00
	Case-mix adjustment factor (see instructions)					203. 00
203.00	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the curren	t E voor domonst		203.00
		iiist year	or the curren	t 5-year demonst	Tation	
204 00	period) Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
200.00	Adjustment to Medicare Part A Inpatient Reimbursement					1200.00
207.00	Program reimbursement under the §410A Demonstration (see insti	ructions)				207 00
	, ,	,				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	11116 39)				208. 00
	Adjustment to Medicare IPPS payments (see instructions)					209. 00
-210.00	Reserved for future use					210.00
						211. 00
	Total adjustment to Medicare IPPS payments (see instructions)					
211. 00	Comparision of PPS versus Cost Reimbursement	244)				010.00
211. 00 212. 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	211)				212.00
211. 00 212. 00 213. 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	•	shumo ome = +\			213. 00
211. 00 212. 00 213. 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	•	nbursement)			1

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 In Lieu of Form CMS-2552-10 Peri od: Worksheet E From 07/01/2022 Part A Exhi bi t 4 To 06/30/2023 Date/Ti me Prepared: 1/24/2024 1:12 pm Provider CCN: 14-0032

						0 00/ 30/ 2023	1/24/2024 1:1	
		W /O F D			XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	On/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier	1.00	0	0	3.00		0.00	1. 00
	payments							
1. 01	DRG amounts other than outlier	1. 01	0	0	()	0	1. 01
	payments for discharges							
1. 02	occurring prior to October 1 DRG amounts other than outlier	1. 02	12, 245, 483	0		12, 245, 483	12, 245, 483	1. 02
1.02	payments for discharges	1.02	12, 243, 403	J		12, 243, 403	12, 243, 403	1.02
	occurring on or after October							
	1							
1. 03	DRG for Federal specific	1. 03	0	0	()	0	1. 03
	operating payment for Model 4							
	BPCI occurring prior to October 1							
1.04	DRG for Federal specific	1. 04	0	0		0	0	1. 04
	operating payment for Model 4							
	BPCI occurring on or after							
0.00	October 1	0.00						0.00
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for	2. 02	0	0	(0	0	2. 01
	discharges for Model 4 BPCI							
2.02	Outlier payments for	2. 03	0	0	()	0	2. 02
	discharges occurring prior to							
2. 03	October 1 (see instructions) Outlier payments for	2. 04	30, 540	0		30, 540	30, 540	2. 03
2.03	di scharges occurring on or	2.04	30, 340	O		30, 340	30, 340	2.03
	after October 1 (see							
	instructions)							
3. 00	Operating outlier	2. 01	0	0	(0	0	3. 00
4.00	reconciliation Managed care simulated	3. 00	0	0	(0	0	4. 00
1. 00	payments	0.00	J	J		,		1.00
	Indirect Medical Education Adju	ustment						
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	(0	0	6. 00
0.00	instructions)	22.00		O		0	0	0.00
6. 01	IME payment adjustment for	22. 01	O	0	(0	0	6. 01
	managed care (see							
	instructions) Indirect Medical Education Adju	ustmont for the	Add on for So	ation 122 of t	bo MMA			
7. 00	IME payment adjustment factor	27.00	0. 000000	0.000000		0.000000		7. 00
7.00	(see instructions)	27.00	0.00000	0.00000	0.00000	0.00000		,,,,,
8.00	IME adjustment (see	28. 00	0	0	(0	0	8. 00
0.04	instructions)	00.04			,			0.01
8. 01	IME payment adjustment add on for managed care (see	28. 01	0	Ü	() U	0	8. 01
	instructions)							
9.00	Total IME payment (sum of	29. 00	0	0	(0	0	9. 00
	lines 6 and 8)							
9. 01	Total IME payment for managed	29. 01	0	0	(0	0	9. 01
	care (sum of lines 6.01 and 8.01)							
	Disproportionate Share Adjustme	ent						
10. 00	Allowable disproportionate	33.00	0. 0559	0. 0559	0. 0559	0. 0559		10. 00
	share percentage (see							
11. 00	instructions) Disproportionate share	34. 00	171, 131	0	(171, 131	171, 131	11 00
11.00	adjustment (see instructions)	34.00	171, 131	O		171, 131	171, 131	11.00
11. 01	Uncompensated care payments	36. 00	812, 886	0	189, 751	623, 135	812, 886	11. 01
	Additional payment for high per		D beneficiary					
12. 00	Total ESRD additional payment	46. 00	이	0	(0	0	12. 00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	13, 260, 040	0	189, 751	13, 070, 289	13, 260, 040	13 00
14. 00	Hospital specific payments	48. 00	15, 675, 659	0	137,73	0 0	0.5, 255, 546	14. 00
55	(completed by SCH and MDH,			J	`			
	small rural hospitals only.)							
4	(see instructions)	,]		1.5
15. 00	Total payment for inpatient	49. 00	15, 675, 659	0	(15, 675, 659	15, 675, 659	15. 00
	operating costs (see instructions)							
16. 00	Payment for inpatient program	50. 00	915, 016	0	(915, 016	915, 016	16. 00
	capital (from Wkst. L, Pt. I,]		
	if applicable)					1		

							u of form CMS	
LOW VOL	LUME CALCULATION EXHIBIT 4			Provider CO		Period: From 07/01/2022 To 06/30/2023	1/24/2024 1:1	pared:
				Title	XVIII	Hospi tal	PPS	
	·	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4. 00	5. 00	
17. 00	Special add-on payments for	54.00	39, 996	2.00		39, 996		17. 00
	new technologies	34.00	37, 770	O	· `	37, 770	37, 770	17.00
								17 01
	Net organ aquisition cost							17. 01
	Credits received from	68. 00	0	0	(ט	0	17. 02
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18. 00	Capital outlier reconciliation	93. 00	0	0	(0	0	18. 00
	adjustment amount (see							
	instructions)							
19. 00	SUBTOTAL			0		16, 630, 671	16, 630, 671	19.00
•		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	914, 652	0	(914, 652	914, 652	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	(0	0	20. 01
	than outlier .							
21. 00	Capital DRG outlier payments	2. 00	364	0	1	364	364	21. 00
	Model 4 BPCI Capital DRG	2. 01	0	0	l i) 0	0	•
-	outlier payments	2.01	Ĭ	J	,		ľ	21.01
	Indirect medical education	5. 00	0. 0000	0. 0000	0. 000	0. 0000		22. 00
	percentage (see instructions)	5.00	0.0000	0.0000	0.000	0.0000		22.00
		/ 00		0			_	22 00
	Indirect medical education	6. 00	0	U	·	0	0	23. 00
	adjustment (see instructions)	40.00						
	Allowable disproportionate	10. 00	0. 0000	0. 0000	0. 0000	0.0000		24. 00
	share percentage (see							
	instructions)							
	Di sproporti onate share	11. 00	0	0	(0	0	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12.00	915, 016	0	(915, 016	915, 016	26.00
	payments (see instructions)							
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.00000	0.000000		27. 00
1	Low volume adjustment	70. 96			()	0	28. 00
_0.00	(transfer amount to Wkst. E,	, 5. , 5			`		Ĭ	-0.00
	Pt. A, line)							
	Low volume adjustment	70. 97					0	29. 00
		10.91						29.00
	(transfer amount to Wkst. E,							1
100.00	Pt. A, line)							100 00
	Transfer low volume		Y					100. 00
ļ	adjustments to Wkst. E, Pt. A.							l

Health Financial Systems ST. ANTHONYS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 14-0032 Peri od: Worksheet E From 07/01/2022 Part A Exhibit 5 Date/Time Prepared: 06/30/2023 1/24/2024 1:12 pm Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 4. 00 0 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 12, 245, 483 12, 245, 483 12, 245, 483 1.02 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 O 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 0 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 30, 540 30, 540 30, 540 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 0.0559 10.00 Allowable disproportionate share percentage 33.00 0.0559 0.0559 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 171.131 171.131 171.131 11.00 0 instructions) 11.01 189, 751 Uncompensated care payments 36, 00 812, 886 623, 135 812, 886 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 13, 260, 040 189, 751 13, 070, 289 Subtotal (see instructions) 13, 260, 040 13 00 14.00 Hospital specific payments (completed by SCH 48.00 15, 675, 659 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 15, 675, 659 0 15, 675, 659 15, 675, 659 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 915, 016 0 915, 016 915, 016 16.00 Wkst. L, Pt. I, if applicable)

54.00

68.00

93.00

39, 996

39, 996

16, 630, 671

C

0

0

39, 996

0

0 18.00

16, 630, 671 19. 00

17.00

17.01

17.02

17.00

17.01

17.02

18.00

19.00

SUBTOTAL

Special add-on payments for new technologies

Credits received from manufacturers for

replaced devices for applicable MS-DRGs

Capital outlier reconciliation adjustment

Net organ acquisition cost

amount (see instructions)

Health Financial Systems	AL HOSPITAL	In Lie	u of Form CMS-2552-10	
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 14-0032	Peri od:	Worksheet E

Title XVIII	HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULAT		TION EXHIBIT 5	Provi der CC	CN: 14-0032	Peri od: From 07/01/2022 To 06/30/2023		pared:
West. L				Title	XVIII	Hospi tal		
0			Wkst. L, line					
20. 00 Capital DRG other than outlier 1. 00 914,652 0 914,652 914,652 20. 00 20. 01 Model 4 BPCI Capital DRG other than outlier 1. 01 0 0 0 0 0 0 0 20. 01 21. 01 Capital DRG outlier payments 2. 00 364 0 364 364 21. 00 21. 01 Model 4 BPCI Capital DRG outlier payments 2. 01 0 0 0 0 0 21. 01 21. 01 Model 4 BPCI Capital DRG outlier payments 2. 01 0 0 0 0 0 21. 01 22. 00 Indirect medical education percentage (see instructions) 22. 00 Indirect medical education adjustment (see instructions) 24. 00 4. 00 0 0 0 0 0 0 0 0 0			0		2.00	3. 00	4. 00	
20. 01 Model 4 BPC Capital DRG other than outlier 2. 00 364 0 364 364 364 21. 00 21. 01 364 364 364 21. 00 364 364 21. 00 364 364 21. 00 364 364 21. 00 364 364 21. 00 364 364 21. 00 364 364 364 21. 00 364 364 364 21. 00 364 364 364 21. 00 364 364 364 21. 00 364 364 364 21. 00 364 364 364 21. 00 364 364 364 21. 00 364 364 364 21. 00 364 364 364 21. 00 364 364 364 21. 00 364 364 364 21. 00 364 364 364 21. 00 364 364 364 21. 00 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364 364	20. 00	Capital DRG other than outlier	1.00					20. 00
21. 00 Capital DRC outlier payments 2. 00 364 0 364 364 21. 00 21. 01 Model 4 BPCI Capital DRG outlier payments 2. 01 0 0 0 0 0 21. 01 22. 00 Indirect medical education percentage (see instructions) 22. 00 Indirect medical education percentage (see instructions) 23. 00 Indirect medical education adjustment (see instructions) 24. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00	20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
22.00 Indirect medical education percentage (see instructions) 22.00	21.00		2.00	364		0 364	364	21.00
22.00 Indirect medical education percentage (see instructions) 22.00	21. 01		2. 01	0		0 0	0	21. 01
1	22. 00		5. 00	0.0000	0.000	0.0000		22. 00
Instructions 24.00 Al lowable disproportionate share percentage (see instructions) 10.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000		instructions)						
24. 00 Allowable disproportionate share percentage (see instructions) 10.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000	23. 00		6. 00	0		0	0	23. 00
(see instructions) Disproportionate share adjustment (see instructions) Disproportionate share adjustment (see instructions) Total prospective capital payments (see instructions) Wkst. E, Pt. A, line Wkst. E, Pt. A)			40.00					
25.00 Disproportionate share adjustment (see instructions) 11.00 0 0 0 0 0 25.00	24.00		10.00	0.0000	0.000	0.0000		24.00
26.00 Total prospective capital payments (see 12.00 915,016 0 915,016 0 915,016 26.00	25 00		11 00			0		25 00
26.00 Total prospective capital payments (see instructions) 12.00 915,016 0 915,016 26.00	25.00		11.00	0		U U	0	25.00
Instructions	26 00		12 00	015 016		015 016	015 016	26 00
Wkst. E, Pt. A, line Wkst. E, Pt. A) 0 1.00 2.00 3.00 4.00	20.00		12.00	715,010		913,010	715,010	20.00
A, line Wkst. E, Pt. A) O 1.00 2.00 3.00 4.00 27.00 28.00 Low volume adjustment prior to October 1 70.96 0 0 0 28.00 29.00 Low volume adjustment on or after October 1 70.97 0 0 0 28.00 29.00 HVBP payment adjustment (see instructions) 70.93 0 0 0 0 0 29.00 30.00 HVBP payment adjustment for HSP bonus payment (see instructions) 70.90 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Thistractions)	Wkst. F. Pt.	(Amt. from				
A) 0 1.00 2.00 3.00 4.00 27.00 28.00 Low volume adjustment prior to October 1 70.96 0 0 0 29.00 29.00 Low volume adjustment on or after October 1 70.97 0 0 0 29.00 29.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0								
27.00 28.00 Low volume adjustment prior to October 1 70.96 0 0 28.00 29.00 Low volume adjustment on or after October 1 70.97 0 0 0 29.00 30.00 HVBP payment adjustment (see instructions) 70.93 0 0 0 0 30.00 30.01 HVBP payment adjustment for HSP bonus 70.90 0 0 0 0 30.01 payment (see instructions) 70.94 -78,263 0 -78,263 -78,263 31.00 31.01 HRR adjustment for HSP bonus payment (see instructions) 70.91 0 0 0 0 31.01 10.00 1.00 2.00 3.00 4.00 32.00 Transfer HAC Reduction Program adjustment to N								
28.00 Low volume adjustment prior to October 1 70.96 0 0 0 0 28.00 29.00 Low volume adjustment on or after October 1 70.97 0 0 0 29.00 30.00 HVBP payment adjustment (see instructions) 70.93 0 0 0 0 0 0 30.00 30.01 HVBP payment adjustment for HSP bonus 70.90 0 0 0 0 0 30.01 payment (see instructions) 70.94 -78,263 0 -78,263 -78,263 31.00 HRR adjustment (see instructions) 70.91 0 0 0 0 0 31.01 instructions) 70.91 0 0 0 0 0 31.01 CAMBER adjustment for HSP bonus payment (see instructions) 70.91 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	1.00	2.00	3. 00	4. 00	
29. 00 Low volume adjustment on or after October 1 70. 97 0 0 0 0 29. 00 30. 00 HVBP payment adjustment (see instructions) 70. 93 0 0 0 0 0 30. 00 30. 01 HVBP payment adjustment for HSP bonus 70. 90 0 0 0 0 0 30. 01 payment (see instructions) 70. 94 -78, 263 0 -78, 263 -78, 263 31. 00 31. 01 HRR adjustment for HSP bonus payment (see instructions) 70. 94 -78, 263 0 -78, 263 -78, 263 31. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
30.00 HVBP payment adjustment (see instructions) 30.01 HVBP payment adjustment for HSP bonus payment (see instructions) 31.00 HRR adjustment (see instructions) 31.01 HRR adjustment for HSP bonus payment (see instructions) 70.93 0 0 0 0 0 0 0 0 30.00 0 30.01 0 0 0 0 0 0 0 30.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28.00			0		0	0	
30. 01 HVBP payment adjustment for HSP bonus payment (see instructions) 31. 00 HRR adjustment (see instructions) 31. 01 HRR adjustment for HSP bonus payment (see instructions) To. 94	29. 00		70. 97	0		0	0	29. 00
payment (see instructions) 70.94 -78,263 0 -78,263 31.00 31.01 HRR adjustment (see instructions) 70.91 0 0 0 31.01	30.00	HVBP payment adjustment (see instructions)	70. 93	0		0 0	0	30. 00
31.00 HRR adjustment (see instructions) 31.01 HRR adjustment for HSP bonus payment (see instructions) 70.94	30. 01		70. 90	0		0	0	30. 01
31.01 HRR adjustment for HSP bonus payment (see 70.91 0 0 0 0 31.01 instructions) RR adjustment for HSP bonus payment (see 70.91 0 0 0 0 31.01 (Amt. to Wkst. E, Pt. A)								
instructions (Amt. to Wkst. E, Pt. A)				-78, 263		0 -78, 263	-78, 263	
Camt. to Wkst. E, Pt. A)	31. 01		70. 91	0		0	0	31. 01
Transfer HAC Reduction Program adjustment to N E, Pt. A)		instructions)						
0								
32.00 HAC Reduction Program adjustment (see 70.99 0 0 32.00 instructions) 100.00 Transfer HAC Reduction Program adjustment to N 100.00			0	1.00	2.00	2 00		
instructions) 100.00 Transfer HAC Reduction Program adjustment to N 100.00	32 00	HAC Peduction Program adjustment (see		1.00	2.00			32 00
100.00 Transfer HAC Reduction Program adjustment to N 100.00	32.00		70. 77					32.00
	100.00			l N				100.00
		Wkst. E, Pt. A.						

Health Financial Systems	ST. ANTHONYS MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0032	Peri od: From 07/01/2022 To 06/30/2023

