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: 14-1334 Worksheet S Peri od: From 04/01/2022 Parts I-III AND SETTLEMENT SUMMARY 03/31/2023 Date/Time Prepared: 8/29/2023 11:32 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 8/29/2023 Time: 11:32 am] Manually prepared cost report use only 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 Contractor use only

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 SAINT JOSEPH MEMORIAL HOSPITAL (14-1334) for the cost reporting period beginning 04/01/2022 and ending 03/31/2023 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 ADM	MI NI STRATOR CHECKBOX	ELECTRONI C SI GNATURE STATEMENT	
1		2	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	109, 205	304, 568	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	-218, 019	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
200.00	TOTAL	0	-108, 814	304, 568	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA

Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1334 Peri od: Worksheet S-2 From 04/01/2022 Part I 03/31/2023 Date/Time Prepared: 8/29/2023 11:22 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2 SOUTH HOSPITAL DRIVE 1.00 PO Box: 1.00 City: MURPHYSBORO 2.00 State: IL Zip Code: 62966 County: JACKSON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX 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 SAINT JOSEPH MEMORIAL 141334 16060 05/01/2004 Ν 0 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF SAINT JOSEPH HOSPITAL 147334 0 16060 11/14/2013 0 7 00 7.00 N SWING BED 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital - Based Health Clinic - FQHC 16.00 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 20.00 Cost Reporting Period (mm/dd/yyyy) 03/31/2023 04/01/2022 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for Ν 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 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν N 22.01 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 Ν Ν 22.02 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 22 03 N N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised 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 3 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.

				in Lieu			<u> </u>
DATA	Provider CC	CN: 14-1334			Part I Date/Ti	me Prepa	
In-State	In-State	Out-of	Out-of		id 0	ther	2 am
pai d days	el i gi bl e unpai d	Medicaid paid days	Medicaid eligible	Timo da	, I		
1.00	days 2. 00	3. 00	unpai d 4. 00	5. 00	6	5. 00	
C	0	0	0		0	0 :	24. 0
n	0	0	0		0		25. 00
			Urban/R	ural S	Date of	Geogr	
wage) status	at the bed	ninning of 1	1. (00		00	26. 0
or rural.				2			27. 00
or "2" for r fication in	ural. If ap column 2.	opl i cabl e,		2			
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ites.	·			0			36. 0 37. 0
the MDH tran	sitional pa	ayment in	15	U			37. 0
es of MDH st	atus. If li	ne 37 is					38. 0
or perrous r	ii excess oi	one and	V /	N.I.	V /	'Al	
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ober 1. Ente	r "Y" for y				N		40. 0
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ception for	extraordi na	ary circumst	ances	N	N		46. 0
				N	N		47. 0 48. 0
					1		56. 0
r "Y" for yes per 27, 2020, column 1 is grams in the e CRs) MA dir	or "N" for under 42 ("Y", or if prior year	no in colu CFR 413.78(b this hospit or penultin	umn 1. For b)(2), see cal was nate year,				30. 0
nber 27, 2020 ch residents in column 1. s cost report tete Worksheet f applicable EFR 413.77(e re on duty, i	in approved If column ing period? E-4. If column For cost (1)(iv) ar f the respo	d GME progra 1 is "Y", c 2 Enter "Y' Dlumn 2 is ' reporting p nd (v), rega onse to line Dlete Worksh	nms trained lid for yes or N", periods ardless of e 56 is "Y" neet E-4.				57. 0
iiibui seilient T	or physicia	ans service	is as	1	1	1 13	58. 0
	wage) status The state Medicaid paid days 1.00	wage) status at the begeor rural. wage) status at the end or "2" for rural. If any fication in column 2. The number of periods of the MDH transitional part for yes or "N" for no. test of MDH status. If lift of periods in excess of more in excess of the more in excess of the more in excess of the more in excess of more in excess of more in excess of the more in excess of more in excess o	In-State Medicaid Paid days eligible Medicaid paid days eligible Medicaid days adays 1.00 2.00 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	In-State Medicaid paid days eligible unpaid days and days are states. Wage) status at the beginning of the for rural. Wage) status at the end of the cost or "2" for rural. If applicable, fication in column 2. The number of periods SCH status in Begin 1.00 Wage) status at the end of the cost or "2" for rural. If applicable, fication in column 2. The number of periods SCH status in Begin 1.00 State Medicaid Medicaid deligible unpaid days are status. If applicable, fication in column 2. The number of periods MDH status in Begin 1.00 Status. Subscript line 36 for number states. Subscript line 36 for number of periods mDH status the MDH transitional payment in for yes or "N" for no. (see see of MDH status. If line 37 is of periods in excess of one and Wage) status. If line 37 is of periods in excess of one and Wage) status are the end of the cost or "2" for yes or "N" for no. In approved GME programs? For cost reporting the programs in the prior year or penultimate year, years in the prior year or penultimate year, or yes on the prior year or penultimate year, or yes on the prior year or penultimate year, or yes on the prior year or penultimate year, or yes on the prior year or penultimate year, or yes on the prior year or penultimate year, or yes on the prior year or penultimate year, or yes on yellown 1 is "Y", did did year yellow ye	DATA Provider CCN: 14-1334 Priorider CCN: 14-1334 P	DATA Provider CCN: 14-1334 Period: From 0d/01/2022 Pariod: Par	DATA Provider CCN: 14-1334 Period: From 04/01/2022 To 03/31/2023 Date/Time Prepared Pre

			To	03/31/2023	Date/Time Pre 8/29/2023 11:	
		<u> </u>		V	XVIII XIX	
50.00 Are costs claimed on Line 100 of Workshoot A2 If was	compl	oto Wkst D 2	. Pt. I.	1. 00 N	0 2.00 3.00	59.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes	, compi	ete WKSt. D-2	NAHE 413.85	Worksheet A	Pass-Through	39.00
			Y/N	Line #	Qualification Criterion Code	
			1. 00	2.00	3.00	
0.00 Are you claiming nursing and allied health education			N			60.00
any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	umn 1. R) NAHE	If column 1				
	Y/N	I ME	Direct GME	I ME	Direct GME	
	1.00	2. 00	3. 00	4. 00	5. 00	
51.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care	N			0.00	0.00	61. 00
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 0
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.0
61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. C
	Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2. 00	3. 00	4. 00	
1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0. 00	61. 1
1. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0. 00	61. 2
					4.22	
ACA Provisions Affecting the Health Resources and Ser	vi ces	Administration	(HRSA)		1. 00	
2.00 Enter the number of FTE residents that your hospital	trai ned			od for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruc 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	Teachi			your hospital	0.00	62. 0 ⁻
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	r Sett ttings	ngs during this c	ost reporting p		N	63.00

Health Financial Systems	SALNT JOSE	EPH MEMORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP			CN: 14-1334 Pe	eriod: com 04/01/2022	Worksheet S-2 Part I	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Base Yea			This base year	is your cost r	reporting	
period that begins on or after. 64.00 Enter in column 1, if line 63 is in the base year period, the nur resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column	s yes, or your facilit mber of unweighted nor ptations occurring in e number of unweighted our hospital. Enter ir	ry trained residents n-primary care all nonprovider I non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64. 00
[8. (88. dim.) : di vi ded 27 (88. dim.)	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 Ratio (col. 1/	65. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	r cost reporti	ng peri ods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column	unweighted non-primar occurring in all nonpr unweighted non-primar tal. Enter in column 3 column 2)). (see ins	ovider settings. Ty care resident The thick the tation of structions)	0.00			
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0. 000000	67.00

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97.00

Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the

If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

applicable column.

applicable column.

94.00

95.00

96.00

### ### ### ### ### ### ### ### ### ##	Health Financial Systems SAINT JOSEPH MEN	MORIAL HOSPITAL	-	In Lie	u of Form CMS	-2552-10
98.00	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	F	rom 04/01/2022	Part I Date/Time Pr	repared:
98.00 Does It He V or XX Folion Medicane (Et He XVIII) for the Interns and residents post systems and guilaments on Misch. B. Pt. 1, col. 25P Entert "For ryse or "N" for no in St. Pt. 1, col. 25P Entert "For ryse or "N" for no in St. Pt. 1, col. 25P Entert "For ryse or "N" for no in St. Pt. 1, col. 25P Entert "For ryse or "N" for no in St. Pt. 1, col. 25P Entert "For ryse or "N" for no in column 7 for Ettle V. and in column 7 for Ettle V. and in column 7 for 11tle V. and in column 8 for 11tle VIII for the declaration of colorability of the St. Pt. 1, col. 14P Entert "For ryse or "N" for no in column 1 for 11tle V. and in column 1 for 11tle V. and in column 2 for Ettle VIII for the calculation of Colorability VIII for the calculation of Colorability VIII for 11tle VIII for the calculation of Colorability VIII for the calculation of Colorability VIII for 11tle VIII for a critical access hospitud (CAP) in N N 98.03 for 11tle VIII for a critical access hospitud (CAP) in N N 98.03 for 11tle VIII for the calculation California VIII for a critical access hospitud (CAP) in N N 98.04 for 11tle VIII for 10tle VIII for a critical access hospitud (CAP) in N N 98.04 for 11tle VIII for 10tle VIII for a critical access hospitud (CAP) in N N 98.04 for 11tle VIII for 10tle VIII for a critical access hospitud (CAP) in N N 98.04 for 11tle VIII for 10tle VIII for a critical access hospitud (CAP) in N N 98.04 for 10tle VIII for 10tle VIII for a critical viii for in the VIII for 10tle VIII for 10tle VIII for a critical viii for 10tle VIII for				V	'	1: 22 alli
stepdom adjustments on Wistl. 8, Pt. 1, col. 252 Enter "Y" for yes or "N" for no in claims." The Title V and in column 2 for title XIV. 98.01 Box 111 EV or XIX follow Medicare (it te XIVI) for the reporting of charges on Boxt. 98.02 Box 111 EV or XIX follow Medicare (it te XIVII) for the reporting of charges on Boxt. 98.02 Box 111 EV or XIX follow Medicare (it te XIVII) for the calculation of observation you have been contained and the column 2 for title V. 98.02 Box 111 EV or XIX follow Medicare (it te XVIII) for a critical access hospital (CAH) N N N 98.03 reinbursed 101s or inperient services costs of the text of rey yes or "N" for no in column 1 for title V. and in column 2 for title XIX follow Medicare (it text of the XIVII) for a critical access hospital (CAH) N N N 98.03 reinbursed 101s or inperient services costs of their "Y" for yes or "N" for no in column 1 for title V. and in column 2 for title XIX follow Medicare (it it is XIVII) for a CAH reinbursed 101s or inperient services costs father "Y" for yes or "N" for no in column 1 for title V. and in column 2 for title XIX follow Medicare (it it is XVIII) and add back the RCE disallowence on column 2 for title XIX follow Medicare (it it is XVIII) and add back the RCE disallowence on column 2 for title XIX follow Medicare (it it is XVIII) and add back the RCE disallowence on column 2 for title XIX follow Medicare (it it is XVIII) and add back the RCE disallowence on column 2 for title XIX follow Medicare (it it is XVIII) and add back the RCE disallowence on column 2 for title XIX follow Medicare (it it is XVIII) and add back the RCE disallowence on column 2 for title XIX follow Medicare (it it is XVIII) and add back the RCE disallowence on column 2 for title XIX follows Medicare (it it is XVIII) and and the XIX follows Medicare (it is XVIII) and add the XIX follows Medicare (it is XVIII) and the XIX follows Medicare (it is						
C. Pt. 17 Enter "Y for yes or "N" for no in column 1 for title V. and in column 2 for title V. and in column 3 for title V. and in column 3 for 1 for v. And in column 3 for title V. and in column 4 for title V. and in column 5 for title V. and in column 5 for title V. and in column 5 for for post of V. an	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	for yes or "N"	for no in		·	
bed costs on Wast. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (Cai) For title V, and in column 1 for title V, and in column 2 for title V XIX 98.05 bloss trile V or XIX follow Medicare (title XVIII) and add back the RCC disallowance on Y 98.05 Substitute V or XIX follow Medicare (title XVIII) and add back the RCC disallowance on Y 98.05 Substitute V or XIX follow Medicare (title XVIII) and add back the RCC disallowance on Y 98.05 For title V XIX 98.06 bloss trile V or XIX follow Medicare (title XVIII) and add back the RCC disallowance on Y 98.06 For title V XIX 98.06 bloss trile V or XIX follow Medicare (title XVIII) and add back the RCC disallowance on Y 98.06 For title XIX 98.06 bloss trile V or XIX follow Medicare (title XVIII) and add back the RCC disallowance on Y 98.06 For title XIX 98.06 bloss trile V or XIX follow Medicare (title XVIII) and add back the RCC disallowance on Y 98.06 For title XIX 98.06 bloss trile V or XIX follow Medicare (title XVIII) and add back the RCC disallowance on Y 98.06 For title XIX 98.06 bloss trile V or XIX follow Medicare (title XVIII) and to Y 98.06 For title XIX 98.06 bloss trile V or XIX follow Medicare (title XVIII) and to Y 98.06 For title XIX 98.06 bloss trile V or XIX follow Medicare (title XVIII) and to Y 98.06 For title XIX 98.06 bloss trile V or XIX follows Medicare (title XVIII) and to Y 98.06 For title XIX 98.06 bloss trile V or XIX follows Medicare (title XVIII) and to Y 98.06 For title XIX 98.06 bloss trile XIX 98.06 For title XIX 98.	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t			Y	Y	98. 01
98. 03 Doess title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAII) 98. 04 Doess title V or XIX follow Medicare (title XVIII) for a CAIP reliablement of the CAIP of title V or XIX follow Medicare (title XVIII) for a CAIP reliablement of the CAIP of title V or XIX follow Medicare (title XVIII) for a CAIP reliablement of the V or XIX follow Medicare (title XVIII) for a CAIP reliablement of the V or XIX follow Medicare (title XVIII) for a CAIP reliablement of the V or XIX follow Medicare (title XVIII) and add back the RCC disal lowence on V Y 98. 05 98. 05 Doess title V or XIX follow Medicare (title XVIII) and add back the RCC disal lowence on V Y Y 98. 06 98. 06 Doess title V or XIX follow Medicare (title XVIII) and add back the RCC disal lowence on V Y Y 98. 06 98. 06 Doess title V or XIX follow Medicare (title XVIII) when cost reliablement for West. D, V Y 98. 06 98. 07 Does the V or XIX follow Medicare (title XVIII) when cost reliablement follows (title V or XIX for V or V Or XIX for No. 100 to Coloura 2 for title XIX. 105. 00 Doess this hospital qualify as a CAIP? 105. 00 Doess this hospital qualify as a CAIP? 106. 00 If this facility qualifies as a CAIP, has it elected the all-inclusive method of payment N 105. 00 107. 00 If this facility qualifies as a CAIP of or file XIX for No. 100 to Coloura 2. If colour in 1 is Y and line 70 or file 75 is Y, do you train 18Rs in an approved medical education program in the CAIP's excluded IPF and/or IRF unit(S)? 107. 00 If this hospital qualifying for an exception to the CRMA for exception 70 to CAIP or Y for	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes			Y	Y	98. 02
98.04 obustitle V or XIX follow Medicare (itite XVIII) for a CAH reinbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (itite XVIII) and add back the RCE disallowance on column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (itite XVIII) and add back the RCE disallowance on column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (itite XVIII) when cost rethbursed for West D. Y Y 98.06 For title XIX. 98.06 Does title V or XIX follow Medicare (ititle XVIII) when cost rethbursed for West D. Y Y 98.06 For XIII for XIII was all in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (ititle XVIII) when cost rethbursed for West D. Y Y 98.06 For XIII for XIII was all XIII wa	98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y			N	N	98. 03
98.05 boses title V or XIX follow Medicare (title XVIII) and add back the RCC disal lowance on Wast. O, Pt. I. col. 47 Enter "Y" for yes or "N" for no in column 1 for title IV. and in column 2 for title XIX. 80.6 bloss title V or XIX follow Medicare (title XVIII) when cost relimbursed for Wast. D, V Y 98.06 column 2 for title XIX. 98.06 bloss title V or XIX follow Medicare (title XVIII) when cost relimbursed for Wast. D, V Y 98.06 column 2 for title XIX. 98.06 bloss title V or XIX follow Medicare (title XVIII) when cost relimbursed for Wast. D, V Y 98.06 column 2 for title XIX. 98.06 bloss title V or XIX follow Medicare (title XVIII) when cost relimbursed for Wast. D, V Y Y 98.06 column 2 for title XIX. 98.06 bloss title V or XIX follow Medicare (title XVIII) when cost relimbursed for Wast. D, V Y Y 98.06 column 2 for title XIX. 98.06 bloss title V or XIX follow Medicare (title XVIII) when cost relimbursed for Wast. D, V Y Y 98.06 column 2 for title XIX. 98.06 bloss ti	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 i			N	N	98. 04
98.06 boes title V or XIX follow Medicare (title XVIII) when cost relmbursed for Wixst. D. Y 99.06 Pts. I through IV? Enter "Y" for yes or "N" for no In column 1 for title V, and In column 2 for title XIX. Namel Providers 105.00 boes this hospital qualify as a CAH? 105.00 boes this hospital qualifies as a CAH, has it elected the all-inclusive method of payment N 105.00 for outpatient services? (see instructions) training programs? Enter "Y for yes or "N" for no in column 1. (see instructions) N 106.00 for outpatient services? (see instructions) training programs? Enter "Y for yes or "N" for no in column 1. (see instructions) N 107.00 for intermining programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 108.00 for intermining programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 108.00 for intermining programs? Enter "Y" for yes or "N" for no in column 2. (see instructions) N 108.00 for intermining for an exception to the CRMA fee schedule? See 42 N 108.00 for intermining for an exception to the CRMA fee schedule? See 42 N 108.00 for intermining for an exception to the CRMA fee schedule? See 42 N 108.00 for intermining for an exception to the CRMA fee schedule? See 42 N 108.00 for intermining for an exception to the CRMA fee schedule? See 42 N 108.00 for intermining for intermining for an exception to the CRMA fee schedule? See 42 N 108.00 for intermining for intermining for an exception of the CRMA fee schedule? See 42 N 108.00 for intermining for	98.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in				Y	98. 05
Rural Providers	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 colum			Y	Y	98. 06
106.00 f this facility qualifies as a CAH, has it elected the all-inclusive method of payment N 106.00	Rural Providers					
107.00(Column 1: If line 105 is Y, is this facility eligible for cost reinbursement for L&R	106.00 If this facility qualifies as a CAH, has it elected the all	-inclusive met	hod of payment			
Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train 18Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 is this a rural hospit all qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 CFR Section \$412.113(c). Enter "Y" for yes or "N" for no. 109.00 if this hospit all 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. 110.00 if this hospit all participate in the Rural Community Hospit all Demonstration project (\$410A N 110.00 Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. 111.00 if this facility qualifies as a CAH, did it participate in the Frontier Community N N 111.00 Period Per	107.00 Column 1: If line 105 is Y, is this facility eligible for c			N	N	107. 00
108.00 s this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 CFR Section \$412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory	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 I	you train I&R PF and/or IRF	s in an			
Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 4.00 1.00 0.00 1.00	108.00 Is this a rural hospital qualifying for an exception to the		dul e? See 42	N		108. 00
109.00 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. 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A N 110.00 Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 21B, and Worksheet E-2, lines 200 through 215, as applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Frontier Community N Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demon in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds: and/or "C" For tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration in column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no 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 special arcous Cost Reporting information 115.00 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 beds) and the definition in CMS Pub. 15-1, chapter 22, \$2208.1. 116.00 St this facility classified as a referral center? Enter "Y" for yes or "N" for no. 117.00 St this facility legally-required to carry ma						_
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A N 110.00 Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Frontier Community N Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration project for ENTER Port of the entering period? Enter "Y" for yes or "N" for Ambulance services: "B" for additional beds; and/or "C" for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 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 soft 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 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 1	100 00 f this bosnital qualifies as a CAH or a cost provider are					100.00
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, Ilnes 200 through 218, and Worksheet E-2, Ilnes 200 through 215, as applicable. 110.00	therapy services provided by outside supplier? Enter "Y"	F IV	IN IN	IN IN	N N	107.00
Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no lf yes. complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services: "B" for additional beds: and/or "C" for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is ""Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participating in in the demonstration, if applicable. Miscel laneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 2. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 1 is yes, enter the method used (A, B, or E only) in column 3 in the definition in CMS Pupicent 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 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1					1.00	
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Community Heal th Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services. 1.00 2.00 3.00 112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 1. 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 is this facility classified as a referral center? Enter "Y" for yes or "N" for no. 117.00 Is this facility legally-required to carry mal practice insurance? Enter "Y" for yes or "N" for no. 118.00 is the mal practice insurance a claims-made or occurrence policy? Enter 1 118.00	Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or	"N" for no. I	f yes,	N	110. 00
Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services. 1.00 2.00 3.00 112.00 Did this hospital participate in the Pennsyl vania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is """, 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 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 Is this facility legally-required to carry mal practice insurance? Enter "Y" for yes or "N" for no. 117.00 Is the mal practice insurance a claims-made or occurrence policy? Enter 1 118.00 Is the mal practice insurance a claims-made or occurrence policy? Enter 1				1. 00	2.00	
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112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 112.00 112.00 N 112.00 N 0115.00 N 0115.00 N 0115.00 115.00 116.00 117.00 118.00			1 00	2 00	3 00	
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. 118.00 Is the mal practice insurance a claims-made or occurrence policy? Enter 1	(PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable.	reporting column 1 is pating in the		2.00	0.00	112.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 116.00	Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide	B, or E only) 93" percent (includes	N			0115.00
117.00 Is this facility legally-required to carry malpractice insurance? Enter Y "Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 1 118.00	116.00 Is this facility classified as a referral center? Enter "Y"	for yes or	N			116. 00
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 1 118.00	117.00 Is this facility legally-required to carry malpractice insu	ırance? Enter	Y			117. 00
	118.00 Is the malpractice insurance a claims-made or occurrence po			1		118. 00

142.00 Street. 1237 L. WAIN SINELI	II O DOX.	3700				1142.00
143.00 Ci ty: CARBONDALE	State:	IL	Zi p Code:	6290)2-3988	143. 00
					1.00	
144.00 Are provider based physicians' c	osts included in Wor	ksheet A?			Y	144. 00
				1. 00	2.00	
145.00 If costs for renal services are	claimed on Wkst. A,	line 74, are the	costs for			145. 00
inpatient services only? Enter "	Y" for yes or "N" fo	or no in column 1	. If column 1 is			
no, does the dialysis facility i	nclude Medicare util	ization for this	cost reporting			
period? Enter "Y" for yes or "N	" for no in column 2	2.				
146.00 Has the cost allocation methodol	ogy changed from the	e previously file	d cost report?	N		146. 00
Enter "Y" for yes or "N" for no	in column 1. (See CN	IS Pub. 15-2, cha	pter 40, §4020) If			
yes, enter the approval date (mm	/dd/yyyy) in column	2.				

Health Financial Systems	SAI NT JOSEPH	MEMOR	_		-		u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Provi der CC	N: 14-1334	Peri From To	od: n 04/01/2022 03/31/2023		epared:
							1. 00	
147.00 Was there a change in the statisti	cal basis? Enter "Y"	for yes	s or "N" for	no.			N	147. 00
148.00 Was there a change in the order of							N	148. 00
149.00 Was there a change to the simplifi	ed cost finding metho	d? Ente					N	149. 00
			Part A	Part E	3	Title V	Title XIX	_
Dood this facility contain a provi	don that qualifies fo		1.00	2.00	ooti on	3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '								
155. 00 Hospi tal	N 101 110 101 each co	IIIporteri	N	N	J. (3ee	N N	N N	155. 00
156. 00 Subprovi der - IPF			N	N		N	N	156. 00
157. 00 Subprovi der - IRF			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								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that ha	s one o	or more campu	ses in dif	ferent	CBSAs?	N	165. 00
, , , , , , , , , , , , , , , , , , , ,	Name		County	State	Zip Co	de 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. 0	166. 00
							1. 00	+
Health Information Technology (HI) incentive in the Am	eri can	Recovery and	Rei nvestr	ment Ac	t		
167.00 is this provider a meaningful user 168.00 if this provider is a CAH (line 10					/") en	ter the	Y	167. 00 168. 00
reasonable cost incurred for the H					,,			
168.01 If this provider is a CAH and is r	ot a meaningful user,	does	this provider	qualify f	or a h	ardshi p		168. 01
exception under §413.70(a)(6)(ii)								
169.00 If this provider is a meaningful u	,	and is	s not a CAH (line 105 i	s "N")	, enter the	0. (00 169. 00
transition factor. (see instruction	ns)							
						Begi nni ng	Endi ng	-
170.00 Enter in columns 1 and 2 the EHR L	oginning data and and	ina dat	to for the re	nonting		1. 00	2. 00	170. 00
period respectively (mm/dd/yyyy)	eginning date and end	ing da	te for the re	por tring				170.00
						1. 00	2. 00	
171.00 If line 167 is "Y", does this prov	ider have any days fo	r indiv	vi dual s enrol	led in		N		0 171. 00
section 1876 Medicare cost plans i "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	Pt. I,	, line 2, col	. 6? Enter				

JSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 14-1334	Peri od: From 04/01/2022 To 03/31/2023	Worksheet S-2 Part II Date/Time Pro 8/29/2023 11:	epared:
				1. 00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEI General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in t	he	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N)		1.0
			Y/N	Date	V/I	
00	lu u	0.16	1.00	2. 00	3. 00	-
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, including	n 3, "V" for	N Y			2.0
	contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members or of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	·			3.0
			Y/N	Туре	Date	
			1.00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A		4.0
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		Y			5.0
	those on the fired financial statements: If yes, submit fee	Oner i rati on.		Y/N	Legal Oper.	
				1. 00	2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for a nursing program? Column the Legal operator of the program?	3	s the provide	r N		6.0
00	Are costs claimed for Allied Health Programs? If "Y" see in: Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during th	e N		7. 00 8. 00
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 0
. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.	r renewed in t		N		10.0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	oroved	N	V /NI	11. 0
					Y/N 1. 00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y Y	12. 0 13. 0
4. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsural instructions.	nce amounts wa	aived? If yes	, see	N	14. 0
	Bed Complement					
5. 00	Did total beds available change from the prior cost reporti			tructions.	N	15. 0
			rt A I Date		t B	
		1. 00	2. 00	Y/N 3. 00	Date 4. 00	
	PS&R Data	1.00	2.00	3.00	4.00	
5. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Υ	07/28/2023	Y	07/28/2023	16. 0
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17. 0
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 0
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 0

Heal th	Financial Systems SAINT JOSEPH MEN	MORIAL HOSPITAL		In Lie	u of Form CMS	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 14-1334	Peri od: From 04/01/2022 To 03/31/2023	Worksheet S Part II Date/Time P 8/29/2023 1	repared:
			ipti on	Y/N	Y/N	
20.00	If line 1/ on 17 is yes were adjustments made to DCOD		0	1. 00	3. 00	20.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	Troper t data for other book be the other day do the received	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)		1.00	
	Capi tal Related Cost		,			
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ng the cost	N	23. 00		
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost rep	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into dur	ing the cost	reporting	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service Re	eserve Fund)	Υ	29. 00
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes,	see	N	30. 00
31. 00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see	N	31. 00
	Instructions. Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through co	ntractual	N	32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appno, see instructions.	olied pertainir	ng to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					
34. 00	Were services furnished at the provider facility under an alf yes, see instructions.	arrangement wit	th provider-ba	ased physicians?	Y	34.00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the p		Y	35. 00
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00				Υ		36.00
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			37. 00
38. 00	If yes, see instructions.					38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other	d of the home o	ffi ce.			39. 00
40. 00	see instructions.		,	N		40. 00
	instructions.	Tionic office:		14		40.00
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
41. 00	held by the cost report preparer in columns 1, 2, and 3,	LUANNE		WARREN		41. 00
42. 00		SI H				42. 00
43. 00		618-457-5200		LUANNE. WARREN@S	SIH. NET	43. 00
	report preparer in columns 1 and 2, respectively.	I				

Heal th			ORIAL HOSPITAL	<u>_</u>	In Lieu of Form CMS-2552-10			
H0SPI	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	NNAI RE	Provi der 0		Peri od:	Worksheet S-2	2	
					From 04/01/2022 To 03/31/2023	Part II Date/Time Pre	enared:	
						8/29/2023 11:		
			3	. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/pos	si ti on	REIMBURSEMENT	DI RECTOR			41.00	
	held by the cost report preparer in columns 1, 2,	, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost repor	rt					42. 00	
	preparer.							
43.00	Enter the telephone number and email address of t	the cost					43.00	
	report preparer in columns 1 and 2, respectively.							