Medit 8 - MEDICAL AND OTHER HEALTH SERVICES 1.00				10 06/30/2023	Date/lime Pre 1/24/2024 1:1:	
Page 18			Title XVIII	Hospi tal		2 p
Page 18						
1.00					1. 00	
2.00 Septical and other services relationsed under OPPS (see instructions)	1 00				4 044	1 00
1, 27, 20, 3, 00 20, 00 20, 01 10, 27, 20, 01 20, 02, 01 20, 02, 02, 03, 03, 03, 04, 07 20, 02, 03, 03, 03, 03, 03, 03, 03, 03, 03, 03		· · · · · · · · · · · · · · · · · · ·	tions)		l	
1.00 Outlier payment (see Instructions) 10,227 4.00 Outlier precedification amount (see Instructions) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00			11 0113)			
0.1 0.1 1.1 1.2 1.2 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3 1.3	4. 00	1			1	4. 00
1	4. 01				1	l l
2.00 Comparison Comparis	5.00	,	ctions)		0.000	5. 00
8.00	6.00	Line 2 times line 5			0	6.00
0.00 Ancillary service ather pass through costs from Wists. D. Pt. IV. col. 13, line 200 0 0.00 0 0 0 0 0 0	7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
10.00 Organ acquist it tions 0 10.00	8.00					
1.00 Confur and 10 Confu			IV, col. 13, line 200		· ·	
Comparison Com					· ·	l
Reasonable Charges	11.00				6, 846	111.00
12.00 Ancil larry service charges 45,602 12.00 13.00 Organ acquisit at on charges (From West. D-4, Pt. III, col. 4, line 69) 0 33.00 13.00 Organ acquisit at on charges (From West. D-4, Pt. III, col. 4, line 69) 0 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 3						1
13.00 Organ acquis sit ton charges (from Wist. D-4. Pt. 111, col. 4, line 69) 0 13.00	12 00	<u> </u>			45 602	12 00
14.00 Ostal reasonable charges (sum of lines 12 and 13) Ostal reasonable charges (sum of lines 12 and 13) Ostal regular amount actually collected from patients liable for payment for services on a charge basis Ostal Agregate amount actually collected from patients liable for payment for services on a chargebasis Ostal Ostal Agregate amount actually collected from patients liable for payment for services on a chargebasis Ostal			ne 69)		1	
Sustainary charges	14. 00					
Amounts that would have been realized from patients lable for payment for services on a chargebasis						
In add such payment been made in accordance with 42 CFR \$413.13(e)*	15.00	Aggregate amount actually collected from patients liable for p	payment for services on a	a charge basis	0	15. 00
17.00 Ratio of line 15 to line 16 (not to exceed 1.00000) 0.000000 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.	16.00	Amounts that would have been realized from patients liable for	r payment for services o	n a chargebasis	0	16. 00
18.00 Total customary charges (see instructions) 18.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00			e)			
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 38.755 19.00 Instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0.20.00 instructions) 6.846 21.00 instructions 6.846 21.00 22.00 instructions 6.846 21.00 22.00 instructions 6.846 21.00 22.00 22.00 instructions 7.647 24.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.	17. 00				ł	
Instructions					l	
Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00	19. 00		ly if line 18 exceeds li	ne 11) (see	38, 756	19.00
Instructions	20.00		ly if line 11 exceeds li	no 10) (coo	0	20 00
Lesser of cost or charges (see instructions) 6. 846 21.00	20.00		Ty IT TITLE IT EXCEEDS IT	(See	0	20.00
Interns and residents (see instructions)	21. 00	,			6. 846	21.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 15, 437, 731 24, 00 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 15, 437, 731 24, 00 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 15, 437, 731 24, 00 26.00 Deductible sand coin surance amounts (for CAH, see instructions) 2, 955, 810 26.00 26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 12, 488, 767 27.01 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 12, 488, 767 27.01 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.0	22. 00	,			1	
COMPUTATION OF RELIMBURSEMENT SETTLEMENT 26.00 Deductible sand coin surance amounts (for CAH, see instructions) 0 25.00 26.00 Deductible sand coin surance amounts relating to amount on line 24 (for CAH, see instructions) 12,488,767 27.00 Subtotal ([(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 12,488,767 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 28.50 REH facility payment amount 28.00 29.50 28.50 SERO (irrect medical education costs (from Wkst. E-4, line 36) 12,488, 767 29.50 SERO (irrect medical education costs (from Wkst. E-4, line 36) 12,488, 767 30.00 Subtotal (sum of lines 27, 28, 28, 50 and 29) 12,488, 139 30.00 Direct medical education costs (from Wkst. E-5, line 36) 12,488, 139 30.00 Composite rate ESRO (from Wkst. I-5, line 11) 0 12,488, 139 31.00 AlLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 0 33,400 32.00 Allowable bad debts (see instructions) 331,693 34,000 35.00 Aljusted relimbursable bad debts (see instructions) 248,100 35,000 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 12,736,239 37,000 37.00 Subtotal (see instructions) 31,552 36,000 38.00 MSP-LOC reconciliation amount from PSRR -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000 -163,000		· · · · · · · · · · · · · · · · · · ·	ructions)		0	23. 00
25.00 Deductibles and coin nsurance amounts (for CAH, see instructions) 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00 2 5.00	24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	•		15, 437, 731	24.00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2, 955, 810 26.00 27.00 Subtotal (Clines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 12, 488, 767 27.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.0		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
12, 488, 767 27. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28.	25. 00	,	•			
Instructions Instructions Instructions Instructions 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0.28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00						
28.00 Direct graduate medical education payments (From Wkst. E-4, line 50) 28.00 28.00 28.50 28.50 ERF decility payment amount 28.00 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00	27. 00		olus the sum of lines 22	and 23] (see	12, 488, 767	27. 00
28.50 EEH Facility payment amount 28.50 29.00 ESRO direct medical education costs (from Wkst. E-4, line 36) 29.00 29.00 29.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00	20.00	,	no FO)			20.00
29.00 SSRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 3ubtotal (sum of lines 27, 28, 28.50 and 29) 12.488, 767 30.00 31.00 Primary payer payments 628 31.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 33.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.0			Tie 50)		0	
30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 12, 488, 767 30.00 31.00 22, 488, 767 30.00 31.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00					0	
Primary payer payments		,				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)					1	
33.00 Composite rate ESRD (From Wkst. 1-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 381, 693 34.00 34.00 Allowable bad debts (see instructions) 248, 100 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 12, 736, 239 37.00 37.00 Subtotal (see instructions) 12, 736, 239 37.00 38.00 MSP-LCC reconciliation amount from PS&R 12, 736, 239 37.00 39.00 MSP-LCC reconciliation amount from PS&R 16.30 39.00 07HER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39	32.00	Subtotal (line 30 minus line 31)			12, 488, 139	32.00
Allowable bad debts (see instructions) 381,693 34,00 35.00 Adjusted reimbursable bad debts (see instructions) 248,100 35.00 Adjusted reimbursable bad debts (see instructions) 310,582 36.00 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 12,736,239 37.00 39.00 39.50 39.00 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50		ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
Adj usted reimbursable bad debts (see instructions) 248, 100 35. 00 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008 31. 008						
36. 00 Alíowable bad debts for dual eligible beneficiaries (see instructions) 310, 582 36. 00 37. 00 Subtotal (see instructions) 12,736, 239 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R -163 38. 00 39. 00 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 50 39. 50 91. oneer ACO demonstration payment adjustment (see instructions) 0 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 5		,			l	
37.00 Subtotal (see instructions) 12,736,239 37.00 38.00 MSP-LCC reconciliation amount from PS&R -163 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.50 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.50 39.97 Pomonstration payment adjustment amount before sequestration 0 39.97 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90						
MSP-LCC reconciliation amount from PS&R -163 38.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.50 39.50 70 70 70 70 70 70 70		, ,	ructions)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.50 79 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50					l	1
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.75 39.75 39.75 39.75 39.75 39.75 200 200 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00					l e	
39. 75 39. 97 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 40. 00 Subtotal (see instructions) 39. 99 Subtotal (see instructions) 39. 99 Acceleration adjustment (see instructions) 30. 00 Acceleration adjustment amount after sequestration 31. 01 Acceleration adjustment amount after sequestration 32. 01 Acceleration adjustment amount after sequestration 32. 02 Acceleration adjustment amount (see instructions) 32. 01 Acceleration adjustment amount (see instructions) 32. 02 Acceleration adjustment amount (see instructions) 32. 03 Acceleration adjustment amount (see instructions) 33. 04 Acceleration adjustment amount (see instructions) 34. 00 Acceleration adjustment amount (see instructions) 39. 00 Acceleration adjustment amount after sequestration 39. 00			5)			
39. 97 Demonstration payment adjustment amount before sequestration 939. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 12, 736, 402 Page 40. 00 Page			-,		n	1
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program (see instructions) 44. 00 Sequestration adjustment (see instructions) 43. 01 Demonstration payments 44. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement (for contractors use only) 43. 00 Original outlier amount (see instructions) 44. 00 Original outlier amount (see instructions) 45. 01 DECOMPLETED BY CONTRACTOR 46. 02 Original outlier amount (see instructions) 47. 02 Outlier reconciliation adjustment amount (see instructions) 48. 01 Outlier reconciliation adjustment amount (see instructions) 49. 00 Outlier reconciliation adjustment amount (see instructions) 40. 01 Oncologo (see instructions) 40. 02 Oncologo (see instructions) 41. 02 Oncologo (see instructions) 42. 03 Oncologo (see instructions) 43. 04 Oncologo (see instructions) 44. 05 Oncologo (see instructions) 45. 07 Oncologo (see instructions) 46. 08 Oncologo (see instructions) 47. 00 Oncologo (see instructions) 48. 00 Oncologo (see instructions) 49. 00 Oncologo (see instructions) 49. 00 Oncologo (see instructions) 49. 00 Oncologo (see instructions) 40. 00 Oncologo (see instructions) 41. 01 Oncologo (see instructions) 42. 01 Oncologo (see instructions) 43. 01 Oncologo (see instructions) 44. 00 Onc					1	
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99	39. 98		ced devices (see instruc	tions)	l	
40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 02 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions) 94. 00 Sequestration adjustment amount (see instructions) 95. 00 Outlier reconciliation adjustment amount (see instructions) 96. 00 Outlier reconciliation adjustment amount (see instructions) 97. 00 Outlier reconciliation adjustment amount (see instructions) 98. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Outlier reconciliation adjustment amount (see instructions)	39. 99	·	(223	,		
40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 0 40. 00 40. 00 40. 00 41. 00 41. 00 42. 00 42. 00 42. 00 42. 00 43. 01 44. 00 45. 00 46. 00 47. 00 47. 00 48. 00 49. 00 49. 00 49. 00 49. 00 49. 00 40. 02 40. 03 40. 03 41. 00 41. 00 41. 00 42. 00 42. 00 42. 00 43. 01 44. 00 45. 00 46. 00 47. 00 47. 00 48. 00 49. 00 49. 00 49. 00 49. 00 40. 00 40. 00 40. 00 40. 00 40. 00 40. 00 40. 00 41. 00 41. 00 42. 00 42. 00 42. 00 43. 01 44. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 49. 00 40. 00 40. 00 40. 00 40. 00 41. 00 41. 00 42. 00 42. 00 42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 47. 00 48. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 40. 00 41. 00 41. 00 41. 00 41. 00 41. 00 42. 00 42. 00 42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 49. 00 49. 00 49. 00 40. 00 41. 00 41. 00 41. 00 41. 00 41. 00 42. 00 42. 00 43. 00 44. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49.	40. 00					
40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 00 Interim payments-PARHM 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, position of the provider	40. 01					
41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8115.2 80.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation of Money 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation of Money 93.00 Outlier reconciliation of Money (see instructions) 94.00 Outlier reconciliation of Money 95.00 Outlier	40. 02				l	
41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\sqrt{115.2}}{\text{TO BE COMPLETED BY CONTRACTOR}} 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 O 93.00		, ,				
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\sqrt{115.2}}{\sqrt{10}} \frac{\sqrt{1000}}{\sqrt{1000}} \frac{\sqrt{1000}}{\	41. 00	' '			12, 516, 902	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 80.00 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)		, ,				
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Sils. 2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) 0 Untlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00 Time Value of Money (see instructions)	42.00	,			0	
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 §115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 91.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Protested amount (see instructions) 0 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00					25 222	
44.00 Protested amounts (nonal owable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Opt. 0 Opt.					-35, 228	
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0utlier reconciliation adjustment amount (see instructions) 0 91.00 P1.00 The rate used to calculate the Time Value of Money 0.00 P2.00 Time Value of Money (see instructions) 0 93.00						
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 1 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 1 0 91.00 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00	44. UU	,	ICE WITH CINS PUD. 15-2, (спартег І,		44.00
90. 00 Original outlier amount (see instructions) 0 90. 00 00 00 00 00 00 00 00 00 00 00 00 0						1
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 0.00 92.00 0.00 93.00	90. 00				0	90.00
92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00	91.00	, ,			1	
	92.00				0.00	
04 00 Total (sum of Lines 01 and 02)	93. 00				ł	
94. 00 10 tai (Suiii 01 11 lies 31 aliu 33)	94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems	ST. ANTHONYS MEMORI	AL HOSPITAL	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0032	Peri od:	Worksheet E	
			From 07/01/2022		
			To 06/30/2023	Date/Time Pr	
				1/24/2024 1:	12 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(0 200. 00

Health Financial Systems ST. AND ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm Provider CCN: 14-0032

					1/24/2024 1: 12	2 pm
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
4 00	TT	1.00	2.00	3. 00	4. 00	4 00
1.00	Total interim payments paid to provider		14, 977, 948		12, 833, 935	1. 00
2.00	Interim payments payable on individual bills, either		C		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
0.00	write "NONE" or enter a zero					0.00
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3. 02			C		0	3. 02
3. 03			C		0	3. 03
3.04			C		0	3. 04
3.05			C		0	3. 05
	Provider to Program	1				
3.50	ADJUSTMENTS TO PROGRAM	01/30/2023	77, 920		317, 033	3. 50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3.53			C		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		-77, 920		-317, 033	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		14, 900, 028		12, 516, 902	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)	1				
	TO BE COMPLETED BY CONTRACTOR			I		
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
E 01	TENTATI VE TO PROVI DER	T		I	1 0	E 01
5. 01 5. 02	TENTATIVE TO PROVIDER		i c			5. 01 5. 02
5. 02			i c			5. 02
5.03	Provider to Program	<u> </u>				5. 03
5. 50	TENTATI VE TO PROGRAM				1 0	5. 50
5. 51	TENTATIVE TO PROGRAW	}	i c			5. 50
5. 51			l d			5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		1 0			5. 99
5. 99	5. 50-5. 98)		_		ا	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER	1	0		0	6. 01
6. 02	SETTLEMENT TO PROVIDER	1	111, 528		35, 228	6. 02
7. 00	Total Medicare program liability (see instructions)	1	14, 788, 500		12, 481, 674	7. 00
7.00	Trotal medicale program frability (see instructions)		14, 700, 500		NPR Date	7.00
				Contractor Number	(Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
0.00	Induite of contractor	1		1	1	0.00

Health Financial Systems ST. ANTHONYS MEMORIAL HOSPITAL In Lieu of Form CMS-25						
CALCUI	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-0032 From 07/01/2022 From 06/30/2023 I					
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO				1.00	
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14						
2.00 Medicare days (see instructions)						
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
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				6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HII technology	Wkst. S-2, Pt. I		7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	30.00 Initial/interim HIT payment adjustment (see instructions)					
31.00	31.00 Other Adjustment (specify)					
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32.00	

Health Financial Systems	ST. ANTHONYS MEMO	ORIAL HOSPITAL	In Lieu of Form CMS-		
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 14-0032	Peri od:	Worksheet E-2	
			From 07/01/2022		
		Component CCN, 14 HO22	To 0//20/2022	Doto/Time Drenered.	

		Component CCN: 14-U032	To 06/30/2023	Date/Time Pro 1/24/2024 1:	epared:
		Title XIX	Swing Beds - SNF		ız piii
			Part A	Part B	
	COMPLITATION OF NET COCT OF COVERED CERVILORS		1. 00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		0		1.00
2. 00	Inpatient routine services - swing bed-NF (see instructions)		ő		2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A, and sum of Wkst. D,	O		3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing	-bed pass-through, see			
0.01	instructions)				0.01
3. 01 4. 00	Nursing and allied health payment-PARHM (see instructions) Per diem cost for interns and residents not in approved teachir	a program (coo	0.00		3. 01 4. 00
4.00	instructions)	ig program (see	0.00		4.00
5.00	Program days		0		5. 00
6.00	Interns and residents not in approved teaching program (see ins		0		6. 00
7. 00	Utilization review - physician compensation - SNF optional meth	od only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0		8. 00
9. 00 10. 00	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		0		9. 00 10. 00
11. 00	Deductibles billed to program patients (exclude amounts applications)	ble to physician	0		11.00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		0		12. 00
13. 00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0		13. 00
14. 00	for physician professional services) 80% of Part B costs (line 12 x 80%)		0		14. 00
	Subtotal (see instructions)		0		15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		O		16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstra	ition) payment			16. 55
16. 99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0		16. 99
	Allowable bad debts (see instructions)		0		17. 00
	Adjusted reimbursable bad debts (see instructions)		O		17. 01
	Allowable bad debts for dual eligible beneficiaries (see instru	ıcti ons)	0		18. 00
	Total (see instructions)		0		19. 00
	Sequestration adjustment (see instructions)		0		19. 01 19. 02
19. 02	Demonstration payment adjustment amount after sequestration) Sequestration adjustment-PARHM pass-throughs		0		19. 02
19. 25	, ,		0		19. 25
20.00	Interim payments		0		20. 00
	Interim payments-PARHM				20. 01
	Tentative settlement (for contractor use only)		0		21. 00 21. 01
	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 19 minus lines 19.01, 19.02,	19 25 20 and 21)	0		22. 00
22. 01	Balance due provider/program-PARHM (see instructions)	17. 20, 20, dia 21)			22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	0		23. 00
	chapter 1, §115.2				
200 00	Rural Community Hospital Demonstration Project (§410A Demonstra Is this the first year of the current 5-year demonstration peri	, ,			200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	od drider the 21st			200.00
	Cost Reimbursement				
201. 00	Medicare swing-bed SNF inpatient routine service costs (from Wk	sst. D-1, Pt. II, line			201. 00
202 00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst D-3 col 3 line	_		202. 00
202.00	200 (title XVIII swing-bed SNF))	WK31. D 3, COI. 3, ITTK			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 f period)	irst year of the currer	it 5-year demonst	ration	
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times)	nes line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				4
	Program reimbursement under the §410A Demonstration (see instru	,			207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, and 3)	cor. I, sum of lines			208. 00
209. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruct	i ons)			209. 00
	Reserved for future use	·			210. 00
045 55	Comparision of PPS versus Cost Reimbursement	0 1 11 010) (045 00
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 20 instructions)	prus rine 210) (see			215. 00
	111001 4001 0110/		1		1

Health Financial Systems ST. ANTHONYS MEMORIAL HOSPITAL In Lieu				u of Form CMS-2	552-10		
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT			Provider CCN: 14-0032	Peri od:	Worksheet E-5	
					From 07/01/2022 To 06/30/2023	Date/Time Prep	
						1/24/2024 1: 12	2 pm
				Title XVIII		PPS	
	·						
						1. 00	
	TO BE COMPLETED BY CONTRACTOR						
1.00	Operating outlier amount from Wkst. E, Pt.	Α,	line 2, or sum of	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line	2				0	2.00
3.00	Operating outlier reconciliation adjustment	nt ar	mount (see instr	uctions)		0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)					0	4.00	
5.00 The rate used to calculate the time value of money (see instructions)					0.00	5.00	
6.00 Time value of money for operating expenses (see instructions)					0	6.00	
7.00 Time value of money for capital related expenses (see instructions)						0	7.00

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

Provider CCN: 14-0032

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

1/24/2024 1:12 pm Speci fi c Endowment Fund General Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1.00 1.00 Cash on hand in banks 56, 337 0 0 0 0 0 2.00 Temporary investments 0 2.00 0 3.00 Notes receivable 0 0 3.00 0 4 00 39, 636, 273 4 00 Accounts receivable 0 0 5.00 Other receivable 919, 891 0 0 5.00 6.00 Allowances for uncollectible notes and accounts receivable -18, 140, 443 6.00 0 7.00 Inventory 4, 296, 198 0 0 7.00 0 8.00 Prepaid expenses 468, 929 0 8.00 0 9.00 Other current assets 185 0 9.00 10 00 Due from other funds 0 0 0 10 00 Total current assets (sum of lines 1-10) 27, 237, 370 0 0 11.00 0 11 00 FIXED ASSETS 12.00 Land 2, 699, 574 0 0 0 12.00 Land improvements 0 0 13.00 3.381.484 13.00 0 οĺ 14.00 Accumulated depreciation -2, 737, 937 0 14.00 15.00 Bui I di ngs 112, 334, 876 0 0 0 0 0 0 0 0 0 0 0 0 0 15.00 -61, 167, 443 16.00 Accumulated depreciation 0 16.00 976, 316 0 17.00 Leasehold improvements 17.00 0 0 18 00 Accumulated depreciation -215, 378 0 18 00 Fi xed equipment 19.00 19.00 0 20.00 Accumulated depreciation 0 20.00 0 21.00 Automobiles and trucks 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 93, 121, 127 0 23.00 Accumulated depreciation -79, 091, 438 24.00 0 24.00 0 25.00 Mi nor equi pment depreci able Λ 25, 00 26.00 Accumulated depreciation C 0 0 26.00 27.00 HIT designated Assets 0 0 0 0 27.00 0 28.00 Accumulated depreciation 0 28.00 0 29.00 Mi nor equi pment-nondepreci abl e 9, 279, 201 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 78, 580, 382 0 30.00 OTHER ASSETS 31 00 Investments 433 182 548 0 0 31 00 0 0 32.00 Deposits on Leases 0 32.00 Due from owners/officers 0 0 0 33.00 33.00 0 34.00 Other assets 150,000 0 0 34.00 0 Total other assets (sum of lines 31-34) 35.00 433, 332, 548 0 35, 00 36.00 Total assets (sum of lines 11, 30, and 35) 539, 150, 300 0 0 0 36.00 CURRENT LIABILITIES 37 00 O 0 n 37 00 4 324 706 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 5, 049, 726 0 38.00 Payroll taxes payable 0 39.00 39.00 0 0 Notes and Loans payable (short term) 469,019 0 40.00 40.00 0 0 Deferred income 41 00 41 00 0 42.00 Accelerated payments 42.00 43.00 Due to other funds 4, 443, 594 0 0 0 43.00 Other current liabilities 0 0 44.00 4. 135. 450 0 44.00 Total current liabilities (sum of lines 37 thru 44) 0 18, 422, 495 0 45.00 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 1, 124, 446 0 46.00 0 0 Notes payable 4, 285, 901 0 47.00 47.00 48 00 Unsecured Loans 0 0 0 48 00 Other long term liabilities 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) 5, 410, 347 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 51.00 23, 832, 842 0 0 0 51.00 CAPITAL ACCOUNTS 515, 317, 458 52.00 General fund balance 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 515, 317, 458 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 539, 150, 300 0 0 0 60.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

18.00

19.00

0

0

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 14-0032 Peri od: Worksheet G-1 From 07/01/2022 06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 481, 350, 702 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 36, 343, 892 2.00 3.00 Total (sum of line 1 and line 2) 517, 694, 594 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 517, 694, 594 11.00 0 11.00 12.00 CHANGE IN NET ASSETS 2, 377, 136 0 12.00 13.00 13.00 14.00 0 14.00 0 0 0 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 2, 377, 136 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 515, 317, 458 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 0 11.00 12.00 CHANGE IN NET ASSETS 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00

0

18.00

19.00

Health Financial Systems ST. STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-0032