		MEMORIAL HOSPITAL		Non-CMS HFS Wo	orksheet
HFS Su	upplemental Information	Provi der CCN: 14-1334	Peri od: From 04/01/2022 To 03/31/2023		epared:
			Title V	Title XIX	
			1. 00	2. 00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the stepdown adjustments on W/S B, Part I, column 25? Enter and Y/N in column 2 for Title XIX. (see S-2, Part I, lin	Y/N in column 1 for Title V	Υ	Υ	1.00
2. 00	Do Title V or XIX follow Medicare (Title XVIII) for the Part I (e.g. net of Physician's component)? Enter Y/N in in column 2 for Title XIX. (see S-2, Part I, line 98.01)	reporting of charges on W/S C		Y	2. 00
3. 00	Do Title V or XIX follow Medicare (Title XVIII) for the Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 2 for Title XIX. (see S-2, Part I, line 98.02)		Υ	3. 00	
3. 01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3. 01
3. 02	Does Title XIX transfer managed care (HMO) days from Wor sum of lines 2, 3, and 4 to Worksheet E-4, column 2, lin			Ϋ́	3. 02
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	CRITICAL ACCESS HOSPITALS				
4. 00	Does Title V follow Medicare (Title XVIII) for Critical reimbursed 101% of cost? Enter Y or N in column 1 for in for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N 2	N	4. 00
5. 00	Does Title XIX follow Medicare (Title XVIII) for Critica reimbursed 101% of cost? Enter Y or N in column 1 for in for outpatient. (see S-2, Part I, lines 98.03 and 98.04)			N	5. 00
			Title V	Title XIX	
			1. 00	2. 00	
	RCE DI SALLOWANCE				
6. 00	Do Title V or XIX follow Medicare and add back the RCE D column 4? Enter Y/N in column 1 for Title V and Y/N in column 5-2, Part I, line 98.05)		Y	Υ	6. 00
7. 00	PASS THROUGH COST Do Title V or XIX follow Medicare when cost reimbursed (worksheets D, parts I through IV? Enter Y/N in column 1 2 for Title XIX. (see S-2, Part I, line 98.06)		Y	Υ	7. 00
	RHC				
8. 00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04) Title V and Y/N in column 2 for Title XIX.	? Enter Y/N in column 1 for	N	N	8. 00
9. 00	FOHC For fiscal year beginning on/after 10/01/2014, use M-ser XIX? Enter Y/N in column 1 for Title V and Y/N in column		N	N	9. 00
			Sta	ate	
			1	00	
				00	
	STATE MEDICALD FORMS Select the state when using state Medicaid forms.				

| Peri od: | Worksheet S-3 | From 04/01/2022 | Part | To 03/31/2023 | Date/Time Prepared: | Part | Health Financial Systems SAINT JOSE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1334

					0 03/31/2023	8/29/2023 11: 2	
						I/P Days / 0/P	- Z - GIII
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	Component	Li ne No.	No. or bods	Avai I abl e	O/III/ REIT HOUTS	"""	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA	11.00	2.00	0.00	11.00	0.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	25	9, 125	21, 426. 02	0	1. 00
	8 exclude Swing Bed, Observation Bed and	00.00		// .20	2.7.20.02		00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					ol	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					ol	6. 00
7. 00	Total Adults and Peds. (exclude observation		25	9, 125	21, 426. 02	ol	7. 00
	beds) (see instructions)				, , , , , ,		
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)		25	9, 125	21, 426. 02	ol	14.00
15. 00	CAH visits				, , , , , ,	ol	15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		25				27.00
28. 00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0				32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges						33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	C		0	34.00

Health Financial Systems SAINT JOSEPH MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO

Provider CCN: 14-1334

						8/29/2023 11:	22 am
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6. 00	7. 00	Pati ents 8.00	& Residents 9.00	Payrol I 10.00	
	PART I - STATISTICAL DATA	0.00	7.00	8.00	7.00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	413	8	892			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)	413	O	072			1.00
2.00	HMO and other (see instructions)	228	141				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	1, 925	0	2, 876			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	., . = 3	0	311			6. 00
7. 00	Total Adults and Peds. (exclude observation	2, 338	8	4, 079			7. 00
7.00	beds) (see instructions)	2,000	ŭ	.,			7.00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	2, 338	8	4, 079	0.00	217. 10	14. 00
15.00	CAH visits	0	0	(15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			()		24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC				0.00	0.00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0.00	26. 25
27. 00	Total (sum of lines 14-26)		-	200	0.00	217. 10	27. 00
28. 00 29. 00	Observation Bed Days Ambulance Trips	0	5	280	'		28. 00 29. 00
		o _l					
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - IRF			(30. 00 31. 00
31.00		0	0	(31.00
32. 00	Labor & delivery days (see instructions) Total ancillary labor & delivery room	U	U	(32.00
32. UI	outpatient days (see instructions)				ή		32.01
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01
	Temporary Expansion COVID-19 PHE Acute Care	0	0	()		34. 00
= =	, , , , , , , , , , , , , , , , , , ,	٦	٩		'		

Health Financial Systems SAINT JOSEPH MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO Provider CCN: 14-1334

					03/31/2023	8/29/2023 11: 2	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	104	2	233	1. 00
2.00	HMO and other (see instructions)			53	42		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4. 00	HMO IRF Subprovider				ol		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				آ		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	0	104	2	233	14.00
15.00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23. 00 24. 00
24. 00	HOSPICE (non-distinct part)						24. 00
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambul ance Trips						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care						34. 00

| Peri od: | Worksheet S-3 | From 04/01/2022 | Part IV | To 03/31/2023 | Date/Time Prepared: | Health Financial Systems
HOSPITAL WAGE RELATED COSTS Provider CCN: 14-1334

	10 03/31/2023	8/29/2023 11: 2	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7. 00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
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)	0	8. 02
8. 03	Heal th 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	0	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	0	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unempl oyment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	0	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00
	•	•	

10SPL 1	FINANCIAL Systems SAINT JOSEPH MEMORIAL FAL UNCOMPENSATED AND INDIGENT CARE DATA Property of the property o	ovider CCN	: 14-1334	Peri od:	u of Form CMS-2 Worksheet S-10	
0311	THE GROOMI ENGRIED AND THOUGHT CARE DATA	ovider con	. 14 1354	From 04/01/2022		
				To 03/31/2023	Date/Time Prep 8/29/2023 11:2	pared 22 am
					1. 00	
	Uncompensated and indigent care cost computation					
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by line	e 202 column	8)	0. 220410	1.0
	Medicaid (see instructions for each line)					
. 00	Net revenue from Medicaid		10, 943, 548	•		
. 00 . 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental	navments	from Medica	i d2	Y N	3. 0 4. 0
. 00	If line 4 is no, then enter DSH and/or supplemental payments from		Trom wearca	ii u :	2, 620, 885	
. 00	Medi cai d charges		65, 503, 500	•		
. 00	Medicaid cost (line 1 times line 6)				14, 437, 626	•
3. 00	Difference between net revenue and costs for Medicaid program (li	ne 7 minus	s sum of lin	es 2 and 5; if	873, 193	8.0
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			0	, ,
0.00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	
1. 00			0			
2. 00	,	ne 11 minu	ıs line 9; i	f < zero then	Ö	
	enter zero)					
	Other state or local government indigent care program (see instru					
3. 00	Net revenue from state or local indigent care program (Not include the state of local indigent care pr			,		13. 0 14. 0
4. 00	Charges for patients covered under state or local indigent care p 10)	orogram (No	ot included	III IIIIes o oi	0	14. (
5. 00	1 '				0	15.0
6. 00		gent care p	orogram (lin	e 15 minus line	0	
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and state/	'local indig	ent care program	is (see	
7. 00	Private grants, donations, or endowment income restricted to fund	ding charit	y care		0	17. C
8. 00	9 11 1				0	
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)	naigent ca	are programs	(Sum of lines	873, 193	19. C
			Uni nsured	Insured	Total (col. 1	
		<u> </u>	patients	pati ents	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1. 00	2. 00	3. 00	
0. 00		itv	828, 98	969, 967	1, 798, 953	20 C
	(see instructions)		,		., ,	
1.00	Cost of patients approved for charity care and uninsured discount	ts (see	182, 71	7 969, 967	1, 152, 684	21.0
	instructions)		4.5	. 7	457	
2. 00	Payments received from patients for amounts previously written of charity care	rr as	45	0	457	22. C
3. 00			182, 26	969, 967	1, 152, 227	23. C
			,			
					1. 00	
4. 00	Does the amount on line 20 column 2, include charges for patient		nd a Length	of stay limit	N	24.0
5. 00	imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit	's length of	0	25. C		
6. 00			4, 108, 710	26.0		
	Medicare reimbursable bad debts for the entire hospital complex (ıctions)		1, 284, 184	•
	Medicare allowable bad debts for the entire hospital complex (see	•			1, 975, 667	•
7. 00					2, 133, 043	28.0
27. 00 27. 01 28. 00	Non-Medicare bad debt expense (see instructions)					
27. 00 27. 01 28. 00 29. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exper	nse (see in	nstructions)		1, 161, 627	29.0
27. 00 27. 01 28. 00 29. 00 30. 00	Non-Medicare bad debt expense (see instructions)	·	nstructi ons)			29. 0 30. 0

16, 324, 481

40, 571, 045

56, 895, 526

56, 895, 526 200. 00

200.00

TOTAL (SUM OF LINES 118 through 199)

Health FinancialSystemsSAINT JOSEPHRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1334

			8/29/2023 11:	22 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FLXT	118, 281	1, 638, 895		1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	960, 409	2, 410, 061		2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 256, 223	4, 126, 482		4. 00
5. 01 00550 DATA PROCESSING	3, 579, 344	3, 579, 344		5. 01
5.02 00560 PURCHASING RECEIVING AND STORES	-4, 319	48, 914		5. 02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	740, 325	1, 279, 358		5. 03
5.04 00590 OTHER ADMINISTRATIVE AND GENERAL	295, 357	5, 138, 145		5. 04
6.00 00600 MAINTENANCE & REPAIRS	-24, 571	1, 262, 610		6. 00
7.00 00700 OPERATION OF PLANT	0	206, 105		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	266, 224		8.00
9. 00 00900 HOUSEKEEPI NG	0	463, 268		9. 00
10. 00 01000 DI ETARY	0	183, 441		10.00
11. 00 01100 CAFETERI A	-150, 844	256, 635		11. 00
13. 00 01300 NURSING ADMINISTRATION	-3, 548	1, 159, 162		13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0, 0.0	37, 769		14. 00
15. 00 01500 PHARMACY	-18, 004	11, 905, 362		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-9, 139	23, 053		16. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	-1, 024, 342	20, 000		19.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1,021,012	<u> </u>		17.00
30. 00 03000 ADULTS & PEDI ATRI CS	-682, 365	3, 312, 311		30.00
ANCI LLARY SERVI CE COST CENTERS	002,000	0,012,011		00.00
50. 00 05000 OPERATING ROOM	0	4, 475, 809		50.00
51. 00 05100 RECOVERY ROOM	0	183, 855		51.00
53. 00 05300 ANESTHESI OLOGY	0	232, 373		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-36, 220	1, 796, 208		54.00
60. 00 06000 LABORATORY	-188, 747	2, 802, 670		60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	904, 026		64. 00
65. 00 06500 RESPIRATORY THERAPY	0	770, 155		65.00
65. 01 03610 SLEEP LAB	-9, 622	794, 249		65. 01
65. 02 03620 GERI ATRI C PSYCH	0,022	314, 441		65. 02
66. 00 06600 PHYSI CAL THERAPY	-1, 303	1, 359, 825		66.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1, 303	964, 927		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 387, 983		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	150, 644		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	291, 359		76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	291, 339		77.00
OUTPATIENT SERVICE COST CENTERS	U	U		17.00
90. 00 09000 CLINIC	0	227 142		90.00
91. 00 09100 EMERGENCY	0 -2, 042, 014	226, 142		90.00
	-2, 042, 014	2, 130, 681		
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)				92. 00
OTHER REIMBURSABLE COST CENTERS	0			100 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
SPECIAL PURPOSE COST CENTERS				110 00
113. 00 11300 INTEREST EXPENSE	0	0		113.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	242, 455	57, 082, 486		118. 00
NONREI MBURSABLE COST CENTERS				1.00.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	-8, 728	46, 767		192. 00
192. 01 19201 UNUSED SPACE	0	0		192. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	233, 727	57, 129, 253		200. 00

COST Center Description				'	8/29/2023 1	
CENERAL SERVICE COST CENTERS 1.00 2.00		Cost Center Description	C	MS Code		1. 22 (111
GENERAL SERVICE COST CENTERS						
GENERAL SERVICE COST CENTERS						
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLOG & FIXT 0.0100 2.00				1. 00	2.00	
AP REL COSTS-MYBLE EQUIP 00200		GENERAL SERVICE COST CENTERS				
4.00 CMPLOYEE BERKETTS DEPARTMENT 0.0400 DATA PROCESSING 5.01 DATA PROCESSING 5.02 PURCHASING RECEI VING AND STORES 5.02 STORES 5.02 STORES 5.03 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.00 CASHI ERI NG/ACCOUNTS RECEIVE RECEIVE CASHI ERI NG/ACCOUNTS RECEIVE R						1.00
DATA PROCESSING 0.0550						11
5.02 PURCHASING RECELVING AND STORES 0.0560 PURCHASING RECELVING AND STORES 0.0560 CASHLERING/ACCOUNTS RECELVABLE 0.0560 CASHLERING/ACCOUNTS RECELVABLE 5.03 5.04 OTHER ADMINISTRATIVE AND GENERAL 0.0590 6.00 6.00 OTHER ADMINISTRATIVE AND GENERAL 0.0590 6.00 0.00 OPERATION OF PLANT 0.0700 7.00 0						11
ASHIERING/ACCOUNTS RECEIVABLE						11
Solid Cashi Ering/Account's Receivable Solid Solid Cashi Ering/Account's Receivable Solid Solid Cashi Ering/Account's Receivable Solid Solid Solid Cashi Ering/Account's Receivable Solid Sol	5. 02	PURCHASING RECEIVING AND STORES		00560		5. 02
THER ADMINISTRATIVE AND GENERAL		01011 50110 (100011170 D50511140) 5				
5.04	5.03	CASHIERING/ACCOUNTS RECEIVABLE		00580		5.03
6. 00 MAINTENANCE & REPAIRS 00600 7. 00 00700 00700 7. 00 007000 007	F 04	OTHER ARMINI CTRATILVE AND CENERAL		00500	RECEIVABLE	F 04
7. 00						
B. 00						11
9.00 HOUSEKEEPI NG						- 11
10. 00 DIETARY 011000 11. 00						11
11. 00 CAFETERIA						11
13. 00 NURSI NG ADMINISTRATION						11
14. 00 CENTRAL SERVICES & SUPPLY						11
15. 00 PHARMACY						11
16. 00						- 11
19.00 NOMPHYSI CIÁN AMESTHÉTISTS 01900 19.00						- 11
NPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 0.3000 30.00	17.00			01700		17.00
ANCI LLARY SERVICE COST CENTERS	30 00			03000		30.00
50.00 FERATI NG ROOM	00.00					
51.00 RECOVERY ROOM S100	50.00			05000		50.00
53.00 ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C 05400 54.00 65.00 66.00						11
54.00 RADIOLOGY-DIAGNOSTIC 05400 54.00 60.00	53.00			05300		53.00
60. 00 LABORATORY 06400 64. 00 65. 00 65. 00 65. 00 65. 01 65. 01 65. 02 66. 01 65. 02 66. 01 66. 00 66. 00 66. 00 66. 01 66. 00 66. 00 66. 01 66. 00 71. 00 72. 00 72. 00 73. 00 74. 00	54.00					54.00
65. 00 RESPIRATORY THERAPY 06500 65. 00 65. 01 65. 02 66. 01 65. 02 66. 02 67. 02	60.00					60.00
65. 01 SLEEP LAB 03610 SLEEP LAB 65. 01 65. 02 GERI ATRI C PSYCH 03620 STRESS TEST 65. 02 66. 00 PHYSI CAL THERAPY 06600 071.00 71. 00 71. 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 07100 71. 00 72. 00 IMPL. DEV. CHARGED TO PATIENTS 07200 72. 00 73. 00 DRUGS CHARGED TO PATIENTS 07300 7300 73. 00 76. 97 CARDI AC REHABI LITATI ON 07697 CARDI AC REHABI LITATI ON 76. 97 77. 00 ALLOGENEI C HSCT ACQUI SI TI ON 07700 07700 07700 077.00 90. 00 CLI NI C 09000 90. 00 91. 00 EMERGENCY 09100 91. 00 92. 00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 09200 92. 00 92. 00 OPICE REI MBURSABLE COST CENTERS 113.00 102. 00 OPICE REI MBURSABLE COST CENTERS 113.00 113. 00 INTEREST EXPENSE 113.00 113. 00 INTEREST EXPENSE 113.00 114. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118. 00 102. 00 OPICE REI MBURSABLE COST CENTERS 190.00 192.00 192. 00 PHYSI CI ANS' PRI VATE OFFICES 192.00 192. 01 UNUSED SPACE 192.01 192.00 192. 01 UNUSED SPACE 192.01 192.00 192. 01 192. 01 193. 00 193. 00 193.	64.00	I NTRAVENOUS THERAPY		06400		64.00
65. 02 GERI ATRIC PSYCH 03620 STRESS TEST 65. 02	65.00	RESPI RATORY THERAPY		06500		65. 00
66.00 PHYSICAL THERAPY 06600 66.00 71.00 71.00 71.00 71.00 71.00 72.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 72.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 72.00 72.00 73.	65. 01	SLEEP LAB		03610	SLEEP LAB	65. 01
71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 07100 72.00 72.00 72.00 72.00 72.00 73.0	65. 02	GERI ATRI C PSYCH		03620	STRESS TEST	65. 02
72.00 IMPL. DEV. CHARGED TO PATIENTS 07200 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 75.97 77.00 77.	66.00	PHYSI CAL THERAPY		06600		66. 00
73.00 DRUGS CHARGED TO PATIENTS 07300 76.97 CARDI AC REHABILITATION 76.97 77.00 ALLOGENEI C HSCT ACQUISITION 07700 07700 77.00 00000 00000 0000 0000 0000 0000 00000 00	71. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS		07100		71.00
76. 97 CARDI AC REHABILITATION 76. 97 77. 00 ALLOGENEIC HSCT ACQUISITION 77. 00 000 77. 00 000 77. 00 000 77. 00 000	72.00	IMPL. DEV. CHARGED TO PATIENTS		07200		72. 00
77. 00 ALLOGENEI C HSCT ACQUI SITI ON 07700 77. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 CLINIC 99. 00 EMERGENCY 99. 00 99100 91. 00 92. 00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 992. 00 OTHER REI MBURSABLE COST CENTERS 102. 00 OPI OI D TREATMENT PROGRAM 10200 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 INTEREST EXPENSE 11300 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 192. 01 UNUSED SPACE 19200 192. 01						- 11
OUTPATI ENT SERVI CE COST CENTERS O9000 90.00 91.00					CARDIAC REHABILITATION	- 11
90. 00 CLINIC 09000 90. 00 91. 00 91. 00 92. 00 08SERVATI ON BEDS (NON-DISTINCT PART) 09200 92. 00 07HER REIMBURSABLE COST CENTERS 102. 00 OPIOI D TREATMENT PROGRAM 10200 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118. 00 118. 00 118. 00 118. 00 119. 0	77. 00			07700		77. 00
91. 00 EMERGENCY 09100 91. 00 92. 00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 09200 92. 00 OTHER REI MBURSABLE COST CENTERS 102. 00 OPI OI D TREATMENT PROGRAM 10200 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 INTEREST EXPENSE 11300 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 192. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 192. 01 UNUSED SPACE 19200 192. 01						
92. 00 OBSERVATI ON BEDS (NON-DISTINCT PART) 09200 92. 00 OTHER REIMBURSABLE COST CENTERS 102. 00 OPI OI D TREATMENT PROGRAM 10200 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 INTEREST EXPENSE 11300 113. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 192. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 192. 01 UNUSED SPACE 19201 1920. 01						- 11
OTHER REIMBURSABLE COST CENTERS 102. 00 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS 113. 00 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 190. 00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 UNUSED SPACE 192. 01 UNUSED SPACE						- 11
102.00 OPI OI D TREATMENT PROGRAM 10200 102.00 SPECI AL PURPOSE COST CENTERS 11300 113.00 113.00 118.00 SUBTOTALS (SUM OF LI NES 1 through 117) 118.00 NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19000 192.00 192.00 192.00 192.00 192.00 192.01 192.01 192.01 192.01 192.01	92. 00			09200		92. 00
SPECIAL PURPOSE COST CENTERS 11300 113.00 113.00 118.00					-	
113. 00 INTEREST EXPENSE 11300 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) NONREI MBURSABLE COST CENTERS 190. 00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19000 192. 00 PHYSI CI ANS' PRI VATE OFFI CES 19200 192. 01 UNUSED SPACE 19201 1920 1	102.00			10200		102. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 192. 00 192. 00 192. 00 192. 00 192. 01 192. 01 192. 01 192. 01				11000		
NONREI MBURSABLE COST CENTERS 190. 00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 190.00 192. 00 PHYSI CI ANS' PRI VATE OFFI CES 19200 192. 01 UNUSED SPACE 19201				11300		- 11
190. 00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 190.00 192. 00 PHYSI CI ANS' PRI VATE OFFI CES 19200 192. 01 UNUSED SPACE 19201	118.00					118.00
192. 00 PHYSI CI ANS' PRI VATE OFFI CES 192.00 192. 01 UNUSED SPACE 19201	400 -			40000		100 00
192. 01 UNUSED SPACE 19201 192. 01						- 11
						- 11
200.00 UP LINES 118 through 199) 200.00				19201		- 11
	∠∪∪. 00	DITOTAL (SUM OF LINES ITO THE OUGH 199)	I		I	200.00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 04/01/2022 To 03/31/2023 Date/Time Prepared: 9/29/2023 11:22 am Provider CCN: 14-1334

					8/29/202	23 11: 22 am
		Increases				
	Cost Center	Li ne #	Salary	Other		
	2.00 A - Dietary	3. 00	4.00	5. 00		
1.00	CAFETERI A	11.00	253, 834	259, 265		1.00
	TOTALS		253, 834	259, 265		
	B - Recl Medical Supplies					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00		964, 927		1.00
2. 00	PATI ENTS					2. 00
2. 00 3. 00						3.00
4. 00						4. 00
5. 00			•			5. 00
6.00						6. 00
7.00						7. 00
8. 00						8. 00
9.00						9. 00
10. 00	+	+				10. 00
	C - Drugs Charged to Patients		<u> </u>	704, 727		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	63, 733		1. 00
2.00		0.00	О	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00	1	0.00	0	0		7.00
8. 00		0.00	ő	0		8. 00
9. 00		0.00	o	Ö		9. 00
10.00		0. 00	О	0		10. 00
11. 00		0.00	•	0		11. 00
	TOTALS		0	63, 733		
1. 00	D - Interest CAP REL COSTS-BLDG & FIXT	1.00		86, 095		1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00		42, 216		2.00
3. 00				,		3. 00
				128, 311		
4 00	E - Implantable Devices	70.00		0.007.000		4 00
1. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00		2, 387, 983		1.00
2. 00	FATTENTS					2. 00
3. 00			•			3. 00
				2, 387, 983		
4 00	F - Contrast Expense	70.00		0.011		
1. 00 2. 00	DRUGS CHARGED TO PATIENTS	73. 00		86, 911		1. 00 2. 00
3. 00			•			3.00
4. 00						4. 00
				86, 911		
4 00	G - CRNA Reclass	40.00	ام	1 001 010		
1. 00	NONPHYSI CI AN ANESTHETI STS TOTALS			1,024,342		1. 00
	H - Recl Depreciation		U ₁	1, 024, 342		
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	0	1, 434, 519		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	O	1, 407, 436		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 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00	1	0.00	0	0		8.00
9. 00		0.00	o	Ö		9. 00
10.00		0.00	Ō	Ö		10.00
11.00		0.00	О	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14.00
15. 00 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	o	o		18. 00
19. 00		0.00	O	0		19. 00
20.00		0.00	0	0		20. 00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22.00
23. 00 24. 00		0. 00 0. 00	0	0		23. 00 24. 00
_ 1.00	1	0.00	ગ	<u> </u>		1 2 7. 00

SAINT JOSEPH MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 04/01/2022 To 03/31/2023 Date/Time Prepared: Provider CCN: 14-1334

					 3/29/2023 11:22 am_
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4. 00	5.00	
25.00		0.00	0	0	25. 00
26.00		0.00	0	0	26. 00
27.00		0.00	0	0	27. 00
	TOTALS		0	2, 841, 955	
	I - Employee Benefits				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		5, 236, 602	1.00
2.00					2. 00
3.00					3. 00
4.00					4. 00
5.00					5. 00
6.00					6. 00
7.00					7. 00
8.00					8. 00
9.00					9. 00
10.00					10.00
11.00					11.00
12.00					12. 00
13.00					13. 00
14.00					14. 00
15.00					15. 00
16.00					16. 00
17.00					17. 00
18.00					18. 00
19.00					19. 00
20.00					20. 00
21.00					21. 00
22.00					22. 00
23.00					23. 00
24.00					24. 00
25.00					25. 00
		†		5, 236, 602	
500.00	Grand Total: Increases		253, 834	12, 994, 029	500.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Peri od: Worksheet A-6 From 04/01/2022 To 03/31/2023 Date/Time Prepared: 9/29/2023 11:22 am Provider CCN: 14-1334

						0 03/31/2023	8/29/2023 11: 22 am
	Coot Contor	Decreases	Colomi	Othor	Wko+ A 7 Dof		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - Dietary	7.00	0.00	7.00	10100		
1.00	DI ETARY	1000	<u>253, 8</u> 34	25 <u>9, 2</u> 65			1. 00
	TOTALS R Dock Modical Supplies		253, 834	259, 265			
1. 00	B - Recl Medical Supplies OTHER ADMINISTRATIVE AND	5. 04		119			1. 00
	GENERAL						
2.00	ADULTS & PEDIATRICS	30.00		4, 584			2. 00
3. 00 4. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00		898, 265 235	I I		3. 00 4. 00
5. 00	ANESTHESI OLOGY	53.00		7, 496			5. 00
6. 00	LABORATORY	60.00		3, 998			6. 00
7.00	INTRAVENOUS THERAPY	64.00		2, 670			7. 00
8.00	RESPIRATORY THERAPY	65.00		38, 563			8.00
9. 00 10. 00	CLI NI C EMERGENCY	90. 00 91. 00		47 8, 950			9. 00 10. 00
10.00	EMERGENO I			964, 927			10.00
	C - Drugs Charged to Patients						
1. 00	OTHER ADMINISTRATIVE AND	5. 04	0	65	0		1.00
2. 00	GENERAL DI ETARY	10.00	o	436	0		2. 00
3. 00	CAFETERI A	11. 00	ő	1, 116	l 1		3. 00
4.00	PHARMACY	15. 00	0	9, 655	I I		4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	14, 184	0		5. 00
6. 00 7. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	16, 778 584	l .		6. 00 7. 00
8. 00	ANESTHESI OLOGY	53.00	o	2, 491			8.00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	O	1, 310	0		9. 00
10.00	INTRAVENOUS THERAPY	64.00	0	6, 148			10.00
11. 00	EMERGENCY	91.00	0	1 <u>0, 9</u> 66			11. 00
	D - Interest		U	63, 733			
1.00					11		1. 00
2.00					11		2. 00
3. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 04		128, 311			3. 00
	GENERAL	+					
	E - Implantable Devices						
1. 00 2. 00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00		50			1.00
3. 00	RADI OLOGY-DI AGNOSTI C	54.00		2, 387, 837 96			2.00
0.00				2, 387, 983			0.00
	F - Contrast Expense	45.00					4.00
1. 00 2. 00	PHARMACY OPERATING ROOM	15. 00 50. 00		2, 226 27, 015			1.00
3. 00	RADI OLOGY-DI AGNOSTI C	54.00		51, 014			3. 00
4.00	RESPIRATORY THERAPY	<u>65.</u> 00		6, 656			4. 00
	C CDNA Darkara		0	86, 911			
1. 00	G - CRNA Reclass ANESTHESIOLOGY	53.00	0	1, 024, 342	0		1.00
00	TOTALS			1, 024, 342			11.00
	H - Recl Depreciation		ام				4 00
1. 00 2. 00		0. 00 0. 00	0	0			1. 00
3. 00	PURCHASING RECEIVING AND	5. 02	ő	7, 947			3. 00
	STORES						
4. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 04	0	1, 368, 555	0		4. 00
5. 00	MAINTENANCE & REPAIRS	6.00	o	39, 860	0		5. 00
6.00	OPERATION OF PLANT	7. 00	О	1, 086	0		6. 00
7.00	HOUSEKEEPI NG	9. 00	0	4, 488	I I		7. 00
8. 00 9. 00	DI ETARY CAFETERI A	10. 00 11. 00	0	6, 095 15, 588	l 1		8. 00 9. 00
10. 00	NURSING ADMINISTRATION	13. 00	0	105, 875	I I		10.00
11. 00	CENTRAL SERVICES & SUPPLY	14. 00	ō	746	· ·		11. 00
12.00	PHARMACY	15. 00	О	29, 233			12. 00
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	1, 106	l 1		13.00
14. 00 15. 00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	0	90, 723 391, 889			14. 00 15. 00
16. 00	RECOVERY ROOM	51.00	0	391, 669	0		16. 00
17. 00	ANESTHESI OLOGY	53. 00	O	14, 196	O		17. 00
18.00	RADI OLOGY-DI AGNOSTI C	54.00	0	485, 760	I I		18. 00
19. 00 20. 00	LABORATORY INTRAVENOUS THERAPY	60. 00 64. 00	0	114, 862 13, 291	l 1		19. 00 20. 00
21. 00	RESPIRATORY THERAPY	65.00	0	22, 514	l 1		21. 00
	. '	1	-1	• 1	1		

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 04/01/2022 | To 03/31/2023 | Date/Time Prepared: 8/29/2023 | 11: 22 am Provider CCN: 14-1334

						8/29/2023 11: 22 am
		Decreases				
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.	
	6. 00	7.00	8.00	9. 00	10. 00	
22.00	SLEEP LAB	65. 01	0	44, 577	0	22. 00
23.00	GERI ATRI C PSYCH	65. 02	0	2, 095		23. 00
24.00	PHYSI CAL THERAPY	66.00	0	8, 555		24. 00
25.00	CARDIAC REHABILITATION	76. 97	0	22, 735	0	25. 00
26.00	CLINIC	90.00	0	10, 768		26. 00
27.00	EMERGENCY	91.00	0	<u>39, 3</u> 47	o	27. 00
	TOTALS		0	2, 841, 955		
	I - Employee Benefits					
1.00	PURCHASING RECEIVING AND	5. 02		15, 102		1.00
	STORES					
2.00	CASHI ERI NG/ACCOUNTS	5. 03		164, 280		2.00
	RECEI VABLE					
3.00	OTHER ADMINISTRATIVE AND	5. 04		1, 636, 015		3.00
	GENERAL					
4.00	MAINTENANCE & REPAIRS	6.00		91, 207		4. 00
5.00	OPERATION OF PLANT	7.00		29, 509		5. 00
6.00	HOUSEKEEPI NG	9.00		113, 720		6. 00
7.00	DI ETARY	10.00		37, 048		7. 00
8.00	CAFETERI A	11.00		88, 916		8. 00
9.00	NURSING ADMINISTRATION	13. 00		293, 762		9. 00
10.00	CENTRAL SERVICES & SUPPLY	14.00		14, 459		10.00
11. 00	PHARMACY	15. 00		116, 000		11.00
12.00	MEDICAL RECORDS & LIBRARY	16. 00		13, 915		12.00
13.00	ADULTS & PEDIATRICS	30.00		368, 554		13. 00
14.00	OPERATING ROOM	50.00		663, 209		14. 00
15.00	RECOVERY ROOM	51.00		34, 489		15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00		282, 502		16. 00
17.00	LABORATORY	60.00		188, 203		17. 00
18.00	I NTRAVENOUS THERAPY	64.00		158, 872		18. 00
19.00	RESPI RATORY THERAPY	65.00		153, 833		19. 00
20.00	SLEEP LAB	65. 01		149, 650		20.00
21.00	GERI ATRI C PSYCH	65. 02		43, 054		21. 00
22.00	PHYSI CAL THERAPY	66.00		253, 604		22. 00
23.00	CARDIAC REHABILITATION	76. 97		49, 290		23. 00
24.00	CLINIC	90.00		49, 622		24. 00
25.00	EMERGENCY	91.00		227, 787	L	25. 00
				5, 236, 602		
	Grand Total: Decreases		253, 834	12, 994, 029		500. 00

Provider CCN: 14-1334

In Lieu of Form CMS-2552-10

Period: Worksheet A-6
From 04/01/2022 Non-CMS Worksheet
To 03/31/2023 Date/Ti me Prepared: 8/29/2023 11:22 am

								8/29/2023 11:	
	Cost Center	Li ne #	ses Sal ary	Other	Cost Center	Decrea Li ne #	ases Sal ary	Other	
	2.00	3. 00	4. 00	5. 00	6.00	7. 00	8. 00	9. 00	
	A - Dietary								
1.00	CAFETERI A	11. 00	253, 834		DI ETARY	10.00	253, 834	<u>259, 265</u>	1. 00
	TOTALS B - Recl Medical Suppl	ios	253, 834	259, 265	101ALS		253, 834	259, 265	
1. 00	MEDI CAL SUPPLI ES	71.00		964, 927	OTHER ADMINISTRATIVE	5. 04		119	1. 00
	CHARGED TO PATIENTS				AND GENERAL				
2.00					ADULTS & PEDIATRICS	30.00		4, 584	2.00
3. 00 4. 00		1			OPERATING ROOM RECOVERY ROOM	50.00 51.00		898, 265 235	3. 00 4. 00
5. 00					ANESTHESI OLOGY	53.00		7, 496	5. 00
6.00					LABORATORY	60.00		3, 998	6. 00
7.00					INTRAVENOUS THERAPY	64.00		2, 670	7. 00
8. 00 9. 00					RESPIRATORY THERAPY CLINIC	65. 00 90. 00		38, 563	8. 00 9. 00
9. 00 10. 00		1			EMERGENCY	91.00		47 8, 950	10.00
10.00		- $+$		964, 927		71.00		964, 927	10.00
	C - Drugs Charged to F								
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	63, 733	OTHER ADMINISTRATIVE AND GENERAL	5. 04	0	65	1. 00
2. 00	PATIENTS	0. 00	0	0	DI ETARY	10.00	0	436	2. 00
3.00		0. 00	o		CAFETERI A	11.00	O	1, 116	3. 00
4.00		0. 00	0		PHARMACY	15. 00	0	9, 655	4. 00
5.00		0.00	0		ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	0	14, 184	5. 00 6. 00
6. 00 7. 00		0.00	0		RECOVERY ROOM	51.00	0	16, 778 584	7. 00
8. 00		0.00	ő		ANESTHESI OLOGY	53.00	Ö	2, 491	8. 00
9.00		0. 00	О		RADI OLOGY-DI AGNOSTI C	54.00	0	1, 310	9. 00
10.00		0.00	0		INTRAVENOUS THERAPY	64.00	0	6, 148	10.00
11. 00	TOTALS — — —	0. 00			EMERGENCY	91.00		1 <u>0, 966</u> 63, 733	11. 00
	D - Interest		<u> </u>	00, 700	TOTALO		<u> </u>	00,700	
1.00	CAP REL COSTS-BLDG &	1. 00		86, 095					1.00
2. 00	FIXT CAP REL COSTS-MVBLE	2. 00		42, 216					2. 00
2.00	EQUI P	2.00		42, 210					2.00
3.00					OTHER ADMINISTRATIVE	5. 04		128, 311	3. 00
		-			AND GENERAL	-		_{128, 311}	
	E - Implantable Device	es	<u> </u>	120, 311			O _I	120, 311	
1.00	IMPL. DEV. CHARGED TO	72. 00		2, 387, 983	ADULTS & PEDIATRICS	30.00		50	1.00
0.00	PATI ENTS				ODERATI NO DOOM	50.00		0 007 007	0.00
2. 00 3. 00		1			OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50.00 54.00		2, 387, 837 96	2. 00 3. 00
0.00		\vdash \vdash		2, 387, 983	INDIGEOUS TO	01.00		2, 387, 983	0.00
	F - Contrast Expense				I				
1. 00	DRUGS CHARGED TO PATIENTS	73. 00		86, 911	PHARMACY	15. 00		2, 226	1. 00
2. 00	FAITLINIS				OPERATING ROOM	50.00		27, 015	2. 00
3.00					RADI OLOGY-DI AGNOSTI C	54.00		51, 014	3. 00
4.00		<u> </u>			RESPI RATORY THERAPY	65.00		<u>6, 6</u> 56	4. 00
	G - CRNA Reclass		0	86, 911			0	86, 911	
1.00	NONPHYSI CI AN	19. 00	0	1, 024, 342	ANESTHESI OLOGY	53.00	0	1, 024, 342	1. 00
	ANESTHETISTS		+				+		
	TOTALS H - Recl Depreciation			1, 024, 342	TOTALS		0	1, 024, 342	
1.00	CAP REL COSTS-BLDG &	1.00	0	1, 434, 519		0.00	0	0	1. 00
	FI XT								
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	1, 407, 436		0.00	0	0	2. 00
3.00	EUUIP	0. 00	0	0	PURCHASING RECEIVING	5. 02	0	7, 947	3. 00
			1		AND STORES			.,	
4.00		0. 00	0	0	OTHER ADMINISTRATIVE	5. 04	0	1, 368, 555	4. 00
5. 00		0. 00	o	0	AND GENERAL MAINTENANCE & REPAIRS	6.00		39, 860	5. 00
6. 00		0.00	0		OPERATION OF PLANT	7.00	ol	1, 086	6. 00
7.00		0. 00	O	0	HOUSEKEEPI NG	9.00	ō	4, 488	7. 00
8.00		0.00	0		DI ETARY	10.00	O	6, 095	8. 00
9. 00 10. 00		0.00	0		CAFETERI A NURSI NG	11. 00 13. 00	0	15, 588 105, 875	9. 00 10. 00
10.00		0.00	٩	0	ADMI NI STRATI ON	13.00	۷	105, 675	10.00
11. 00		0. 00	0	0	CENTRAL SERVICES &	14.00	0	746	11. 00
12.00		0.00		2	SUPPLY	15 00		20, 222	12 00
12. 00	1	0.00	O	0	PHARMACY	15.00	0	29, 233	12.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 14-1334

| Peri od: | Worksheet A-6 | From 04/01/2022 | Non-CMS Worksheet | To 03/31/2023 | Date/Time Prepared: | 8/29/2023 | 11: 22 am

Cost Center									8/29/2023 11:	22 am
2.00			Incre	ases			Decre	ases		
14.00		Cost Center	Li ne #	Sal ary	0ther	Cost Center	Li ne #	Sal ary	0ther	
14.00		2.00	3.00	4.00	5. 00	6, 00	7.00	8. 00	9, 00	
1. DO	13. 00			0				0	1, 106	13. 00
14.00				٦]	.,	
15 0	14 00		0.00	0	0		30 00	٥	90 723	14 00
16.00		i								
17. 00			1					_		
18. 00			1					-		
19 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0										
20 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1					_		
21 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				-				_		
22 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				- 1						
23.00 0.00 0 0 0 0 0 0 0	21.00		0.00	0	0	RESPI RATORY THERAPY	65.00	0	22, 514	21.00
24. 00 0. 00 0 0 0 0 0 0 0	22.00		0.00	0	0	SLEEP LAB	65. 01	0	44, 577	22.00
25.00 0.00 0 0 0 0 0 0 0	23.00		0.00	0	0	GERIATRIC PSYCH	65. 02	ol	2, 095	23.00
25.00 0.00 0 0 0 0 0 0 0	24 00		0.00	0	0	PHYSICAL THERAPY	66 00	0	8 555	24 00
REHABILITATION 0.00 0 10,768 26.00 27.00 10 10 768 26.00 27.00 10 768 26.00 27.00 10 768 27.00 2841,955 107ALS 1.00 2.841,955 1.00 2.841,955 107ALS 1.00 2.841,955 107ALS 1.00 2.841,955 1.00 2.941,955 1.00 2.			1	-				_		
26.00	23.00		0.00	٩	0		'0. //	ď	22, 733	23.00
TOTALS	26 00		0.00	0	0		on nn	٥	10 768	26 00
TOTALS			1	-1				-		
L. Employee Benefits	27.00	TOTAL C	0.00				91.00			27.00
1. 00 DEPLOYEE BENEFITS 1. 00 DEPARTMENT				U	2, 841, 955	IUIALS		U	2, 841, 955	
AND STORES CASHIERING CAS										
2. 00 CASH ERING/ACCOUNTS RECH VABLE RECH VABLE S. 04 1,636,015 3. 00 4. 00 MAIN TERMANCE & REPAIRS 6. 00 91,207 4. 00 5. 00 MAIN TERMANCE & REPAIRS 6. 00 91,207 4. 00 5. 00 MAIN TERMANCE & REPAIRS 6. 00 91,207 4. 00 7. 00 DI ETARY 10. 00 29,509 5. 00 7. 00 RECHETRIA 11. 00 88,916 8. 00 9. 00 NURSI NG 13. 00 293,762 9. 00 10. 00 NURSI NG 13. 00 293,762 9. 00 110. 00 CENTRAL SERVICES & 14. 00 14,459 10. 00 112. 00 MEDI CAL RECORDS & 16. 00 13,915 12. 00 113. 00 LI BRARY ADULTS & PEDI ATRI CS 30. 00 663, 209 14. 00 14. 00 RECOVERY ROOM 50. 00 6663, 209 14. 00 15. 00 RECOVERY ROOM 50. 00 663, 209 14. 00 16. 00 RECOVERY ROOM 50. 00 663, 209 14. 00 17. 00 RECOVERY ROOM 50. 00 663, 209 14. 00 18. 00 RECOVERY ROOM 50. 00 663, 209 14. 00 18. 00 RECOVERY ROOM 50. 00 663, 209 14. 00 18. 00 RECOVERY ROOM 50. 00 663, 209 14. 00 19. 00 LABORATORY 60. 00 188, 203 17. 00 19. 00 SLEEP LAB 65. 01 155, 833 19. 00 22. 00 SLEEP LAB 65. 01 149, 650 20. 00 23. 00 CARDI AC 76. 97 49, 209 23. 00 24. 00 CARDI AC 76. 97 49, 209 23. 00 25. 00 Grand Total : 253, 834 12, 994, 029 600 no 250. 00 Grand Total : 253, 834 12, 994, 029 500. 00 250. 00 Cardol Total : 253, 834 12, 994, 029 500. 00 250. 00 Cardol Total : 253, 834 12, 994, 029 500. 00 250. 00 Cardol Total : 253, 834 12, 994, 029 500. 00 250. 00 Cardol Total : 253, 834 12, 994, 029 500. 00 250. 00 Cardol Total : 253, 834 12, 994, 029 500. 00 250. 00 Cardol Total : 253, 834 12, 994, 029 500. 00 250. 00 Cardol Total : 253, 834 12, 994, 029 500. 00 250. 00 Cardol Total : 253, 834 12, 994, 029 500. 00 250. 00 Cardol Total : 253, 834 12, 994, 029 500. 00 250. 00 Cardol Total : 253, 834 20, 994, 029 500. 00 250. 00 Cardol Total : 253, 834	1. 00		4. 00		5, 236, 602		5. 02		15, 102	1. 00
RECEL VABLE OTHER ADMINI STRATIVE S. 04 1, 636, 015 3. 00		DEPARTMENT								
3.00	2.00					CASHI ERI NG/ACCOUNTS	5.03		164, 280	2.00
AND GENERAL MAI NTENANCE & REPAIRS 5.00 6.00 7.00 6.00 7.00 8.00 9.00 113,720 6.00 9.00 114,720 6.00 10 LETARY 10.00 88,916 8,916 8,00 9.00 11.00 10.00 11.0						RECEI VABLE				
MAI NTENANCE & REPAI RS 6, 00 91, 207 4, 00 5. 00 0 0 0 0 0 0 0 0 0	3.00					OTHER ADMINISTRATIVE	5.04		1, 636, 015	3.00
Depart of Plant 7,00						AND GENERAL				
Depart on Off Plant 7, 00 29, 509 5, 00	4.00					MAINTENANCE & REPAIRS	6.00		91, 207	4.00
HOUSEKEEPING	5 00						7 00		29 509	5 00
Toology										
8. 00 9. 00 10. 00 10. 00 11. 00 11. 00 11. 00 11. 00 11. 00 12. 00 11. 00 12. 00 13. 00 14. 00 14. 00 15. 00 16. 00 17. 00 18. 00 18. 00 19.										
NURSI NG										
ADMINISTRATION CENTRAL SERVICES & 14.00 14.459 10.00 11.00 12.00 15.00 116,000 11.00 12.00 12.00 13.915 12.00 13.915 12.00 14.00 14.00 13.915 12.00 14.00 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 17.00 16.00 18.00 10.00 10.00 16.00 10										
10.00 11.0	9.00						13.00		293, 762	9.00
SUPPLY										
11. 00 12. 00	10. 00						14.00		14, 459	10.00
12.00 MEDI CAL RECORDS & 16.00 13,915 12.00 13,915 12.00 13,000 14.00 14.00 15.00 15.00 15.00 16.00										
LI BRARY ADULTS & PEDI ATRI CS 30.00 368,554 13.00 14.00 15.00 RECOVERY ROOM 51.00 344,489 15.00 16.00 RADI OLOGY-DI AGNOSTI C 54.00 282,502 16.00 17.00 188,203 17.00 188,00 188,203 17.00 188,00 188,203 17.00 188,00 188,203 17.00 188,00 188,203 17.00 188,872 18.00 188,872 18.00 188,872 18.00 188,872 18.00 188,872 18.00 188,872 18.00 188,873 19.00 188										
ADULTS & PEDI ATRI CS 30.00 368, 554 13.00 14.00 OPERATI NG ROOM 50.00 663, 209 14.00 15.00 RECOVERY ROOM 51.00 34, 489 15.00 17.00 RADI OLOGY-DI AGNOSTI C 54.00 282, 502 16.00 18.00 LABORATORY 60.00 188, 203 17.00 18.00 INTRAVENOUS THERAPY 64.00 158, 872 18.00 19.00 RESPI RATORY THERAPY 65.00 153, 833 19.00 20.00 SLEEP LAB 65.01 149, 650 20.00 21.00 GERI ATRI C PSYCH 65.02 43, 054 21.00 22.00 PHYSI CAL THERAPY 66.00 253, 604 22.00 23.00 CARDI AC 76.97 49, 290 23.00 24.00 CARDI AC 76.97 49, 290 23.00 24.00 CARDI AC 76.97 49, 290 23.00 24.00 CARDI AC 76.97 49, 290 23.00 25.00 Grand Total : 253, 834 12, 994, 029 Grand Total : 253, 834 12, 994, 029 500.00 25.00 Grand Total : 253, 834 12, 994, 029 Grand Total : 253, 834 12, 994, 029 500.00 26.00 CARDI AC 76.97	12.00					MEDICAL RECORDS &	16.00		13, 915	12.00
14. 00 15. 00 16. 00 RECOVERY ROOM 51. 00 34, 489 15. 00 16. 00 34, 489 15. 00 16. 00 17. 00 188, 203 17. 00 188, 20						LI BRARY				
RECOVERY ROOM S1.00 34, 489 15.00 16.00 17.00 282, 502 16.00 17.00 18.00 188, 203 17.00 18.00 188, 203 17.00 18.00 188, 203 17.00 188, 872 18.00 188, 872 18.00 188, 872 18.00 158, 872 18.00 158, 872 18.00 158, 872 18.00 158, 872 18.00 158, 872 18.00 158, 872 18.00 158, 872 18.00 158, 872 18.00 158, 872 18.00 158, 872 18.00 158, 872 18.00 158, 872 18.00 158, 872 18.00 158, 872 18.00 158, 872 18.00 159, 833 19.00 159, 833 19.00 159, 833 19.00 159, 833 19.00 159, 833 19.00 159, 833 19.00 159, 833 19.00 159, 834 19.00	13.00					ADULTS & PEDIATRICS	30.00		368, 554	13.00
RECOVERY ROOM	14.00						50.00			14.00
RADI OLOGY - DI AGNOSTI C	15.00					RECOVERY ROOM	51.00			15. 00
17. 00 18. 00 19. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 25. 00 26. 00 27. 00 28. 00 29. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20										
18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 25. 00 26. 00 27. 00 29. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20										
19. 00 20. 00 21. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 25. 00 26. 00 27. 00 29. 00 29. 00 20										
20. 00 SLEEP LAB 65. 01 149, 650 20. 00 21. 00 GERI ATRI C PSYCH 65. 02 43, 054 21. 00 22. 00 PHYSI CAL THERAPY 66. 00 253, 604 22. 00 23. 00 CARDI AC 76. 97 49, 290 23. 00 24. 00 CHINI C 90. 00 49, 622 24. 00 25. 00 EMERGENCY 91. 00 227, 787 25. 00 25. 00 Grand Total : 253, 834 12, 994, 029 Grand Total : 253, 834 12, 994, 029 500. 00										
21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 25. 00 26. 00 27. 787 29. 00 29. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 25. 00 26. 00 27. 787 28. 00 28. 00 29. 00 29. 00 20. 00										
22. 00 23. 00 24. 00 25. 00 25. 00 27. 00 28. 00 29. 00 29. 00 20										
23. 00 CARDI AC REHABI LI TATI ON CLI NI C 90. 00 49, 622 24. 00 25. 00 EMERGENCY 91. 00 5, 236, 602 500. 00 Grand Total: 253, 834 12, 994, 029 Grand Total: 253, 834 12, 994, 029 500. 00										
24. 00 25. 00 CLI NI C EMERGENCY 90. 00 49, 622 24. 00 25. 00 MERGENCY 91. 00 5, 236, 602 500. 00 Grand Total: 253, 834 12, 994, 029 500. 00	22.00					PHYSI CAL THERAPY	66.00		253, 604	22. 00
24. 00 25. 00	23.00					CARDI AC	76. 97		49, 290	23.00
24. 00 25. 00						REHABI LI TATI ON				
25. 00	24.00						90.00	İ	49, 622	24.00
500. 00 Grand Total: 253, 834 12, 994, 029 Grand Total: 253, 834 12, 994, 029 Grand Total: 253, 834 12, 994, 029 500. 00										
500.00 Grand Total: 253,834 12,994,029 Grand Total: 253,834 12,994,029 500.00	25.00		\vdash	— — — \	5 236 602	LINE ROLLING I	- 1 . 50	— — — /		25.00
	E00 00	Crand Total	+ -			Crand Total				E00 00
ling eases				253, 834	12, 994, 029			253, 834	12, 994, 029	300. UU
		ITTICI EdSES				Inect gases	ı l	ı		

9.00

Reconciling Items

10.00 Total (line 8 minus line 9)

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 14-1334 Peri od: Worksheet A-7 From 04/01/2022 Part I 03/31/2023 Date/Time Prepared: 8/29/2023 11:22 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 179, 386 0 1.00 17, 958 1, 227, 353 0 2.00 Land Improvements 1,687 1, 687 2.00 0 3.00 20, 831, 434 2, 567, 599 2, 567, 599 2, 656, 008 3.00 Buildings and Fixtures 0 4.00 Building Improvements 13, 663, 219 1, 736, 089 1, 736, 089 55, 774 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 17, 865, 657 820, 274 820, 274 620, 979 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 53, 767, 049 5, 125, 649 5, 125, 649 3, 350, 719 8.00 9.00 Reconciling Items 0 9.00 53, 767<u>,</u> 049 Total (line 8 minus line 9) 5, 125, 649 3, 350, 719 10.00 0 5, 125, 649 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 179, 386 0 1.00 2.00 Land Improvements 1, 211, 082 0 2.00 20, 743, 025 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 15, 343, 534 4.00 5.00 Fi xed Equipment 0 5.00 6.00 Movable Equipment 18, 064, 952 0 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 55, 541, 979 0 8.00

55, 541, 979

Heal th	Financial Systems SA	AINT JOSEPH MEM	ORIAL HOSPITAL	L	In Lie	eu of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der 0	CCN: 14-1334	Peri od: From 04/01/2022	Worksheet A-7	
						Date/Time Pre	pared:
						8/29/2023 11:	22 am
			S	SUMMARY OF CAF	PLTAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9.00	10.00	11.00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	(0	0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	(0	0 0	0	2. 00
3.00	Total (sum of lines 1-2)	0	(0	0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sur	m			
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	and 2			
1. 00	CAP REL COSTS-BLDG & FLXT	이	(0		l	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	이	(0		l	2. 00
3.00	Total (sum of lines 1-2)	0	(0		ļ	3. 00

Heal th	Financial Systems SA	AINT JOSEPH MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
					From 04/01/2022	Part III	
					To 03/31/2023		
		COM	DUTATION OF DAT	TI 00	ALLOCATION OF	8/29/2023 11: 2	22 am
		COM	PUTATION OF RAT	1105	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col			
				2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FIXT	37, 477, 028	0	37, 477, 02	8 0. 674751	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18, 064, 952	0	18, 064, 95	0. 325249	o	2.00
3.00	Total (sum of lines 1-2)	55, 541, 980	0	55, 541, 98	1. 000000	0	3.00
		ALLOCA ⁻	TION OF OTHER (API TAL	SUMMARY 0	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	'		Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS		•			
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 1, 552, 800	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 2, 367, 845	o	2.00
3.00	Total (sum of lines 1-2)	0	0		0 3, 920, 645	ol	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	'		instructions)		Capi tal -Relate		
					d Costs (see	through 14)	
					instructions)	J ,	

11. 00

86, 095 42, 216 128, 311

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT

12.00

0 0 0 13.00

0 0 0 14.00

0 0 0 15.00

1, 638, 895 2, 410, 061 4, 048, 956 1.00

2. 00

1.00

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

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 14-1334

					To 03/31/2023	Date/Time Prep 8/29/2023 11:2	
				Expense Classification on	Worksheet A	0/29/2023 11.2	ZZ dIII
				To/From Which the Amount is			
					-		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2 00	COSTS-BLDG & FIXT (chapter 2)		0	CAR REL COCTE MARIE FOLLIR	2 00		2 00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other		0		0.00	o	3. 00
	(chapter 2)						
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
5.00	expenses (chapter 8)		Ü		0.00	,	3.00
6.00	Rental of provider space by		0		0.00	О	6. 00
	suppliers (chapter 8)						
7. 00	Tel ephone servi ces (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		0		0.00	o	8. 00
	(chapter 21)						
9. 00	Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physician	A-8-2	-2, 902, 833			0	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	o	11. 00
11.00	(chapter 23)		0		0.00	ı	11.00
12.00	Related organization	A-8-1	10, 057, 257			o	12.00
	transactions (chapter 10)						
13.00	Laundry and linen service	D.	150.044	CAFETERIA	0.00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-150, 844 0	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
13.00	and others		Ü		0.00	,	13.00
16.00	Sale of medical and surgical		0		0.00	o	16.00
	supplies to other than						
17 00	patients		0		0.00		17 00
17. 00	Sale of drugs to other than patients		U		0.00	0	17. 00
18. 00	Sale of medical records and	В	-9, 139	MEDICAL RECORDS & LIBRARY	16.00	o	18. 00
	abstracts						
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00	Vending machines		0		0.00	o	20. 00
	Income from imposition of		0		0.00	ō	21. 00
	interest, finance or penalty						
00.00	charges (chapter 21)				0.00		00.00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of						
24.00	limitation (chapter 14)	A-8-3	0	DHVSI CAL THEDADV	44 00		24 00
24. 00	Adjustment for physical therapy costs in excess of	H-0-3	Ü	PHYSICAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FLXT	1.00		26. 00
20.00	COSTS-BLDG & FLXT		Ü	CAF REE COSTS-BEDG & TIXT	1.00	١	20.00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	О	27. 00
	COSTS-MVBLE EQUIP						
	Non-physician Anesthetist	A	-1, 024, 342	NONPHYSICIAN ANESTHETISTS	19.00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00	0	29. 00 30. 00
30.00	therapy costs in excess of	N-0-3	U	Cost center bereted """	67.00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
04 00	instructions)		=	****			04.00
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
	limitation (chapter 14)						
	CAH HIT Adjustment for		0		0.00	ا	32. 00
32. 00	oral in I ray as their to		U		0.00	٠ ٧	
32. 00	Depreciation and Interest		0		0.00	Ĭ	