			To 06/30/2023	Date/Time Pre 1/24/2024 1:1	
	Cost Center Description	Inpatient	Outpati ent	Total	Z piii
	0000 00000 00000 00000	1, 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	15, 130, 38	3	15, 130, 383	1.00
2.00	SUBPROVIDER - IPF			.,,	2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5. 00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6.00
7. 00	SKILLED NURSING FACILITY				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)	15, 130, 38	3	15, 130, 383	10.00
	Intensive Care Type Inpatient Hospital Services	10,100,00	<u> </u>	10/100/000	
11. 00	INTENSIVE CARE UNIT	3, 159, 55	9	3, 159, 559	11.00
12. 00	CORONARY CARE UNIT	3, 131, 33		2,,	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	3, 159, 55	9	3, 159, 559	16. 00
10.00	11-15)	0, 107, 00		0, 107, 007	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	18, 289, 94	2	18, 289, 942	17. 00
18. 00	Ancillary services	68, 383, 56		350, 085, 167	
19. 00	Outpati ent servi ces	7, 865, 19		42, 467, 213	1
20. 00	RURAL HEALTH CLINIC	7,000,17	0 01,002,010	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		o o	0	21.00
22. 00	HOME HEALTH AGENCY		21, 653, 303		1
23. 00	AMBULANCE SERVI CES		21,000,000	21,000,000	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE		0 12, 155, 321	12, 155, 321	ı
27. 00	PROFESSI ONAL SERVI CES	1, 806, 44		8, 101, 180	
27. 00	OTHER NRCC	1, 000, 44	0 4, 888, 356	4, 888, 356	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	96, 345, 14		457, 640, 482	28. 00
20.00	G-3, line 1)	70, 343, 14	4 301, 273, 330	437, 040, 402	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		156, 510, 865		29. 00
30.00	ADD (SPECIFY)		0		30.00
31. 00			o		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	DEDUCT (SI ECITY)		0		38.00
39. 00			0		39. 00
40. 00			0		40.00
41. 00			0		41.00
41.00	Total deductions (sum of lines 37-41)		۸		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	er	156, 510, 865		43.00
43.00	to Wkst. G-3, line 4)	C1	130, 310, 803		45.00
	100 11.00 1.00 1.00 1.00 1.00 1.00 1.00	1	1	l	I

	Financial Systems ST. ANTHONYS MEMI MENT OF REVENUES AND EXPENSES	Provi der CCN: 14-0032	Peri od:	u of Form CMS-2 Worksheet G-3		
			From 07/01/2022 To 06/30/2023		pared:	
				1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, I	ine 28)		457, 640, 482	1. 00	
2. 00	Less contractual allowances and discounts on patients' acco	,		294, 205, 370		
3. 00	Net patient revenues (line 1 minus line 2)	uites		163, 435, 112		
4. 00	Less total operating expenses (from Wkst. G-2, Part II, Iin	e 43)		156, 510, 865		
5. 00	Net income from service to patients (line 3 minus line 4)	5 .5)		6, 924, 247	1	
	OTHER I NCOME			27 12 17 2 11		
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00						
8.00						
9.00						
10.00	Purchase di scounts			0	10.00	
11.00	Rebates and refunds of expenses			0	11. 00	
12.00	Parking lot receipts			0	12. 00	
13.00	Revenue from Laundry and Linen service			0	13. 00	
14.00	Revenue from meals sold to employees and guests			0	14. 00	
15.00	Revenue from rental of living quarters			0	15. 00	
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00	
17.00	Revenue from sale of drugs to other than patients			0	17. 00	
18. 00	Revenue from sale of medical records and abstracts			0	18. 00	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00	
21.00	Rental of vending machines			0	21. 00	
22. 00	Rental of hospital space			0	22. 00	
23.00	Governmental appropriations			0	23. 00	
24. 00	OTHER I NCOME			12, 941, 208	24. 00	
24. 50	COVI D-19 PHE Fundi ng			0	24. 50	
25. 00	Total other income (sum of lines 6-24)			29, 223, 320	25. 00	
26. 00	Total (line 5 plus line 25)			36, 147, 567	26. 00	
27. 00	OTHER NON OPERATING			-196, 325	27. 00	

-196, 325 27. 00 -196, 325 28. 00 36, 343, 892 29. 00

27. 00 OTHER NON OPERATING

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

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

0

0

0

0

0

0

-865, 633

0

0

0

0

13, 816, 123

0

0

0

0

O

0

19 00

20.00

21.00

22.00

23 00

23.50

24.00

Ω

Ω

19 00

20.00

21.00

22.00

23.00

23. 50

Health Promotion Activities

Home Delivered Meals Program

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

24.00 Total (sum of lines 1-23)

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportati on	Subtotal (cols. 0-4)	
		0	1.00	2.00	3. 00	4. 00	4A. 00	
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. & Fixtures	0	0				0	1. 00
2.00	Capital Related - Movable	0		0			0	2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	425, 245	0	0	425, 245		0	3. 00
4. 00 5. 00	Transportation Administrative and General	2, 292, 763	0	0	425, 245) 5	2, 718, 008	4. 00 5. 00
5.00	HHA REIMBURSABLE SERVICES	2, 272, 103	U _I	0	425, 245	<u> </u>	2, 710, 000	3.00
6.00	Skilled Nursing Care	6, 716, 728	0	0	C	0	6, 716, 728	6.00
7.00	Physical Therapy	2, 785, 944	0	0			2, 785, 944	
8.00	Occupational Therapy	1, 152, 567	0	0		0	1, 152, 567	8. 00
9. 00 10. 00	Speech Pathology Medical Social Services	220, 500 24, 520	0	0			220, 500 24, 520	1
11. 00	Home Heal th Aide	182, 272	0	0			182, 272	1
12. 00	Supplies (see instructions)	13, 561	o	0	d	ol ol	13, 561	12.00
13. 00	Drugs	0	0	0	C	·	0	
14. 00	DME	0	0	0	(0	0	14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	O	0	0		ol ol	0	15. 00
16. 00	Respiratory Therapy		0	0		·	0	16. 00
17. 00	Private Duty Nursing		o	0		- 1	0	17. 00
18. 00	Clinic	0	o	0	C	o o	0	18. 00
19. 00	Health Promotion Activities	0	0	0	C	0	0	19. 00
20.00	Day Care Program	0	0	0	0		0	20.00
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0	0			0	21. 00 22. 00
23. 00	All Others (specify)		o o	0			0	23. 00
23. 50	Tel emedi ci ne	O	o	0	C	o	0	23. 50
24. 00	Total (sum of lines 1-23)	13, 814, 100	0	0	425, 245	5 0	13, 814, 100	24. 00
		Administrative						
		& General 5.00	4A + 5) 6.00					
	GENERAL SERVICE COST CENTERS	0.00	0.00		-			
1.00	Capital Related - Bldg. &							1. 00
2.00	Fixtures							2.00
2. 00	Capital Related - Movable Equipment							2. 00
3.00	Plant Operation & Maintenance							3. 00
4.00	Transportation							4. 00
5.00	Administrative and General	2, 718, 008						5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	1, 645, 273	8, 362, 001					6. 00
7. 00	Physical Therapy	682, 423	3, 468, 367					7.00
8.00	Occupational Therapy	282, 324	1, 434, 891					8. 00
9.00	Speech Pathology	54, 012	274, 512					9. 00
	Medical Social Services	6, 006	30, 526					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	44, 648 3, 322	226, 920 16, 883					11. 00 12. 00
13. 00	Drugs	3, 322	10, 663					13. 00
14. 00	DME	O	o					14. 00
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	0					15. 00
16.00	Respiratory Therapy Private Duty Nursing	0	0					16.00
17. 00 18. 00	Clinic	0	0					17. 00 18. 00
19. 00	Health Promotion Activities		0					19.00
20. 00	Day Care Program		Ö					20. 00
21. 00	Home Delivered Meals Program	0	О					21. 00
22. 00	Homemaker Service	0	0					22. 00
23. 00 23. 50	1 3/	0	0					23. 00 23. 50
	Total (sum of lines 1-23)		13, 814, 100					24. 00
			.,, .50					

Health Financial Systems	ST	T. ANTHONYS MEN	ORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - HHA STATISTICAL BAS	SLS		Provi der C		Peri od:	Worksheet H-1	
					From 07/01/2022 To 06/30/2023		
					Home Health Agency I	PPS	
	Capital Rel	ated Costs					
	BI dgs &	Movabl e	PI ant	Transportati o	nReconciliation	Admi ni strati ve	
	Fixtures (SQUARE FEET)	Equipment (DOLLAR VALUE)	Operation & Maintenance (SQUARE FEET)	(MI LEAGE)		& General (ACCUM. COST)	
	1.00	2.00	3.00	4.00	5A. 00	5. 00	
GENERAL SERVICE COST CENTERS							

Worksheet H-2 Part I Date/Time Prepared: 1/24/2024 1:12 pm Provi der CCN: 14-0032 Peri od: From 07/01/2022 To 06/30/2023 HHA CCN: 14-7661 Home Health PPS

						Agency I	PPS	
			CAPITAL REL	ATED COSTS		Agency 1		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1. 00	2. 00	4. 00	4A	5. 00	
1.00	Administrative and General	0	79, 044	48, 659	185, 031	312, 734		1. 00
2.00	Skilled Nursing Care	8, 362, 001	0	0	1, 218, 381	9, 580, 382		2. 00
3.00	Physical Therapy	3, 468, 367	0	0				3.00
4.00	Occupational Therapy	1, 434, 891	0	0	208, 309	1, 643, 200	535, 336	4.00
5.00	Speech Pathology	274, 512	0	0	39, 853	314, 365	102, 417	5.00
6.00	Medical Social Services	30, 526	0	0	0	30, 526	9, 945	6.00
7.00	Home Health Aide	226, 920	0	0	32, 939			7. 00
8.00	Supplies (see instructions)	16, 883	0	0	0	16, 883	1	8. 00
9. 00	Drugs	0	0	0	0	0	0	9. 00
10.00	DME	0	0	0	0	0	0	10.00
11. 00 12. 00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00 12. 00
13. 00	Respiratory Therapy Private Duty Nursing		0	0	0	0	0	13. 00
14. 00	Clinic	0	0	0	0	0	0	14. 00
15. 00	Health Promotion Activities	0	0	Ö	0	0	Ö	15. 00
16. 00	Day Care Program	0	0	o	Ö	0	o	16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	О	17.00
18. 00	Homemaker Service	0	0	0	0	0	0	18.00
19. 00	All Others (specify)	0	0	0	0	0	0	19.00
19. 50		0	0	0	0	0	0	19. 50
20. 00	Total (sum of lines 1-19) (2)	13, 814, 100	79, 044	48, 659	2, 188, 031	16, 129, 834		20. 00
21. 00	Unit Cost Multiplier: column					0. 000000		21. 00
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		6. 00	PLANT 7.00	LINEN SERVICE 8.00	9. 00	10.00	11.00	
1.00	Administrative and General	6, 314	153, 607	0	32, 435	0		1. 00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2. 00
3.00	Physi cal Therapy	0	0	0	0	0	0	3. 00
4.00	Occupational Therapy	0	0	0	0	0	0	4. 00
5. 00 6. 00	Speech Pathology Medical Social Services	0	0	0	0	0	0	5. 00 6. 00
7. 00	Home Health Aide	0	0	0	0	0	0	7. 00
8. 00	Supplies (see instructions)		0	0		0	0	8. 00
9. 00	Drugs	0	0	0	0	0	ő	9. 00
10. 00	DME	0	0	0	Ö	Ö	o	10. 00
11. 00	Home Dialysis Aide Services	0	0	О	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14. 00	Clinic	0	0	0	0	0	0	14. 00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15. 00
	Day Care Program	0	0	0	0	0	١	16.00
17. 00 18. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00 18. 00
19. 00	Homemaker Service All Others (specify)	0	0	0				19.00
19. 50	Tel emedi ci ne	1 0	0	0	١		o	19. 50
20. 00	Total (sum of lines 1-19) (2)	6, 314	153, 607	0	32, 435	l o	394, 641	20. 00
21. 00	Unit Cost Multiplier: column]]			21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.	l						

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS	Provi der CC	N: 14-0032	Peri od: From 07/01/2022	Worksheet H-2 Part I	
			HHA CCN:	14-7661	To 06/30/2023		pared: 2 pm
					Home Health Agency I	PPS	
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	Subtotal	
	13. 00	14.00	15. 00	16.00	17. 00	24.00	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Home Delivered Meals Program 19.50 Telemedicine 20.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) (2) 21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	0 0 0 0 0 0 0 0 0 0 0	42, 752 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	74, 705 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	152, 6£	32 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 271, 755	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
	25. 00	26. 00	27. 00	28. 00			
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 1.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) (2) 21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		1, 271, 755 12, 701, 572 5, 265, 881 2, 178, 536 416, 782 40, 471 344, 518 22, 383 0 0 0 0 0 0 0 0 0 0 22, 241, 898	770, 300 319, 355 132, 119 25, 276 2, 454 20, 894 1, 357 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13, 471, 87 5, 585, 23 2, 310, 65 442, 05 42, 92 365, 41 23, 74	86 55 88 82 92 90 90 90 90 90 90 90 90 90 90		1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems	AL HOSPITAL	In Lieu of Form CMS-2552-10		
ALLOCATION OF GENERAL SERVICE COSTS TO BASIS) HHA COST CENTERS STATISTICAL	Provider CCN: 14-0032	Peri od: From 07/01/2022	Worksheet H-2 Part II
Briorio		HHA CCN: 14-7661	To 06/30/2023	Date/Time Prepared:

1/24/2024 1:12 pm Home Health PPS Agency I CAPITAL RELATED COSTS MVBLE EQUIP **EMPLOYEE** ReconciliationADMINISTRATIVE MAINTENANCE & Cost Center Description BLDG & FIXT (SQUARE FEET) (DOLLAR VALUE) **BENEFITS** & GENERAL REPAIRS. **DEPARTMENT** (ACCUM. COST) (HOURS OF (GROSS SERVICE) SALARI ES) 5.00 6.00 1.00 2.00 5A 4.00 1.00 Administrative and General 4,902 29.798 989, 214 0 312, 734 206 1.00 0 2.00 Skilled Nursing Care 6, 513, 692 9, 580, 382 2.00 3.00 Physical Therapy 0 0 2, 691, 906 0 3, 971, 885 3.00 Occupational Therapy 0 0 4.00 1, 113, 660 0 1, 643, 200 0 4.00 οĺ 5.00 Speech Pathology 213, 062 314, 365 5.00 6.00 Medical Social Services 0 00000000 0 30, 526 6.00 0 7.00 Home Health Aide 176, 100 259, 859 7.00 0 16, 883 Supplies (see instructions) 0 8.00 8.00 C 0 9.00 Drugs C 0 0 9.00 10.00 10.00 DMF 0 0 0 11.00 Home Dialysis Aide Services 0 0 11.00 0 0 12.00 Respiratory Therapy C 12.00 13.00 Private Duty Nursing 13.00 0 0 0 14.00 Clinic 0 0 14.00 0 0 Health Promotion Activities 15.00 15.00 16.00 Day Care Program 16.00 0 0 17.00 Home Delivered Meals Program 0 0 17.00 0 0 Homemaker Service 18.00 18.00 ol 0 0 0 19.00 All Others (specify) 19.00 19.50 Tel emedi ci ne 0 0 0 0 19.50 Total (sum of lines 1-19) 11, 697, 634 16, 129, 834 20.00 4,902 29, 798 206 20.00 21.00 Total cost to be allocated 79.044 48.659 2. 188. 031 5. 254. 928 6.314 21.00 16. 124847 0. 325789 22.00 Unit cost multiplier 1. 632962 0.187049 30. 650485 22.00 Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG PLANT LINEN SERVICE (SQUARE FEET) (PATIENT DA ADMI NI STRATI ON (FTES) (SQUARE FEET) (POUNDS OF YS) LAUNDRY) (DIRECT NRSING HRS) 8.00 7.00 9.00 10.00 11.00 13.00 1.00 Administrative and General 4, 902 4, 902 13, 683 1. 00 0 2.00 Skilled Nursing Care 0 000000000000000000 0 2.00 C 0 0 o 3 00 Physical Therapy Ω O 3 00 4.00 Occupational Therapy 0 0 0 4.00 5.00 Speech Pathology 0 0 0 5.00 0 6.00 Medical Social Services 0 0 0 0 O 6 00 0 7.00 Home Heal th Aide 0 7.00 8.00 Supplies (see instructions) 0 8.00 Drugs 0 0 9.00 0 0 0 0 0 0 0 0 9.00 0 0 10 00 10.00 DMF Ω Home Dialysis Aide Services 11.00 0 11.00 Respiratory Therapy 0 0 12.00 12.00 13.00 Private Duty Nursing 0 0 0 0 13.00 0 14.00 0 14.00 Clinic 0 15.00 Health Promotion Activities 0 15.00 Day Care Program 16.00 16.00 0 Home Delivered Meals Program 0 0 0 17.00 17.00 0 18.00 Homemaker Service C 18.00 0 19.00 All Others (specify) 0 0 0 19.00 19.50 Tel emedi ci ne 0 0 0 19.50 Total (sum of lines 1-19) 0 0 20.00 20.00 4.902 4.902 13,683

32, 435

6.616687

0.000000

394, 641

28. 841701

21.00

22.00

0.000000

21.00

22.00

Total cost to be allocated

Unit cost multiplier

153, 607

0.000000

31. 335577

Health Financial Systems	ST. ANTHONYS MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO BASIS	HHA COST CENTERS STATISTICAL Provider CCN: 14-0032	Period: Worksheet H-2 From 07/01/2022 Part II
DASI 5	HHA CCN: 14-7661	To 06/30/2023 Date/Time Prepared:

				HHA CCN:	14-7661	10 06/30/2023	1/24/2024 1:12	
						Home Health	PPS	
						Agency I		
	Cost Center Description	CENTRAL	PHARMACY		SOCIAL SERVIC	E		
		SERVICES &	(COSTED	RECORDS &				
		SUPPLY	REQUIS.)	LI BRARY	(PATIENT DA			
		(COSTED		(GROSS CHAR	YS)			
		REQUIS.)		GES)				
	T	14. 00	15. 00	16. 00	17. 00			
1.00	Administrative and General	844, 274	14, 307	21, 420, 006)	0		1.00
2.00	Skilled Nursing Care	0	0	0)	0		2. 00
3.00	Physi cal Therapy	0	0	0)	0		3.00
4.00	Occupational Therapy	0	0	0)	0		4. 00
5.00	Speech Pathology	0	0	0)	0		5. 00
6.00	Medical Social Services	0	0	0		0		6. 00
7.00	Home Health Aide	0	0	0		0		7. 00
8.00	Supplies (see instructions)	0	0	0)	0		8.00
9.00	Drugs	0	0	0)	0		9. 00
10. 00	DME	0	0	0)	0		10. 00
11. 00	Home Dialysis Aide Services	0	0	0)	0		11. 00
12.00	Respiratory Therapy	0	0	0)	0		12. 00
13.00	Private Duty Nursing	0	0	0)	0	'	13. 00
14.00	Clinic	0	0	0)	0		14. 00
15. 00	Health Promotion Activities	0	0	0)	0	'	15. 00
16. 00	Day Care Program	0	0	0)	0	'	16. 00
17. 00	Home Delivered Meals Program	0	0	0)	0		17. 00
18. 00	Homemaker Service	0	0	0		0		18. 00
19.00	All Others (specify)	0	0	0		o	-	19. 00
19. 50	Tel emedi ci ne	0	0	0		0	-	19. 50
20.00	Total (sum of lines 1-19)	844, 274	14, 307	21, 420, 006		0] :	20. 00
21.00	Total cost to be allocated	42, 752	74, 705	152, 682	2	o	:	21. 00
22. 00	Unit cost multiplier	0. 050638	5. 221570	0. 007128	0.00000	O	:	22. 00