From 04/01/2022 | WUI NOTICE TO A-0
TO 03/31/2023 | Date/Time Prepared:

				T	03/31/2023	Date/Time Pre 8/29/2023 11:	
	·			Expense Classification on	Worksheet A	0/2//2020 11.	ZZ GIII
				To/From Which the Amount is			
				To Trom will on the rundart 13	to be haj astea		
	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. 00	EMPLOYEE OUTPATIENT INS	В	-2, 829, 218	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
	PAYMENTS						
33. 01	LEASEHOLD REVENUE	В	-5, 238	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 01
33. 02	PURCHASE DI SCOUNTS	В	-4, 319	PURCHASING RECEIVING AND	5. 02	0	33. 02
				STORES			
33. 03	INTEREST INCOME	В	-62, 115	OTHER ADMINISTRATIVE AND	5. 04	0	33. 03
				GENERAL			
33.04	BOND REVENUE	В	-32	OTHER ADMINISTRATIVE AND	5. 04	0	33. 04
				GENERAL			
33. 05	NONALLOWABLE INTEREST EXPENSE	Α	-361, 328	OTHER ADMINISTRATIVE AND	5. 04	0	33. 05
				GENERAL			
33. 06	MI SCELLANEOUS I NCOME	В	-119	SLEEP LAB	65. 01	0	33. 06
33. 08	CONTRACT PHARMACY	В	-18, 004	PHARMACY	15. 00	0	33. 08
34.00	Lobbyi ng Expense	Α	-18, 921	OTHER ADMINISTRATIVE AND	5. 04	0	34.00
				GENERAL			
35.00	Shawnee Building Depreciation	Α	-657	CAP REL COSTS-BLDG & FIXT	1. 00	9	35. 00
35. 01	Shawnee Property Insurance	Α	-661	OTHER ADMINISTRATIVE AND	5. 04	0	35. 01
				GENERAL			
36.00	Medicaid Provider Tax	Α	-2, 391, 655	OTHER ADMINISTRATIVE AND	5. 04	0	36. 00
				GENERAL			
37.00	Real Estate Taxes	Α	-7, 586	SLEEP LAB	65. 01	0	37. 00
37. 01	Real Estate Taxes	Α	-8, 728	PHYSICIANS' PRIVATE OFFICES	192.00	0	37. 01
38. 00	Cabl e TV	Α	-24, 571	MAINTENANCE & REPAIRS	6. 00	0	38. 00
38. 01	Cabl e TV	A		SLEEP LAB	65. 01	0	
38. 02	Cabl e TV	A	-1, 303	PHYSI CAL THERAPY	66.00	0	38. 02
50.00	TOTAL (sum of lines 1 thru 49)		233, 727	1			50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽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: 14-1334

Worksheet A-8-1

From 04/01/2022 03/31/2023 Date/Time Prepared: 8/29/2023 11:22 am Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 3.00 4.00 5.00 1.00 2.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 HOME OFFICE EXPENSE 124, 176 1.00 2. OO CAP REL COSTS-MVBLE EQUIP HOME OFFICE EXPENSE 0 2.00 960, 409 2.00 0 4. 00 EMPLOYEE BENEFITS DEPARTMENT 3.00 HOME OFFICE EXPENSE 1, 572, 995 3.00 4.00 5. 01 DATA PROCESSING HOME OFFICE EXPENSE 3, 579, 344 0 4.00 4.01 5. 03 CASHI ERI NG/ACCOUNTS RECEI VAB HOME OFFICE EXPENSE 740, 325 0 4.01 5. 04 OTHER ADMINISTRATIVE AND GEN HOME OFFICE EXPENSE 4 02 3, 130, 069 0 4 02 54. 00 RADI OLOGY-DI AGNOSTI C 4.03 RENT 54, 176 90, 396 4.03 4.04 60. 00 LABORATORY RENT 20, 695 34, 536 4.04 TOTALS (sum of lines 1-4) 124, 932 5.00 5 00 10, 182, 189 Transfer column 6, line 5 to Worksheet A-8, column 2,

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

·			Related Organization(s) and/	or Home Office	
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 RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	SI HS	100.00	RELATED ORG	100. 00	6. 00
7.00	В	SI HE	100.00	RELATED ORG	100.00	7. 00
8.00	В	HSSI	100.00	RELATED ORG	100. 00	8. 00
9.00	В	SIMS	100.00	RELATED ORG	100. 00	9. 00
10.00	В	SIH CAYMAN	100.00	RELATED ORG	100. 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.
- Corporation, partnership, or other organization has financial interest in provider.
- Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

line 12

5.00 10, 057, 257 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 par

4.00

4.01

4 02

4.03

4.04

5 00

nas not	been posted to worksheet A,	cordinate and of 2, the amount arrowable should be marcated in cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

i ei ilibui	Selliert under title Aviii.	
6.00	HEALTHCARE	6.00
7.00	HEALTHCARE	7.00
8.00	HEALTHCARE	8.00
9.00	HEALTHCARE	9.00
10.00	CAPTI VE	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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

4.00

4.01

4 02

4.03

4.04

3, 579, 344

3, 130, 069

740, 325

-36, 220

-13, 841

0

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| Period: | Worksheet A-8-2 | From 04/01/2022 | To 03/31/2023 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 14-1334

					-	To 03/31/2023	B Date/Time Pre 8/29/2023 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	22 (111
		I denti fi er	Remuneration	Component	Component		ider Component	
				· ·			Hours	
	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00		EMERGENCY	2, 042, 014	2, 042, 014	. 0	C	0	
2.00		LABORATORY	174, 906			_	0	2. 00
3.00	76. 97	CARDIAC REHABILITATION	3, 650		3, 650	C	0	3. 00
4.00		SLEEP LAB	36, 000		00,000	C	0	4. 00
5.00		ADULTS & PEDIATRICS	682, 365		0	C	0	5. 00
6.00		NURSING ADMINISTRATION	3, 548				0	6. 00
7. 00		OPERATING ROOM	18, 304		10,001		0	7. 00
8. 00		CLI NI C	2, 578		2,0,0		0	8. 00
9. 00		RESPI RATORY THERAPY	2, 737		2, 737		0	9. 00
10.00	0.00		0		0		0	10. 00
200.00			2, 966, 102				0	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		ldenti fi er	Limit		Memberships &	Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1.00	2.00	8. 00	9. 00	Education 12.00	12 13. 00	14.00	
1. 00		EMERGENCY	8.00					1. 00
2. 00		LABORATORY		·	1		_	2. 00
3. 00		CARDI AC REHABI LI TATI ON		1	_		0	3. 00
4. 00		SLEEP LAB					0	4. 00
5. 00		ADULTS & PEDIATRICS	0				Ö	5. 00
6. 00		NURSI NG ADMI NI STRATI ON	0		0	l c	l o	6. 00
7. 00		OPERATING ROOM	0	0	0		l o	
8. 00		CLI NI C	0	0	0		l o	8. 00
9. 00		RESPI RATORY THERAPY	0	0	0	l c	Ō	9. 00
10. 00	0.00		0	l o	0	l c	Ō	10.00
200.00			0	0	0	d	O	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		EMERGENCY	0		_	_, _,,		1. 00
2.00	60. 00 LABORATORY		0	1	_	174, 906	1	2. 00
3.00	76. 97 CARDI AC REHABI LI TATI ON		0	0		C	•	3. 00
4.00	65. 01 SLEEP LAB		0	0	0	C		4. 00
5. 00	30.00 ADULTS & PEDIATRICS 13.00 NURSING ADMINISTRATION		0	0	0	682, 365		5. 00
6.00			0	0	0	3, 548		6. 00
7.00		OPERATING ROOM	0	0	0	[C		7. 00
8.00		CLINIC	0	0	0	C		8. 00
9.00		RESPI RATORY THERAPY	0	0	. 0			9. 00
10.00	0. 00		0	0	. 0	0 000 000		10.00
200.00			0	0	0	2, 902, 833	1	200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1334 Peri od: Worksheet B From 04/01/2022 Part I Date/Time Prepared: 03/31/2023 8/29/2023 11:22 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** DATA PROCESSI NG for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 1, 638, 895 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 1, 638, 895 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2, 410, 061 2, 410, 061 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 126, 482 15, 314 22, 520 4, 164, 316 4.00 00550 DATA PROCESSING 3, 579, 344 10, 739 3, 597, 386 5 01 7, 303 5 01 5.02 00560 PURCHASING RECEIVING AND STORES 48, 914 7, 218 10, 615 11, 804 10, 581 5.02 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 1, 279, 358 21, 672 31, 870 134, 732 190, 450 5.03 5.04 00590 OTHER ADMINISTRATIVE AND GENERAL 5, 138, 145 325, 334 478, 416 256, 687 306, 836 5.04 00600 MAINTENANCE & REPAIRS 70, 980 1, 262, 610 164.674 242, 159 105, 805 6 00 6 00 7.00 00700 OPERATION OF PLANT 206, 105 2, 462 3, 621 49, 470 42, 322 7.00 00800 LAUNDRY & LINEN SERVICE 266, 224 16, 716 8.00 11, 367 8.00 9.00 00900 HOUSEKEEPI NG 463, 268 16, 245 87, 599 21, 161 9.00 11.047 01000 DI ETARY 79, 655 117, 136 31, 015 10.00 183, 441 74,064 10.00 11.00 01100 CAFETERI A 256, 635 7, 927 11,657 65, 125 0 11.00 01300 NURSING ADMINISTRATION 13.00 1, 159, 162 37, 458 55,084 295, 249 31, 742 13.00 01400 CENTRAL SERVICES & SUPPLY 37, 769 11, 582 14.00 7.876 9, 682 14.00 0 15 00 01500 PHARMACY 11, 905, 362 16, 933 24, 900 145, 268 52, 903 15 00 23, 053 78, 306 16.00 01600 MEDICAL RECORDS & LIBRARY 115, 152 42, 322 16.00 8, 252 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 312, 311 142, 766 209, 943 482, 307 507, 866 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 475, 809 217, 226 319, 440 672, 815 666, 575 50.00 51.00 05100 RECOVERY ROOM 183, 855 23, 966 35, 243 42, 974 42.322 51.00 53.00 05300 ANESTHESI OLOGY 232, 373 1, 316 1, 934 10, 581 53.00 05400 RADI OLOGY-DI AGNOSTI C 301, 422 54.00 1, 796, 208 86, 621 127, 379 201, 030 54.00 60.00 06000 LABORATORY 2, 802, 670 39, 600 58, 233 200, 716 169, 289 60.00 64.00 06400 I NTRAVENOUS THERAPY 904.026 46, 886 68, 947 192, 680 222, 191 64.00 16, 294 84, 644 06500 RESPIRATORY THERAPY 770, 155 134, 869 65.00 11,081 65.00 65.01 03610 SLEEP LAB 794, 249 63, 852 93, 898 148, 956 158, 708 65.01 03620 GERLATRIC PSYCH 314.441 20.407 30,010 59. 516 65.02 52, 903 65.02 66.00 06600 PHYSI CAL THERAPY 1, 359, 825 20, 238 29, 761 322, 329 190, 450 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 964, 927 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 387, 983 72.00 72.00 0 0 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 150,644 \cap Λ 73.00 76. 97 07697 CARDIAC REHABILITATION 291, 359 31, 909 46, 924 71, 149 52, 903 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 226, 142 43, 091 63, 367 50, 183 137, 547 90.00 91.00 09100 EMERGENCY 2, 130, 681 80,060 117, 732 318, 537 222, 191 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 1, 623, 565 3, 597, 386 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 57, 082, 486 2, 387, 517 118.00 4, 164, 316 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 7, 370 10,838 192.00 19200 PHYSICIANS' PRIVATE OFFICES o 0 192. 00 46, 767 C 192. 01 19201 UNUSED SPACE 7, 960 0 192.01 11, 706 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 57, 129, 253 1, 638, 895 2, 410, 061 3, 597, 386 202. 00 4, 164, 316

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1334

				1	0 03/31/2023	8/29/2023 11:	
	Cost Center Description	PURCHASI NG	CASHI ERI NG/ACC	Subtotal	OTHER	MAINTENANCE &	C. C.
	, , , , , , , , , , , , , , , , , , ,	RECEIVING AND	OUNTS		ADMI NI STRATI VE	REPAI RS	
		STORES	RECEI VABLE		AND GENERAL		
		5. 02	5. 03	5A. 03	5. 04	6. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00550 DATA PROCESSING						5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	89, 132					5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	422	1, 658, 504				5. 03
5.04	00590 OTHER ADMINISTRATIVE AND GENERAL	167	0	6, 505, 585	6, 505, 585		5. 04
6.00	00600 MAINTENANCE & REPAIRS	0	0	., ,		2, 083, 485	6. 00
7.00	00700 OPERATION OF PLANT	0	1		· ·	4, 675	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	,	37, 821	21, 582	8. 00
9.00	00900 HOUSEKEEPI NG	16		,		20, 973	9. 00
10.00	01000 DI ETARY	17	0	,	· ·	151, 233	10. 00
11. 00	01100 CAFETERI A	43			43, 871	15, 050	1
13. 00	01300 NURSING ADMINISTRATION	0	1		· ·	71, 118	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1	0		8, 599	14, 954	14. 00
15. 00	01500 PHARMACY	778				32, 149	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0			148, 672	16. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1			I		
30. 00	03000 ADULTS & PEDI ATRI CS	7, 687	21, 459	4, 684, 339	601, 980	271, 054	30. 00
	ANCILLARY SERVICE COST CENTERS		100 700	. 700 40/	074 044		
50.00	05000 OPERATING ROOM	24, 623				412, 424	50.00
51.00	05100 RECOVERY ROOM	127	10, 423		· ·	45, 501	51.00
53.00	05300 ANESTHESI OLOGY	1, 894				2, 498	
54. 00	05400 RADI OLOGY - DI AGNOSTI C	2, 621	326, 026		365, 134	164, 458	54.00
60.00	06000 LABORATORY	20, 326	277, 398			75, 184	60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	5, 276			188, 369	89, 017	64. 00 65. 00
	l l	520				21, 038	
65. 01	03610 SLEEP LAB	157	50, 419			121, 230	65. 01
65. 02	03620 GERI ATRI C PSYCH 06600 PHYSI CAL THERAPY	1 7	4, 590		61, 925 254, 851	38, 745 38, 425	
66.00	1	462	60, 070		· ·		1
71. 00 72. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	14, 076				0	71. 00 72. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	42, 254 196, 739			0	73.00
73. 00 76. 97	07697 CARDI AC REHABI LI TATI ON	-				60, 583	1
76. 97	07700 ALLOGENEI C HSCT ACQUISITION	145	7, 690 0	1		00, 583	•
77.00	OUTPATIENT SERVICE COST CENTERS		U		U	0	77.00
90. 00	09000 CLINIC	672	12, 488	533, 490	68, 558	81, 813	90.00
91.00	09100 EMERGENCY	9, 098				152, 002	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7,070	74, 100	2, 772, 377		132,002	92.00
72.00	OTHER REIMBURSABLE COST CENTERS			· · · · · ·			72.00
102 00	10200 OPLOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
.02.00	SPECIAL PURPOSE COST CENTERS						102.00
113.00	11300 INTEREST EXPENSE						113. 00
118.00		89, 132	1, 658, 504	57, 044, 612	6, 494, 708	2, 054, 378	118. 00
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	18, 208	2, 340	13, 993	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	46, 767	6, 010	0	192. 00
	19201 UNUSED SPACE	0	0	19, 666	2, 527	15, 114	192. 01
200.00	Cross Foot Adjustments			0			200. 00
201.00		0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	89, 132	1, 658, 504	57, 129, 253	6, 505, 585	2, 083, 485	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1334 Peri od: Worksheet B From 04/01/2022 Part I Date/Time Prepared: 03/31/2023 8/29/2023 11:22 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A **PLANT** LINEN SERVICE 9.00 10.00 11.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00550 DATA PROCESSING 5 01 5 01 5.02 00560 PURCHASING RECEIVING AND STORES 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.03 5.04 00590 OTHER ADMINISTRATIVE AND GENERAL 5.04 00600 MAINTENANCE & REPAIRS 6.00 6 00 7.00 00700 OPERATION OF PLANT 347, 719 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 3,610 357, 320 8.00 00900 HOUSEKEEPING 1, 107 9 00 3.508 701, 944 9 00 10.00 01000 DI ETARY 25, 297 724, 290 10.00 63 11.00 01100 CAFETERI A 2,517 0 10,066 412, 891 11.00 01300 NURSING ADMINISTRATION 11, 896 26, 904 13.00 13.00 0 0 C 2, 530 01400 CENTRAL SERVICES & SUPPLY 2.501 0 14.00 0 0 14.00 15.00 01500 PHARMACY 5, 377 0 6,571 0 14, 581 15.00 01600 MEDICAL RECORDS & LIBRARY 24, 868 0 16.00 16 00 1,678 2, 448 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 45, 339 135, 260 219, 209 724, 290 30.00 30.00 66, 458 ANCILLARY SERVICE COST CENTERS 68, 984 05000 OPERATING ROOM 40. 357 162, 729 50.00 82.261 50.00 51.00 05100 RECOVERY ROOM 7,611 13,882 9, 926 0 5, 903 51.00 53.00 05300 ANESTHESI OLOGY 418 419 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 27, 509 33, 552 36, 344 54.00 46, 362 54.00 06000 LABORATORY 60.00 12.576 C 8. 248 31,610 60 00 0 64.00 06400 I NTRAVENOUS THERAPY 14,890 r 49,630 17, 383 64.00 06500 RESPIRATORY THERAPY 3, 519 65.00 1,035 5,033 0 0 0 18, 145 65.00 03610 SLEEP LAB 20. 278 16, 776 20.538 65.01 360 65.01 03620 GERLATRIC PSYCH 65.02 6, 481 C 8,668 7, 345 65.02 66.00 06600 PHYSI CAL THERAPY 6, 427 0 0 35, 582 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 0 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 Ω O 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 0 Λ 73.00 76. 97 07697 CARDIAC REHABILITATION 333 8, 388 0 8,814 76. 97 10.134 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 13,685 3,826 25, 164 0 5, 713 90.00 91.00 09100 EMERGENCY 25, 425 114, 735 135, 887 0 30, 332 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 342, 850 357, 320 701, 944 724, 290 412, 891 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 2, 341 C

2,528

347.719

0

0

701, 944

Ω

C

357, 320

0

0

724, 290

0 192. 00

0 192. 01

412, 891 202. 00

200.00

192.00 19200 PHYSICIANS' PRIVATE OFFICES

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

192. 01 19201 UNUSED SPACE

200.00

201.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 Provider CCN: 14-1334

				Io	03/31/2023	Date/lime Pre 8/29/2023 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	NONPHYSI CI AN	22 (1111
	occi contor boson per on	ADMI NI STRATI ON	SERVICES &	1 1 3 11 11 10 1	RECORDS &	ANESTHETI STS	
			SUPPLY		LI BRARY		
		13. 00	14. 00	15. 00	16. 00	19. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00550 DATA PROCESSING						5. 01
5.02	00560 PURCHASING RECEIVING AND STORES						5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5.04	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 04
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						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 891, 490					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	95, 494				14. 00
15. 00	01500 PHARMACY	0	0				15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		479, 074		16.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(00.007		47.407	, 200		00.00
30. 00	03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS	633, 387	0	17, 407	6, 200	0	30.00
50. 00	05000 OPERATING ROOM	633, 179	0	28, 627	116, 508	0	50.00
51. 00	05100 RECOVERY ROOM	66, 876	0	- , -	3, 012	0	
53. 00	05300 ANESTHESI OLOGY	00,070	0		17, 454	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0		94, 203	0	54.00
60.00	06000 LABORATORY		0	,	80, 153	0	1
64. 00	06400 I NTRAVENOUS THERAPY	175, 147	0	15, 404	7, 453	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	21, 693	0		9, 193	0	65. 00
65. 01	03610 SLEEP LAB	21,070	0	0	14, 568	0	65. 01
65. 02	03620 GERI ATRI C PSYCH	18, 040	0	0	1, 326	0	65. 02
66. 00	06600 PHYSI CAL THERAPY	10,040	0	150	17, 357	0	66.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		95, 494	0	9, 571	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		75, 474		12, 209	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	- 1	56, 847	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	20, 045	0		2, 222	0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	
,,,,,,	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u>_</u>	<u> </u>	<u>_</u>		77.00
90.00	09000 CLI NI C	32, 577	0	4, 327	3, 608	0	90.00
91. 00	09100 EMERGENCY	290, 546	0		27, 190	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		_	,	= 1, 112		92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE		<u> </u>			<u> </u>	113. 00
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1, 891, 490	95, 494	13, 765, 696	479, 074	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19201 UNUSED SPACE	0	0	0	0		192. 01
200.00	,						200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	1, 891, 490	95, 494	13, 765, 696	479, 074	0	202. 00

| Period: | Worksheet B | From 04/01/2022 | Part | To 03/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1334

					To 03/31/2023	Date/Time Prepared: 8/29/2023 11:22 am
	Cost Center Description	Subtotal	Intern &	Total		072472023 11.22 aiii
			esidents Cost			
			& Post			
			Stepdown			
		24. 00	Adjustments 25.00	26. 00		
GENER	RAL SERVICE COST CENTERS	24.00	23.00	20.00		
	CAP REL COSTS-BLDG & FIXT					1.00
	CAP REL COSTS-MVBLE EQUIP					2. 00
1	EMPLOYEE BENEFITS DEPARTMENT					4. 00
	DATA PROCESSING					5. 01
	PURCHASING RECEIVING AND STORES CASHIERING/ACCOUNTS RECEIVABLE					5. 02 5. 03
	OTHER ADMINISTRATIVE AND GENERAL	-				5. 03
	MAINTENANCE & REPAIRS					6. 00
1	OPERATION OF PLANT					7. 00
	LAUNDRY & LINEN SERVICE					8. 00
9.00 00900	HOUSEKEEPI NG					9. 00
10.00 01000	DI ETARY					10. 00
	CAFETERI A					11. 00
	NURSING ADMINISTRATION					13. 00
	CENTRAL SERVICES & SUPPLY					14.00
	PHARMACY					15. 00
	MEDICAL RECORDS & LIBRARY NONPHYSICIAN ANESTHETISTS					16. 00 19. 00
	TIENT ROUTINE SERVICE COST CENTERS					19.00
	ADULTS & PEDIATRICS	7, 404, 923	0	7, 404, 92	:3	30.00
	LARY SERVICE COST CENTERS	.,,	-1	., ., ., .		
	OPERATING ROOM	9, 196, 581	0	9, 196, 58	1	50.00
	RECOVERY ROOM	535, 889	0	535, 88		51. 00
i i	ANESTHESI OLOGY	371, 991	0	371, 99		53.00
1	RADI OLOGY-DI AGNOSTI C	3, 610, 475	0	3, 610, 47		54. 00
	LABORATORY INTRAVENOUS THERAPY	4, 234, 553 2, 023, 094	0	4, 234, 55 2, 023, 09		60. 00 64. 00
	RESPIRATORY THERAPY	1, 263, 889	0	1, 263, 88		65. 00
	SLEEP LAB	1, 672, 367	ő	1, 672, 36		65. 01
	GERIATRIC PSYCH	624, 401	O	624, 40		65. 02
66. 00 06600	PHYSI CAL THERAPY	2, 335, 927	o	2, 335, 92	.7	66. 00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 247, 261	0	1, 247, 26	1	71. 00
	IMPL. DEV. CHARGED TO PATIENTS	2, 754, 753	0	2, 754, 75		72. 00
	DRUGS CHARGED TO PATIENTS	14, 124, 202	0	14, 124, 20		73.00
	CARDI AC REHABI LI TATI ON	677, 120	0	677, 12		76. 97
	ALLOGENEIC HSCT ACQUISITION ATIENT SERVICE COST CENTERS	0	0		0	77. 00
	CLINIC	772, 761	o	772, 76	.1	90. 00
	EMERGENCY	4, 149, 572	o	4, 149, 57		91. 00
	OBSERVATION BEDS (NON-DISTINCT PART)		0	,		92. 00
	R REIMBURSABLE COST CENTERS					
	OPIOID TREATMENT PROGRAM	0	0		0	102. 00
	AL PURPOSE COST CENTERS					
1	INTEREST EXPENSE	F. 600 75	_	F/ 222 ==		113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	56, 999, 759	0	56, 999, 75	9	118. 00
	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	36, 882	ol	36, 88	2	190. 00
	PHYSICIANS' PRIVATE OFFICES	52, 777	ol Ol	52, 77		190.00
	UNUSED SPACE	39, 835	ől	39, 83		192. 01
200. 00	Cross Foot Adjustments	0	Ō		0	200. 00
201. 00	Negative Cost Centers	o	o		0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	57, 129, 253	O	57, 129, 25	3	202. 00

Health Financial Systems
COST ALLOCATION STATISTICS In Lieu of Form CMS-2552-10
Worksheet Non-CMS W SAINT JOSEPH MEMORIAL HOSPITAL Peri od: From 04/01/2022 To 03/31/2023 Provider CCN: 14-1334

Date/Time Prepared: 8/29/2023 11:22 am

	Cost Center Description	Statistics	Statistics Description	
		Code		
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	DATA PROCESSING	5	NUMBER OF PCS	5. 01
5.02	PURCHASING RECEIVING AND STORES	6	PURCHASING SUPPLIES	5. 02
5.03	CASHI ERI NG/ACCOUNTS RECEI VABLE	7	GROSS REVENUE	5. 03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5. 04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6. 00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7. 00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8. 00
9.00	HOUSEKEEPI NG	9	HOURS OF SERVICE	9. 00
10.00	DI ETARY	10	MEALS SERVED	10.00
11.00	CAFETERI A	11	NUMBER OF FTES	11. 00
13.00	NURSI NG ADMINI STRATI ON	13	DI RECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15. 00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16. 00
19. 00	NONPHYSI CI AN ANESTHETI STS	19	ASSIGNED TIME	19. 00

Heal th Financial Systems

SAINT JOSEPH MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023
Date/Time Prepared:
8/29/2023 11: 22 am