	Hoal th	Einancial Systems	ç-	F ANTHONVS MEM	ODIAL HOSDITA		In Lie	of Form CMS 3)552 10
Cost Center Description From, Wast Facility Cost Cost Center Description From, Wast Facility Cost Cost Center Description From, Wast Cost Center Description From, Wast Facility Cost Cost Center Description From, Wast Facility Cost Cost Center Description From, Wast Facility Cost Cost Center Description From, Wast Facility Cost F				I. ANTHONIS WEW					332-10
Cost Center Description	ALTORI	TOWNER OF TATIENT SERVICE 6031	3				From 07/01/2022	Part I Date/Time Prep	
Cost Center Description From. Wisst. Facility Costs Shared Costs (Cols. 1 Col. 28, 1 In Col. 28,					Ti tl	e XVIII			<u> </u>
PART I - COMPUTATION OF LESSER OF AGRECATE PROCRAME COST. ACCRECATE OF THE PROCRAME LIMITATION COST. ON		Cost Center Description	H-2, Part I,	(from Wkst.	Ancillary Costs (from	Costs (cols.	Total Visits	Per Visit (col. 3 ÷ col.	
PART 1 - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST, LIMITATION COST, OR COST, PR. VI SI L'ORDUSTATION COST, PR. VI SI L'ORDUSTATION COST, PR. VI SI L'ORDUSTATION COST, PRINCE AND COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR COST, PRINCE AND COST, PRINC			0	1.00		2.00	4.00		
BINEFICIARY COST_LIMITATION		PART I - COMPUTATION OF LESSER							
1.00 Skilled Nursing Care 2.00 13,471,872 13,471,872 0.5,585,236 2.0,000 2.00 10,000 2.00 10,000 2.00 2.00 10,000 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00			or Acontonie	1100101111 0001, 71	CONEONIE OI I	TIE TROOKIM ET	17111 011 0001, 0	``	
Physical Therapy		-							
0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		1						1	
4.00 Speech Pathology								1	
Medical Social Services									
Nome Heal th Aide									
Cost Center Description Cost Limits CBSA No. (1) Part A Not Subject to Deduct bite is & Coinsurance Cost Limits CBSA No. (1) Part A Not Subject to Deduct bite is & Coinsurance Cost Limits CBSA No. (1) Part A Not Subject to Deduct bite is & Coinsurance CBSA No. (1) CBSA No. (1		4				1		1	
Cost Center Description Cost Limits CBSA No. (1) Part A Not Subject to Deductibles & Cost Computation Cost Limits CBSA No. (1) Part A Not Subject to Deductibles & Cost Computation Cost Cost Cost Cost Cost Cost Cost Cost	7.00	Total (sum of lines 1-6)		22, 218, 158					7. 00
Cost Center Description									
Limitation Cost Computation		Coot Contan Doponintian	Coot limite	CDCA No. (1)	Dont A				
Limitation Cost Computation Skilled Nursing Care 16060 0 106 8.00 8.01 Skilled Nursing Care 16580 0 138 8.01 8.02 Skilled Nursing Care 16580 0 2.430 8.02 8.03 Skilled Nursing Care 19500 0 2.430 8.02 8.03 Skilled Nursing Care 44180 0 5.932 8.03 8.04 Skilled Nursing Care 44180 0 2.707 8.04 Skilled Nursing Care 44180 0 2.707 8.04 Skilled Nursing Care 44180 0 2.707 8.04 Skilled Nursing Care 44100 0 2.707 8.04 Skilled Nursing Care 44100 0 2.707 8.04 Skilled Nursing Care 44100 0 2.707 8.04 Skilled Nursing Care 99914 0 12.925 8.05 Skilled Nursing Care 99914 0 2.925 8.05 Skilled Nursing Care 99914 0 2.915 9.00 9.02 Physical Therapy 16580 0 31 9.01 9.02 9.00 9.01 Physical Therapy 16580 0 31 9.01 9.02 9.02 9.95 2.04 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05		cost center bescription	COST LIMITS	CBSA NO. (1)	Part A				
Section Skilled Nursing Care 16060 0 106 8.00			0	1.00	2. 00			5. 00	
8.01 Skilled Nursing Care 16580 0 138 8.02 8.02 8.03 8.04 8.02 8.03 8.11 ed Nursing Care 41180 0 5,932 8.03 8.04 Skilled Nursing Care 41180 0 2,707 8.04 8.05 Skilled Nursing Care 41180 0 2,707 8.04 8.05 Skilled Nursing Care 49914 0 12,925 8.05 8.05 8.05 Skilled Nursing Care 99914 0 12,925 8.05 9.00 Physical Therapy 16060 0 22 9,00 9.00 9.01 Physical Therapy 16580 0 31 9,01 9.02 9.02 9.03 Physical Therapy 19500 0 1,727 9.02 9.03 Physical Therapy 41180 0 2,915 9.03 9.04 9.05 Physical Therapy 99914 0 5,075 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9			T	144040		ما م	0.1	1	
8.02 Skilled Nursing Care 19500 0 2,430 8.02 8.03 Skilled Nursing Care 41180 0 5,932 8.03 8.04 Skilled Nursing Care 44100 0 2,707 8.04 8.05 Skilled Nursing Care 99914 0 12,925 8.05 9.00 Physical Therapy 16560 0 22 9.00 9.01 Physical Therapy 16580 0 31 9.01 9.02 Physical Therapy 19500 0 1,727 9.02 9.03 Physical Therapy 41180 0 2,915 9.03 9.04 Physical Therapy 44100 0 888 9.04 9.05 Physical Therapy 44100 0 8.88 9.04 9.05 Physical Therapy 41606 0 2 10.00 10.00 Occupati onal Therapy 16580 0 4 10.01 10.02 Occupati onal Therapy 41180 <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td> <td></td> <td></td> <td></td>						1			
8. 03 Skilled Nursing Care 41180 0 5,932 8.03 8. 04 Skilled Nursing Care 99914 0 12,925 8.04 8. 05 Skilled Nursing Care 99914 0 12,925 8.05 9. 00 Physical Therapy 16660 0 22 9.00 9. 01 Physical Therapy 16580 0 31 9.01 9. 02 Physical Therapy 19500 0 1,727 9.02 9. 03 Physical Therapy 41180 0 2,915 9.03 9. 04 Physical Therapy 44100 0 858 9.04 9. 05 Physical Therapy 16660 0 2 10.00 10. 00 Occupati onal Therapy 16660 0 2 10.00 10. 01 Occupati onal Therapy 16580 0 4 10.01 10. 02 Occupati onal Therapy 41180 0 801 10.02 10. 04 Occupati onal Therapy									
8. 04 Skilled Nursing Care 44100 0 2,707 8. 04 8.05 Skilled Nursing Care 99914 0 12,925 8.05 9.00 Physical Therapy 16660 0 22 9.00 9.01 Physical Therapy 16580 0 31 9.01 9.02 Physical Therapy 19500 0 1,727 9.02 9.03 Physical Therapy 41180 0 2,915 9.03 9.04 Physical Therapy 44100 0 858 9.04 9.05 Physical Therapy 44100 0 858 9.05 10.00 0ccupati onal Therapy 16660 0 2 10.00 10.01 0ccupati onal Therapy 16580 0 4 10.01 10.02 0ccupati onal Therapy 41180 0 801 10.02 10.03 0ccupati onal Therapy 41180 0 801 10.03 10.04 0ccupati onal Therapy									
9.00 Physical Therapy 16580 0 31 9.01 9.01 Physical Therapy 16580 0 31 9.01 9.02 Physical Therapy 19500 0 1,727 9.02 9.03 Physical Therapy 41180 0 2,915 9.03 9.04 Physical Therapy 44100 0 888 9.04 9.05 Physical Therapy 99914 0 5,075 9.05 10.00 Occupational Therapy 16680 0 2 10.00 10.01 Occupational Therapy 16580 0 4 10.01 10.02 Occupational Therapy 19500 0 633 10.02 10.03 Occupational Therapy 41180 0 801 10.03 10.04 Occupational Therapy 44100 0 571 10.04 10.05 Occupational Therapy 99914 0 16580 1 10.02 10.05 Occupational Therapy 19600 0 571 10.04 10.05 Occupational Therapy 19914 0 1,690 10.05 11.00 Speech Pathol ogy 16580 0 0 11.00 11.01 Speech Pathol ogy 16580 0 0 11.00 11.01 Speech Pathol ogy 16580 0 0 11.01 11.02 Speech Pathol ogy 17500 0 85 11.02 11.03 Speech Pathol ogy 17500 0 85 11.02 11.03 Speech Pathol ogy 17500 0 85 11.02 11.04 Speech Pathol ogy 17500 0 85 11.02 11.05 Speech Pathol ogy 17500 0 90 11.04 11.05 Speech Pathol ogy 17500 0 90 11.04 11.05 Speech Pathol ogy 17500 0 9914 0 202 11.05 11.01 Occupational Therapy 19914 0 202 11.05 11.02 Speech Pathol ogy 17500 0 90 11.04 11.05 Speech Pathol ogy 17500 0 90 11.04 11.05 Speech Pathol ogy 17500 0 90 11.04 11.06 Speech Pathol ogy 17500 0 90 11.04 11.07 Speech Pathol ogy 17500 0 90 11.04 11.08 Speech Pathol ogy 17500 0 90 11.04 11.09 Speech Pathol ogy 17500 0 90 11.04 11.00 Medi cal Soci al Services 16060 0 0 12.01 12.01 Medi cal Soci al Services 15000 0 39 12.02 12.02 Medi cal Soci al Services 19500 0 39 12.02 12.03 Medi cal Soci al Services 19500 0 39 12.02 12.04 Medi cal Soci al Services 19500 0 187 12.02 13.04 Home Heal th Ai de 1600 0 19 13.00 13.01 Home Heal th Ai de 19500 0 187 13.01 13.03 Home Heal th Ai de 44100 0 312 13.04 13.04 Home Heal th Ai de 44100 0 312 13.05				44100					8. 04
9.01 Physical Therapy 16580 0 31 9.01 Physical Therapy 19500 0 1,727 9.02 9.03 Physical Therapy 41180 0 2,915 9.03 9.04 Physical Therapy 44100 0 858 9.04 9.05 Physical Therapy 99914 0 5,075 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.05 9.0						1			
9. 02 Physical Therapy						~			
9. 03 Physical Therapy									
9. 04 Physical Therapy 99914 0 5,075 9,05 9,05 10,00 Occupational Therapy 16606 0 2 10.00 Occupational Therapy 16580 0 4 10.01 Occupational Therapy 1990 19500 0 633 10.01 Occupational Therapy 19500 0 633 10.02 Occupational Therapy 19500 0 633 10.02 10.03 Occupational Therapy 19500 0 633 10.02 10.04 Occupational Therapy 19914 0 5,071 10.03 10.04 Occupational Therapy 19914 0 1,690 10.05 Occupational Therapy 19914 0 1,690 10.05 Occupational Therapy 19914 0 1,690 11.00 Speech Pathol ogy 16580 0 0 1 1 11.00 11.00 Speech Pathol ogy 16580 0 0 0 11.01 Speech Pathol ogy 199500 0 85 11.02 Speech Pathol ogy 199500 0 85 11.02 Speech Pathol ogy 199914 0 311 0 3 Speech Pathol ogy 11.05 Speech Pathol ogy 11.									
9.05 Physical Therapy 99914 0 5,075 9.05 10.00 Occupational Therapy 16680 0 2 10.00 10.01 Occupational Therapy 16580 0 4 10.01 10.02 Occupational Therapy 19500 0 633 10.02 10.03 Occupational Therapy 41180 0 801 10.03 10.04 Occupational Therapy 44100 0 5771 10.04 10.05 Occupational Therapy 99914 0 1,690 10.05 11.00 Speech Pathol ogy 16680 0 1 1 11.00 11.01 Speech Pathol ogy 16580 0 0 11.01 11.02 Speech Pathol ogy 19500 0 85 11.02 11.03 Speech Pathol ogy 19500 0 85 11.02 11.04 Speech Pathol ogy 41180 0 311 11.03 11.05 Speech Pathol ogy 41180 0 311 11.03 11.05 Speech Pathol ogy 99914 0 202 11.05 12.00 Medi cal Soci al Servi ces 16680 0 0 0 12.01 12.01 Medi cal Soci al Servi ces 16680 0 0 0 12.01 12.02 Medi cal Soci al Servi ces 16680 0 0 0 12.01 12.03 Medi cal Soci al Servi ces 19500 0 39 12.02 12.04 Medi cal Soci al Servi ces 41180 0 27 12.03 12.05 Medi cal Soci al Servi ces 99914 0 61 12.05 13.00 Home Heal th Ai de 16680 0 6 13.01 13.02 Home Heal th Ai de 41180 0 594 13.03 13.03 Home Heal th Ai de 41180 0 594 13.04 13.05 Home Heal th Ai de 99914 0 2.082 13.05									
10. 01 Occupati onal Therapy 16580 0 4 10. 01 10. 02 Occupati onal Therapy 19500 0 633 10. 02 10. 03 Occupati onal Therapy 41180 0 801 10. 03 10. 04 Occupati onal Therapy 44100 0 571 10. 04 10. 05 Occupati onal Therapy 99914 0 1,690 10. 05 11. 00 Speech Pathol ogy 16600 0 1 11. 00 11. 01 Speech Pathol ogy 16580 0 0 0 11. 01 11. 02 Speech Pathol ogy 19500 0 85 11. 02 11. 03 Speech Pathol ogy 41180 0 311 11. 03 11. 04 Speech Pathol ogy 44100 0 90 11. 04 11. 05 Speech Pathol ogy 99914 0 202 11. 04 12. 00 Medi cal Social Services 16060 0 0 12. 01 12. 01 Medi cal Social Services 19500 0 39 12. 02 12. 02 Medi cal Social Services 19500 0 37 12. 04 12. 05 Medi cal Social Services 41180 </td <td>9. 05</td> <td></td> <td></td> <td>99914</td> <td></td> <td></td> <td></td> <td></td> <td>9. 05</td>	9. 05			99914					9. 05
10. 02 Occupati onal Therapy 19500 0 633 10. 02 10. 03 Occupati onal Therapy 41180 0 801 10. 03 10. 04 Occupati onal Therapy 44100 0 571 10. 04 10. 05 Occupati onal Therapy 99914 0 1, 690 10. 05 11. 00 Speech Pathol ogy 16660 0 1 11. 00 11. 02 Speech Pathol ogy 16580 0 0 11. 01 11. 02 Speech Pathol ogy 19500 0 85 11. 02 11. 03 Speech Pathol ogy 41180 0 311 11. 03 11. 04 Speech Pathol ogy 44100 0 90 11. 04 12. 00 Medi cal Social Servi ces 16060 0 0 0 12. 00 12. 01 Medi cal Social Servi ces 16580 0 0 0 12. 01 12. 02 Medi cal Social Servi ces 19500 0 39 12. 02 12. 03 Medi cal Social Servi ces 41180 0 27						0			10.00
10. 03 Occupati onal Therapy 41180 0 801 10. 03 10. 04 Occupati onal Therapy 44100 0 571 10. 04 10. 05 Occupati onal Therapy 99914 0 1,690 10. 05 11. 00 Speech Pathol ogy 16060 0 1 11. 00 11. 01 Speech Pathol ogy 16580 0 0 11. 01 11. 02 Speech Pathol ogy 19500 0 85 11. 02 11. 03 Speech Pathol ogy 41180 0 311 11. 03 11. 04 Speech Pathol ogy 44100 0 90 11. 04 11. 05 Speech Pathol ogy 44100 0 90 11. 04 12. 00 Medi cal Social Services 16580 0 0 0 12. 00 12. 01 Medi cal Social Services 16580 0 0 39 12. 02 12. 03 Medi cal Social Services 41180 0 27 12. 03 12. 04 Medi cal Social Services 44100 0 61 12.						~			
10. 04 Occupati onal Therapy 44100 0 571 10. 04 10. 05 Occupati onal Therapy 99914 0 1,690 10. 05 11. 00 Speech Pathol ogy 16060 0 1 11. 00 11. 01 Speech Pathol ogy 16580 0 0 11. 01 11. 02 Speech Pathol ogy 19500 0 85 11. 02 11. 03 Speech Pathol ogy 41180 0 311 11. 03 11. 04 Speech Pathol ogy 44100 0 90 11. 04 11. 05 Speech Pathol ogy 44100 0 202 11. 03 12. 00 Medi cal Soci al Servi ces 16060 0 0 0 12. 00 12. 01 Medi cal Soci al Servi ces 16580 0 0 0 12. 01 12. 02 Medi cal Soci al Servi ces 41180 0 27 12. 03 12. 04 Medi cal Soci al Servi ces 44100 0 37 12. 04 12. 05 Medi cal Soci al Servi ces 44100 0 37									
10. 05 Occupati onal Therapy 99914 0 1, 690 10. 05 11. 00 Speech Pathol ogy 16060 0 1 11. 00 11. 01 Speech Pathol ogy 16580 0 0 11. 01 11. 02 Speech Pathol ogy 19500 0 85 11. 02 11. 03 Speech Pathol ogy 41180 0 311 11. 03 11. 04 Speech Pathol ogy 44100 0 90 11. 04 11. 05 Speech Pathol ogy 44100 0 90 11. 04 11. 05 Speech Pathol ogy 99914 0 202 11. 05 12. 00 Medi cal Soci al Services 16580 0 0 0 12. 00 12. 01 Medi cal Soci al Services 19500 0 39 12. 02 12. 02 12. 03 Medi cal Soci al Services 41180 0 27 12. 03 12. 04 12. 04 12. 04 12. 04 12. 04 12. 04 12. 04 12. 04 12. 04 12. 04 12. 04 12. 04 12. 04 12. 04									
11. 00 Speech Pathol ogy 16060 0 1 11. 00 11. 01 Speech Pathol ogy 16580 0 0 11. 01 11. 02 Speech Pathol ogy 19500 0 85 11. 02 11. 03 Speech Pathol ogy 41180 0 311 11. 03 11. 04 Speech Pathol ogy 44100 0 90 11. 04 11. 05 Speech Pathol ogy 99914 0 202 11. 05 12. 00 Medi cal Soci al Servi ces 16060 0 0 0 12. 01 12. 01 Medi cal Soci al Servi ces 16580 0 0 0 12. 01 12. 02 Medi cal Soci al Servi ces 19500 0 39 12. 02 12. 03 Medi cal Soci al Servi ces 41180 0 27 12. 03 12. 04 Medi cal Soci al Servi ces 44100 0 37 12. 04 13. 00 Home Heal th Ai de 16060 0 19 13. 00 13. 01 Home Heal th Ai de 16060 0 187									
11. 02 Speech Pathol ogy 19500 0 85 11. 02 11. 03 Speech Pathol ogy 41180 0 311 11. 03 11. 04 Speech Pathol ogy 44100 0 90 11. 03 11. 05 Speech Pathol ogy 99914 0 202 11. 05 12. 00 Medi cal Soci al Servi ces 16060 0 0 12. 00 12. 01 Medi cal Soci al Servi ces 16580 0 0 12. 01 12. 02 Medi cal Soci al Servi ces 19500 0 39 12. 02 12. 03 Medi cal Soci al Servi ces 41180 0 27 12. 03 12. 04 Medi cal Soci al Servi ces 44100 0 37 12. 04 12. 05 Medi cal Soci al Servi ces 99914 0 61 12. 05 13. 00 Home Heal th Ai de 16060 0 19 13. 00 13. 01 Home Heal th Ai de 16580 0 6 13. 01 13. 02 Home Heal th Ai de 19500 0 187 13. 03 13. 04 Home Heal th Ai de 41180 0 594 13. 03 13. 05 Home Heal th Ai de 44100									
11. 03 Speech Pathology 41180 0 311 11. 03 11. 04 Speech Pathology 44100 0 90 11. 04 11. 05 Speech Pathology 99914 0 202 11. 05 12. 00 Medi cal Social Services 16060 0 0 0 12. 00 12. 01 Medi cal Social Services 16580 0 0 0 12. 01 12. 02 Medi cal Social Services 19500 0 39 12. 02 12. 03 Medi cal Social Services 41180 0 27 12. 03 12. 04 Medi cal Social Services 44100 0 37 12. 04 12. 05 Medi cal Social Services 99914 0 61 12. 05 13. 00 Home Heal th Ai de 16060 0 19 13. 00 13. 01 Home Heal th Ai de 19500 0 187 13. 03 13. 04 Home Heal th Ai de 41180 0 594 13. 03 13. 05 Home Heal th Ai de 44100 0 312	11. 01	Speech Pathology		16580		0			11. 01
11. 04 Speech Pathology 44100 0 90 11. 05 Speech Pathology 99914 0 202 12. 00 Medi cal Soci al Servi ces 16060 0 0 12. 01 Medi cal Soci al Servi ces 16580 0 0 12. 02 Medi cal Soci al Servi ces 19500 0 39 12. 03 Medi cal Soci al Servi ces 41180 0 27 12. 04 Medi cal Soci al Servi ces 44100 0 37 12. 04 12. 05 Medi cal Soci al Servi ces 99914 0 61 12. 05 13. 00 Home Heal th Ai de 16060 0 19 13. 00 13. 01 Home Heal th Ai de 16580 0 6 13. 01 13. 02 Home Heal th Ai de 41180 0 594 13. 03 13. 04 Home Heal th Ai de 44100 0 312 13. 04 13. 05 Home Heal th Ai de 99914 0 2, 082 13. 05									
11. 05 Speech Pathology 99914 0 202 11. 05 12. 00 Medi cal Soci al Servi ces 16060 0 0 12. 00 12. 01 Medi cal Soci al Servi ces 16580 0 0 12. 01 12. 02 Medi cal Soci al Servi ces 19500 0 39 12. 02 12. 03 Medi cal Soci al Servi ces 41180 0 27 12. 02 12. 04 Medi cal Soci al Servi ces 44100 0 37 12. 04 12. 05 Medi cal Soci al Servi ces 99914 0 61 12. 05 13. 00 Home Heal th Ai de 16060 0 19 13. 00 13. 01 Home Heal th Ai de 16580 0 6 13. 01 13. 02 Home Heal th Ai de 41180 0 594 13. 03 13. 04 Home Heal th Ai de 44100 0 312 13. 04 13. 05 Home Heal th Ai de 99914 0 2, 082 13. 05		,		1		- 1			
12.00 Medical Social Services 16060 0 0 0 12.01 Medical Social Services 16580 0 0 0 12.02 Medical Social Services 19500 0 39 12.02 12.03 Medical Social Services 41180 0 27 12.03 12.04 Medical Social Services 44100 0 37 12.04 12.05 Medical Social Services 99914 0 61 12.05 13.00 Home Heal th Ai de 16060 0 19 13.00 13.01 Home Heal th Ai de 16580 0 6 13.01 13.02 Home Heal th Ai de 19500 0 187 13.02 13.03 Home Heal th Ai de 41180 0 594 13.03 13.04 Home Heal th Ai de 44100 0 312 13.04 13.05 Home Heal th Ai de 99914 0 2,082 13.05									
12.01 Medical Social Services 16580 0 0 39 12.01 12.02 Medical Social Services 19500 0 39 12.02 12.03 Medical Social Services 41180 0 27 12.03 12.04 Medical Social Services 44100 0 37 12.04 12.05 Medical Social Services 99914 0 61 12.05 13.00 Home Heal th Ai de 16060 0 19 13.00 13.01 Home Heal th Ai de 16580 0 6 13.01 13.02 Home Heal th Ai de 19500 0 187 13.02 13.03 Home Heal th Ai de 41180 0 594 13.03 13.04 Home Heal th Ai de 44100 0 312 13.04 13.05 Home Heal th Ai de 99914 0 2,082 13.05		1 93		1		•			
12. 02 Medi cal Soci al Servi ces 19500 0 39 12. 02 12. 03 Medi cal Soci al Servi ces 41180 0 27 12. 03 12. 04 Medi cal Soci al Servi ces 44100 0 37 12. 04 12. 05 Medi cal Soci al Servi ces 44100 0 61 12. 05 13. 00 Home Heal th Ai de 16060 0 19 13. 00 13. 01 Home Heal th Ai de 16580 0 6 13. 00 13. 02 Home Heal th Ai de 19500 0 187 13. 02 13. 03 Home Heal th Ai de 41180 0 594 13. 03 13. 04 Home Heal th Ai de 44100 0 312 13. 04 13. 05 Home Heal th Ai de 99914 0 2, 082 13. 05		1				- 1			
12. 04 Medical Social Services 44100 0 37 12. 04 12. 05 Medical Social Services 99914 0 61 12. 05 13. 00 Home Heal th Aide 16060 0 19 13. 00 13. 01 Home Heal th Aide 16580 0 6 13. 01 13. 02 Home Heal th Aide 19500 0 187 13. 03 13. 03 Home Heal th Aide 41180 0 594 13. 03 13. 04 Home Heal th Aide 44100 0 312 13. 04 13. 05 Home Heal th Aide 99914 0 2, 082 13. 05	12. 02	Medical Social Services		19500		0			12.02
12.05 Medical Social Services 99914 0 61 12.05 13.00 Home Heal th Ai de 16060 0 19 13.00 13.01 Home Heal th Ai de 16580 0 6 13.01 13.02 Home Heal th Ai de 19500 0 187 13.02 13.03 Home Heal th Ai de 41180 0 594 13.03 13.04 Home Heal th Ai de 44100 0 312 13.04 13.05 Home Heal th Ai de 99914 0 2,082 13.05		1				-1			
13. 00 Home Heal th Ai de 16060 0 19 13. 00 13. 01 Home Heal th Ai de 16580 0 6 13. 01 13. 02 Home Heal th Ai de 19500 0 187 13. 02 13. 03 Home Heal th Ai de 41180 0 594 13. 03 13. 04 Home Heal th Ai de 44100 0 312 13. 04 13. 05 Home Heal th Ai de 99914 0 2, 082 13. 05		1				- 1			
13. 01 Home Heal th Ai de 16580 0 6 13. 02 Home Heal th Ai de 19500 0 187 13. 02 13. 03 Home Heal th Ai de 41180 0 594 13. 04 Home Heal th Ai de 44100 0 312 13. 05 Home Heal th Ai de 99914 0 2,082		1				-			
13. 02 Home Heal th Ai de 19500 0 187 13. 03 Home Heal th Ai de 41180 0 594 13. 04 Home Heal th Ai de 44100 0 312 13. 05 Home Heal th Ai de 99914 0 2,082 13.05		l .				-1			
13. 03 Home Heal th Ai de 41180 0 594 13. 03 13. 04 Home Heal th Ai de 44100 0 312 13. 04 13. 05 Home Heal th Ai de 99914 0 2, 082 13. 05		1				-1			
13. 04 Home Heal th Ai de 44100 0 312 13. 04 13. 05 Home Heal th Ai de 99914 0 2, 082 13. 05									
14.00 Total (sum of lines 8-13) 0 42,620 14.00				99914					
	14. 00	lotal (sum of lines 8-13)	I			0 42, 6	20	1 1	14. 00

	Financial Systems		T. ANTHONYS MEM				eu of Form CMS-2	
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provider C	CN: 14-0032	Peri od: From 07/01/2022	Worksheet H-3 Part I	
				HHA CCN:	14-7661	To 06/30/2023		pared:
				Ti tl e	e XVIII	Home Health	PPS	Ζ μιιι
	Cost Center Description	From Wkst. H-2	Facility Costs	Shared	Total HHA	Agency I Total Charges	Ratio (col. 3	
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols. + 2)		÷ col. 4)	
		0	1.00	Part II) 2.00	3.00	4. 00	5. 00	
45.00	Supplies and Drugs Cost Comput		00.740			40 044 40:	2 0 440005	45.00
15. 00 16. 00	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00		C	•	40 211, 40 ⁻	l .	
			Program Visits		Cost of Services			
	Cost Center Description	Part A	Not Subject to		Part A	Part B Not Subject to	Subject to	
	cost center bescription	rait A	Deductibles & Coinsurance		raitA	Deductibles &		
		6. 00	7.00	8. 00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE I	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIN	MITATION COST, C	PR	
1.00	Skilled Nursing Care	С	24, 238			0 4, 915, 709	9	1.00
2.00	Physical Therapy	C				0 2, 817, 802		2.00
3. 00 4. 00	Occupational Therapy Speech Pathology		3, 701 689			0 1, 121, 69° 0 178, 11	l .	3. 00 4. 00
5.00	Medical Social Services	Č	164			0 11, 48:		5. 00
6.00	Home Heal th Ai de	C	3, 200			0 214, 752		6. 00
7. 00	Total (sum of lines 1-6) Cost Center Description	С	42, 620			0 9, 259, 558	3	7.00
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
0.00	Limitation Cost Computation	Г	1		1			
8. 00 8. 01	Skilled Nursing Care Skilled Nursing Care							8. 00 8. 01
8. 02	Skilled Nursing Care							8. 02
8. 03	Skilled Nursing Care							8. 03
8. 04 8. 05	Skilled Nursing Care Skilled Nursing Care							8. 04 8. 05
9. 00	Physical Therapy							9. 00
9. 01	Physical Therapy							9. 01
9. 02 9. 03	Physical Therapy							9. 02 9. 03
9.03	Physical Therapy Physical Therapy							9.03
9. 05	Physical Therapy							9. 05
10.00	Occupational Therapy							10.00
10. 01 10. 02	Occupational Therapy Occupational Therapy							10. 01 10. 02
10. 02								10. 03
10. 04	Occupational Therapy							10. 04
10.05								10.05
11. 00 11. 01	Speech Pathology Speech Pathology							11. 00
11. 02								11. 02
11. 03	1 33							11. 03
11. 04								11. 04 11. 0!
11. 05 12. 00								12. 00
12.01	Medical Social Services							12. 0
12. 02	1							12. 02
12. 03 12. 04	Medical Social Services Medical Social Services							12. 03 12. 04
12. 04	Medical Social Services							12. 02
13.00	Home Health Aide							13.00
13. 01	Home Health Aide							13. 01
13. 02 13. 03	Home Health Aide Home Health Aide							13. 02 13. 03
13. 03	•							13. 04
	Home Heal th Ai de		1					13. 05
	Total (sum of lines 8-13)							14.00

Heal th	Financial Systems	S	Γ. ANTHONYS MEMOF	RIAL HOSPITAL			In Lie	u of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COST			Provider CO			i od:	Worksheet H-3	
				HHA CCN:	14-7661	To	m 07/01/2022 06/30/2023	Part I Date/Time Pre 1/24/2024 1:1	pared: 2 pm
				Title	XVIII	Н	ome Health Agency I	PPS	
		Prog	ram Covered Char	ges	Cost of Services		Agency 1		
			Part	В			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & D	Subject to	Part A	De	t Subject to eductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00		10. 00	11. 00	
15. 00 16. 00	Supplies and Drugs Cost Computa Cost of Medical Supplies Cost of Drugs	ations C	211, 407	0		0	23, 740	0	•
	Cost Center Description	Total Program Cost (sum of cols. 9-10)					5		
	PART I - COMPUTATION OF LESSER	12.00	 PROGRAM COST AGO	SREGATE OF TH	F PROGRAM II	MITA	TION COST OR)	
	BENEFICIARY COST LIMITATION	S. AGGREGATE I			L INCONTRI LI	WI IA			
1. 00	Cost Per Visit Computation Skilled Nursing Care	4, 915, 709							1.00
2. 00	Physical Therapy	2, 817, 802							2.00
3.00	Occupational Therapy	1, 121, 699							3.00
4. 00 5. 00	Speech Pathology Medical Social Services	178, 113 11, 483							4. 00 5. 00
6.00	Home Heal th Aide	214, 752							6.00
7. 00	Total (sum of lines 1-6)	9, 259, 558							7. 00
	Cost Center Description	12. 00							
	Limitation Cost Computation						'		
8.00	Skilled Nursing Care								8. 00 8. 01
8. 01 8. 02	Skilled Nursing Care Skilled Nursing Care								8. 02
8. 03	Skilled Nursing Care								8. 03
8. 04 8. 05	Skilled Nursing Care Skilled Nursing Care								8. 04 8. 05
9. 00	Physical Therapy								9.00
9. 01	Physi cal Therapy								9. 01
9. 02	Physical Therapy								9. 02
9. 03 9. 04	Physical Therapy Physical Therapy								9. 03 9. 04
9. 05	Physi cal Therapy								9. 05
10.00	Occupational Therapy								10.00
10. 01 10. 02	Occupational Therapy Occupational Therapy								10. 01 10. 02
10. 03	Occupational Therapy								10. 03
10.04	Occupational Therapy								10.04
10. 05 11. 00	Occupational Therapy Speech Pathology								10. 05 11. 00
11. 01	Speech Pathology								11. 01
11. 02	Speech Pathology								11. 02
11. 03 11. 04	Speech Pathology Speech Pathology								11. 03 11. 04
11. 05	Speech Pathology								11. 04
12. 00	Medical Social Services								12.00
12. 01 12. 02	Medical Social Services Medical Social Services								12. 01 12. 02
12. 02	Medical Social Services								12. 02
12. 04	Medical Social Services								12. 04
12. 05 13. 00	Medical Social Services Home Health Aide								12. 05 13. 00
13. 00	Home Heal th Aide								13.00
13. 02	Home Health Aide								13. 02
13. 03	Home Health Aide Home Health Aide								13. 03
12 04		I .	I .						13.04
13. 04 13. 05	1								13. 05

Heal th	Financial Systems	. ANTHONYS MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
APPOR1	TIONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 14-0032	Peri od:	Worksheet H-3	
				HHA CCN:	14-7661	From 07/01/2022 To 06/30/2023	Part II Date/Time Pre 1/24/2024 1:1:	
						Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2. 00	3.00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physi cal Therapy	66. 00	0. 312038	0)	0 col. 2, line 2	. 00	1. 00
2.00	Occupati onal Therapy	67. 00	0. 150469	0		0 col. 2, line 3	. 00	2. 00
3.00	Speech Pathology	68. 00	0. 390277	0		Ocol. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71. 00	1. 261290	0		0 col. 2, line 1	5. 00	4. 00
5. 00	Cost of Drugs	73. 00	0. 150120	0		0 col. 2, line 1	6. 00	5. 00

	Financial Systems ST. ANTHONYS MEMORI ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der Co			ri od:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	14-7661		om 07/01/2022	Part I-II Date/Time Pre 1/24/2024 1:13	par
		Title	XVIII		Home Health Agency I	PPS	<u> </u>
		'	D A	N	Par	t B	
			Part A		ot Subject to Deductibles &	Deductibles &	
			1.00		Coi nsurance 2. 00	Coi nsurance 3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	DMARY CHARGE			2. 00	0.00	
^	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)		I	0	0	0	
0	Total charges			0	9, 323, 115	0	
	Customary Charges						
0	Amount actually collected from patients liable for payment for on a charge basis (from your records)	r servi ces		0	0	0	
0	Amount that would have been realized from patients liable for	pavment		0	0	0	
	for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)						
0	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000		0. 000000	0. 000000	
0 0	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost	(complete		0	9, 323, 115 9, 323, 115	0	
U	only if line 6 exceeds line 1)	(comprete		U	9, 323, 113	U	
0	Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	yifline		0	0	0	
0	Primary payer amounts			0	1, 214	0	
					Part A Services	Part B Servi ces	
					1. 00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				-1		
00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				0	-1, 214 6, 766, 982	
00	Total PPS Reimbursement - Full Episodes with Outliers				o	1, 322, 939	
00	Total PPS Reimbursement - LUPA Episodes				0	125, 607	
00	Total PPS Reimbursement - PEP Episodes				0	45, 912	
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes				0	407, 380 3, 776	
00	Total Other Payments				0	3, 770	1
00	DME Payments				0	0	1
00	Oxygen Payments				0	0	1
00	Prosthetic and Orthotic Payments				0	0	2
00	Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21)	ur ance)			0	0 8, 671, 382	2
00	Excess reasonable cost (from line 8)				Ö	0	2
00	Subtotal (line 22 minus line 23)				0	8, 671, 382	2
00	Coinsurance billed to program patients (from your records)					0	2
00	Net cost (line 24 minus line 25) Allowable bad debts (from your records)				0	8, 671, 382 0	2
	Adjusted reimbursable bad debts (see instructions)					0	
00	Allowable bad debts for dual eligible (see instructions)					0	
00	Total costs - current cost reporting period (see instructions))			0	8, 671, 382	2
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`			0	0	
50	Prioneer ACO demonstration payment adjustment (see instructions	5)			0	0	
99 00	Demonstration payment adjustment amount before sequestration Subtotal (see instructions)				0	0 8, 671, 382	3
01	Sequestration adjustment (see instructions)				ő	173, 425	
02	Demonstration payment adjustment amount after sequestration				o	0	3
75	Sequestration adjustment for non-claims based amounts (see in	structions)			0	0	3
00	Interim payments (see instructions)				0	8, 497, 957	3:
00	Tentative settlement (for contractor use only)	7 21 75 22	and 22)		0	0	3
00	Balance due provider/program (line 31 minus lines 31.01, 31.0). Protested amounts (nonallowable cost report items) in accordance.				O O		
00	Protested amounts (nonallowable cost report items) in accordanchapter 1, §115.2	nce with CMS	Pub. 15-2,		0		0

ST. ANTHONYS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems ST. ANTHONYS MEMO ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Provider CCN: 14-0032 Peri od: From 07/01/2022 To 06/30/2023 Worksheet H-5 14-7661 Date/Time Prepared: 1/24/2024 1:12 pm HHA CCN:

				Home Health Agency I	PPS	<u> piii</u>
		Inpatien	t Part A		t 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 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	8, 497, 957 0	1. 00 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) Program to Provider					3. 00
3. 01				0	0	3. 01
3.02				0	0	3.02
3.03				0	0	3. 03
3. 04				0	0	3. 04
3. 05				0	0	3. 05
3. 50	Provider to Program			0	1 0	3. 50
3. 51				0		3. 50
3. 52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)				0 407 057	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	8, 497, 957	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01				0	0	5. 01
5. 02 5. 03				0	0	5. 02 5. 03
5.03	Provider to Program			U	0	5. 05
5. 50	Trovider to Frogram			0	0	5. 50
5. 51				O	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0	0	6. 01 6. 02
6. 02 7. 00	Total Medicare program liability (see instructions)			0	8, 497, 957	6. 02 7. 00
7.00	Total mearcure program trabitity (see instructions)			Contractor Number	NPR Date (Mo/Day/Yr)	7.00
		()	1. 00	2.00	
8. 00	Name of Contractor				Π	8. 00

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS Provider CCN: 14-0032 Peri od: From 07/01/2022 To 06/30/2023 Worksheet 0 Date/Time Prepared: 1/24/2024 1:12 pm Hospi ce CCN: 14-1658