CAPITAL RELATED COSTS

Cost Center Description

Directly
Assigned New
Capital

Capital

Department

						8/29/2023 11:	22 am_
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	15, 314	22, 520	37, 834	37, 834	4. 00
5.01	00550 DATA PROCESSING	0	7, 303	10, 739	18, 042	0	5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	0	7, 218	10, 615	17, 833	107	5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	21, 672	31, 870	53, 542	1, 224	5. 03
5.04	00590 OTHER ADMINISTRATIVE AND GENERAL	0	325, 334	478, 416	803, 750	2, 332	5. 04
6.00	00600 MAINTENANCE & REPAIRS	0	164, 674	242, 159	406, 833	645	6. 00
7.00	00700 OPERATION OF PLANT	0	2, 462	3, 621	6, 083	449	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	11, 367		28, 083		8. 00
9.00	00900 HOUSEKEEPI NG	0	11, 047		27, 292		9. 00
10. 00	01000 DI ETARY	0	79, 655		196, 791	282	10.00
11. 00	01100 CAFETERI A	0	7, 927		19, 584	592	
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	37, 458		92, 542		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	7, 876		19, 458		1
15. 00	01500 PHARMACY	0	16, 933		41, 833		
16. 00	01600 MEDICAL RECORDS & LIBRARY		78, 306		193, 458		
19. 00	01900 NONPHYSICIAN ANESTHETISTS		70,300		173, 430		
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			U U	U	U	17.00
30. 00	03000 ADULTS & PEDIATRICS	T 0	142, 766	209, 943	352, 709	4, 382	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS		142,700	207, 743	332, 709	4, 302	30.00
50. 00	05000 OPERATING ROOM	1 0	217, 226	319, 440	536, 666	6, 113	50.00
51. 00	05100 RECOVERY ROOM	0	23, 966				
	05300 ANESTHESI OLOGY	0			59, 209		
53.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 316		3, 250		53. 00 54. 00
54.00		0	86, 621		214, 000		1
60.00	06000 LABORATORY	0	39, 600		97, 833		60.00
64.00	06400 I NTRAVENOUS THERAPY	0	46, 886		115, 833		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	11, 081		27, 375		1
65. 01	03610 SLEEP LAB	0	63, 852		157, 750		1
65. 02	03620 GERI ATRI C PSYCH	0	20, 407		50, 417		1
66. 00	06600 PHYSI CAL THERAPY	0	20, 238		49, 999		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	-	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	-	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	31, 909	46, 924	78, 833		
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	43, 091	63, 367	106, 458	456	90. 00
91.00	09100 EMERGENCY	0	80, 060	117, 732	197, 792	2, 894	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
	OTHER REIMBURSABLE COST CENTERS						1
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS	1					1
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		0	1, 623, 565	2, 387, 517	4, 011, 082		118. 00
2. 50	NONREI MBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,	,,	., ,	2.,301	1
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	<u> </u>	7, 370	10, 838	18, 208	n	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	,,370	10,000	13, 200 N		192. 00
	19201 UNUSED SPACE		7, 960	11, 706	19, 666		192. 01
200.00			,, 700	11, 700	17,000		200. 00
200.00					0		200.00
201.00		0	1, 638, 895	2, 410, 061	4, 048, 956		201.00
202.00	TOTAL (Suill Filles 116 till ougil 201)	1	1,030,893	2, 410, 001	4, 040, 930	31,834	1202.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 04/01/2022 | Part II | Date/Time Prepared: 8/29/2023 | 11:22 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS SAINT JOSEPH MEMORIAL HOSPITAL Provider CCN: 14-1334

				'	0 03/31/2023	8/29/2023 11:	
	Cost Center Description	DATA	PURCHASI NG	CASHI ERI NG/ACC	OTHER	MAINTENANCE &	
	·	PROCESSI NG	RECEIVING AND	OUNTS	ADMI NI STRATI VE	REPAI RS	
			STORES	RECEI VABLE	AND GENERAL		
		5. 01	5. 02	5. 03	5. 04	6. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00550 DATA PROCESSING	18, 042					5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	53	17, 993				5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	955	85	55, 806			5. 03
5.04	00590 OTHER ADMINISTRATIVE AND GENERAL	1, 539	34	0	807, 655		5. 04
6.00	00600 MAINTENANCE & REPAIRS	531	0	0	29, 455	437, 464	6. 00
7.00	00700 OPERATION OF PLANT	212	0	0	4, 850	982	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	4, 695	4, 531	8. 00
9.00	00900 HOUSEKEEPI NG	106	3	0	9, 562	4, 404	9. 00
10.00	01000 DI ETARY	371	3	0	7, 743	31, 754	10. 00
11. 00	01100 CAFETERI A	0	9	1	-,	3, 160	11. 00
13.00	01300 NURSING ADMINISTRATION	159	0	0	25, 187	14, 932	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	1, 067	3, 140	14. 00
15.00	01500 PHARMACY	265	157	0	193, 785	6, 750	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	212	0	0	4, 261	31, 216	16. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 547	1, 552	723	74, 734	56, 913	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	3, 346				86, 598	50. 00
51.00	05100 RECOVERY ROOM	212	l .		5, 407	9, 554	51. 00
53.00	05300 ANESTHESI OLOGY	53	382			524	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 008	529		45, 330	34, 531	54.00
60.00	06000 LABORATORY	849	4, 103		56, 928	15, 786	60. 00
64.00	06400 I NTRAVENOUS THERAPY	1, 114	1, 065		23, 385	18, 691	64. 00
65.00	06500 RESPI RATORY THERAPY	425	105	1		4, 417	65. 00
65. 01	03610 SLEEP LAB	796	32			25, 454	65. 01
65. 02	03620 GERI ATRI C PSYCH	265	l e		7, 688	8, 135	65. 02
66. 00	06600 PHYSI CAL THERAPY	955	93	1		8, 068	66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 842	1		0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	265	29			12, 720	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS			T.			
90.00	09000 CLI NI C	690	ł	1	8, 511	17, 178	90. 00
91. 00	09100 EMERGENCY	1, 114	1, 837	3, 169	47, 422	31, 915	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS	_	T _	1 -	TT		
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS		I	I	T T		
	11300 I NTEREST EXPENSE	40.040	47.000	== 00/	00/ 005	101 050	113. 00
118. 00		18, 042	17, 993	55, 806	806, 305	431, 353	118.00
400.00	NONREI MBURSABLE COST CENTERS			1 -	200	0.000	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	1			192. 00
	19201 UNUSED SPACE	0	0	0	314	3, 173	192. 01
200.00	1 1	_	_	_	_	=	200. 00
201.00		0	17.000	1	007.755		201. 00
202. 00	TOTAL (sum lines 118 through 201)	18, 042	17, 993	55, 806	807, 655	437, 464	J202. 00

Health Financial Systems SAINT JOSEPH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1334 Peri od: Worksheet B From 04/01/2022 Part II Date/Time Prepared: 03/31/2023 8/29/2023 11:22 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A **PLANT** LINEN SERVICE 9.00 10.00 11.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00550 DATA PROCESSING 5 01 5 01 5.02 00560 PURCHASING RECEIVING AND STORES 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.03 5.04 00590 OTHER ADMINISTRATIVE AND GENERAL 5.04 00600 MAINTENANCE & REPAIRS 6.00 6 00 7.00 00700 OPERATION OF PLANT 12, 576 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 131 37, 440 8.00 00900 HOUSEKEEPI NG 9 00 127 42, 406 9 00 116 10.00 01000 DI ETARY 915 237, 866 10.00 11.00 01100 CAFETERI A 91 C 608 29, 490 11.00 01300 NURSING ADMINISTRATION 1, 922 13.00 0 13.00 430 0 C 01400 CENTRAL SERVICES & SUPPLY 0 14.00 90 0 0 181 14.00 15.00 01500 PHARMACY 194 0 397 0 1,041 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16 00 899 101 175 16.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 1, 640 14, 171 13, 244 237, 866 4, 747 30.00 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 2, 496 4, 229 5, 873 50.00 9,831 50.00 51.00 05100 RECOVERY ROOM 275 1, 455 600 0 422 51.00 53.00 05300 ANESTHESI OLOGY 15 25 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 995 4,858 2, 596 54.00 2.027 54.00 06000 LABORATORY 2, 258 60.00 455 C 498 60 00 0 64.00 06400 I NTRAVENOUS THERAPY 539 C 2,998 1, 242 64.00 06500 RESPIRATORY THERAPY 1, 296 65.00 127 108 304 0 0 0 65.00 1, 467 03610 SLEEP LAB 1.013 65.01 733 38 65.01 03620 GERLATRIC PSYCH 65.02 234 C 524 525 65.02 66.00 06600 PHYSI CAL THERAPY 232 0 0 2,541 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 0 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 Ω O 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 0 Λ 73.00 76. 97 07697 CARDIAC REHABILITATION 35 507 0 630 76. 97 367 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 495 401 1,520 0 408 90.00 91.00 09100 EMERGENCY 920 12,022 8, 209 0 2, 166 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS

12, 400

12.576

85

91

0

37, 440

37 440

C

C

42, 406

C

0

0

C

42.406

237, 866

237, 866

0

0

113 00

0 190. 00

0 192. 00

0 192. 01

200.00 0 201.00

29, 490 118. 00

29, 490 202. 00

113. 00 11300 INTEREST EXPENSE

192. 01 19201 UNUSED SPACE

NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

Cross Foot Adjustments

Negative Cost Centers

192. 00 19200 PHYSICIANS' PRIVATE OFFICES

118.00

200.00

201.00

202.00

SUBTOTALS (SUM OF LINES 1 through 117)

TOTAL (sum lines 118 through 201)

| Peri od: | Worksheet B | From 04/01/2022 | Part | I | To 03/31/2023 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS SAINT JOSEPH MEMORIAL HOSPITAL Provider CCN: 14-1334

				Io	03/31/2023	Date/lime Pre 8/29/2023 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	NONPHYSI CI AN	ZZ dili
	555 55 TEST 5555 FEE 611	ADMI NI STRATI ON	SERVICES &		RECORDS &	ANESTHETI STS	
			SUPPLY		LI BRARY		
		13.00	14. 00	15. 00	16. 00	19. 00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT						1. 00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00550 DATA PROCESSING						5. 01
	00560 PURCHASING RECEIVING AND STORES						5. 02
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 04
	00600 MAI NTENANCE & REPAI RS						6. 00
	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8.00
4	00900 HOUSEKEEPI NG						9.00
4	01000 DI ETARY						10.00
	01100 CAFETERI A	407.054					11.00
4	01300 NURSI NG ADMI NI STRATI ON	137, 854	04.004				13.00
	01400 CENTRAL SERVICES & SUPPLY	0	24, 024	0.45 7.40			14. 00
	01500 PHARMACY	0	0	245, 742	000 007		15. 00
	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	230, 397		16.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	U	0	0	0	0	19. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	46, 162	0	311	2, 981		30.00
	ANCILLARY SERVICE COST CENTERS	40, 102	0	311	2, 701		30.00
	05000 OPERATI NG ROOM	46, 147	0	511	56, 061		50.00
	05100 RECOVERY ROOM	4, 874	0	13	1, 448		51.00
53. 00	05300 ANESTHESI OLOGY	0	0	55	8, 392		53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	29	45, 297		54.00
	06000 LABORATORY	0	0	0	38, 541		60.00
64. 00	06400 I NTRAVENOUS THERAPY	12, 765	0	275	3, 584		64. 00
	06500 RESPI RATORY THERAPY	1, 581	0	0	4, 420		65. 00
65. 01	03610 SLEEP LAB	0	0	0	7, 005		65. 01
	03620 GERI ATRI C PSYCH	1, 315	0	0	638		65. 02
66. 00	06600 PHYSI CAL THERAPY	0	0	3	8, 346		66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	24, 024	0	4, 602		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	0	5, 871		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0	244, 127	27, 334		73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 461	0	0	1, 068		76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	o		77. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	2, 374	0	77	1, 735		90. 00
4	09100 EMERGENCY	21, 175	0	341	13, 074		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS	1			al		
	10200 OPIOLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0		102. 00
	11300 I NTEREST EXPENSE						113. 00
118.00		137, 854	24, 024	245, 742	230, 397	Ō	118. 00
	NONREIMBURSABLE COST CENTERS	137,034	24, 024	243, 742	230, 377	0	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ol		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	Ö	ő		192. 00
	19201 UNUSED SPACE		0	0	Ö		192. 01
200.00	Cross Foot Adjustments		J		Ĭ	n	200.00
201.00	Negative Cost Centers	n	n	n	n		201. 00
202.00		137, 854	24, 024	245, 742	230, 397		202.00
	, , , , , , , , , , , , , , , , , , , ,		., . = -1				•

| Provider CCN: 14-1334 | Period: | Worksheet B | From 04/01/2022 | Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

ALLOGA	THON OF CHITTAL RELATED GOSTS		Trovider 6	ON. 14 1354	From 04/01/2022 To 03/31/2023	Part II Date/Time Prepared:
				T +		8/29/2023 11: 22 am
	Cost Center Description	Subtotal	Intern & esidents Cost	Total		
		"	& Post			
			Stepdown			
			Adjustments			
	GENERAL SERVICE COST CENTERS	24. 00	25. 00	26.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01	00550 DATA PROCESSING					5. 01
5.02	00560 PURCHASING RECEIVING AND STORES					5. 02
5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 03
5.04	00590 OTHER ADMINISTRATIVE AND GENERAL					5. 04
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT					6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8.00
9. 00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY					16.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS					19. 00
30. 00	03000 ADULTS & PEDIATRICS	814, 682	C	814, 68	82	30.00
00.00	ANCILLARY SERVICE COST CENTERS	011,002		011,00	<u>52 </u>	30. 00
50.00	05000 OPERATING ROOM	884, 554	0	884, 55	54	50.00
51. 00	05100 RECOVERY ROOM	84, 236	0	84, 23	36	51.00
53.00	05300 ANESTHESI OLOGY	19, 653	0	,		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	364, 920	0			54. 00
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	228, 418	0	228, 4		60. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	184, 111 59, 197	0	184, 1° 59, 1°		65. 00
65. 01	03610 SLEEP LAB	218, 243	0	218, 24		65. 01
65. 02	03620 GERI ATRI C PSYCH	70, 438	0	70, 43		65. 02
66. 00	06600 PHYSI CAL THERAPY	106, 827	0	106, 82		66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	48, 731	0	48, 73	31	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	46, 066	0	46, 00		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	283, 629	0			73.00
76. 97 77. 00	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION	104, 830	0	,		76. 97
77.00	OUTPATIENT SERVICE COST CENTERS	0			0	77. 00
90. 00	09000 CLINIC	140, 860	C	140, 80	50	90.00
91. 00	09100 EMERGENCY	344, 050	Ö			91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
	OTHER REIMBURSABLE COST CENTERS					
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		0	102. 00
	SPECIAL PURPOSE COST CENTERS			1		
	11300 I NTEREST EXPENSE	4 002 445	•	4 000 4	4.5	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	4, 003, 445	0	4, 003, 4	40	118. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21, 521	0	21, 52	21	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	746	0	1	46	192. 00
	19201 UNUSED SPACE	23, 244	0	1		192. 01
200.00	Cross Foot Adjustments	0	0	1	0	200. 00
201.00		0	0		0	201. 00
202.00	TOTAL (sum lines 118 through 201)	4, 048, 956	0	4, 048, 95	56	202. 00

Cost Center Description			ALINI JUSEPH WEN		ou 44 4004 F		u or rorm cms-	
CAPITAL SELVED COST Center Description	COST A	ILLOCATION - STATISTICAL BASIS		Provider Co	F	rom 04/01/2022	Worksheet B-1 Date/Time Pre	
COST Center Description						0 00, 01, 2020		
COLUMN STORES COLUMN STORES COLUMN C			CAPI TAL REI	LATED COSTS				
COLUMN STORES COLUMN STORES COLUMN C		Cost Center Description	BLDG & FLXT	MVRLE FOLLE	FMPLOYEE	DATA	PURCHASING	
BEPARTMENT COMBINES CRISTINS CRISTIN		cost center beserretron						
CREATION			(040/11/2 / 22/)	(040/11/2 1221)				
CHINEMAL SINVICE COST CENTERS								
ERICRAL SERVICE COST CENTERS 1.00 00100 (AP) RELL COSTS-LOBE & FIXT 2.00 00200 (AP) RELL COSTS-LOBE & FIXT 3.00 00400 (AP) RELL COSTS-LOBE & SERVICE					SALARI ES)		SUPPLI ES)	
0.0100 CAP REL COSTS-BUDG & FIXT			1. 00	2. 00	4. 00	5. 01	5. 02	
2.00			07.475	1				
4.00 0.0400 BIRLOVER BENEFITS DEPARTIENT 908 908 16, 230, 935 4.00 5.01 0.0550 0.0560 NICHASING RECELIVING AND STORES 4.38 4.28 4.48 4.6 , 0.00 1. 2.09, 6.55 5.01 0.0550 0.0560 NICHASING RECELIVING AND STORES 4.38 4.28 4.6 , 0.00 1. 2.09, 6.55 5.01			97, 175					1
5.01 0.0550 DATA PROCESSING 433 433 0 340 1 2,00,655 5.02 0.0500 DATA PROCESSING 1 2,00,655 5.03 0.0500 DATA PROCESSING 1 2,00,655 5.03 0.0500 DATA PROCESSING 1 2,00 5.03 0.0500 DATA PROCESSING 1 2,00 5.03 0.0500 DATA PROCESSING 1 2,00 5.03 0.0500 0.0500 DATA PROCESSING 1 2,00 0.0500 0.0			000			-		
0.000								1
5.03 00800 CASHIERING/ACCOUNTS RECEIVABLE 1,285 1,285 1,285 1,000,469 20 4,130 5,00 6.00 00600 CHEP ADMINISTRATIVE AND GENERAL 19,290 19,290 19,000 10,000,469 20 4,130 5,00 6.00 00600 CHEP ADMINISTRATIVE AND GENERAL 19,290 19,290 19,000 19,000 10,000,469 10 0 0 0 0 8.00 00800 CLANDRY & LINEN SERVICE 674 6							l .	
5.04 0.0500 OTHER ARMINISTRATIVE ARD CENERAL 19, 200 1, 000, 469 29 4, 130 5, 04 0.0			· ·	l .			1	
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 0.00000 0.00000								
0.000 0.0000 LUMDRY & LINEN SERVICE 674 675 655 635 314, 428 2 403 90. 10.000 0.1000 DICTARY 4, 723 4, 723 120, 886 7 419 10. 00 10.000 0.1000 CEFTERIA 4, 720 4, 723 120, 886 7 419 10. 10. 00 10.000 1.000 CEFTERIA 4, 720 4, 723 4, 723 120, 886 7 419 10. 10. 00 10.000 0.1000 CEFTERIA 4, 720 4, 720 4, 723 1, 150, 769 3 0 13. 00 10.000 0.1000 CETTRAL SERVICES & SUPPLY 467 467 37, 735 0 16 14. 00 10.000 0.1000 CETTRAL SERVICES & SUPPLY 4, 648 4, 643 32, 165 40 0 16. 00 10.000 0.1000 CETTRAL SERVICES & SUPPLY 4, 648 4, 643 32, 165 40 0 16. 00 10.000 0.1000 CETTRAL SERVICE COST CENTERS 4, 648 4, 648 3, 24, 168 40 0 16. 00 10.000 0.000 0.000 0.000 0.000 0.000 0.000 10.000 0.00			•					
0.000 0.0000 DICEARY 0.000 0.000 DICEARY 0.000 DIC	7.00	00700 OPERATION OF PLANT	146	146	192, 816	4	0	7. 00
10.00 01000 DIETARY 4.723 4.723 120,886 7	8.00	00800 LAUNDRY & LINEN SERVICE	674	674	C	0	0	8. 00
11.00 01100 CAFETERIA	9.00	00900 HOUSEKEEPI NG	655	655	341, 428	2	403	9. 00
13.00 01300 NURSING ADMINISTRATION 2,221 2,221 1,150.769 3 0 13.00 1			1				l .	
14. 00 01-400 CENTRAL SERVICES & SUPPLY			1	l .			1	
15.00 0 1500 PHARMACY			1				1	
16.00 01600 MEDICAL RECORDS & LIBRARY 4,643 4,643 3.2,163 4 0 16.00 19.00			1	l .			l .	1
19. 00 01900 NOMPYSICIAN AMESTHETISTS 0 0 0 0 0 19. 00 0 19. 00 0 19. 00 0 0 0 0 0 0 0 0 0			•				1	
INPATIENT ROUTINE SERVICE COST CENTERS 8, 465 1, 879, 849 48 100, 567 50.00 50.00 50.00 50.00 50.00 60.0							l e	
30.00	19.00] 0	0) U		19.00
MACILLARY SERVICE COST CENTERS 50.00 COOO OPERATIN ROOM 12,880 12,880 2,622,395 63 610,415 50.00 51.00 05100 OPERATIN ROOM 1,421 1,421 167,495 4 3,148 51.00 053.00 053.00 OS3.00 OS3.	30 00		8 465	8 465	1 879 840	18	190 567	30.00
50 00 05000 0FEATI NG ROOM 12,880 12,880 2,622,395 63 610,451 50.00 51.00 05100 RECOVERY ROOM 1,421 1,441	30.00		0, 403	0, 403	1,077,047	,	170, 307	30.00
1. 1. 1. 1. 1. 1. 1. 1.	50.00		12, 880	12, 880	2, 622, 395	63	610, 451	50.00
54.00 05400 RADIO LOGY-DIAGNOSTIC 5, 136 5, 136 1, 174, 828 19 64, 966 54.00								1
60.00 06000 LABDRATORY 2, 348	53.00	05300 ANESTHESI OLOGY	78					
64.00 06400 INTRAVENDUS THERAPY 2, 780 2,780 750,992 21 130,802 64.00 65.00 06500 RESPIRATORY THERAPY 657 657 525,667 8 12,890 65.00 65.01 03610 SLEEP LAB 3,786 3,786 580,573 15 3,902 64.00 66.00 06600 PMSI CAL THERAPY 1,200 1,200 1,256,315 18 11,449 66.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 74.97 07697 CARDIAC REHABILITATION 1,892 1,892 277,313 5 3,599 76.97 75.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77.00 07900 CLINIC COST CENTERS 0 0 0 0 0 0 79.00 09000 CLINIC COST CENTERS 0 0 0 0 0 0 79.00 09000 08ERVENTION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 79.00 09000 08ERVENTION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 79.00 09000 09000 0000 0 0 0	54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 136	5, 136	1, 174, 828	19	64, 966	54.00
65.0 06500 RESPIRATORY THERAPY 6.57 6.57 5.25, 6.67 8 12, 890 65, 00 65.01 03.01 SLEEP LAB 3, 786 3, 786 580, 573 15 3, 902 65, 01 65.02 03620 GERIATRIC PSYCH 1, 210 1, 210 231, 971 5 90 65, 02 66.00 06600 PHYSICAL THERAPY 1, 200 1, 200 1, 256, 315 18 11, 449 66, 00 67.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 67.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 67.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 67.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 67.00 07400 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 67.00 07400 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 67.00 07400 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 67.00 07400 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 67.00 074700 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 67.00 074700 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 67.00 074700 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 67.00 074700 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 67.00 074700 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 67.00 074700 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 67.00 074700 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 67.00 074700 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0	60.00		2, 348	2, 348	782, 315	16	503, 900	60.00
65.00 03610 SLEEP LAB 3,786 3,786 580,573 15 3,902 65.02 66.00 06600 PHYSI CAL THERAPY 1,210 1,210 231,971 5 90 65.02 67.00 0700 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 348,961 71.00 77.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 78.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 79.07 0700 0700 0700 0700 0700 0		06400 I NTRAVENOUS THERAPY					130, 802	
65. 02 03620 GERIATRIC PSYCH 1, 210 1, 210 231, 971 5 90 65. 02 06600 PHYSICAL THERAPY 1, 200 1, 200 1, 256, 315 18 11, 449 66. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 348, 961 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 348, 961 71. 00 73. 00 07300 PRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 72. 00 73. 00 07300 PRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 73. 00 76. 97 07500 PROVED CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 73. 00 76. 97 07500 PROVED CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								1
66.00 06600 PHYSI CAL THERAPY 1, 200 1, 200 1, 256, 315 18 11, 449 66. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 348, 961 71. 00 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 75. 07 07697 CARDIA CREHABILITATION 1, 892 1, 892 277, 313 5 3, 599 769 76. 97 07697 CARDIA CREHABILITATION 1, 892 1, 892 277, 313 5 3, 599 769 77. 00 0700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 77. 00 00000 00000 0 0 0 77. 00 00000 00000 0 0 0 78. 00 09000 00000 0 0 0 79. 00 09000 00000 0 0 0 79. 00 09000 00000 0 0 0 79. 00 09000 00000 0 0 0 79. 00 09000 00000 0 0 0 79. 00 09000 00000 0 0 79. 00 09000 00000 0 0 79. 00 09000 00000 0 0 79. 00 09000 00000 0 0 79. 00 09000 00000 0 79. 00 09000 00000 0 0 79. 00 09000 00000 0 79. 00 09000 00000 0 0 79. 00 00000 0 0 0 79. 00 00000 0 0 79. 00 00000 0 0 79. 00 00000 0 0 79. 00 00000 0 0 79. 00 00000 0 0 79. 00 00000 0 0 79. 00 00000 0 0 79. 00 00000 0 79. 00 00000 0 0 79. 00 00000 0 0 79. 00 00000 0 79. 00 00000 0 0 79. 00 00000 0 79.			1					1
171.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0			1				l	1
172.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0					1			
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 76.97 07697 CARDI AC REHABILITATION 1,892 1,892 277,313 5 3,599 76.97 77.00 O7700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0 0			-	_	·	-	1	
76. 97 07697 CARDIA C REHABILITATION 1,892 1,892 277,313 5 3,599 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0			-	_			1	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0			1		277 313	-		
OUTPATIENT SERVICE COST CENTERS OUTPATIENT PROGRAM OUT			1					
90. 00			-					1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 0THER REIMBURSABLE COST CENTERS 92. 00 102.00 101.00 101.00 101.00 102.00 102.00 101.00 102.00 102.00 101.00 102.00 10	90.00		2, 555	2, 555	195, 596	13	16, 649	90.00
OTHER REIMBURSABLE COST CENTERS O			4, 747	4, 747	1, 241, 534	21	225, 546	91.00
102. 00 10200 OPI OID TREATMENT PROGRAM O O O O O O O O O	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
113.00 11300 1NTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 96, 266 96, 266 16, 230, 935 340 2, 209, 655 118.00								
113.00	102.00		0	0	(0	0	102. 00
18.00 SUBTOTALS (SUM OF LINES 1 through 117) 96, 266 96, 266 16, 230, 935 340 2, 209, 655 118.00			1	T				
NONRET MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 437 437 0 0 0 190. 00 192. 00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 192. 01 192.01 19201 UNUSED SPACE 472 472 0 0 0 192. 01 200. 00 201. 00 Negative Cost Centers 201. 00 Negative Cost Centers 201. 00 203. 00 Unit cost multiplier (Wkst. B, Part I) 16. 865397 24. 801245 37, 834 18, 042 17, 993 204. 00 205. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 0. 002331 53. 064706 0. 008143 205. 00 206. 00 NAHE adjustment amount to be allocated (per Wkst. D, 207. 00 NAHE unit cost multiplier (Wkst. D, 207. 00 207. 00 NAHE unit cost multiplier (Wkst. D, 207. 00 207. 00 207. 00 207. 00 NAHE unit cost multiplier (Wkst. D, 207. 00 207. 00			0/ 2//	0/ 2//	1/ 220 025	240	2 200 /55	
190. 00	118.00		96, 266	96, 266	16, 230, 935	340	2, 209, 655	1118.00
192.00 19200	100 00		127	127				100 00
192.01 19201 UNUSED SPACE Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 207.00 NAHE unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII								
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) NAHE unit cost multiplier (Wkst. B, Part II) NAHE unit cost multiplier (Wkst. B, Part III) NAHE unit cost multiplier (Wkst. B, Part IIII) 207.00 NAHE unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			-				l .	
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 16.865397 24.801245 27.410,061 4,164,316 3,597,386 89,132 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 16.865397 24.801245 0.256567 10,580.547059 0.040338 203.00 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 0.002331 53.064706 0.008143 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, Part II) 207.00 207.00 NAHE unit cost multiplier (Wkst. D, Part II) 207.00			1,72	172				
202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost								
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. B, Part II) NAHE unit cost multiplier (Wkst. D, Part II) NAHE unit cost multiplier (Wkst. D, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, Part II) 208.00 NAHE unit cost multiplier (Wkst. D, Part III) 209.00 NAHE unit cost multiplier (Wkst. D, Part III) 209.00 NAHE unit cost multiplier (Wkst. D, Part IIII) 200.00 NAHE unit cost multiplier (Wkst. D, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			1, 638, 895	2, 410, 061	4, 164, 316	3, 597, 386	89, 132	202. 00
204.00 Cost to be allocated (per Wkst. B, Part II) 37,834 18,042 17,993 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.002331 53.064706 0.008143 205.00 10 10 10 10 10 10 10		Part I)						
Part II) Unit cost multiplier (Wkst. B, Part II) 205.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	203.00		16. 865397	24. 801245	0. 256567	10, 580. 547059	0. 040338	203. 00
205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	204.00				37, 834	18, 042	17, 993	204. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	00= 5=				0 00055	F0 0/1==	0 0001:-	005 05
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D,	205.00				0. 002331	53. 064706	0. 008143	205. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	204 00							206 00
207.00 NAHE unit cost multiplier (Wkst. D,	200. UC							200.00
	207. 00							207. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1334 Peri od: Worksheet B-1 From 04/01/2022 03/31/2023 Date/Time Prepared: 8/29/2023 11:22 am Cost Center Description CASHIERING/ACC Reconciliation MAINTENANCE & OPERATION OF **OTHER** ADMI NI STRATI VE OUNTS **REPAIRS** PLANT RECEI VABLE AND GENERAL (SQUARE FEET) (SQUARE FEET) (GROSS (ACCUM. COST) REVENUE) 5.04 7. 00 5.03 5A. 04 6.00 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 00550 DATA PROCESSING 5.01 5. 01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 258, 608, 241 5.03 5.04 00590 OTHER ADMINISTRATIVE AND GENERAL -6, 505, 585 50, 623, 668 5.04 6.00 00600 MAINTENANCE & REPAIRS 1, 846, 228 65,067 6.00 0 00700 OPERATION OF PLANT 303.980 64, 921 7 00 0 Ω 146 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 0 294, 307 674 674 8.00 9.00 00900 HOUSEKEEPI NG 0 599, 336 655 655 9.00 10.00 01000 DI ETARY 0 0 0 485, 328 4,723 4,723 10.00 01100 CAFFTERIA Ω 11 00 341 387 470 11 00 470 01300 NURSING ADMINISTRATION 2, 221 13.00 0 1, 578, 695 2, 221 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 0 0 66, 910 467 467 14.00 01500 PHARMACY 15 00 0 12 146 144 1 004 1 004 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 267, 085 4,643 4,643 16.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 0 30 00 03000 ADULTS & PEDIATRICS 3, 346, 157 4, 684, 339 8, 465 8, 465 30 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 62, 943, 748 6, 780, 196 12, 880 12, 880 0 50.00 1, 421 1, 421 51.00 05100 RECOVERY ROOM 1, 625, 370 0 338, 910 51.00 05300 ANESTHESI OLOGY 9, 419, 163 308 503 53 00 53 00 0 78 78 54.00 05400 RADI OLOGY-DI AGNOSTI C 50, 838, 269 0 2, 841, 307 5, 136 5, 136 54.00 06000 LABORATORY 43, 255, 628 3, 568, 232 60.00 2.348 2, 348 60.00 06400 I NTRAVENOUS THERAPY 4, 022, 245 2, 780 64.00 1.465.801 2, 780 64.00 4, 961, 038 1, 049, 378 06500 RESPIRATORY THERAPY 65.00 657 657 65.00 03610 SLEEP LAB 7, 861, 940 1, 310, 239 3, 786 3, 786 65.01 65.01 03620 GERLATRIC PSYCH 715, 750 65 02 481, 871 1, 210 1, 210 65 02 06600 PHYSI CAL THERAPY 9, 366, 885 0 1, 983, 135 1, 200 1, 200 66,00 66,00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 5, 165, 323 C 1, 012, 128 0 Λ 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 588, 730 2, 430, 237 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 30, 678, 154 0 347, 383 O 73.00 07697 CARDIAC REHABILITATION 502, 079 1, 892 76.97 1, 199, 123 0 76.97 1,892 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 947, 341 533, 490 2, 555 2, 555 90.00 91.00 09100 EMERGENCY C 2, 972, 399 4, 747 91.00 14, 673, 377 4,747 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 64, 158 64, 012 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 258, 608, 241 -6, 505, 585 50, 539, 027 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 18, 208 437 437 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 46, 767 0 192.00 192. 01 19201 UNUSED SPACE 0 472 472 192.01 19,666 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 658, 504 6, 505, 585 2, 083, 485 347, 719 202. 00 Part I) 203 00 Unit cost multiplier (Wkst. B, Part I) 0.006413 0.128509 32 020610 5. 356033 203. 00 204.00 Cost to be allocated (per Wkst. B, 55, 806 807,655 437, 464 12, 576 204. 00 Part II) 0.015954 0. 193712 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 0.000216 6.723285 II) 206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207. 00 Parts III and IV)