SALARIES							1/24/2024 1.1	z piii
					1			
CAP RRI COSTS-BLOG & FIXT*			SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
CENERAL SERVICE COST CENTERS					1 plus col. 2)	CATI ONS		
1.00 CAP REL COSTS-BLOG & FIXT			1.00	2.00	3.00	4. 00	5. 00	
1.00 CAP REL COSTS-BLOG & FIXT		GENERAL SERVICE COST CENTERS						
2.00 CAP REL COSTS-AWBLE EQUIP" 3.00 EMPLOYEE EMERITS DEPARTMENT" 4.00 AMM IN STRATIVE & GENERAL" 5.00 PLANT OPERATION TO 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00			0		0	Ō	1 00
BIMPLOYEE BERRETI'S DEPARTIMENT*				451 410	451 410	0		
ADMINISTRATIVE & GENERAL* 1,393,801 173,100 1,507,011 0 0 34,959 0 34,959 0 34,959 0 34,959 0 34,959 0 34,959 0 0 0 0 0 0 0 0 0		·		031,010	051,010	0		
DESCRIPTION & MAINTENANCE* 0 34,959 0 34,959 0 0 0 0 0 0 0 0 0			0	U	y o	0		
AURINDRY & LINEN SERVICE*	4. 00		1, 393, 861	173, 150	1, 567, 011	0	1, 567, 011	4. 00
7.00 MOUSEKEPING" 0 0 0 0 0 0 0 0 0	5.00	PLANT OPERATION & MAINTENANCE*	0	34, 959	34, 959	0	34, 959	5. 00
B.00 DIETARY* 0 B15 B15 0 B15 B.00 0 0 0 0 0 0 0 0 0	6.00	LAUNDRY & LINEN SERVICE*	0	0	ol	0	0	6. 00
B.00 DIETARY* 0 B15 B15 0 B15 B.00 0 0 0 0 0 0 0 0 0	7 00	HOUSEKEEPI NG*	ام	0		0	0	7 00
9,00 NURSI NA ADMINISTRATION* 0 0 0 0 0 9,00 11.00 ROUTINE MEDICAL SUPPLIES* 0 127,534 127,534 127,534 10.00 11.00 MEDICAL RECORDS* 0 0 0 0 0 0 0 11.00 13.00 MEDICAL RECORDS* 0 0 0 0 0 0 0 11.00 13.00 VOLUNTEER SERVICE COORDINATION* 0 0 0 0 0 0 0 13.00 15.00 PHYSICI AN ADMINISTRATIVE SERVICES* 0 0 0 0 0 0 0 0 0			ام	815	815	0		
10. 00 ROUTH N. MEDICAL SUPPLIES" 0 127, 534 127, 534 -127, 534 0. 10. 00 10. 00 11. 00 12. 00 0 0 0 0 0 0 12. 00 12. 00 13. 00 13. 00 0 0 0 0 0 0 0 0 0				010	013	0		
11.00 MEDICAL RECORDS* 0 0 0 0 0 0 11.00 12.00 STAFF TRANSPORTATION* 0 0 0 0 0 0 12.00 13.00 VOLUNTEER SERVIC CCOORDINATION* 0 0 499,368 499,368 -499,368 0.14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES* 0 0 0 0 0 0 0 0 17.00 PHYSICIAN ADMINISTRATIVE SERVICES* 0 0 0 0 0 0 0 0 17.00 PHYSICIAN ADMINISTRATIVE SERVICES* 0 0 0 0 0 0 0 0 18.00 OPERATOR OF A SERVICES 0 0 0 0 0 0 0 0 0 19.00 PATIENT/RESIDENTIAL CARE SERVICES 0 135,656 135,656 135,656 135,656 20,000 19.00 PATIENT/RESIDENTIAL CARE SERVICES* 0 135,656 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 135,656 0 0 0 0 0 0 0 0 0			0	407.504	107.50	407.504		
12.00 STARF TRANSPORTATION* 0 0 0 0 0 12.00 13.00 VOLUNTEER SERVICE COORDINATION* 0 499, 368 499, 368 -499, 368 0 14.00 15.00 PHARMACY* 0 499, 368 499, 368 -499, 368 0 16.00 15.00 PHASINGO* 0 0 0 0 0 0 0 15.00 PHASINGO* 0 0 0 0 0 0 0 16.00 OTHER GENERAL SERVICE* 0 0 0 0 0 0 0 16.00 OTHER GENERAL SERVICE* 0 0 0 0 0 0 0 16.00 OTHER GENERAL SERVICES* 17.00 17.00 PATHEMET CARE SERVICE COST CENTERS 1 15.24, 733 1,524, 733 0 1,524, 733 25.00 17.00 PHASICIAN SERVICES** 0 135, 566 135, 566 0 135, 566 20.00 17.00 PHASICIAN SERVICES** 0 135, 566 135, 566 0 135, 566 20.00 17.00 PHASICIAN SERVICES** 0 0 0 0 0 0 0 0 0			0	127, 534	127, 534	-127, 534	_	
13. 00 VOLUNTEER SERVICE COORDINATION* 0 0 0 0 11. 00	11. 00	MEDI CAL RECORDS*	0	0	0	0	0	11. 00
14. 00 PHAMMACY* 0 499, 368 -499, 368 -499, 368 0 14. 00	12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
14. 00 PHARMACY* 0 499, 368 499, 368 -499, 368 0 14. 00	13.00	VOLUNTEER SERVICE COORDINATION*	o	0	ol ol	0	0	13.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES* 0 0 0 0 0 15.00 10.00 PATIENT FEST DENTIAL CARE SERVICES 0 0 0 0 0 16.00 17.00 PATIENT CARE-CONTRACTED** 1.524,733 1.524,733 0 1.524,733 25.00 10.00 PATIENT CARE-CONTRACTED** 1.524,733 1.524,733 0 1.524,733 25.00 10.00 PATIENT CARE-CONTRACTED** 0 135,656 0 135,656 26.00 10.00 PATIENT CARE-CONTRACTED** 0 135,656 0 0 0 0 0 0 0 0 10.00 0 0 0 0 0 0 0 0 0	14 00	1	l ol	499 368	499 368	-499 368	0	14 00
16.00 OTHER GENERAL SERVICES O O O O O 16.00		1	٥	177, 000	177,000	177, 550		
17. 00 PATI ENT/RESI DENTIAL CARE SERVI CES				0	1	0		
DIRECT PATIENT CARE SERVICE COST CENTERS 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733 1,524,733		4	٩	U	y o	U	U	
25. 00 INPATIENT CARE-CONTRACTED**	17.00							17.00
26.00 PHYSICIAN SERVICES** 0 135,656 135,656 0 135,656 20.00 27.00 27.00 28.00 REGISTERED NURSE** 2,615,047 14,847 2,629,894 0 2,629,894 28.00 29.00 129.00 144,847 2,629,894 0 2,629,894 28.00 29.00 129.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 2		DIRECT PATIENT CARE SERVICE COST CENTERS						
27.00 NURSE PRACTITIONER** 2, 615, 047 11, 847 2, 629, 894 0 2, 629, 894 28.00 29.00 LPM/LVN** 0 0 0 0 0 0 0 2, 69, 894 28.00 29.00 LPM/LVN** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00	INPATIENT CARE-CONTRACTED**		1, 524, 733	1, 524, 733	0	1, 524, 733	25.00
27.00 NURSE PRACTITIONER**	26.00	PHYSI CI AN SERVI CES**	l ol	135, 656	135, 656	Ō	135, 656	26. 00
28.00 REGISTERED NURSE** 2,615,047 14,847 2,629,894 0 2,629,894 28.00	27 00	1	l ol	. 0	ا ا	0		27 00
29.00 PHYLVN**			2 615 047	1/ 9/7	2 620 804	0		
30.00 PHYSICAL THERAPY**			2,013,047	14, 047	2,027,074	0		
33.00 OCCUPATIONAL THERAPPY** 0 0 0 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY** 0 0 0 0 0 32.00 33.00 MEDI CAL SOCI AL SERVI CES** 261,527 1,484 263,011 0 263,011 33.00 34.00 SPIRI TUAL COUNSELI NO** 129,066 733 129,799 0 129,799 34.00 35.00 DETARY COUNSELINO** 0 0 0 0 0 0 35.00 36.00 COUNSELI NO** 0 0 0 0 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES** 369,678 2,098 371,776 0 371,776 371,770 38.00 DURABLE MEDI CAL EQUI PMENT/DXYGEN** 0 0 0 0 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON** 0 0 0 0 0 0 39.00 40.00 IMAGI MG SERVI CES** 0 0 0 0 0 0 0 0 41.00 LABS & DI AGNOSTI CS** 0 0 0 0 0 0 0 0 42.00 WEDI CAL SUPPLIES-NON-ROUTI NE** 0 0 0 0 0 0 0 42.50 DUROUS CHARGED TO PATI ENTS** 0 0 0 0 0 0 0 0 43.00 OUTPATI ENT SERVI CES** 0 0 0 0 0 0 0 0 44.00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 45.00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 46.00 THER PATI IENT CARE SERVI CES (SPECI FY)** 2, 218 12 2, 230 0 2, 230 46.00 OTHER PROGRAM * 0 0 0 0 0 0 0 0 46.00 HONERI HUBURSABLE COST CENTERS 0 0 0 0 0 0 0 46.00 OTHER PROGRAM * 0 0 0 0 0 0 0 46.00 OTHER PROGRAM * 0 0 0 0 0 0 0 46.00 OTHER PROGRAM * 0 0 0 0 0 0 0 46.00 OTHER PROGRAM * 0 0 0 0 0 0 0 46.00 OTHER PROGRAM * 0 0 0 0 0 0 0 46.00 OTHER PROGRAM * 0 0 0 0 0 0 0 46.00 OTHER PROGRAM * 0 0 0 0 0 0 0 46.00 OTHER PROGRAM * 0 0 0 0 0 0 0 46.00 OTHER PROGRAM * 0 0 0 0 0 0 0 46.00 OTHER PROGRAM * 0 0 0 0 0 0 0 46.00 OTHER PROGRAM * 0 0 0 0 0 0 0 46.00 OTHER PROGRAM * 0 0 0 0 0 0 0 46.00 OTHER PROGRAM * 0 0		1	0	U		U		
32. 00 SPEECH/LANGUAGE PATHOLOGY** 0 0 0 0 0 0 0 0 32. 00 32. 00 MEDI CAL SOCI AL SERVI CES** 261, 527			0	Ü	ol ol	0		
33. 00 MEDICAL SOCIAL SERVICES** 261, 527 1, 484 263, 011 0 SPIRITUAL COUNSELING** 129, 066 733 129, 799 0 129, 799 34. 00 35. 00 0 DIETARY COUNSELING** 0 0 0 0 0 0 0 0 0 0 35. 00 36. 00 COUNSELING** 0 0 0 0 0 0 0 0 0 0 0 35. 00 36. 00 COUNSELING** 0 0 0 0 0 0 0 0 0 0 0 36. 00 37. 00 HOSPIC CE AIDE & HOMEMAKER SERVICES** 369, 678 3, 00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 0 0 0 0 0 0 0 0 0 371, 776 38. 00 39. 00 PATI ENT TRANSPORTATION** 0 0 0 0 0 0 0 0 0 0 39. 00 41. 00 LABS & DIAGNOSTICS** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	이	0	0	
34. 00 SPIRITUAL COUNSELING** 0 0 0 0 0 0 0 0 0 35. 00 35. 00 DIETARY COUNSELING** 0 0 0 0 0 0 0 0 35. 00 36. 00 COUNSELING - OTHER** 0 0 0 0 0 0 0 0 35. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 369, 678 2,098 371, 776 0 371, 776 37. 00 39. 00 DURABLE MEDICAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 0 0 0 38. 00 39. 00 PATIENT TRANSPORTATION** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
34. 00 SPIRITUAL COUNSELING** 0 DIFARTY COUNSELING** 0 O 0 O 0 O 0 O 0 O 0 O 0 O 0 O 0 O 0 O	33.00	MEDICAL SOCIAL SERVICES**	261, 527	1, 484	263, 011	0	263, 011	33.00
35. 00 DI ETARY COUNSELING** 36. 00 COUNSELING** 37. 00 HOSPI CE AI DE & HOMENAKER SERVI CES** 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 39. 00 PATIENT TRANSPORTATION** 0 0 0 0 0 0 0 0 0 0 0 38. 00 40. 00 IMAGING SERVI CES** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	34 00	SPERITUAL COUNSELENG**				0		34 00
36. 00 COUNSELING - OTHER** 36. 00 JOUNDABLE MODEMAKER SERVICES** 369, 678 2, 098 371, 776 0 371, 706 37. 00 39. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 30. 00 PATIENT TRANSPORTATION** 00 00 0 0 0 0 0 0 38. 00 40. 00 IMAGING SERVICES** 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		I and the second	·	, 55	1 .27,77	0	-	
37.00 HOSPICE AIDE & HOMEMAKER SERVICES** 369, 678 2,098 371,776 0 371,776 37.00 38.00 DURABLE MEDICAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 39.00 PATIENT TRANSPORTATION** 0 0 0 0 0 0 40.00 IMAGING SERVICES** 0 0 0 0 0 0 0 41.00 LABS & DI AGNOSTICS** 0 0 0 0 0 0 0 42.00 MEDICAL SUPPLIES-NOM-ROUTINE** 0 0 0 0 0 0 42.50 DRUGS CHARGED TO PATIENTS** 0 0 0 0 0 0 0 43.00 OUTPATIENT SERVICES** 0 0 0 0 0 0 0 44.00 DALLIATIVE RADIATION THERAPY** 0 0 0 0 0 0 0 45.00 PALLIATIVE CHEMOTHERAPY** 2,218 12 2,230 0 2,230 46.00 OTHER PATIENT CARE SERVICES (SPECIFY)** 2,218 12 2,230 0 0 0 61.00 OULUNTEER PROGRAM * 0 0 0 0 0 0 62.00 FUNDRAI SING* 0 0 0 0 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS* 0 0 0 0 0 0 64.00 PALLIATIVE CARE PROGRAM* 0 0 0 0 0 0 65.00 OTHER PROGRAM * 0 0 0 0 0 0 66.00 OTHER PROGRAM * 0 0 0 0 0 0 66.00 OTHER PROGRAM* 0 0 0 0 0 0 66.00 OTHER PROGRAM* 0 0 0 0 0 67.00 OTHER PROGRAM* 0 0 0 0 0 68.00 OTHER PROGRAM* 0 0 0 0 0 68.00 OTHER PROGRAM* 0 0 0 0 0 67.00 OTHER PROGRAM* 0 0 0 0 68.00 OTHER PROGRAM* 0 0 0 0 68.00 OTHER PROGRAM* 0 0 0 0 69.00 OTHER PROGRAM* 0				0		0		
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 0 38. 00 ANDRE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0/0/70	0.000	074 77	0	_	
39. 00 PATLENT TRANSPORTATION** 40. 00 I MAGI NG SERVI CES** 40. 00 I MAGI NG SERVI CES** 41. 00 LABS & DI AGNOSTI CS** 42. 00 MEDI CAL SUPPLIES-NON-ROUTI NE** 42. 00 MEDI CAL SUPPLIES-NON-ROUTI NE** 43. 00 OUTPATI ENT SERVI CES** 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 44. 00 PALLI ATI VE CHEMOTHERAPY** 45. 00 PALLI ATI VE CHEMOTHERAPY** 46. 00 PALLI ATI VE CHEMOTHERAPY** 46. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 47. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 48. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 49. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES (SPECI FY) ** 40. 00 OUTBER PATI ENT CARE SERVI CES ** 40. 00 OUTBER PATI ENT CARE SERVI CES ** 40. 00 OUTBER PATI ENT CARE SERVI CES ** 40. 00 OUTBER PATI ENT CARE SERVI CES ** 40. 00 OUTBER PATI ENT CARE SERVI CES ** 40. 00 OUTBER PATI ENT CARE SERVI CES ** 40. 00 OUTBER PATI ENT CARE SERVI CES ** 40. 00 OUTBER PATI ENT CARE SERVI CES ** 40. 00 OUTBER PATI ENT CARE SERVI CES ** 40. 00 OUTBER PATI ENT CARE SERVI CES ** 40. 00 OUTBER PATI ENT CARE SERVI CES ** 40. 00 OUTBER PATI ENT CARE SERVI CES ** 40. 00 OUTBER PATI ENT CARE SERVI CES **			369, 678	2, 098	3/1, //6	0		
40.00 IMAGI NG SERVI CES**		I and the second	0	0	이	0		
41. 00 LABS & DI AGNOSTI CS** 0 0 0 0 0 0 0 0 0 42. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 0 0 0 0 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 0 0 0 0 42. 00 43. 00 UTPATI ENT SERVI CES** 0 0 0 0 0 0 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 0 45. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) ** 2, 218 12 2, 230 0 2, 230 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) ** 2, 218 12 2, 230 0 0 2, 230 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) ** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	39. 00	PATIENT TRANSPORTATION**	0	0	0	0	0	39. 00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 0 0 0 0 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 0 0 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES** 0 0 0 0 0 0 0 0 0 43. 30 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	40.00	I MAGING SERVI CES**	0	0	0	0	0	40.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 0 0 0 0 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 0 0 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES** 0 0 0 0 0 0 0 0 0 43. 30 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	41 00	LABS & DLAGNOSTLCS**	ام	0		0	0	41 00
42.50 DRUGS CHARGED TO PATIENTS** 0 0 0 0 0 0 0 42.50 43.00 OUTPATIENT SERVICES** 0 0 0 0 0 0 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 0 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 0 44.00 0 0 0 0 0 0 0 0			ام	0		0		
43.00 OUTPATIENT SERVICES** 44.00 PALLIATIVE RADIATION THERAPY** 45.00 PALLIATIVE CHEMOTHERAPY** 46.00 OTHER PATIENT CARE SERVICES (SPECIFY)** 46.00 OTHER PATIENT CARE SERVICES (SPECIFY)** 46.00 OTHER PATIENT CARE SERVICES (SPECIFY)** 46.00 OTHER PATIENT PROGRAM * 46.00 BEREAVEMENT PROGRAM * 40.00 FUNDRAI SING* 40.00 FUNDRAI SING* 40.00 OTHER PHYSICIAN SERVICES* 40.00 OTHER PHYSICIA		I and the second		0	1	0		
44. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 0 0 0 0 44. 00 45. 00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 2, 218 12 2, 230 0 2, 230 46. 00 NONREI MBURSABLE COST CENTERS 60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 0 0 60. 00 61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 0 0 0 61. 00 62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLIATIVE MEDICINE FELLOWS* 0 0 0 0 0 0 0 63. 00 64. 00 PALLIATIVE CARE PROGRAM* 0 0 0 0 0 0 0 63. 00 65. 00 OTHER PHYSI CIAN SERVICES* 0 0 0 0 0 0 0 0 66. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 0 66. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 0 0 0 68. 00 69. 00 THRT FT STORE* 0 0 0 0 0 0 0 0 0 68. 00 71. 00 OTHER PNONREI MBURSABLE (SPECIFY)* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	U		U		
45. 00 PALLIATI VE CHEMOTHERAPY** 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 2, 218 12 2, 230 0 2, 230 46. 00 NONREI MBURSABLE COST CENTERS 60. 00 BEREAVEMENT PROGRAM * 60. 00 O O O O O O O O O O O O O O O O O		y control of the cont	0	Ü	ol ol	0		
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)** 2,218 12 2,230 0 2,230 46.00 NONREI MBURSABLE COST CENTERS	44. 00	y and the second	0	0	0	0	0	44. 00
NONREI MBURSABLE COST CENTERS	45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
NONREI MBURSABLE COST CENTERS	46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	2, 218	12	2, 230	0	2, 230	46.00
60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 0 0 60. 00 61. 00 61. 00 0 0 0 0 0 0 0 61. 00 62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 0 0 62. 00 63. 00 64. 00 0 0 0 0 0 0 0 0 63. 00 63. 00 64. 00 9ALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 0 0 64. 00 65. 00 66. 00 7HER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 0 0 65. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00		NONRELMBURSABLE COST CENTERS	<u> </u>					
61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 0 0 61. 00 62. 00 63. 00 FUNDRAI SI NG* 0 0 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 0 0 64. 00 65. 00 0 0 0 0 0 0 0 0 65. 00 66. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60 00		0	0		0	0	60 00
62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 0 62. 00 63. 00 64. 00 65. 00 0 0 0 0 0 0 0 63. 00 64. 00 65. 00 0 0 0 0 0 0 0 0 65. 00 65. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			٥	0		0		
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 0 63. 00 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 0 0 65. 00 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 0 0 68. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 0 0 0 0 68. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 0 0 0 0 0 0 0 70. 00 71. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	0	,	0		
64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 0 0 0 0 69. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 100. 00 TOTAL 0 0 0 0 0 0 0 0 0 0 71. 00		1	0	U	ا ا	0		
65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 0 0 65. 00 66. 00 67. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 0 0 0 0 68. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 0 0 0 0 0 0 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 0 0 0 0 0 0 0 71. 00 100. 00 TOTAL 4, 771, 397 3, 166, 999 7, 938, 396 -626, 902 7, 311, 494 100. 00			0	C	0	0		
66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 0 0 0 0 68. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 100. 00 TOTAL 0 0 0 0 0 0 0 0 71. 00 100. 00 TOTAL	64. 00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 0 0 0 0 68. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 100. 00 TOTAL 0 0 0 0 0 0 0 0 71. 00 100. 00 TOTAL	65.00	OTHER PHYSICIAN SERVICES*	0	0	o o	0	0	65.00
67. 00 ADVERTI SI NG* 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 0 70. 00 NURSI NG FACILITY ROOM & BOARD* 0 0 0 0 0 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 0 0 0 0 70. 00 TOTAL 4,771,397 3,166,999 7,938,396 -626,902 7,311,494 100.00	66. 00		l ol	0	ol ol	0	0	
68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 68. 00 69. 00 1 1 1 1 1 1 1 1 1		1	ام	n	ا م	n	n	
69. 00 THRI FT STORE* 0 0 0 0 0 0 0 69. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 7				0		0		
70. 00 NURSING FACILITY ROOM & BOARD* 0 0 0 0 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70.				0	(0		
71. 00 OTHER NONREIMBURSABLE (SPECIFY)* 0 0 0 0 0 71. 00 100. 00 TOTAL 4, 771, 397 3, 166, 999 7, 938, 396 -626, 902 7, 311, 494 100. 00		·	ا ا	-	<u>'</u>	0		
100. 00 TOTAL 4, 771, 397 3, 166, 999 7, 938, 396 -626, 902 7, 311, 494 100. 00			0	0	ן ס	0		
		. ,	0	0	0	0		
	100.00	TOTAL	4, 771, 397	3, 166, 999	7, 938, 396	-626 <u>,</u> 902	7, 311, 494	100.00
	* Tran	sfer the amounts in column 7 to Wkst. 0-5. col	lumn 1, line as	appropri ate.				

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. ** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm Hospi ce CCN: 14-1658 Hospi ce I

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
	CENEDAL CEDVICE COST CENTEDS	6. 00	7. 00		
1. 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT*		0		1.00
2.00	CAP REL COSTS-BLDG & FIXT		651, 610	l .	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	031,010		3. 00
4. 00	ADMINISTRATIVE & GENERAL*	-14, 283	1, 552, 728		4. 00
5. 00	PLANT OPERATION & MAINTENANCE*	- 14, 203	34, 959	•	5. 00
6. 00	LAUNDRY & LINEN SERVICE*		34, 737	1	6. 00
7. 00	HOUSEKEEPI NG*		0	l .	7. 00
8. 00	DI ETARY*		815	l .	8.00
9. 00	NURSING ADMINISTRATION*		015		9. 00
10.00	ROUTINE MEDICAL SUPPLIES*		0		10.00
11. 00	MEDI CAL RECORDS*		0		11.00
12. 00	STAFF TRANSPORTATION*		0	1	12.00
13. 00	VOLUNTEER SERVICE COORDINATION*		0	1	13. 00
14. 00	PHARMACY*		0	1	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*		0	1	15. 00
16. 00	OTHER GENERAL SERVICE*		0	•	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	Ĭ	J		17. 00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS				17.00
25. 00	INPATIENT CARE-CONTRACTED**	ol	1, 524, 733		25. 00
26. 00	PHYSI CI AN SERVI CES**		135, 656	•	26. 00
27. 00	NURSE PRACTITIONER**		0		27. 00
28. 00	REGISTERED NURSE**		2, 629, 894		28. 00
29. 00	LPN/LVN**	0	0	l .	29. 00
30. 00	PHYSI CAL THERAPY**		0		30.00
31. 00	OCCUPATIONAL THERAPY**		0		31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	o	0		32. 00
33. 00	MEDICAL SOCIAL SERVICES**	l ol	263, 011		33. 00
34.00	SPIRITUAL COUNSELING**	o	129, 799		34.00
35. 00	DI ETARY COUNSELI NG**	o	. 0		35. 00
36. 00	COUNSELING - OTHER**	o	0		36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	o	371, 776		37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	o	0	1	38. 00
39.00	PATI ENT TRANSPORTATION**	o	0		39. 00
40.00	I MAGI NG SERVI CES**	o	0		40.00
41.00	LABS & DI AGNOSTI CS**	o	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	o	0		42.00
42. 50	DRUGS CHARGED TO PATIENTS**	o	0		42. 50
43.00	OUTPATI ENT SERVI CES**	o	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	o	0		44. 00
45.00	PALLIATIVE CHEMOTHERAPY**	o	0		45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY) **	o	2, 230		46. 00
	NONREI MBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61. 00
62.00	FUNDRAI SI NG*	0	0		62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63. 00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64. 00
65. 00	OTHER PHYSICIAN SERVICES*	0	0	l .	65. 00
66. 00	RESI DENTI AL CARE*	0	0	l .	66. 00
67. 00	ADVERTI SI NG*	0	0	l .	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0	l .	68. 00
69. 00	THRI FT STORE*	0	0		69. 00
70. 00	NURSING FACILITY ROOM & BOARD*	0	0		70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71. 00
100.00	TOTAL	-14, 283	7, 297, 211		100. 00

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. ** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provi der CCN: 14-0032

Hospi ce CCN: 14-1658

Period: Worksheet 0-2 From 07/01/2022

06/30/2023 To Date/Time Prepared: 1/24/2024 1:12 pm Hospi ce I SUBTOTAL (col SALARI ES RECLASSI FI -SUBTOTAL OTHER 1 + col. CATI ONS 1.00 2.00 5. 00 3 00 4 00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 25.00 PHYSICIAN SERVICES 131, 870 0 131, 870 26.00 131,870 26.00 NURSE PRACTITIONER 27.00 27.00 28.00 REGISTERED NURSE 2, 542, 071 14, 433 2, 556, 504 0 0 0 0 0 0 2, 556, 504 28.00 29.00 LPN/LVN 29.00 30.00 PHYSI CAL THERAPY 0 0 0 30.00 0 OCCUPATIONAL THERAPY 0 31.00 0 C 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 32.00 33.00 MEDICAL SOCIAL SERVICES 254, 229 1, 443 255, 672 255, 672 33.00 34.00 SPIRITUAL COUNSELING 125, 464 126, 176 126, 176 712 34.00 35.00 DIETARY COUNSELING 35.00 36.00 COUNSELING - OTHER 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 359, 361 2, 040 361, 401 37.00 361, 401 37.00 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 38.00 0 0 39.00 PATIENT TRANSPORTATION 0 0 0 0 0 0 0 0 0 0 39.00 40.00 I MAGING SERVICES 0 0 40.00 0 0 0 41.00 LABS & DIAGNOSTICS 0 0 41.00 MEDICAL SUPPLIES-NON-ROUTINE 0 42.00 C 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 42.50 OUTPATIENT SERVICES 0 0 43.00 0 0 43.00 PALLIATIVE RADIATION THERAPY 44.00 C 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 2, 156 2, 168 0 2, 168 46.00 100.00 TOTAL * 150, 510 3, 433, 791 100. 00 3, 283, 281 3, 433, 791

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	INPATIENT CARE-CONTRACTED			25. 00
26.00	PHYSI CI AN SERVI CES	0	131, 870	26. 00
27.00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	2, 556, 504	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	255, 672	33. 00
34.00	SPIRITUAL COUNSELING	0	126, 176	34.00
35.00	DI ETARY COUNSELING	0	o	35. 00
36.00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	361, 401	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o	38. 00
39.00	PATIENT TRANSPORTATION	0	o	39. 00
40.00	I MAGING SERVICES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	o	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	o	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	o	42. 50
43.00	OUTPATIENT SERVICES	0	o	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	o	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	o	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	2, 168	46. 00
100.00	TOTAL *	0	3, 433, 791	100. 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

Provi der CCN: 14-0032 Peri od: Worksheet 0-3 From 07/01/2022 To 06/30/2023 RESPITE CARE Date/Time Prepared: 1/24/2024 1:12 pm Hospi ce CCN: 14-1658

				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
			1 + col . 2)	CATI ONS		
	1.00	2. 00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED		114, 642	114, 642	0	114, 642	25. 00
26. 00 PHYSI CI AN SERVI CES	0	285	285	0	285	26. 00
27. 00 NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00 REGI STERED NURSE	5, 487	31	5, 518	0	5, 518	28. 00
29. 00 LPN/LVN	0	0	0	0	0	29. 00
30.00 PHYSI CAL THERAPY	0	0	0	0	0	30. 00
31. 00 OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00 MEDICAL SOCIAL SERVICES	549	3	552	0	552	33. 00
34.00 SPIRITUAL COUNSELING	271	2	273	o	273	34. 00
35. 00 DI ETARY COUNSELI NG	O	0	o	o	0	35. 00
36. 00 COUNSELING - OTHER	0	0	o	o	0	36. 00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	776	4	780	o	780	37. 00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	O	0	o	o	0	38. 00
39.00 PATIENT TRANSPORTATION	O	0	o	o	0	39. 00
40. 00 I MAGI NG SERVI CES	O	0	o	o	0	40. 00
41.00 LABS & DIAGNOSTICS	O	0	0	0	0	41. 00
42. 00 MEDICAL SUPPLIES-NON-ROUTINE	O	0	0	0	0	42. 00
42.50 DRUGS CHARGED TO PATIENTS	o	0	o	o	0	42. 50
43. 00 OUTPATIENT SERVICES	o	0	o	o	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	o	0	o	o	0	44. 00
45.00 PALLIATIVE CHEMOTHERAPY	O	0	o	o	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	5	0	5	o	5	46. 00
100. 00 TOTAL *	7, 088	114, 967	122, 055	0	122, 055	100. 00
* Transfer the amount in column 7 to Which O.E. and	1 1: 52					

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5	
		ADJUSTINIENTS	± col. 6)	
		6, 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS		,	
25.00	INPATIENT CARE-CONTRACTED	0	114, 642	25. 00
26.00	PHYSI CI AN SERVI CES	0	285	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	5, 518	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	552	33.00
34.00	SPI RI TUAL COUNSELI NG	0	273	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	780	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	5	46.00
100.00	TOTAL *	0	122, 055	100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

Provi der CCN: 14-0032 Peri od: Worksheet 0-4 From 07/01/2022 To 06/30/2023 INPATIENT CARE Date/Time Prepared: 1/24/2024 1:12 pm Hospi ce CCN: 14-1658

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2.00	3.00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATIENT CARE-CONTRACTED		1, 410, 091	1, 410, 091	0	1, 410, 091	25. 00
26. 00	PHYSI CI AN SERVI CES	0	3, 501	3, 501	0	3, 501	26. 00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28.00	REGI STERED NURSE	67, 489	383	67, 872	0	67, 872	28. 00
29.00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	6, 749	38	6, 787	0	6, 787	33. 00
34.00	SPIRITUAL COUNSELING	3, 331	19	3, 350	0	3, 350	34.00
35.00	DI ETARY COUNSELI NG	o	0	0	0	0	35. 00
36.00	COUNSELING - OTHER	o	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	9, 541	54	9, 595	0	9, 595	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00	PATIENT TRANSPORTATION	o	0	0	0	0	39. 00
40.00	I MAGI NG SERVI CES	o	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	o	0	0	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	o	0	0	0	0	42. 00
42.50	DRUGS CHARGED TO PATIENTS	o	0	0	0	0	42. 50
43.00	OUTPATIENT SERVICES	o	0	o	o	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	o	0	o	o	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	o	0	o	o	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	57	0	57	0	57	1
	TOTAL *	87, 167	1, 414, 086	1, 501, 253	0	1, 501, 253	100.00
	ofor the amount in column 7 to Wkst O.E. colu				-		

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Transfer the amount fir cordinir 7 to wast. 0-5, co			
	ADJUSTMENTS	TOTAL (col. 5	
		± col. 6)	
DUDENT DATIENT CARE CERVILOE COCT OFNITERS	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS		4 440 004	05.00
25. 00 INPATIENT CARE-CONTRACTED		1, 410, 091	25. 00
26. 00 PHYSI CI AN SERVI CES		3, 501	26. 00
27. 00 NURSE PRACTITIONER		0	27. 00
28. 00 REGI STERED NURSE		67, 872	28. 00
29. 00 LPN/LVN		0	29. 00
30. 00 PHYSI CAL THERAPY		0	30.00
31. 00 OCCUPATI ONAL THERAPY	C	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	C	6, 787	33.00
34. 00 SPI RI TUAL COUNSELI NG	0	3, 350	34.00
35. 00 DI ETARY COUNSELING	C	0	35.00
36. 00 COUNSELING - OTHER	C	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	(9, 595	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	(0	38.00
39. 00 PATIENT TRANSPORTATION	C	0	39.00
40.00 I MAGI NG SERVI CES	C	0	40.00
41.00 LABS & DIAGNOSTICS	C	0	41.00
42.00 MEDICAL SUPPLIES-NON-ROUTINE	C	0	42.00
42.50 DRUGS CHARGED TO PATIENTS		0	42. 50
43.00 OUTPATIENT SERVICES		0	43.00
44.00 PALLIATIVE RADIATION THERAPY		0	44.00
45.00 PALLIATIVE CHEMOTHERAPY		0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	C	57	46.00
100. 00 TOTAL *	C	1, 501, 253	100.00
* T C II I 7 I 7 I 7 I 7 I			

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Hoal +h	Financial Systems ST. ANTHONYS MEMO	NELIASON IVIDO		In Lie	eu of Form CMS-:	2552 10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der C		Peri od:	Worksheet 0-5	
	SES FOR ALLOCATION	Trovider C		From 07/01/2022		
L/G LIVE	25 TON NEEDONTON	Hospi ce CCI		To 06/30/2023		
				Hospi ce I	1/24/2024 1:1	2 pm
	Descriptions		HOSPICE DIREC		TOTAL EXPENSES	
	beset i per ons		EXPENSES (se		(sum of cols.	
			instructions		1 + 2)	
				WKST B PART I	ĺ	
				(see		
				instructions)		
	T		1.00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS		1			
1.00	CAP REL COSTS-BLDG & FIXT		(54.4	0 0	0 (57 000	
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT		651, 61			
4.00	ADMINISTRATIVE & GENERAL		1, 552, 72	0,2, ., 0	4, 395, 940	1
5.00	PLANT OPERATION & MAINTENANCE		34, 95		34, 959	1
6.00	LAUNDRY & LINEN SERVICE		34, 70	0 0	0	
7. 00	HOUSEKEEPI NG				0	
8. 00	DI ETARY		81	٥	815	
9. 00	NURSI NG ADMI NI STRATI ON			0 0	0.0	1
10. 00	ROUTI NE MEDI CAL SUPPLI ES			0 6, 458	6, 458	
11. 00	MEDI CAL RECORDS			0 85, 363		
12.00	STAFF TRANSPORTATION			0	0	12. 00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY			0 2, 607, 480	2, 607, 480	14. 00
15. 00	PHYSI CI AN ADMINI STRATI VE SERVI CES			0	0	
16. 00	OTHER GENERAL SERVI CE			0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17. 00
F0 00	LEVEL OF CARE		ı			
50.00	HOSPI CE CONTI NUOUS HOME CARE		2 422 76	0	0	
51. 00 52. 00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE		3, 433, 79 122, 05		3, 433, 791 122, 055	
53. 00	HOSPICE GENERAL INPATIENT CARE		1, 501, 25		1, 501, 253	
33.00	NONREI MBURSABLE COST CENTERS		1, 301, 20	73	1, 301, 233	33.00
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61. 00	VOLUNTEER PROGRAM			o	Ö	
62. 00	FUNDRAI SI NG			0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	
64.00	PALLIATIVE CARE PROGRAM			0	0	64. 00
65.00	OTHER PHYSI CI AN SERVI CES			0	0	
66. 00	RESI DENTI AL CARE			0	0	
67. 00	ADVERTI SI NG			0	0	
68 NN	TELEHEALTH/TELEMONITORING		I		l n	1 68 NN

68. 00

69. 00 70. 00

71. 00 99. 00 0

0 0

13, 737, 589 100. 00

6, 440, 378

68. 00 | TELEHEALTH/TELEMONI TORI NG

100. 00 TOTAL

69.00 THELEHEALTH TELEMONTTORING
69.00 THRIFT STORE
70.00 NURSING FACILITY ROOM & BOARD
71.00 OTHER NONREIMBURSABLE (SPECIFY)
99.00 NEGATIVE COST CENTER

Health Financial S	Systems		ST. ANTHONYS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10		
COCT ALLOCATION	LICCULTAL	DACED HOCDLOE CENEDAL	CEDVI CE COCTO	Dravi dan CCN, 14 0022	Dorsi od.	Wo	rskahaat 0 (

Peri od: From 07/01/2022 To 06/30/2023 COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 14-0032 Part I Date/Time Prepared: Hospi ce CCN: 14-1658 1/24/2024 1:12 pm Hospi ce I TOTAL EXPENSES CAP REL BLDG & CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions EQUI P **BENEFITS** FIX DEPARTMENT 1.00 2.00 0 3.00 3A GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 657, 000 2.00 CAP REL COSTS-MVBLE EQUIP 657,000 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 892, 475 0 657,000 1, 549, 475 3.00 ADMINISTRATIVE & GENERAL 4, 395, 940 452, 645 4, 848, 585 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 34, 959 0 0 34, 959 5.00 LAUNDRY & LINEN SERVICE 0 6.00 0 0 0 0 6.00 7.00 HOUSEKEEPI NG 0 0 7.00 8.00 DI ETARY 815 0 0 815 8.00 0 NURSING ADMINISTRATION 0 9.00 0 9.00 0 0 0 ROUTINE MEDICAL SUPPLIES 10.00 6.458 6.458 10.00 11.00 MEDICAL RECORDS 85, 363 0 0 0 0 85, 363 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 0 13.00 13.00 0 0 0 0 2, 607, 480 14.00 PHARMACY 2, 607, 480 C 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 0 16.00 OTHER GENERAL SERVICE 0 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 0 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 HOSPICE ROUTINE HOME CARE 3, 433, 791 1, 066, 222 4, 500, 013 51.00 51.00 122, 055 52.00 HOSPICE INPATIENT RESPITE CARE 0 0 2, 301 124, 356 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 1,501,253 0 0 28, 307 1, 529, 560 53.00 NONREI MBURSABLE COST CENTERS 60 00 BEREAVEMENT PROGRAM n 60 00 0 0 VOLUNTEER PROGRAM 0 0 61.00 0 0 61.00 0 62.00 FUNDRAI SI NG 0 0 62.00 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 00000 0 0 63.00 PALLIATIVE CARE PROGRAM 0 0 64.00 0 64.00 0 65.00 OTHER PHYSICIAN SERVICES 0 0 65.00 0 0 66.00 RESIDENTIAL CARE 0 0 66.00 67 00 ADVERTI SI NG 0 0 67 00 0 0 TELEHEALTH/TELEMONI TORI NG 68.00 0 0 68.00 0 69.00 THRIFT STORE 0 0 69.00 0 70.00 NURSING FACILITY ROOM & BOARD 0 70.00 0 OTHER NONREIMBURSABLE (SPECIFY) 71.00 71 00 Ω 0 0 99.00 NEGATIVE COST CENTER 0 0 0 99.00 100.00 TOTAL 13, 737, 589 657, 000 1, 549, 475 13, 737, 589 100. 00

Heal th	Financial Systems	ST. ANTHONYS MEMO	ORIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der C	CN: 14-0032	Peri od:	Worksheet 0-6	
					From 07/01/2022	Part I	
			Hospi ce CC	N: 14-1658	To 06/30/2023		
			·			1/24/2024 1:1	2 pm
					Hospi ce I		
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	r r r r	& GENERAL	OPERATION &	LINEN SERVIC			
		u 02.12.0.2	MAI NTENANCE	CONTRACTOR	-		
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	_
1 00	CAP REL COSTS-BLDG & FIXT						1.00
1.00							
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL	4, 848, 585					4. 00
5.00	PLANT OPERATION & MAINTENANCE	19, 069	54, 028	3			5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0		0		6. 00
7.00	HOUSEKEEPI NG	o	0	ol	0		7. 00
8. 00	DI ETARY	445	0		0	1, 260	1
9. 00	NURSING ADMINISTRATION	0	0		0	1,200	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	3, 523	0		0		10.00
		1	0	()	0		
11. 00	MEDI CAL RECORDS	46, 562	Ü)	0		11. 00
12. 00	STAFF TRANSPORTATION	0	0)	0		12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0)	0		13. 00
14.00	PHARMACY	1, 422, 273	0)	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15. 00
16.00	OTHER GENERAL SERVICE	o	0	ol .	0		16. 00
17. 00		0	0		0		17. 00
	LEVEL OF CARE			1			1
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51. 00		1 -					1
	HOSPICE ROUTINE HOME CARE	2, 454, 570					51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	67, 831	5, 596	1	0		
53. 00	HOSPICE GENERAL INPATIENT CARE	834, 312	48, 432	2	0 0	1, 165	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0)	0		60.00
61.00	VOLUNTEER PROGRAM	O	0		0		61.00
62.00	FUNDRAI SI NG	l ol	Ö	ol .	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	ol	0		0		63. 00
64. 00	PALLIATIVE CARE PROGRAM		0		0		64. 00
65. 00	OTHER PHYSICIAN SERVICES		0		0		65.00
		0	U	<u>'</u>	0		
66. 00	RESI DENTI AL CARE	0	U	'	0 0	0	
67. 00	ADVERTI SI NG	0	0	'	0		67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0)	0		68. 00
69. 00	THRI FT STORE	0	0)	0		69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	o	O		0 0	0	71. 00
99. 00	, ,	n	n	ol	0 0	0	1
	TOTAL	4, 848, 585	54, 028		0 0		100.00
100.00	71.01.12	1, 0 10, 000	01,020	7	51	1, 200	1.55.55

Health Financial Systems	ST. ANTHONYS MEMOR	RIAL HOSPITAL	In Li€	eu of Form CMS-2552-10
OOCT ALLOCATION HOCDITAL	PACED HOCDLOE OFNEDAL CEDITION OF COCTO	D 1 1 00N 44 0000	Tp	W 1 1 0 6