		TION - STATISTICAL BASIS	WINT SOSEITI MEM	Provi der C	CN: 14-1334 P	eri od:	Worksheet B-1	
						rom 04/01/2022 o 03/31/2023	Date/Time Pre	pared:
							8/29/2023 11:	
		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (HOURS OF	DI ETARY (MEALS SERVED)	CAFETERIA (NUMBER OF	NURSI NG ADMI NI STRATI ON	
			(POUNDS OF	SERVI CE)	(FTES)		
			LAUNDRY)				(DI RECT NURS.	
			8. 00	9. 00	10.00	11.00	HRS.) 13. 00	
	GENER	AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01		DATA PROCESSING						5. 01
5.02		PURCHASING RECEIVING AND STORES						5. 02
5. 03 5. 04		CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMINISTRATIVE AND GENERAL						5. 03 5. 04
6.00		MAINTENANCE & REPAIRS						6. 00
7. 00		OPERATION OF PLANT						7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	39, 692 123	5, 021				8. 00 9. 00
10.00	1	DI ETARY	7	3, 021	17, 827			10.00
11. 00		CAFETERI A	o	72	0	15, 178		11. 00
13.00	1	NURSING ADMINISTRATION	0	0	0		127, 390	
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	47	0		0	
16. 00		MEDICAL RECORDS & LIBRARY	o	12			0	1
19. 00		NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	15, 025	1, 568	17, 827	2, 443	42, 658	30.00
30.00	ANCI L	LARY SERVICE COST CENTERS	15,025	1, 500	17,027	2, 443	42,030	30.00
50.00		OPERATING ROOM	4, 483	1, 164		•	42, 644	
51. 00 53. 00		RECOVERY ROOM ANESTHESI OLOGY	1, 542	71	0		4, 504 0	
54. 00		RADI OLOGY-DI AGNOSTI C	5, 150	240	•	I	0	1
60.00		LABORATORY	0	59			0	
64.00	1	I NTRAVENOUS THERAPY	0	355			11, 796	
65. 00 65. 01		RESPI RATORY THERAPY SLEEP LAB	115 40	36 120	•		1, 461 0	1
65. 02		GERIATRIC PSYCH	0	62			1, 215	1
66. 00	1	PHYSI CAL THERAPY	0	0	0	,	0	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	0	-	0	
73. 00		DRUGS CHARGED TO PATIENTS	o	0	Ö		0	
		CARDI AC REHABILITATION	37	60			1, 350	1
77. 00		ALLOGENEIC HSCT ACQUISITION TIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
90.00		CLINIC	425	180	0	210	2, 194	90.00
91. 00		EMERGENCY	12, 745	972			19, 568	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
102.00		REIMBURSABLE COST CENTERS OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
102.00		AL PURPOSE COST CENTERS	<u> </u>			<u> </u>		102.00
	1	INTEREST EXPENSE						113. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	39, 692	5, 021	17, 827	15, 178	127, 390]118. 00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	ol	0	190. 00
	1	PHYSICIANS' PRIVATE OFFICES	o	0	0	o	0	192. 00
		UNUSED SPACE	0	0	0	0	0	192. 01
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00		Cost to be allocated (per Wkst. B,	357, 320	701, 944	724, 290	412, 891	1, 891, 490	
000 00		Part I)	0.000040	400 004/00	40 (00004	07.000055	4.4.0.4000.4	000 00
203. 00 204. 00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	9. 002318 37, 440	139. 801633 42, 406	1	l .	14. 848026 137, 854	
204.00		Part II)	37, 440					
205.00)	Unit cost multiplier (Wkst. B, Part	0. 943263	8. 445728	13. 343019	1. 942944	1. 082141	205. 00
206.00								206. 00
200.00		(per Wkst. B-2)						
207. 00)	NAHE unit cost multiplier (Wkst. D,						207. 00
	1	Parts III and IV)	ı l		I	ı I		I

Health Financial Systems	SAINT JOSEPH MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CC	N: 14-1334 F	eri od:	Worksheet B-1
				rom 04/01/2022 o 03/31/2023	Date/Time Prepared:
			'	0 03/31/2023	8/29/2023 11: 22 am
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	NONPHYSI CI AN	
	SERVICES &	(COSTED	RECORDS &	ANESTHETI STS	
	SUPPLY	REQUIS.)	LI BRARY	(ASSI GNED	
	(COSTED REQUIS.)		(GROSS REVENUE)	TIME)	
	14.00	15. 00	16. 00	19. 00	
GENERAL SERVICE COST CENTERS	11.00	10.00	10.00	17.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT					1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01 O0550 DATA PROCESSING					5. 01
5. 02 00560 PURCHASING RECEIVING AND STORES					5. 02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 03
5.04 00590 OTHER ADMINISTRATIVE AND GENERAL 6.00 00600 MAINTENANCE & REPAIRS					5. 04 6. 00
7. 00 00700 OPERATION OF PLANT					7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11. 00
13.00 O1300 NURSING ADMINISTRATION					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	964, 927				14. 00
15. 00 01500 PHARMACY	0	11, 226, 882	050 (00 04		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	258, 608, 241		16.00
19.00 01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	Ų		0	19. 00
30. 00 03000 ADULTS & PEDIATRICS	0	14, 197	3, 346, 157	0	30.00
ANCI LLARY SERVICE COST CENTERS	<u> </u>	17, 177	3, 340, 137	٥	30.00
50. 00 05000 OPERATI NG ROOM	0	23, 347	62, 943, 748	0	50.00
51.00 05100 RECOVERY ROOM	0	583	1, 625, 370		51. 00
53. 00 05300 ANESTHESI OLOGY	0	2, 491	9, 419, 163	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 310	50, 838, 269		54. 00
60. 00 06000 LABORATORY	0	0	43, 255, 628		60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	12, 563	4, 022, 245		64.00
65. 00 06500 RESPI RATORY THERAPY 65. 01 03610 SLEEP LAB	0	O O	4, 961, 038 7, 861, 940		65. 00 65. 01
65. 02 03620 GERIATRIC PSYCH	0	0	7, 861, 940		65. 02
66. 00 06600 PHYSI CAL THERAPY		122	9, 366, 885		66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	964, 927	0	5, 165, 323		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	O	6, 588, 730		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	11, 153, 182	30, 678, 154	0	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	1, 199, 123		
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	77. 00
OUTPATIENT SERVICE COST CENTERS		2 520	4 047 044		
90. 00 09000 CLINIC	0	3, 529	1, 947, 341		
91.00 09100 EMERGENCY 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART)	9	15, 558	14, 673, 377	U	92.00
OTHER REIMBURSABLE COST CENTERS					92.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	C	0	102. 00
SPECIAL PURPOSE COST CENTERS	-1			-	
113. 00 11300 NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	964, 927	11, 226, 882	258, 608, 241	0	118. 00
NONREI MBURSABLE COST CENTERS					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(-	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0	192. 00
192.01 19201 UNUSED SPACE 200.00 Cross Foot Adjustments	0	O ₁	C		192. 01 200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst. B,	95, 494	13, 765, 696	479, 074	0	202. 00
Part I)	,3,174	.5, .55, 576	1, 7, 37	i i	202.00
203.00 Unit cost multiplier (Wkst. B, Part I	0. 098965	1. 226137	0.001853	0. 000000	203. 00
204.00 Cost to be allocated (per Wkst. B,	24, 024	245, 742	230, 397		204. 00
Part II)					
205.00 Unit cost multiplier (Wkst. B, Part	0. 024897	0. 021889	0. 000891	0. 000000	205. 00
NAUF adjustment amount to be all costs					20/ 22
206.00 NAHE adjustment amount to be allocate (per Wkst. B-2)	eu				206. 00
207.00 NAHE unit cost multiplier (Wkst. D,					207. 00
Parts III and IV)					257.00
	,				

Health Financial Systems	SAINT JOSEPH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1334	Peri od: From 04/01/2022 To 03/31/2023	Worksheet C Part I Date/Time Prepared: 8/29/2023 11:22 am	
	Ti +1 o V// I I	Hospi tal	Coct	

				To 03/31/2023	Date/Time Pre 8/29/2023 11:	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	7, 404, 923		7, 404, 92	3 0	0	30. 00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	9, 196, 581		9, 196, 58		0	50.00
51.00 05100 RECOVERY ROOM	535, 889		535, 88		0	51.00
53. 00 05300 ANESTHESI OLOGY	371, 991		371, 99 ⁻		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 610, 475		3, 610, 47		0	54.00
60. 00 06000 LABORATORY	4, 234, 553		4, 234, 55	3 0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	2, 023, 094		2, 023, 09	4 0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 263, 889	0	1, 263, 88	9 0	0	65. 00
65. 01 03610 SLEEP LAB	1, 672, 367	0	1, 672, 36	7 0	0	65. 01
65. 02 03620 GERI ATRI C PSYCH	624, 401	0	624, 40	1 0	0	65. 02
66. 00 06600 PHYSI CAL THERAPY	2, 335, 927	0	2, 335, 92	7 0	0	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 247, 261		1, 247, 26	1 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 754, 753		2, 754, 75	3 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	14, 124, 202		14, 124, 20	2 0	0	73.00
76. 97 07697 CARDIAC REHABILITATION	677, 120		677, 120	0 0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	772, 761		772, 76	1 0	0	90.00
91. 00 09100 EMERGENCY	4, 149, 572		4, 149, 57	2 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	507, 864		507, 86	4	0	92.00
OTHER REIMBURSABLE COST CENTERS						
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
200.00 Subtotal (see instructions)	57, 507, 623	0	57, 507, 62	3 0	0	200. 00
201.00 Less Observation Beds	507, 864		507, 86	4	0	201. 00
202.00 Total (see instructions)	56, 999, 759	0	56, 999, 75	9 0	0	202. 00

Health Financial Sy	vstems SA	AINT JOSEPH MEMO	ORIAL HOSPITAL	·	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATI	0 OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C	
					From 04/01/2022	Part I	
					To 03/31/2023	Date/Time Pre 8/29/2023 11:	
			Title	· XVIII	Hospi tal	Cost	22 diii
			Charges				
Cost Co	enter Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	UTINE SERVICE COST CENTERS						
	& PEDIATRICS	2, 882, 772		2, 882, 77	2		30. 00
	RVICE COST CENTERS						
50. 00 05000 OPERAT		89, 228	62, 854, 520	62, 943, 74		0.000000	50. 00
51. 00 05100 RECOVE	RY ROOM	9, 040	1, 616, 330	1, 625, 37	0. 329703	0.000000	51. 00
53. 00 05300 ANESTHI		16, 512	9, 402, 651	9, 419, 16	3 0. 039493	0.000000	53. 00
54. 00 05400 RADI OL	OGY-DI AGNOSTI C	832, 926	50, 005, 343	50, 838, 26	9 0. 071019	0.000000	54.00
60. 00 06000 LABORA	TORY	1, 416, 153	41, 839, 475	43, 255, 62	8 0. 097896	0.000000	60.00
64. 00 06400 I NTRAVI	ENOUS THERAPY	125, 112	3, 897, 133	4, 022, 24	5 0. 502976	0.000000	64.00
65. 00 06500 RESPI RA	ATORY THERAPY	1, 203, 016	3, 758, 021	4, 961, 03	7 0. 254763	0.000000	65. 00
65. 01 03610 SLEEP I	LAB	0	7, 861, 940	7, 861, 94	0. 212717	0.000000	65. 01
65. 02 03620 GERI ATI	RIC PSYCH	O	715, 750	715, 75	0. 872373	0.000000	65. 02
66. 00 06600 PHYSI C	AL THERAPY	2, 536, 388	6, 830, 497	9, 366, 88	5 0. 249381	0.000000	66. 00
71. 00 07100 MEDI CAI	L SUPPLIES CHARGED TO PATIENTS	126, 188	5, 039, 135	5, 165, 32	3 0. 241468	0.000000	71. 00
72.00 07200 I MPL. I	DEV. CHARGED TO PATIENTS	1, 950	6, 586, 780	6, 588, 73	0. 418101	0.000000	72. 00
73. 00 07300 DRUGS (CHARGED TO PATIENTS	2, 105, 506	28, 572, 647	30, 678, 15	3 0. 460399	0.000000	73. 00
76. 97 07697 CARDI A	C REHABILITATION	O	1, 199, 123	1, 199, 12	3 0. 564679	0.000000	76. 97
77. 00 07700 ALLOGE	NEIC HSCT ACQUISITION	O	0		0. 000000	0.000000	77. 00
OUTPATIENT S	ERVICE COST CENTERS						
90. 00 09000 CLI NI C		1, 000	1, 946, 341	1, 947, 34	1 0. 396829	0.000000	90. 00
91. 00 09100 EMERGEI	NCY	296, 777	14, 376, 600	14, 673, 37	7 0. 282796	0.000000	91. 00
92. 00 09200 OBSERV	ATION BEDS (NON-DISTINCT PART)	7, 749	455, 636	463, 38	5 1. 095987	0.000000	92. 00
OTHER REIMBU	RSABLE COST CENTERS						
102. 00 10200 OPI 0I D	TREATMENT PROGRAM	0	0		0		102. 00
	OSE COST CENTERS						
113. 00 11300 I NTERES							113. 00
	al (see instructions)	11, 650, 317	246, 957, 922	258, 608, 23	9		200. 00
201.00 Less 0	bservation Beds						201. 00
202. 00 Total	(see instructions)	11, 650, 317	246, 957, 922	258, 608, 23	9		202. 00

Health Financial Systems	SAINT JOSEPH MEMORIAL HOS	SPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provid	der CCN: 14-1334	From 04/01/2022	Worksheet C Part I Date/Time Prepared: 8/29/2023 11: 22 am

			10 03/31/2023	8/29/2023 11: 22 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60. 00
64.00 06400 INTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65. 00
65. 01 03610 SLEEP LAB	0. 000000			65. 01
65. 02 03620 GERI ATRI C PSYCH	0. 000000			65. 02
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				102.00
102. 00 10200 OPI OI D TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				200.00
202.00 Total (see instructions)				202. 00
202.00 Total (See Histiactions)				J202. 00

Health Financial Systems SA	NINT JOSEPH MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 04/01/2022 To 03/31/2023	Worksheet C Part I Date/Time Pre 8/29/2023 11:	
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

			Titl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	TIENT ROUTINE SERVICE COST CENTERS						
	O ADULTS & PEDIATRICS	7, 404, 923		7, 404, 923	0	7, 404, 923	30. 00
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	9, 196, 581		9, 196, 581	0	9, 196, 581	
	O RECOVERY ROOM	535, 889		535, 889		535, 889	
	O ANESTHESI OLOGY	371, 991		371, 991	0	371, 991	53. 00
54.00 0540	O RADI OLOGY-DI AGNOSTI C	3, 610, 475		3, 610, 475	0	3, 610, 475	54.00
60.00 0600	O LABORATORY	4, 234, 553		4, 234, 553	0	4, 234, 553	60.00
64.00 0640	O INTRAVENOUS THERAPY	2, 023, 094		2, 023, 094	0	2, 023, 094	64.00
65. 00 0650	O RESPIRATORY THERAPY	1, 263, 889	0	1, 263, 889	0	1, 263, 889	65. 00
65. 01 0361	O SLEEP LAB	1, 672, 367	0	1, 672, 367	0	1, 672, 367	65. 01
65. 02 0362	O GERIATRIC PSYCH	624, 401	0	624, 401	O	624, 401	65. 02
66. 00 0660	O PHYSI CAL THERAPY	2, 335, 927	0	2, 335, 927	0	2, 335, 927	66. 00
71. 00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 247, 261		1, 247, 261	0	1, 247, 261	71. 00
72. 00 0720	O IMPL. DEV. CHARGED TO PATIENTS	2, 754, 753		2, 754, 753	0	2, 754, 753	72. 00
73.00 0730	O DRUGS CHARGED TO PATIENTS	14, 124, 202		14, 124, 202	0	14, 124, 202	73. 00
76. 97 0769	7 CARDI AC REHABI LI TATI ON	677, 120		677, 120	0	677, 120	76. 97
77. 00 0770	O ALLOGENEIC HSCT ACQUISITION	0		C	0	0	77. 00
OUTP.	ATIENT SERVICE COST CENTERS	•		•			1
90. 00 0900	O CLI NI C	772, 761		772, 761	0	772, 761	90. 00
91.00 0910	O EMERGENCY	4, 149, 572		4, 149, 572	0	4, 149, 572	91. 00
92. 00 0920	O OBSERVATION BEDS (NON-DISTINCT PART)	507, 864		507, 864		507, 864	92.00
OTHE	R REIMBURSABLE COST CENTERS						1
	O OPIOID TREATMENT PROGRAM	0		C		0	102. 00
SPEC	IAL PURPOSE COST CENTERS			<u>'</u>			1
113. 00 1130	O INTEREST EXPENSE						113. 00
200. 00	Subtotal (see instructions)	57, 507, 623	0	57, 507, 623	0	57, 507, 623	200.00
201. 00	Less Observation Beds	507, 864	l e	507, 864		507, 864	
202.00	Total (see instructions)	56, 999, 759	l e				
!					-1		•

Health Financial Systems	SAINT JOSEPH MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 04/01/2022 To 03/31/2023	Date/Time Pre 8/29/2023 11:	pared: 22 am
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	+ col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 882, 772		2, 882, 77	2		30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	89, 228	62, 854, 520	62, 943, 74	8 0. 146108	0.000000	50.00
51.00 O5100 RECOVERY ROOM	9, 040	1, 616, 330	1, 625, 37	0. 329703	0.000000	51.00
53. 00 05300 ANESTHESI OLOGY	16, 512	9, 402, 651	9, 419, 16	3 0. 039493	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	832, 926	50, 005, 343	50, 838, 26	9 0. 071019	0.000000	54. 00
60. 00 06000 LABORATORY	1, 416, 153	41, 839, 475			0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	125, 112	3, 897, 133			0.000000	64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 203, 016	3, 758, 021			0.000000	65. 00
65. 01 03610 SLEEP LAB	0	7, 861, 940			0.000000	65. 01
65. 02 03620 GERI ATRI C PSYCH	0	715, 750			0.000000	65. 02
66. 00 06600 PHYSI CAL THERAPY	2, 536, 388	6, 830, 497	9, 366, 88		0.000000	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	126, 188	5, 039, 135			0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 950	6, 586, 780			0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 105, 506	28, 572, 647			0. 000000	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	1, 199, 123	1, 199, 12		0.000000	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000	0.000000	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 000	1, 946, 341			0. 000000	90. 00
91. 00 09100 EMERGENCY	296, 777	14, 376, 600			0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 749	455, 636	463, 38	5 1. 095987	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	1	0		102. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE					i	113. 00
200.00 Subtotal (see instructions)	11, 650, 317	246, 957, 922	258, 608, 23	9		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	11, 650, 317	246, 957, 922	258, 608, 23	9		202. 00

Health Financial Systems	SAINT JOSEPH MEMO	ORIAL HOSPITAL	In Lie	u of Form CMS-2	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 14-1334	Peri od: From 04/01/2022 To 03/31/2023	Worksheet C Part I Date/Time Prep 8/29/2023 11:2	
		Title XIX	Hospi tal	Cost	

Title XIX Hospital Cost
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 3000 ADULTS & PEDI ATRI CS
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 3000 ADULTS & PEDI ATRI CS 30.00 3000 ADULTS & PEDI ATRI CS 30.00 3000 OPERATI NG ROOM 0.000000 50.00 5
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRI CS 30.00 ADULTS & PEDIATRI CS 30.00 ADULTS & PEDIATRI CS 30.00 3000 ADULTS & PEDIATRI CS 30.00 30.00 ANEXTHESI OE COST CENTERS 50.00 05000 OPERATI NG ROOM 0.000000 51.00 55.00 55.00 05100 RECOVERY ROOM 0.000000 51.00 05400 RADI OLOGY - DI AGNOSTI C 0.000000 54.00 05400 RADI OLOGY - DI AGNOSTI C 0.000000 06000 LABORATORY 0.000000 06000 LABORATORY 0.000000 06500 RESPIRATORY HERAPY 0.000000 06500 RESPIRATORY THERAPY 0.000000 07000 TO
30. 00 03000 ADULTS & PEDIATRICS ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0. 000000 51. 00 05100 RECOVERY ROOM 0. 000000 51. 00 05300 ANESTHESI OLOGY 0. 000000 53. 00 05400 RADIOLOGY-DI AGNOSTI C 0. 000000 54. 00 06400 LABORATORY 0. 000000 64. 00 06400 LABORATORY 0. 000000 06500 RESPI RATORY THERAPY 0. 000000 06500 RESPI RATORY THERAPY 0. 000000 065. 00 06500 RESPI RATORY THERAPY 0. 000000 065. 00 06500 GERI ATRI C PSYCH 0. 000000 065. 01 03610 SLEEP LAB 0. 000000 065. 02 06600 PHYSI CAL THERAPY 0. 000000 065. 02 06600 PHYSI CAL THERAPY 0. 000000 066. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 072. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 075. 07507 CARDI AC REHABI LI TATI ON 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000
ANCI LLARY SERVI CE COST CENTERS 50. 00
50. 00 05000 OPERATI NG ROOM 0.000000 50.00 51. 00 05100 RECOVERY ROOM 0.000000 51.00 53. 00 05300 ANESTHESI OLOGY 0.000000 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 60. 00 06400 LABORATORY 0.000000 60.00 64. 00 06400 INTRAVENOUS THERAPY 0.000000 64.00 65. 00 06500 RESPI RATORY THERAPY 0.000000 65.00 65. 01 03610 SLEEP LAB 0.000000 65.01 65. 02 03620 GERI ATRI C PSYCH 0.000000 65.02 66. 00 06600 PHYSI CAL THERAPY 0.000000 66.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.000000 72.00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 76.97 77. 00 00000 00000 00000 000000 000000
51.00 05100 RECOVERY ROOM 0.000000 51.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 60.00 06000 LABORATORY 0.000000 60.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 65.00 65.01 03610 SLEEP LAB 0.000000 65.00 65.01 03610 SLEEP LAB 0.000000 65.01 65.02 03620 GERI ATRI C PSYCH 0.000000 65.02 66.00 D6600 PHYSI CAL THERAPY 0.000000 65.02 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 76.97 O7697 CARDI AC REHABI LI TATI ON 0.000000 76.97 77.00 OUTPATI ENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 <t< td=""></t<>
53. 00 05300 ANESTHESI OLOGY 0.000000 53. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54. 00 06000 LABORATORY 0.000000 66. 00 06400 INTRAVENOUS THERAPY 0.000000 65. 00 06500 RESPI RATORY THERAPY 0.000000 65. 01 03610 SLEEP LAB 0.000000 65. 01 03610 SLEEP LAB 0.000000 65. 02 03620 GERI ATRI C PSYCH 0.000000 65. 02 03620 GERI ATRI C PSYCH 0.000000 66. 00 071. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 072. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0.7000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000
54. 00
60. 00
64. 00
65. 00
65. 01
65. 02
66. 00
71. 00
72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 76. 97 07697 CARDI AC REHABILITATION 0.000000 77. 00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000
76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 77. 00 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0. 000000 91. 00 09100 EMERGENCY 0. 000000 91. 00
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0.000000 90.00 91. 00 09100 EMERGENCY 0.000000 91.00
90. 00
91. 00 09100 EMERGENCY 0. 000000 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 92. 00
OTHER REIMBURSABLE COST CENTERS
102. 00 10200 OPI OI D TREATMENT PROGRAM 102. 00
SPECIAL PURPOSE COST CENTERS
113. 00 11300 INTEREST EXPENSE 113. 00
200.00 Subtotal (see instructions) 200.00
201.00 Less Observation Beds 201.00
202.00 Total (see instructions)

Health Financial Sy	ystems	SAINT JOSEPH MEMORI	AL H	HOSPI T	AL		In Lie	u of Form CMS-	2552-10
			_			 			

Health Financial Systems S.	AINT JOSEPH MEN	IORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider Co		Period: From 04/01/2022 To 03/31/2023		
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	·		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1		1			
50. 00 05000 OPERATI NG ROOM	884, 554		•		539	50.00
51. 00 05100 RECOVERY ROOM	84, 236					51.00
53. 00 05300 ANESTHESI OLOGY	19, 653		l .			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	364, 920				1, 081	54. 00
60. 00 06000 LABORATORY	228, 418					
64.00 06400 I NTRAVENOUS THERAPY	184, 111					
65. 00 06500 RESPIRATORY THERAPY	59, 197				2, 454	
65. 01 03610 SLEEP LAB	218, 243				0	65. 01
65. 02 03620 GERI ATRI C PSYCH	70, 438		0. 09841		0	65. 02
66. 00 06600 PHYSI CAL THERAPY	106, 827	9, 366, 885	0. 01140	5 141, 558	1, 614	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	48, 731	5, 165, 323	0.00943	4 22, 108	209	71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	46, 066	6, 588, 730	0. 00699	2 650		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	283, 629	30, 678, 153	0.00924	5 302, 390	2, 796	73. 00
76. 97 07697 CARDIAC REHABILITATION	104, 830	1, 199, 123	0. 08742	2 0	0	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	140, 860	1, 947, 341	0. 07233	5 0	0	90.00
91. 00 09100 EMERGENCY	344, 050	14, 673, 377	0. 02344	7 6, 157	144	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	55, 875	463, 385	0. 12058	0	0	92.00
200.00 Total (lines 50 through 199)	3, 244, 638	255, 725, 467		1, 218, 728	12, 117	200. 00

Health Financial Systems	SAINT JOSEPH MEMOR	IAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENTHROUGH COSTS	T ANCILLARY SERVICE OTHER PASS	Provi der CCN: 14-1334	Peri od: From 04/01/2022 To 03/31/2023	Worksheet D Part IV Date/Time Prepared:

					Го 03/31/2023	Date/Time Prep 8/29/2023 11:	pared: 22 am
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0	(0	0	51. 00
53.00	05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
60.00	06000 LABORATORY	0	0	(0	0	60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	(0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
65. 01	03610 SLEEP LAB	0	0	(0	0	65. 01
65. 02	03620 GERI ATRI C PSYCH	0	0	(0	0	65. 02
66. 00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	0	0	(0 0	<u> </u>	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	(0	0	90. 00
	09100 EMERGENCY	0	0	(0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0)	0	92. 00
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

	5' ' 6	CALNT IOCEDII MEN	IODI AL LIOCDI TAL			6.5. 046.4	2550 40
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	SAINT JOSEPH MEN			In Lie Period:	eu of Form CMS-2 Worksheet D	2552-10
	H COSTS	ERVICE DINER PAS	5 Provider C		From 04/01/2022		
TTIKOUG	11 (0313				To 03/31/2023	Date/Time Pre	pared:
						8/29/2023 11:	22 am_
	· · · · · · · · · · · · · · · · · · ·			e XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see instructions)	
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00	05000 OPERATING ROOM	0			0 62, 943, 748	0.000000	50.00
51. 00	05100 RECOVERY ROOM	0	l o		1, 625, 370	l .	51.00
53. 00	05300 ANESTHESI OLOGY	0			9, 419, 163	l .	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	l o		50, 838, 269		
60.00	06000 LABORATORY	0			43, 255, 628		60.00
64.00	06400 I NTRAVENOUS THERAPY	0	l c		0 4, 022, 245		64. 00
65.00	06500 RESPI RATORY THERAPY	0	l c		4, 961, 037	0.000000	65. 00
65. 01	03610 SLEEP LAB	0	0		7, 861, 940	0.000000	65. 01
65.02	03620 GERIATRIC PSYCH	0	0		715, 750	0.000000	65. 02
66.00	06600 PHYSI CAL THERAPY	0	0		9, 366, 885	0.000000	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		5, 165, 323	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		6, 588, 730	0. 000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		30, 678, 153	0.000000	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0		1, 199, 123		
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0)	0 (C	0.000000	77. 00

0 0 0

0 0

0

0

1, 947, 341

14, 673, 377

255, 725, 467

463, 385

0.000000

0.000000

0.000000

91.00

92.00

200.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

OUTPATIENT SERVICE COST CENTERS

90. 00 09000 CLINIC

91. 00 09100 EMERGENCY

Health Financial Systems SAINT JOSEPH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10						
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provi der CCN: 14-1334		Worksheet D Part IV Date/Time Pre 8/29/2023 11:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through	Outpatient Program Charges	Outpatient Program Pass-Through	
	(col. 6 ÷ col.	orial ges	Costs (col.		Costs (col. 9	
	7)		x col . 10)		x col . 12)	
	9, 00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	38, 367		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	9, 040		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	9, 162		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	150, 607		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	307, 668		0 0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	25, 394		0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	205, 627		0	0	65. 00
65. 01 03610 SLEEP LAB	0. 000000	0		0	0	
65. 02 03620 GERI ATRI C PSYCH	0. 000000	0		0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	141, 558		0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	22, 108		0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	650		0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	302, 390		0	0	
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0		0	0	1
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	
91. 00 09100 EMERGENCY	0. 000000	6, 157		0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	
200.00 Total (lines 50 through 199)		1, 218, 728		0 0	0	200. 00

Health Financial Systems	SAI NT	JOSEPH MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE	OTHER PASS	Provider CCN: 14-1334	Peri od: From 04/01/2022 To 03/31/2023	Worksheet D Part IV Date/Time Prepared: 8/29/2023 11: 22 am

				8/29/2023 11:22 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PSA Adj. Non P	SA Adj. All		
	Physician Ot	ther Medical		
	Anesthetist Ed	ucation Cost		
	Cost			
	21. 00	24. 00		
ANCILLARY SERVICE COST CENTERS		·		
50. 00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	o		51.00
53. 00 05300 ANESTHESI OLOGY	0	o		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	O	o		54.00
60. 00 06000 LABORATORY	o	o		60.00
64. 00 06400 I NTRAVENOUS THERAPY	o	o		64. 00
65. 00 06500 RESPIRATORY THERAPY	o	o		65. 00
65. 01 03610 SLEEP LAB	o	o		65. 01
65. 02 03620 GERI ATRI C PSYCH	o	o		65. 02
66. 00 06600 PHYSI CAL THERAPY	o	o		66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	o		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	o		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	o		73. 00
76. 97 07697 CARDIAC REHABILITATION	o	o		76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	o	o		77. 00
OUTPATIENT SERVICE COST CENTERS	·	'		
90. 00 09000 CLI NI C	0	0		90.00
91. 00 09100 EMERGENCY	o	0		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92. 00
200.00 Total (lines 50 through 199)	0	0		200. 00
	1			· ·

Health Financial Systems	SAINT JOSEPH MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
ADDODELONMENT OF MEDICAL	OTHER HEALTH CERVICES AND VACCINE COST	Dravidor CCN, 14 1224	Doni od.	Waskahaat D

Health Financial Systems S.	AINT JOSEPH MEN	MORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 04/01/2022 To 03/31/2023	Date/Time Pre 8/29/2023 11:	pared: 22 am
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins.			
	1.00		(see inst.)	(see inst.)		
ANOLLI ADV. CEDVI OF COCT. OFNITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.44/400		1 4 004 40			F0 00
50. 00 05000 OPERATING ROOM	0. 146108	1	16, 991, 18		0	50.00
51. 00 05100 RECOVERY ROOM	0. 329703		362, 61		0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 039493	1	2, 395, 61		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 071019	1	13, 451, 39		ŭ	54. 00 60. 00
60. 00 06000 LABORATORY	0. 097896	1	10, 213, 82		0	
64. 00 06400 I NTRAVENOUS THERAPY	0. 502976	1	1, 049, 98	· ·	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 254763	1	1, 155, 18		0	65. 00 65. 01
65. 01 03610 SLEEP LAB	0. 212717	1	1, 643, 18		0	65.01
65. 02 03620 GERI ATRI C PSYCH	0. 872373	1	375, 80		0	66.00
66.00 06600 PHYSICAL THERAPY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 249381 0. 241468	1	1, 532, 28		0	71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0. 241468		1, 625, 60		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 418101	1	2, 172, 41 8, 505, 18		0	73.00
76. 97 07697 CARDI AC REHABILITATION	0. 564679		503, 92		0	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	1	303, 92	0	0	77.00
OUTPATIENT SERVICE COST CENTERS	0.000000	0		U U	0	17.00
90. 00 09000 CLINIC	0. 396829	0	616, 35	3 0	0	90.00
91. 00 09100 EMERGENCY	0. 282796	1	3, 023, 18		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 095987	1	5,025,10	0 110,000	0	92.00
200.00 Subtotal (see instructions)	1.070707	0	65, 617, 73	5 136, 291	-	200.00
201.00 Less PBP Clinic Lab. Services-Program			35,017,75	0 0	Ü	201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	65, 617, 73	5 136, 291	0	202. 00

				To 03/31/2023	Date/Time Pre 8/29/2023 11:	pared: 22 am
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subj ect To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATING ROOM	2, 482, 547	0				50.00
51.00 05100 RECOVERY ROOM	119, 555					51. 00
53. 00 05300 ANESTHESI OLOGY	94, 610					53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	955, 305					54. 00
60. 00 06000 LABORATORY	999, 893					60.00
64. 00 06400 I NTRAVENOUS THERAPY	528, 119					64. 00
65. 00 06500 RESPI RATORY THERAPY	294, 298					65. 00
65. 01 03610 SLEEP LAB	349, 533	0				65. 01
65. 02 03620 GERI ATRI C PSYCH	327, 839	0				65. 02
66. 00 06600 PHYSI CAL THERAPY	382, 122	0				66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	392, 530	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	908, 291	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 915, 779	97				73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	284, 553	0				76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	244, 587	0				90. 00
91. 00 09100 EMERGENCY	854, 944	31, 356				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92. 00
200.00 Subtotal (see instructions)	13, 134, 505	44, 128				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	13, 134, 505	44, 128				202. 00

Health Financial Systems	SAINT JOSEPH MEMORIAL HOSPITAL	SAINT JOSEPH MEMORIAL HOSPITAL In Lieu		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-1334	Peri od: From 04/01/2022	Worksheet D-1	
		To 03/31/2023	Date/Time Prepared: 8/29/2023 11:22 am	
	Title XVIII	Hospi tal	Cost	

Cost Center Description PART I - ALL PROVIDER COMPONENTS 1.00					8/29/2023 11:	22 am
PART 1 - ALL PROVIDER COMPONENTS 1.00			Title XVIII	Hospi tal		
PART 1 - ALL PROVIDER COMPONENTS 1.00		Cost Center Description				
MPATIENT DAYS		'			1.00	
MPATIENT DAYS		PART I - ALL PROVIDER COMPONENTS				
1.00 Inpatient days (Including private room days and sking-bed days, excluding newborn) 1.172 2.00 Inpatient days (Including private room days, excluding sking-bed and newborn days) 1.172 2.00 Inpatient days (Including private room days) 1.172 2.00 Inpatient days Inpatient						1
1.72 2.00 1 inpatient days (including private room days, excluding swing-bed and newborn days) 2.00 2.01 2.02 2.03 2.03 2.04 2.05 2.05 2.05 2.05 2.05 2.05 2.05 2.05	1.00		s. excluding newborn)		4, 359	1.00
2.00 private room days (excluding swing-bed and observation bed days). If you have only private room days. 3.0 on ont complete this I line. 3.0 on one of the cost reporting period (I cale lendar year, enter 0 on this I line) 4.0 on one of the cost reporting period (I cale lendar year, enter 0 on this I line) 5.0 on total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (I cale lendar year, enter 0 on this I line) 6.0 on total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (I cale lendar year, enter 0 on this I line) 6.0 on total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (I cale lendar year, enter 0 on this I line) 6.0 on total swing-bed and resident days (including year) (including private room days) 6.0 on the cost reporting period (I cale lendar year, enter 0 on this I line) 7.0 on Swing-bed SWI type Inpatient days applicable to the Program (excluding swing-bed and resident days) 8.1 on through December 31 of the cost reporting period (I cale and year, onter 0 on this I line) 8.0 on through December 31 of the cost reporting period (I cale and year, onter 0 on this I line) 8.0 sing-bed SWI type Inpatient days applicable to thic XVII only (Including private room days) after 6.0 on the cost reporting period (I cale and year, onter 0 on this I line) 8.0 on through December 31 of the cost reporting period (I cale and year, onter 0 on this I line) 8.0 on through December 31 of the cost reporting period (I cale and year, onter 0 on this I line) 9.0 on the cost reporting period (I cale and year, onter 0 on this I line) 9.0 on the cost reporting period (I line 8 of xVII line XVII line XVIII l						•
do not complete finis line. 4. Osenia-private room days (excluding swing-bed and observation bed days) 5. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calender year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calender year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calender year, enter 0 on this line) 9. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calender year, enter 0 on this line) 9. 01 Total Inpatient days including private room days applicable to the Program (excluding swing-bed and loss in the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Swing-bed SNF type inpatient days applicable to title WIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title WIII only (including private room days) 12. 00 Swing-bed SNF type inpatient days applicable to title WIII only (including private room days) 13. 01 Swing-bed NF type inpatient days applicable to title WIII only (including private room days) 14. 00 Swing-bed NF type inpatient days applicable to title WIII only (including private room days) 15. 01 Swing-bed NF type inpatient days applicable to title WIII only (including private room days) 16. 02 Swing-bed NF type inpatient days applicable to title WIII only (including private room days) 17. 02 Swing-bed NF type inpatient days applicable to title WIII only (including private room days) 18. 00 Swing-bed NF type inpatient days applicable to title WIII only (including private room days) 18. 01 Swing-bed NF type inpatient routine services applicable to the Program (excluding swing-bed days) 18. 01 Swing-bed Cost applicable SWF services applicable to services after December 3				ivate room days		3.00
Seei _private room days (excluding swing-bed and observation bed days) To Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting December 31 of the cost after December 31 of	0.00		ys). It you have only pri	i vate room days,	١	0.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and neathorn days) (see instructions) Swing-bed SNF type inpatient days applicable to the foreins instructions) Swing-bed SNF type inpatient days applicable to the foreins instructions of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) In the SNF type inpatient days applicable to titles V or XIX only (including private room days) In the SNF type inpatient days applicable to titles V or XIX only (including private room days) In the SNF type inpatient days applicable to titles V or XIX only (including private room days) In the SNF type inpatient days applicable to titles V or XIX only (including private room days) In the SNF type inpatient days applicable to titles V or XIX only (including private room days) In the SNF type inpatient days applicable to titles V or XIX only (including private room days) In	4 00		ed days)		892	4.00
reporting period (if calendar year, enter 0 on this line) 7.0. Total similar bead Wife type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.0. Total similar bead Wife type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.0. Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.0. Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 7.0. Swing-bed SWI type inpatient days applicable to till eXVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 7.0. Swing-bed SWI type inpatient days applicable to till eXVIII only (including private room days) after strongly December 31 of the cost reporting period (see instructions) 7.0. Swing-bed NF type inpatient days applicable to till eXVIII only (including private room days) after shrough December 31 of the cost reporting period (see instructions) 7.0. Swing-bed NF type inpatient days applicable to tilles V or XIX only (including private room days) 7.0. Swing-bed NF type inpatient days applicable to tilles V or XIX only (including private room days) 7.0. Swing-bed NF type inpatient days applicable to tilles V or XIX only (including private room days) 7.0. Swing-bed NF type inpatient days applicable to tilles V or XIX only (including private room days) 7.0. Swing-bed NF type inpatient days applicable to tilles V or XIX only (including private room days) 7.0. Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period (including private room days) 7.0. Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days) 7.0. Swing-bed Availary (including privat				r 31 of the cost		
10tal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.0 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost swing-bed (if cal endar year, enter 0 on this line) 9.00 Total inpatient days including private room days after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) 1.304 Total inpatient days including private room days applicable to the Program (excluding private room days) 1.305 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 1.306 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) 1.307 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.308 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.309 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.309 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.300 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.300 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.300 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.300 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.300 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.300 Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days) 1.300 Medicate rate for swing-bed NF services applicable to services after Decemb	5.00		om days) tri odgi becember	31 01 1110 0031	2, 137	3.00
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Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endor year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endor year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and rotal inpatient days including private room days) applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if cal endor year, enter 0 on this line) 10.00 Sking-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if cal endor year, enter 0 on this line) 12.00 Sking-bed NF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if cal endor year, enter 0 on this line) 13.00 Sking-bed NF type inpatient days applicable to title XVIII only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total reporting period 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Sking-bed Dayustems 17.00 Medically necessary private room days applicable to services after December 31 of the cost reporting period 18.00 Medically processary private room days applicable to services after December 31 of the cost reporting period 18.00 Medical processary private room days applicable to services after December 31 of the cost reporting period 18.00 Medically processary private room days applicable to services after December 31 of the cost reporting period 18.00 Medically processary private room days applicable to services after December 31 of the cost reporting period 18.00 Medically processary private room days applicable to services after December 31 of the cost reporting period	0.00		on days) arter becember	or the cost	, , , ,	0.00
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30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 125, 778) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 .0000000 31.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00 .0000000 32.00000000 32.0000000000000000			a and observation bed ch	ai ges)		
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32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 125, 778 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			Line 20)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 125, 778 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 33.0 33.00 Jac 0 J		,	FILLE ZO)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 125, 778 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 34.0 34.00 Jack Program (line 32 minus line 33) (see instructions) 0 0 0 34.0 35.00 Jack Program (line 34 x line 31) 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 125, 778 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 35.00 36.00 37.00 37.00 38.00 Average per diem private room cost differential (line 2, 125, 778) 38.00 Average per diem private room cost differential (line 2, 125, 778) 38.00 Average per diem private room cost differential (line 2, 125, 778) 38.00 Average per diem private room cost differential (line 2, 125, 778) 38.00 Average per diem private room cost differential (line 2, 125, 778) 39.00 Average per diem private room cost differential (line 2, 125, 778) 39.00 Average per diem private room cost differential (line 2, 125, 778) 39.00 Average per diem private room cost differential (line 2, 125, 778) 39.00 Average per diem private room cost differential (line 2, 125, 778) 39.00 Average per diem private room cost differential (line 2, 125, 778) 39.00 Average per diem private room cost differential (line 2, 125, 778) 39.00 Average per diem private room cost differential (line 2, 125, 778) 39.00 Average per diem private room cost differential (line 2, 125, 778) 40.00 Average per diem private room cost differential (line 2, 125, 778) 40.00 Average per diem private room cost differential (line 2, 125, 778) 40.00 Average per diem private room cost differential (line 2, 125, 778) 40.00 Average per diem private room cost differential (line 3 x line 35) 40.00 Average per diem private room cost differential (line 3 x line 35) 40.00 Average per diem private room cost d			nus line 22) (see instruc	tions)		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 125, 778 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 2, 125, 778 37.00 37.00 37.00 37.00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				LI UIIS)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 125, 778 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		9	ie 31 <i>)</i>			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,813.79 39.00 Program general inpatient routine service cost (line 9 x line 38) 749,095 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			and private room cost di	fferential (line		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,813.79 38.00 Program general inpatient routine service cost (line 9 x line 38) 749,095 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. UU	,	and private room cost dr	irerentiai (IIIIe	∠, 1∠5, //8 	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,813.79 38.00 Program general inpatient routine service cost (line 9 x line 38) 749,095 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						1
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,813.79 39.00 Program general inpatient routine service cost (line 9 x line 38) 749,095 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.0			ISTMENTS			-
39.00 Program general inpatient routine service cost (line 9 x line 38) 749,095 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 749,095 39.00 40.00	20 00			ı	1 012 70	20 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		, , , , , , , , , , , , , , , , , , , ,				
		9 9	•			
41. Ou Total Togram general Inpatrent Toutine Service Cost (Time 39 + Time 40) 749,095 41. U		, , , , , , , , , , , , , , , , , , , ,	,			
	41.00	Tiotai Trogram general Tripatrent routine Service Cost (Tibe 39	+ IIIIC 40 <i>)</i>	I	749, 095	1 41.00

	Financial Systems S ATION OF INPATIENT OPERATING COST	AINT JOSEPH MEN		CN: 14-1334 F	Period: From 04/01/2022	Worksheet D-1		
					To 03/31/2023			
				e XVIII	Hospi tal	Cost		
	Cost Center Description	Total	Total Inpatient Days	Average Per	Program Days	Program Cost (col. 3 x col.		
				col . 2)		4)		
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42. 00	
	Intensive Care Type Inpatient Hospital Units							
	INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 00 44. 00	
	BURN INTENSIVE CARE UNIT						45. 00	
	SURGICAL INTENSIVE CARE UNIT						46. 00	
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00	
10.00	·					1.00	10.00	
	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III line 10	column 1)	296, 796 0	1	
	Total Program inpatient costs (sum of lines					1, 045, 891		
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	nationt routing	sorvices (from	n Wkst D sum	of Parts L and	0	50.00	
	III)		•	·				
51. 00	Pass through costs applicable to Program inp and IV)	atient ancilla	ry services (fr	om Wkst. D, su	um of Parts II	0	51.00	
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52. 00	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-phy	ysician anesthe	etist, and	0	53. 00	
	TARGET AMOUNT AND LIMIT COMPUTATION	52)						
	Program di scharges					0		
	Target amount per discharge Permanent adjustment amount per discharge					0.00	1	
	Adjustment amount per discharge (contractor use only) 0.00 55							
59. 00	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,		om prior year o	cost report, up	odated by the	0.00	60.00	
1 00	market basket)						/1 00	
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les					0	61. 00	
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	(60), or 1 % of	f the target an	mount (line 56)), otherwise			
62. 00	Relief payment (see instructions)					0	62. 00	
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63. 00	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of the	e cost reportir	ng period (See	2, 528, 423	64. 00	
/F 00	instructions)(title XVIII only)	.+6+ D	21 - +					
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions) (title XVIII only)	its arter beceili	ber 31 of the C	cost reporting	perrod (see	963, 122	65. 00	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line 6	55)(title XVIII	only); for	3, 491, 545	66. 00	
67. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through	n December 31 d	of the cost rep	porting period	0	67. 00	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	o costs after [Occombor 21 of	the cost repor	sting poriod	0	68. 00	
06. 00	(line 13 x line 20)	ie costs arter i	becember 31 01	the cost repor	triig perrou		08.00	
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70. 00	
71. 00	Adjusted general inpatient routine service of	ost per diem (I					71. 00	
	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (line 14 x li	ne 35)			72. 00 73. 00	
74. 00	Total Program general inpatient routine serv		•				74. 00	
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from V	Vorksheet B, Pa	art II, column		75. 00	
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00	
77. 00	Program capital-related costs (line 9 \times line	76)					77. 00	
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		orovi den irecerc	4s)			78. 00 79. 00	
30.00	Total Program routine service costs for comp	, ,		•	us line 79)		80.00	
	Inpatient routine service cost per diem limi		13				81.00	
82. 00	Inpatient routine service cost limitation (I	ine y x line 8	I)			I	82. 00	

Health Financial Systems SA	ALNT JOSEPH MEM	IORI AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 04/01/2022 To 03/31/2023	Date/Time Pre 8/29/2023 11:	
		Title	XVIII	Hospi tal	Cost	
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 (OST					
90.00 Capital -related cost	814, 682	7, 404, 923	0. 11001	9 507, 864	55, 875	90.00
91.00 Nursing Program cost	0	7, 404, 923	0.00000	0 507, 864	0	91.00
92.00 Allied health cost	0	7, 404, 923	0.00000	0 507, 864	0	92.00
93.00 All other Medical Education	0	7, 404, 923	0. 00000	507, 864	0	93. 00

Health Financial Systems SAINT JOSEP	H MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO		Peri od:	Worksheet D-3	
			From 04/01/2022 To 03/31/2023	Date/Time Pre 8/29/2023 11:	pared: 22 am
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	r i r r r r	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			384, 215		30.00
ANCI LLARY SERVI CE COST CENTERS			304, 213		30.00
50. 00 05000 OPERATI NG ROOM		0. 14610	8 38, 367	5, 606	50. 00
51. 00 05100 RECOVERY ROOM		0. 32970		2, 981	51.00
53. 00 05300 ANESTHESI OLOGY		0. 03949	3 9, 162	362	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 07101	9 150, 607	10, 696	54.00
60. 00 06000 LABORATORY		0. 09789			1
64. 00 06400 I NTRAVENOUS THERAPY		0. 50297			
65. 00 06500 RESPI RATORY THERAPY		0. 25476		52, 386	
65. 01 03610 SLEEP LAB		0. 21271		0	
65. 02 03620 GERI ATRI C PSYCH		0. 87237		0	65. 02
66. 00 06600 PHYSI CAL THERAPY		0. 24938			1
71. 00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 24146		5, 338	l .
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 41810 0. 46039		272 139, 220	
73. 00 07300 DRUGS CHARGED TO PATTENTS 76. 97 07697 CARDI AC REHABI LI TATI ON		0. 46039		139, 220	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0. 00000		0	77. 00
OUTPATIENT SERVICE COST CENTERS		0.00000	0 0	0	77.00
90. 00 09000 CLI NI C		0. 39682	9 0	0	90.00
91. 00 09100 EMERGENCY		0. 28279		1, 741	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 09598		0	•
200.00 Total (sum of lines 50 through 94 and 96 through	98)		1, 218, 728	296, 796	
201.00 Less PBP Clinic Laboratory Services-Program only			0		201. 00
202.00 Net charges (line 200 minus line 201)			1, 218, 728		202. 00

Health Financial Systems SAINT JOSEPH MEMOR	RLAL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO	CN: 14-1334	Peri od:	Worksheet D-3	
			From 04/01/2022		
	Component	CCN: 14-Z334	To 03/31/2023	Date/Time Pre 8/29/2023 11:	
	Title	XVIII :	Swing Beds - SNF		ZZ alli
Cost Center Description	11 11 0	Ratio of Cost		Inpati ent	
oust defited beset per on		To Charges	Program	Program Costs	
		l onar goo	Charges	(col . 1 x col .	
			3	2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
ANCILLARY SERVICE COST CENTERS					1
50. 00 05000 OPERATING ROOM		0. 14610	8 0	0	50. 00
51. 00 05100 RECOVERY ROOM		0. 32970	3 0	0	51.00
53. 00 05300 ANESTHESI OLOGY		0. 03949	3 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 07101	9 95, 756	6, 800	54.00
60. 00 06000 LABORATORY		0. 09789	6 225, 107	22, 037	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 50297	6 12, 017	6, 044	64. 00
65. 00 06500 RESPIRATORY THERAPY		0. 25476	391, 736	99, 800	65. 00
65. 01 03610 SLEEP LAB		0. 21271	7 0	0	65. 01
65. 02 03620 GERI ATRI C PSYCH		0. 87237	3 0	0	65. 02
66. 00 06600 PHYSI CAL THERAPY		0. 24938	1, 367, 029	340, 911	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 24146	8, 360	2, 019	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 41810	1 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 46039	9 809, 335	372, 617	73. 00
76.97 07697 CARDIAC REHABILITATION		0. 56467	9 0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0. 00000	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLI NI C		0. 39682	9 0	0	90. 00
91. 00 09100 EMERGENCY		0. 28279	6 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 09598	7 0	0	92. 00
Total (sum of lines FO through 04 and 04 through 00)			2 000 240	050 220	200 00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

850, 228 200. 00 201. 00 202. 00

2, 909, 340

Health Financial Cystems CALNT IOSEDU MEMODI	AL HOCDITAL		المانا	u of Form CMC	2552 10
Health Financial Systems SAINT JOSEPH MEMORI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 14-1334	Peri od:	worksheet D-3	
THE THE THOUSE SERVICE SOOT THE ORIGINAL TO			From 04/01/2022		
	Component	CCN: 14-Z334	To 03/31/2023	Date/Time Pre 8/29/2023 11:	
	Ti tl	e XIX	Swing Beds - SNF		22 4111
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					00.00
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 14610	0 8	0	50.00
51. 00 05100 RECOVERY ROOM		0. 14610		0	51.00
53. 00 05300 ANESTHESI OLOGY		0. 03949		0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 0710		0	54.00
60. 00 06000 LABORATORY		0. 09789		o o	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 50297		0	64. 00
65. 00 06500 RESPIRATORY THERAPY		0. 25476		Ō	65.00
65. 01 03610 SLEEP LAB		0. 2127	17 0	0	65. 01
65. 02 03620 GERI ATRI C PSYCH		0. 87237	73 0	0	65. 02
66. 00 06600 PHYSI CAL THERAPY		0. 24938	31 0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 24146	0 8	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 41810		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 46039		0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 56467		0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 39682		0	70.00
91. 00 09100 EMERGENCY		0. 28279		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 09598	37 0	0	
Total (sum of lines 50 through 94 and 96 through 98)	(line (1)				200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges 202.00 Net charges (line 200 minus line 201)	(iine 61)		0		201. 00 202. 00
202. 00 Net charges (True 200 IIII hus True 201)		I	1	ļ	1202.00