Heal th	Financial Systems	ST. ANTHONYS MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der Co		Peri od:	Worksheet 0-6	
					From 07/01/2022	Part I	
			Hospi ce CCI	N: 14-1658	To 06/30/2023	Date/Time Pre	
					Hospi ce I	1/24/2024 1:1	z piii
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
	beset i per ons	ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATION	SERVI CE	
		ADMINI STRATI ON	SUPPLI ES	KECOKDS	TIVANSI OKTATI ON	COORDI NATI ON	
		9.00	10. 00	11.00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS	7,00	101.00	111.00	12.00	101.00	
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPING						7. 00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0.001				9.00
10.00	ROUTINE MEDICAL SUPPLIES	o _l	9, 981	404.00	_		10.00
11.00	MEDI CAL RECORDS	O O		131, 92	5		11.00
12. 00	STAFF TRANSPORTATION	0			0	_	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	O			0	0	13. 00
14. 00	PHARMACY	O			0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0			0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50. 00	HOSPICE CONTINUOUS HOME CARE	0	0		이	0	50. 00
51. 00	HOSPICE ROUTINE HOME CARE	0	9, 702	128, 24	3 0	0	51. 00
52.00	HOSPICE INPATIENT RESPITE CARE	0	21	27		0	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	0	258	3, 40	5 0	0	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61. 00	VOLUNTEER PROGRAM				0	0	61. 00
62.00	FUNDRAI SI NG	0			0	0	62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63. 00
64.00	PALLIATIVE CARE PROGRAM	o			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			o	0	65. 00
66.00	RESI DENTI AL CARE	ol			o	0	66. 00
67.00	ADVERTI SI NG	O			o	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	o			o	0	68. 00
69. 00	THRI FT STORE	l			o	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD					_	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0			٥	0	71.00
99. 00	NEGATIVE COST CENTER	ol	Ω		ol öl	0	99. 00
	TOTAL	o o	9, 981	131, 92	5 0		100.00
. 55. 50	·1 · · · · · · =	١	,, ,01	101,72	-, 9	0	1.00.00

Heal th	Financial Systems	ST. ANTHONYS MEN	ORIAL HOSPITAL		In Li€	eu of Form CMS-	2552-10
COST A	NLLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der CO Hospi ce CCI		Period: From 07/01/2022 To 06/30/2023	Date/Time Pre	pared:
						1/24/2024 1:1	2 pm
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERA	Hospi ce I L PATI ENT/	TOTAL	
	Descriptions	PHARWACY	ADMI NI STRATI VE		RESI DENTI AL	TOTAL	
			SERVI CES	JERVI CE	CARE SERVICES		
		14. 00	15. 00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						9. 00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11. 00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13. 00
14.00	PHARMACY	4, 029, 753					14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15. 00
16.00	OTHER GENERAL SERVICE	0			0		16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	-	l .	0	0	
51. 00	HOSPICE ROUTINE HOME CARE	3, 917, 293		•	0	11, 009, 821	1
52. 00	HOSPICE INPATIENT RESPITE CARE	8, 457			0		1
53. 00	HOSPICE GENERAL INPATIENT CARE	104, 003	0		0 0	2, 521, 135	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	
61. 00	VOLUNTEER PROGRAM	0			0	0	
62. 00	FUNDRAI SI NG	0			0	0	
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	
64. 00	PALLIATIVE CARE PROGRAM	0			0	0	
65. 00	OTHER PHYSICIAN SERVICES	0			0	0	
66.00	RESI DENTI AL CARE	0	0		0	1	
67.00	ADVERTI SI NG	0			0	0	
68. 00	TELEHEALTH/TELEMONI TORI NG	0			0	0	
69. 00	THRIFT STORE				U	0	
70.00	NURSING FACILITY ROOM & BOARD					0	
71. 00	OTHER NONREIMBURSABLE (SPECIFY)		0	•	0 0	0	1
99.00	NEGATIVE COST CENTER TOTAL	4, 029, 753	0	1	0 0	-	
100.00	N TOTAL	4,029,753	1	1	O _I 0	13, 131, 389	1100.00

Health Financial Systems	ST. ANTHONYS MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENE STATISTICAL BASIS	RAL SERVICE COSTS	Provider CCN:	Peri od: From 07/01/2022 To 06/30/2023	Worksheet 0-6 Part II Date/Time Prepared:

SIAIIS	TITCAL BASIS		Hospi ce CCN	l: 14-1658	To 06/30/2023	Date/Time Pre	
					Hospi ce I	1,21,2021 111	
	Cost Center Descriptions	CAP REL BLDG & C. FIX (SQUARE FEET) (D	EQUI P	EMPLOYEE BENEFITS DEPARTMENT	RECONCI LI ATI ON	ADMI NI STRATI VE & GENERAL (ACCUMULATED	
			·	(GROSS		COSTS)	
		1.00	2.00	SALARI ES)	4.0	4.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3. 00	4A	4. 00	
1.00	CAP REL COSTS-BLDG & FLXT	0					1.00
2. 00	CAP REL COSTS-MVBLE EQUIP		3, 301				2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	o	3, 301	4, 771, 39	6		3. 00
4.00	ADMINISTRATIVE & GENERAL	O	0	1, 393, 86	1 -4, 848, 585	8, 889, 004	4.00
5.00	PLANT OPERATION & MAINTENANCE	o	o	(o	34, 959	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	(0	0	6. 00
7.00	HOUSEKEEPI NG	0	0	(0	0	7. 00
8.00	DI ETARY	0	0	(0	815	
9.00	NURSING ADMINISTRATION	0	0	(이	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	(0	6, 458	•
11.00	MEDI CAL RECORDS	0	0	(0	85, 363	11.00
12.00	STAFF TRANSPORTATION	0	0	(0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	9		0	13.00
14. 00 15. 00	PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES	0	0			2, 607, 480 0	14. 00 15. 00
16. 00	OTHER GENERAL SERVICES	0	0			0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0	`		0	17. 00
17.00	LEVEL OF CARE		<u> </u>		<u> </u>	0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE			(l o	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			3, 283, 28	1 0	4, 500, 013	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	o	o	7, 08	7 0	124, 356	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	87, 16	7 0	1, 529, 560	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	(0	0	61.00
62. 00 63. 00	FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	,		0	62. 00 63. 00
64. 00	PALLIATIVE CARE PROGRAM	0	0	,		0	64.00
65. 00	OTHER PHYSICIAN SERVICES		0			0	65.00
66. 00	RESI DENTI AL CARE		0	,		0	66.00
67. 00	ADVERTI SI NG		0			0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	l ol	o			0	68. 00
69. 00	THRI FT STORE	O	O	(o o	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				o		70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	o	(ol ol	0	71. 00
99. 00	NEGATI VE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	657, 000	1, 549, 47		4, 848, 585	
101.00	UNIT COST MULTIPLIER	0. 000000	199. 030597	0. 32474:	<u>2 </u>	0. 545459	101. 00

Health Financial Systems	ST. ANTHONYS MEM	NORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STATISTICAL BASIS	SERVICE COSTS	Provi der Co		Peri od: From 07/01/2022 To 06/30/2023	Worksheet 0-6 Part II Date/Time Prep 1/24/2024 1:12	
				Hospi ce I		
Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPI NO (SQUARE FEET		NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	
	5. 00	6. 00	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS 1. 00 CAP REL COSTS-BLDG & FIXT 2. 00 CAP REL COSTS-MVBLE EQUIP 3. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 ADMINISTRATIVE & GENERAL 5. 00 PLANT OPERATION & MAINTENANCE	280					1. 00 2. 00 3. 00 4. 00 5. 00

	cost center bescriptions	OPERATION & MAINTENANCE (SQUARE FEET)	LINEN SERVICE (IN-FACILITY DAYS)		DAYS)	ADMI NI STRATI ON (DI RECT NURS. HRS.)	
	CENEDAL CEDALCE COCT CENTEDO	5. 00	6. 00	7. 00	8. 00	9. 00	
1 00	GENERAL SERVICE COST CENTERS	T	I	T		I	1 00
1.00	CAP REL COSTS MYOUR FOUND						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00 5. 00	ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE	280					4. 00 5. 00
6. 00	LAUNDRY & LINEN SERVICE	200					6. 00
7. 00	HOUSEKEEPI NG			΄			7. 00
8. 00	DI ETARY				931		8. 00
9. 00	NURSING ADMINISTRATION				731	0	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES					l ő	10. 00
11. 00	MEDI CAL RECORDS					Ö	11. 00
12. 00	STAFF TRANSPORTATION			0		0	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION			0		0	13. 00
14. 00	PHARMACY	0		0		0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			0		0	15. 00
16. 00	OTHER GENERAL SERVICE			0		0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17. 00
	LEVEL OF CARE		'		l		
50.00	HOSPI CE CONTI NUOUS HOME CARE					0	50. 00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	29	O	0	70	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	251	0	0	861	0	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61. 00	VOLUNTEER PROGRAM	0		0		0	61. 00
62.00	FUNDRAI SI NG	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0		0		0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0		0		0	65. 00
66. 00	RESI DENTI AL CARE	0	0	0	0	0	66. 00
67. 00	ADVERTI SI NG	0		0		0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		0		0	68. 00
69. 00	THRIFT STORE	0		0		0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71. 00			0	٥		0	71.00
	NEGATIVE COST CENTER	E4 020		1	1 240		99. 00 100. 00
)COST TO BE ALLOCATED (per Wkst. O-6, Part I) UNIT COST MULTIPLIER	54, 028 192. 957143	l .	0. 000000	1, 260 1. 353383		
101.00	JUNII COSI MULIIPLIEK	192. 90/143	0.00000	η υ. υυυυυυ	1. 303383	1 0.000000	101.00

Health Financial Systems	ST. ANTHONYS MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS	Provider CCN: Hospice CCN:	Peri od: From 07/01/2022 To 06/30/2023	Worksheet 0-6 Part II Date/Time Prepared: 1/24/2024 1:12 pm

			Hospi ce CCI	N: 14-1658 T	o 06/30/2023	Date/Time Pre 1/24/2024 1:1	
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MI LEAGE)	COORDI NATI ON (HOURS OF	PHARMACY (CHARGES)	
					SERVICE)		
	I	10.00	11. 00	12. 00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS	I		ı			
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION	00.040					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	33, 362	00.040				10.00
11. 00	MEDI CAL RECORDS		33, 362				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13. 00	VOLUNTEER SERVICE COORDINATION			0	0		13. 00
14. 00	PHARMACY			0	0	499, 366	1
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15. 00
16. 00	OTHER GENERAL SERVICE			0	0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1	-	0	
51. 00	HOSPICE ROUTINE HOME CARE	32, 431	32, 431	1		485, 430	1
52. 00	HOSPICE INPATIENT RESPITE CARE	70	70			1, 048	1
53. 00	HOSPICE GENERAL INPATIENT CARE	861	861	0	0	12, 888	53. 00
(0.00	NONREI MBURSABLE COST CENTERS	1		1 0		0	/0.00
60.00	BEREAVEMENT PROGRAM			0		0	60.00
61. 00 62. 00	VOLUNTEER PROGRAM FUNDRALSING			0		0	61. 00 62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM				0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES				0	0	65.00
66. 00	RESIDENTIAL CARE				0	0	66.00
67. 00	ADVERTI SI NG				0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG				0	0	68. 00
69. 00	THRIFT STORE				0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD			١	U	U	70.00
	OTHER NONREIMBURSABLE (SPECIFY)					0	1
	NEGATIVE COST CENTER	•			١	U	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	9, 981	131, 925		0	4, 029, 753	1
	UNIT COST MULTIPLIER	0. 299173			١	8. 069738	
101.00	UNIT COST WOLTELLER	0. 2771/3	J. 704349	0.00000	0.000000	0.007/30	1101.00

Health Financial Systems	ST. ANTHONYS MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS		032 Peri od: Worksheet 0-6 From 07/01/2022 Part II Date/Time Prepared: 1/24/2024 1:12 pm 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024 1/24/2024

			Hospi ce CC	N: 14-1658	10		1/24/2024	
						Hospi ce I	17 2 17 202 1	1. 12 piii
	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVI CE (SPECI FY BASI S)	PATIENT/ RESIDENTIAL CARE SERVICE (IN-FACILIT	S			
		(I AITENT DATS)	BASI 3)	DAYS)	•			
		15. 00	16.00	17.00				
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FLXT							1. 00
2.00	CAP REL COSTS-MVBLE EQUIP							2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3. 00
4.00	ADMINISTRATIVE & GENERAL							4. 00
5.00	PLANT OPERATION & MAINTENANCE							5. 00
6.00	LAUNDRY & LINEN SERVICE							6. 00
7. 00	HOUSEKEEPI NG							7. 00
8. 00	DI ETARY							8. 00
9.00	NURSI NG ADMINI STRATI ON							9. 00
10.00	ROUTINE MEDICAL SUPPLIES							10.00
11.00	MEDI CAL RECORDS							11. 00
12. 00 13. 00	STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION							12. 00 13. 00
	PHARMACY							14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0						15. 00
16. 00	OTHER GENERAL SERVICE	0						16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		`		0			17.00
17.00	LEVEL OF CARE			1				- 17.00
50.00		0	(o				50.00
51.00	HOSPICE ROUTINE HOME CARE	0		o				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0		o	0			52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	0	()	0			53. 00
	NONREI MBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0				60.00
61.00	VOLUNTEER PROGRAM		9					61.00
62.00	FUNDRAL SI NG)				62.00
63. 00 64. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM							63. 00 64. 00
65. 00	OTHER PHYSICIAN SERVICES)					65. 00
66. 00	RESI DENTI AL CARE	0)		0			66.00
67. 00	ADVERTI SI NG	0			۷			67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG							68. 00
	THRIFT STORE			ol .				69. 00
70. 00	NURSING FACILITY ROOM & BOARD		1					70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0		o	0			71. 00
	NEGATIVE COST CENTER							99. 00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	(0	0			100. 00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 0000	00			101. 00

Health Financial Systems	ST. ANTHONYS MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED	SERVICE COSTS BY	Provi der CC	N: 14-0032	Peri od:	Worksheet 0-7	
LEVEL OF CARE				From 07/01/2022		
ELVEL OF OTHE		Hospi ce CCN	l: 14-1658	To 06/30/2023	Date/Time Pre	
		·			1/24/2024 1: 1	2 pm
				Hospi ce I		
			Charges by	LOC (from Provid	der Records)	
			o ,	·	, and the second	
Cost Center Descriptions	From Wkst. C, Co	ost to Charge	HCHC	HRHC	HI RC	
2222 22231 20001 \$11 0110	Part I, Col. 9	Ratio				
	line	Natio				
	TITLE					

				Charges by L	OC (from Provi	der Records)	
	Cost Center Descriptions	Part I, Col. 9	Cost to Charge Ratio	НСНС	HRHC	HI RC	
		l i ne 0	1.00	2.00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	
1.00	PHYSI CAL THERAPY	66.00	0. 312038	0	0	0	1.00
2. 00	OCCUPATIONAL THERAPY	67. 00			0	0	2.00
3. 00	SPEECH PATHOLOGY	68. 00			0	0	3. 00
4.00	DRUGS CHARGED TO PATIENTS	73. 00			0	0	1
5.00	DURABLE MEDICAL EQUIP-RENTED	96. 00					5. 00
6.00	LABORATORY	60.00	0. 140475	0	0	0	6. 00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	1. 261290	0	0	0	7. 00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93. 00					8. 00
9.00	RADI OLOGY-THERAPEUTI C	55. 00					9. 00
10.00	BACTERI OLOGY & MI CROBI OLOGY	76. 00	0. 000000	0	0	0	10.00
10. 01	VASCULAR LAB	76. 01	0. 137599	0	0	0	10. 01
10. 02	TELEMEDI CI NE	76. 02			0	0	10. 02
	WOUND CARE	76. 03			0	0	10. 03
	CARDIAC REHABILITATION	76. 97	0. 334989	0	0	0	10. 97
11. 00	Totals (sum of lines 1-11)						11. 00
		Charges by LOC		Shared Service	e Costs by LOC		
		(from Provider					
	Cost Center Descriptions	Records) HGI P	UCUC (ast 1 v	HRHC (col. 1 x	III DC (aal 1 v	UCLD (and 1 v	
	cost center bescriptions	погр	col. 2)	col. 3)	col. 4)	col. 5)	
		5. 00	6.00	7.00	8. 00	9. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	2. 00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3. 00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4. 00
5.00	DURABLE MEDICAL EQUIP-RENTED						5. 00
6.00	LABORATORY	0	0	0	0	0	6. 00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	,,,,,
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8. 00
9. 00	RADI OLOGY-THERAPEUTI C						9. 00
10. 00	BACTERI OLOGY & MI CROBI OLOGY	0	0	0	0	0	10.00
10. 01	VASCULAR LAB	0	0	0	0	0	10. 01
	TELEMEDI CI NE	0	0	~	0	0	10. 02
10.03	WOUND CARE	0	0	0	0	0	10. 03
	CARDIAC REHABILITATION	0	0	0	0	0	10. 97
11.00	Totals (sum of lines 1-11)		0	0	0	0	11. 00

Health Financial Systems	ST. ANTHONYS MEMOR	RLAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PE	R DIEM COST	Provider CCN: 14-0032	Peri od: From 07/01/2022	Worksheet 0-8

Hospice CCN: 14-1658 To 06/30/2023 Date/Time Prepared: 1/24/2024 1:12 pm Hospi ce I

		TITLE XVIII	TITLE XIX	TOTAL	
		MEDI CARE	MEDI CAI D	0.00	
	HOSPICE CONTINUOUS HOME CARE	1.00	2. 00	3. 00	
1. 00	Total cost (Wkst. 0-6, Part I, col. 18, Line 50 plus Wkst. 0-7, col. 6,			0	1.00
1.00	line 11)			U	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0. 00	
4. 00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	o		4. 00
5.00	Program cost (line 3 times line 4)	0	0		5. 00
	HOSPICE ROUTINE HOME CARE		'		1
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7,			11, 009, 821	6.00
	line 11)				1
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			32, 431	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)			339. 48	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	28, 073	157		9. 00
10.00	Program cost (line 8 times line 9)	9, 530, 222	53, 298		10.00
	HOSPICE INPATIENT RESPITE CARE				
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8,			206, 633	11. 00
	li ne 11)				
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				12.00
13. 00	Total average cost per diem (line 11 divided by line 12)			2, 951. 90	
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	53	0		14.00
15.00	Program cost (line 13 times line 14)	156, 451	O ₁		15. 00
47.00	HOSPICE GENERAL INPATIENT CARE			0 504 405	14 00
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9,			2, 521, 135	16. 00
17. 00	line 11) Total unduplicated days (Wkst. S-9, col. 4, line 13)			861	17. 00
18. 00	Total average cost per diem (line 16 divided by line 17)			2, 928. 15	
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	547	15	2, 920. 13	19.00
	Program cost (line 18 times line 19)	1, 601, 698			20.00
20.00	TOTAL HOSPICE CARE	1,001,090	43, 722		20.00
21. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			13, 737, 589	21 00
22. 00				33, 362	
	Average cost per diem (line 21 divided by line 22)			411. 77	1
20.00	1. The age deet per arom (Trie 21 arvided by Trie 22)	1	1	111.77	0. 00

CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 14-0032	Peri od:	Worksheet L	
			From 07/01/2022 To 06/30/2023	Parts I-III	norod.
			To 06/30/2023	Date/Time Pre 1/24/2024 1:1:	
		Title XVIII	Hospi tal	PPS	
	DART I FULLY PROPERTING METURE			1. 00	
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				1
1. 00	Capital DRG other than outlier			914, 652	1.00
1. 00	Model 4 BPCI Capital DRG other than outlier			914, 032	1
2. 00	Capital DRG outlier payments			364	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3. 00	Total inpatient days divided by number of days in the cost re	porting period (see inst	ructions)	29. 74	3. 00
4. 00	Number of interns & residents (see instructions)	Principle (con the	,	0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1.01	, columns 1 and	0	6.00
	1.01) (see instructions)				
7.00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (Worksheet E	E, part A line	0.00	7. 00
	30) (see instructions)				
8. 00	Percentage of Medicaid patient days to total days (see instru	ıcti ons)		0.00	
9.00	Sum of lines 7 and 8			0.00	
10.00	Allowable disproportionate share percentage (see instructions	5)		0.00	
11.00	Disproportionate share adjustment (see instructions)			015.01/	
12. 00	Total prospective capital payments (see instructions)			915, 016	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			11.00	
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstanc	es (see instructions)		0	2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00
4.00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (see in			0.00	
7. 00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 >	(line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as appli			0	
10.00	Current year comparison of capital minimum payment level to c			0	10.00
11. 00	Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14)	capitai payment (from pri	or year	0	11. 00
	INDIA SUEELI FALLIII IIIE 147				I
12 00		wments (line 10 nlus lir	ne 11)	<u> </u>	12 00
12. 00 13. 00	Net comparison of capital minimum payment level to capital pa			0	12. 00 13. 00
12. 00 13. 00 14. 00		the amount on this line	e)	0 0	13. 00

15.00 0 16. 00 0 17. 00

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

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