Health Financial Systems	SAINT JOSEPH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1334	Peri od: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 8/29/2023 11:22 am

	71.11 70.01	8/29/2023 11:	22 am
	Title XVIII Hospita	I Cost	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1. 00	Medical and other services (see instructions)	13, 178, 633	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)	0	
3.00	OPPS or REH payments	0	
4.00	Outlier payment (see instructions)	0	
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)	0.000	
6. 00	Line 2 times line 5	0.000	1
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	1
8. 00	Transitional corridor payment (see instructions)	0	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	
10.00	Organ acqui si ti ons	0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	13, 178, 633	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges		-
12. 00	Ancillary service charges	0	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	0	
	Customary charges		
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge bas	sis 0	15. 00
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargeba	ısi s 0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)	0.000000	17.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)	0.000000	1
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	1
17.00	instructions)		17.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
	instructions)		
21. 00	Lesser of cost or charges (see instructions)	13, 310, 419	1
22. 00	Interns and residents (see instructions)	0	
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instructions)	0 0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT		24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	115, 400	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	11, 188, 273	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	e 2, 006, 746	27. 00
	instructions)		
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	1
28. 50	REH facility payment amount		28. 50
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	2, 006, 746	
31. 00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments	548	1
32. 00	Subtotal (line 30 minus line 31)	2, 006, 198	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	, , , , , ,	
	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
	Allowable bad debts (see instructions)	1, 930, 324	1
35. 00	Adjusted reimbursable bad debts (see instructions)	1, 254, 711	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	911, 663	
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	3, 260, 909	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)	Ĭ	39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	
40. 00	Subtotal (see instructions)	3, 260, 909	1
40. 01	Sequestration adjustment (see instructions)	57, 066	
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs	0	40. 02
41. 00	Interim payments	2, 899, 275	
41. 01	Interim payments	2,077,270	41.0
42. 00	Tentative settlement (for contractors use only)	0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)		42. 0°
43. 00	Balance due provider/program (see instructions)	304, 568	
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44.00
	§115. 2		1
			4
	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	0	90 00
90. 00	Original outlier amount (see instructions)	0	1
		0	91.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions)	0	91. 00 92. 00 93. 00

Health Financial Systems	SAINT JOSEPH MEMORI	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1334	Peri od: From 04/01/2022 To 03/31/2023		pared: 22 am
		Title XVIII	Hospi tal	Cost	
				Overri des	
				1.00	
WORKSHEET OVERRIDE VALUES					
112.00 Override of Ancillary service charges (lir	ne 12)			0	112. 00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet E-1
From 04/01/2022	Part
To 03/31/2023	Date/Time Prepared:
8/29/2023	11: 22 am Heal th Financial Systems SAINT JOSEPH MEMORIAL HOSPITAL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CO Provider CCN: 14-1334

1.00 2.00 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 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 3.01 3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROVIDER 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none,	е,	Title Inpatien nm/dd/yyyy 1.00	XVIII t Part A Amount 2.00 847,775	mm/dd/yyyy 3.00	8/29/2023 11: 2	
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 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 ADJUSTMENTS TO PROVIDER 3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	е,	nm/dd/yyyy	Amount 2.00 847,775	mm/dd/yyyy 3.00	Amount 4.00 2,704,374	
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none write "NONE" or enter a zero 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 3.01 3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROVIDER 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	е,		2. 00 847, 775	3. 00	4. 00 2, 704, 374	
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none write "NONE" or enter a zero 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 3.01 3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROVIDER 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	е,		2. 00 847, 775	3. 00	4. 00 2, 704, 374	
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none write "NONE" or enter a zero 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 3.01 3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after			847, 775		2, 704, 374	
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 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 3.01 3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after						1. 00
write "NONE" or enter a zero 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 3.01 3.02 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after						2. 00
for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM ADJUSTMENTS TO PROGRAM ADJUSTMENTS TO PROGRAM S.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after						3. 00
Program to Provider 3.01 3.02 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	'					
3.01 3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROVIDER 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after						
3. 02 3. 03 3. 04 3. 05 Provider to Program ADJUSTMENTS TO PROGRAM 3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 4. 00 Subtotal interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after			0	10/12/2022	182, 372	3. 01
3. 03 3. 04 3. 05 Provider to Program 3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 4. 00 Subtotal interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after			0		118, 428	3. 02
3. 04 3. 05 Provider to Program 3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 4. 00 Subtotal interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	ا ا	01/12/2023	10, 934		413, 357	3. 03
3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		03/27/2023	68, 433		0	3. 04
Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	"	507 277 2020	00, 100			3. 05
3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after						3. 03
3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	1	11/30/2022	83, 887		0	3. 50
3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		, 00, 2022	0		519, 256	3. 51
3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after			0		0	3. 52
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after			0		0	3. 53
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after			0		0	3. 54
3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after			-4, 520	į	194, 901	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after			•		·	
TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after			843, 255		2, 899, 275	4. 00
5.00 List separately each tentative settlement payment after						
desk review. Also show date of each payment. If none						5. 00
write "NONE" or enter a zero. (1)						
Program to Provider						
5. 01 TENTATI VE TO PROVI DER			0		0	5. 01
5. 02			0		0	5. 02
5. 03			0		0	5. 03
Provi der to Program						F F0
5.50 TENTATIVE TO PROGRAM 5.51			0		0	5. 50 5. 51
			0			
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines			0			5. 52 5. 99
5. 50-5. 98)			O			
6.00 Determined net settlement amount (balance due) based on the cost report. (1)						6. 00
6. 01 SETTLEMENT TO PROVIDER			109, 205	l .	304, 568	6. 01
6. 02 SETTLEMENT TO PROGRAM			0		0	6. 02
7.00 Total Medicare program liability (see instructions)			952, 460		3, 203, 843	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C)	1. 00	2.00	
8.00 Name of Contractor						8. 00

AL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 14-1334 | Period: From 04/01/2022 | Part I Date/Time Prepared: 8/29/2023 11: 22 am Health Financial Systems SAINT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		'			8/29/2023 11:	22 am
				wing Beds - SNF		
		Inpatien	t Part A	Par	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		3, 900, 195		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	11/30/2022	38, 770		0	3. 01
3.02		03/27/2023	517, 364		0	3. 02
3.03			0		0	3. 03
3. 04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program			1		
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
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		556, 134		0	3. 99
4 00	3. 50-3. 98)		4 457 000			4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 456, 329		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			l o		0	5. 02
5. 03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER		0		0	6. 01
6.02	SETTLEMENT TO PROGRAM		218, 019		0	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 238, 310		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	TH. 60 1	()	1. 00	2. 00	0.00
8.00	Name of Contractor	l				8. 00

Heal th	Financial Systems SAINT JOSEPH MEMOR	IAL HOSPITAL	In Lie	u of Form CMS-	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1334	Peri od: From 04/01/2022 To 03/31/2023		pared:
	<u> </u>	Title XVIII	Hospi tal	Cost	
	TO DE COURT STEP BY CONTRACTOR FOR MONOTANDARD COST REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
1. 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		. 14		1.00
2. 00	Total hospital discharges as defined in AARA §4102 from Wkst. Medicare days (see instructions)	5-3, Pt. 1 COL. 15 TIME	14		2.00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00 Total inpatient days (see instructions)					4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00
7. 00					
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9. 00	Seguestration adjustment amount (see instructions)				9. 00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31. 00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32. 00
				Overri des	
				1. 00	
	CONTRACTOR OVERRIDES				1

108. 00

CONTRACTOR OVERRIDES

108.00 Override of HIT payment

Health Financial Systems	SAINT JOSEPH MEMOR	IAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 14-1334	Peri od: From 04/01/2022	Worksheet E-2
		Component CCN: 14-Z334	To 03/31/2023	Date/Time Prepared:

		Component CCN: 14-Z334	To 03/31/2023	Date/Time Pre 8/29/2023 11:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
	COMPUTATION OF HET COOT OF CONFERENCES		1. 00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES		2 524 440	0	1.00
2.00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)		3, 526, 460	U	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A and sum of Wkst D	858, 730	0	1
0.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing			Ü	0.00
	instructions)	, ,			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teachir	ng program (see		0. 00	4. 00
F 00	instructions)		1 005	0	F 00
5. 00 6. 00	Program days Interns and residents not in approved teaching program (see ins	structions)	1, 925	0	
7. 00	Utilization review - physician compensation - SNF optional meth	and only	0	U	7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	iod om y	4, 385, 190	0	
9. 00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		4, 385, 190	0	10. 00
11. 00	Deductibles billed to program patients (exclude amounts applica	able to physician	0	0	11. 00
40.00	professional services)		4 005 400		40.00
12. 00 13. 00	Subtotal (line 10 minus line 11)	(avaluda asi nauranaa	4, 385, 190	0	12.00
13.00	Coinsurance billed to program patients (from provider records) for physician professional services)	(exclude coinsurance	72, 444	0	13. 00
14. 00	80% of Part B costs (line 12 x 80%)			0	14. 00
15. 00	Subtotal (see instructions)		4, 312, 746	0	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1
16. 50	Pioneer ACO demonstration payment adjustment (see instructions))			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstra	ation) payment	0		16. 55
47.00	adjustment (see instructions)				4, 00
16. 99	Demonstration payment adjustment amount before sequestration		1 (25	0	
17.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		1, 625 1, 056	0	
18. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ıctions)	1,030	0	1
	Total (see instructions)	2011 0113)	4, 313, 802	0	1
19. 01	Sequestration adjustment (see instructions)		75, 492	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs				19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	
	Interim payments		4, 456, 329	0	20. 00
	Interim payments-PARHM				20. 01
21. 00 21. 01	Tentative settlement (for contractor use only)		0	0	21. 00
21.01	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 19 minus lines 19.01, 19.02,	10 25 20 and 21)	-218, 019	0	1
22. 00	Balance due provider/program-PARHM (see instructions)	17. 23, 20, and 21)	-210, 017	O	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	0	0	1
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstra				
200.00	Is this the first year of the current 5-year demonstration peri	od under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement				
201 00	Medicare swing-bed SNF inpatient routine service costs (from W	est N-1 Pt II line			201. 00
201.00	66 (title XVIII hospital))	CSt. D-1, It. II, IIIle			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, lin	e		202. 00
	200 (title XVIII swing-bed SNF))	·			
	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	first year of the curre	nt 5-year demonst	ration	
205.00	period) Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times)	nes line 204)			206. 00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				200.00
207.00	Program reimbursement under the §410A Demonstration (see instru				207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	col. 1, sum of lines	1		208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruct	tions)			209. 00
210. 00	Reserved for future use				210. 00
215 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 20	00 plus line 210) (ccc			215. 00
Z 13. UU	instructions)	77 prus rine 210) (See			2 10.00
	1		1		

Health Financial Systems	SAINT JOSEPH MEMOR	NAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 14-1334	Peri od:	Worksheet E-2
		C CON 14 7224	From 04/01/2022	

		Component CCN: 14-Z334	To 03/31/2023	Date/Time Pre 8/29/2023 11:	epared:
		Title XIX	Swing Beds - SNF		ZZ dili
	<u> </u>		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)		o		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 teachin	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 applica	ble to physician	ő		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) for physician professional services)	(excl ude coi nsurance	0		13. 00
14. 00	80% of Part B costs (line 12 x 80%)		0		14. 00
	Subtotal (see instructions)		ő		15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16. 00
	Pioneer ACO demonstration payment adjustment (see instructions)				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstra	tion) payment			16. 55
16. 99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0		16. 99
	Allowable bad debts (see instructions)		ő		17. 00
	Adjusted reimbursable bad debts (see instructions)		0		17. 01
	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)	0		18. 00
	Total (see instructions)		0		19.00
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration)		0		19. 01 19. 02
19. 03	1				19. 03
19. 25			0		19. 25
	Interim payments		0		20. 00
	Interim payments-PARHM				20. 01
	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)		0		21. 00 21. 01
	Balance due provider/program (line 19 minus lines 19.01, 19.02,	19. 25. 20. and 21)	o		22. 00
22. 01	Balance due provider/program-PARHM (see instructions)	,			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 Rural Community Hospital Demonstration Project (§410A Demonstra	tion) Adiustment			-
200.00	Is this the first year of the current 5-year demonstration peri	, j			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement		1		
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wk 66 (title XVIII hospital))	st. D-1, Pt. II, line			201. 00
202.00	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))				202.00
	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 or the curren	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 tim	es line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				1
	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 or rines			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)	y plus line 210) (see			215. 00
	This is don't only		1		I

Health Financial Systems	SAINT JOSEPH MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1334	Peri od: From 04/01/2022 To 03/31/2023	Worksheet E-3 Part V Date/Time Prepared: 8/29/2023 11:22 am
				_

				8/29/2023 11: 2	22 am
		Title XVIII	Hospi tal	Cost	
				1, 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE P	ART A SERVICES - COST	REI MBURSEMENT		
1.00	Inpatient services			1, 045, 891	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	15)		0	2.00
3. 00	Organ acqui si ti on	,		0	3. 00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4. 00	Subtotal (sum of lines 1 through 3.01)			1, 045, 891	4. 00
5. 00	Primary payer payments			1, 043, 071	5.00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 056, 350	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 030, 330	0.00
	Reasonable charges				
7 00	3			0	7. 00
7.00	Routine service charges				
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	9.00
10. 00	Total reasonable charges			0	10.00
44.00	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for pa			0	
12. 00	Amounts that would have been realized from patients liable for	payment for services or	n a charge basis	0	12. 00
	had such payment been made in accordance with 42 CFR 413.13(e)				
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
	Total customary charges (see instructions)			0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete only	ıif line 14 exceeds liı	ne 6) (see	0	15. 00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds line	e 14) (see	0	16. 00
	instructions)				
17. 00	Cost of physicians' services in a teaching hospital (see instru	ıctions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Direct graduate medical education payments (from Worksheet E-4,	line 49)		0	
	Cost of covered services (sum of lines 6, 17 and 18)			1, 056, 350	
20. 00	Deductibles (exclude professional component)			115, 342	20. 00
21. 00	Excess reasonable cost (from line 16)			0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			941, 008	22. 00
23.00	Coi nsurance			0	23. 00
24.00	Subtotal (line 22 minus line 23)			941, 008	24. 00
25. 00	Allowable bad debts (exclude bad debts for professional service	es) (see instructions)		43, 718	25. 00
26.00	Adjusted reimbursable bad debts (see instructions)			28, 417	26. 00
27.00	Allowable bad debts for dual eligible beneficiaries (see instru	ıcti ons)		19, 169	27. 00
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			969, 425	28. 00
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
	Recovery of accelerated depreciation.			0	
	Demonstration payment adjustment amount before sequestration			0	29. 99
	Subtotal (see instructions)			969, 425	
	Sequestration adjustment (see instructions)			16, 965	
	Demonstration payment adjustment amount after sequestration			0	30. 02
	Sequestration adjustment-PARHM			O	30. 02
	Interim payments			843, 255	
	. •			043, 233	31.00
	Interim payments-PARHM Tentative contractor use only)			0	32.00
	Tentative settlement (for contractor use only)			٥	
	Tentative settlement-PARHM (for contractor use only)	21 22)		100 005	32. 01
	Balance due provider/program (line 30 minus lines 30.01, 30.02,		1 00 01)	109, 205	
	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, mir				33. 01
34. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2, o	cnapter 1,	0	34. 00
	§115. 2				

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

Provider CCN: 14-1334

| Peri od: | Worksheet G | From 04/01/2022 | To 03/31/2023 | Date/Time Prepared: 8/29/2023 11: 22 am

fund-t onl y)	ype accounting records, complete the General Fund column		T.	rom 04/01/2022 o 03/31/2023	Date/Time Pre 8/29/2023 11:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
-	CURRENT ASSETS					
1.00	Cash on hand in banks	-1, 672, 641		1, 350	0	
2. 00 3. 00	Temporary investments		0	0	0	2. 00 3. 00
4.00	Notes recei vabl e Accounts recei vabl e	27, 684, 196	ή	0	0	4. 00
5.00	Other receivable	27,004,190		0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-18, 297, 572	o o	o	0	6. 00
7. 00	Inventory	1, 707, 583		Ö	0	
8.00	Prepai d expenses	135, 306	0	0	0	8. 00
9.00	Other current assets	81, 201	0	0	0	9. 00
10. 00	Due from other funds	C	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	9, 638, 073	3 0	1, 350	0	11. 00
12. 00	FI XED ASSETS Land	179, 386	0	ol	0	12. 00
13. 00	Land improvements	1, 211, 082		o	0	13. 00
14.00	Accumul ated depreciation	-953, 780		0	0	14. 00
15. 00	Bui I di ngs	36, 084, 227	0	0	0	15. 00
16. 00	Accumulated depreciation	-20, 040, 067	0	0	0	16. 00
17. 00	Leasehold improvements	2, 333		0	0	17. 00
18.00	Accumulated depreciation	-719	1	0	0	18.00
19.00	Fixed equipment	C	0	0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	127, 114	0	0	0	20.00
22. 00	Accumulated depreciation	-121, 340		0	0	22.00
23. 00	Major movable equipment	17, 937, 838	1	0	0	23. 00
24. 00	Accumulated depreciation	-13, 604, 903		o	0	24. 00
25. 00	Mi nor equi pment depreci abl e	c	0	0	0	25. 00
26. 00	Accumulated depreciation	C	0	0	0	26. 00
27. 00	HIT designated Assets	C	0	0	0	27. 00
28. 00	Accumulated depreciation	C	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	20 021 171	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	20, 821, 171	1 0	0	0	30.00
31. 00	Investments	C	0	0	0	31. 00
32. 00	Deposits on Leases	C	0	0	0	32. 00
33. 00	Due from owners/officers	C	0	0	0	33. 00
34. 00	Other assets	C	0		0	34. 00
35. 00	Total other assets (sum of lines 31-34)	20 450 244	0	52, 009	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	30, 459, 244	1 0	53, 359	0	36. 00
37. 00	Accounts payable	1, 321, 724	1 0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	1,021,721	o o	0	0	38. 00
39. 00	Payroll taxes payable	2, 389, 051	0	0	0	
40.00	Notes and Loans payable (short term)	249, 315	0	0	0	40.00
41. 00	Deferred income	C	0	0	0	41. 00
42. 00	Accel erated payments	C				42. 00
43.00	Due to other funds	3, 504, 871		0	0	
44. 00	Other current liabilities	394, 427		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	7, 859, 388	3 0	0	0	45.00
46. 00	Mortgage payable	13, 035, 070	0	0	0	46. 00
47.00	Notes payable	c	o	0	0	
48. 00	Unsecured Loans	C	0	0	0	48. 00
49. 00	Other long term liabilities	327, 628		0	0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	13, 362, 698			0	
51. 00	Total liabilities (sum of lines 45 and 50)	21, 222, 086	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	9, 237, 158	al .			52. 00
53. 00	Specific purpose fund	7, 237, 130	ĺ			53.00
54. 00	Donor created - endowment fund balance - restricted			53, 359		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			О		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
EO 00	replacement, and expansion	0 007 150		E2 252	^	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	9, 237, 158 30, 459, 244		53, 359 53, 359	0	59. 00 60. 00
50.00	59)	30, 437, 244	΄	33, 339	U	55.00
	· •	•				•

Health Financial Systems In Lieu of Form CMS-2552-10 SAINT JOSEPH MEMORIAL HOSPITAL STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 14-1334 Peri od: Worksheet G-1 From 04/01/2022 03/31/2023 Date/Time Prepared: 8/29/2023 11:22 am 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 17, 877, 027 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -6, 612, 474 2.00 3.00 Total (sum of line 1 and line 2) 11, 264, 553 0 3.00 4.00 Additions (credit adjustments) (specify) 0 4 00 0 5.00 Contribution to Affiliates -2, 027, 397 0 5.00 6.00 Restricted Donations 17,835 6.00 2 0 7.00 ROUNDI NG 0 7.00 0 8.00 0 8.00 0 9.00 0 0 9.00 10.00 Total additions (sum of line 4-9) -2, 027, 395 10.00 Subtotal (line 3 plus line 10) 9, 237, 158 0 11 00 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 Restricted Grants 0000 249, 392 13.00 Restricted Donations 0 3, 172 14.00 14.00 15.00 ROUNDI NG 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 9, 237, 158 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6.00 1.00 Fund balances at beginning of period 288, 089 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 288.089 0 3.00 Additions (credit adjustments) (specify) 4.00 4.00 5.00 Contribution to Affiliates 0 5.00 Restricted Donations 0 6.00 6.00 7.00 ROUNDI NG 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 17,835 0 10.00 0 11.00 Subtotal (line 3 plus line 10) 305, 924 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 Restricted Grants 13.00 13.00 14.00 Restricted Donations 0 14.00

252, 565

53, 359

0

0

15.00

16.00

17.00

18.00

19.00

ROUNDI NG

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

15.00

16.00

17.00

18.00

Health Financial Systems SAII
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1334

			То	03/31/2023	Date/Time Prep 8/29/2023 11:3	
	Cost Center Description	Inpat	ent	Outpati ent	Total	ZZ dili
	oost ochter beschiptron	1.0		2. 00	3. 00	
	PART I - PATIENT REVENUES	1.0		2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	1.3	46, 638		1, 346, 638	1. 00
2.00	SUBPROVIDER - I PF	''	,		., ,	2. 00
3.00	SUBPROVIDER - IRF					3. 00
4.00	SUBPROVI DER					4. 00
5.00	Swing bed - SNF	1.5	36, 134		1, 536, 134	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)	2, 8	82, 772		2, 882, 772	10.00
	Intensive Care Type Inpatient Hospital Services		•	•		
11.00	INTENSIVE CARE UNIT					11. 00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of line	es	0		0	16. 00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2, 8	82, 772		2, 882, 772	17. 00
18.00	Ancillary services	8, 4	61, 143	230, 180, 222	238, 641, 365	18. 00
19.00	Outpati ent servi ces	3	05, 526	16, 778, 577	17, 084, 103	19. 00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY					22. 00
23. 00	AMBULANCE SERVICES					23.00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE					26. 00
27. 00	Other (specify)		0	0	0	27. 00
27. 99	EMPLOYEE INS AND WC CHARGES		0	8, 175, 692	8, 175, 692	27. 99
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to N	Vkst. 11,6	49, 441	255, 134, 491	266, 783, 932	28. 00
	G-3, line 1)					
00.00	PART II - OPERATING EXPENSES			F (00F F0 (00.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		0	56, 895, 526		29. 00
30.00	ADD (SPECIFY)		0			30. 00
31. 00			0			31. 00
32. 00 33. 00			0			32. 00 33. 00
			0			34. 00
34. 00 35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		U	0		36. 00
37. 00	DEDUCT (SPECIFY)		0	ď		37. 00
38. 00	DEDUCT (SILCITI)		0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			0			41. 00
42. 00	Total deductions (sum of lines 37-41)		9	0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(ti	ransfer		56, 895, 526		43. 00
	to Wkst. G-3, line 4)			22, 370, 020		
		•	1	ı	1	

Heal th	Financial Systems SAINT JOSEPH MEMOR	RLAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 14-1334	Peri od:	Worksheet G-3	
			From 04/01/2022		
			To 03/31/2023	Date/Time Prep 8/29/2023 11:	
				0/27/2023 11.	22 (1111
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		266, 783, 932	1. 00
2.00	Less contractual allowances and discounts on patients' accour	nts		180, 772, 224	2. 00
3.00	Net patient revenues (line 1 minus line 2)			86, 011, 708	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		56, 895, 526	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			29, 116, 182	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			247, 069	6. 00
7.00	Income from investments			445, 996	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			4, 319	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			150, 844	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 t	than patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			18, 004	17. 00
18.00	Revenue from sale of medical records and abstracts			9, 139	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			5, 238	22. 00
23. 00	Governmental appropriations			17, 517	23. 00
	MI SCELLANEOUS			119	
24 50	00/1 D 40 DUE E 1'			0/0 047	1 04 50

860, 017 24. 50 1, 758, 262 25. 00 30, 874, 444 26. 00 37, 486, 918 27. 00 37, 486, 918 28. 00 -6, 612, 474 29. 00

24.00 MISCELLANEOUS
24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 CORP ALLOC, CONTR, MISCELLANEOUS
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)

CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 14-1334	Peri od: From 04/01/2022 To 03/31/2023	Date/Time Pre	
		Title XVIII	Hospi tal	8/29/2023 11: 2 Cost	22 am
		THE AVIII	nospi tui	0031	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			0	1.0
1.01	Model 4 BPCI Capital DRG other than outlier			0	1.0
2. 00	Capital DRG outlier payments			0	2.0
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2.0
3. 00	Total inpatient days divided by number of days in the	ne cost reporting period (see ins	tructions)	0. 00	3.0
1. 00	Number of interns & residents (see instructions)			0. 00	4.0
5. 00	Indirect medical education percentage (see instruct			0.00	5.0
5. 00	Indirect medical education adjustment (multiply line	e 5 by the sum of lines 1 and 1.0°	l, columns 1 and	0	6.0
7. 00	1.01) (see instructions)	Don't A notiont days (Workshoot I	- nort Alino	0.00	7.0
7.00	Percentage of SSI recipient patient days to Medicard 30) (see instructions)	e Part A patrent days (worksheet i	E, part A rine	0. 00	/. 0
3. 00	Percentage of Medicaid patient days to total days (see instructions)		0. 00	8. C
9. 00	Sum of lines 7 and 8	see That detrons)		0.00	9.0
10. 00	Allowable disproportionate share percentage (see in:	structions)		0.00	10.0
11. 00	Disproportionate share adjustment (see instructions			0.00	11.0
12. 00	Total prospective capital payments (see instructions			Ö	12. 0
	DART LL DAVISTE LINES DE LOCALIS COOT			1. 00	
1 00	PART II - PAYMENT UNDER REASONABLE COST			0	
1.00	Program inpatient routine capital cost (see instructions)	•		0	1.0
2. 00	Program inpatient ancillary capital cost (see instru	,		0	2. 0 3. 0
				I 01	1 3.0
3. 00	Total inpatient program capital cost (line 1 plus I)	ne 2)			
3. 00 4. 00	Capital cost payment factor (see instructions)	·		0	4.0
3. 00		·		0	4. 0 5. 0
3. 00 4. 00	Capital cost payment factor (see instructions)	·			4.0
3. 00 4. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line PART III - COMPUTATION OF EXCEPTION PAYMENTS	·		0	4.0
3. 00 4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)	4)		1.00	4. C 5. C
3. 00 4. 00 5. 00 1. 00 2. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary c	4) rcumstances (see instructions)		1.00	4. 0 5. 0 1. 0 2. 0
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary c Net program inpatient capital costs (line 1 minus l	4) rcumstances (see instructions)		1.00	4. C 5. C 1. C 2. C 3. C
3. 00 4. 00 5. 00 4. 00 2. 00 3. 00 4. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary c Net program inpatient capital costs (line 1 minus l Applicable exception percentage (see instructions)	4) rcumstances (see instructions) ine 2)		1.00 0 0 0 0.00	1. C 2. C 4. C
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary context (line 1 minus line) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line)	4) ircumstances (see instructions) ine 2) ine 4)		0 1.00 0 0 0.00 0.00	4. 0 5. 0 1. 0 2. 0 3. 0 4. 0 5. 0
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary context program inpatient capital costs (line 1 minus line) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line) Percentage adjustment for extraordinary circumstance	4) ircumstances (see instructions) ine 2) ine 4) es (see instructions)		0 1.00 0 0 0.00 0.00 0.00	4. 0 5. 0 1. 0 2. 0 3. 0 4. 0 5. 0 6. 0
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary context program inpatient capital costs (line 1 minus line) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line) Percentage adjustment for extraordinary circumstance Adjustment to capital minimum payment level for extraordinary	4) ircumstances (see instructions) ine 2) ine 4) es (see instructions)	αline 6)	0 1.00 0 0 0.00 0.00	4. C 5. C 1. C 2. C 3. C 4. C 5. C 6. C 7. C
3. 00 4. 00 5. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 3. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary c Net program inpatient capital costs (line 1 minus I Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x I Percentage adjustment for extraordinary circumstance Adjustment to capital minimum payment level for ext Capital minimum payment level (line 5 plus line 7)	4) ircumstances (see instructions) ine 2) ine 4) es (see instructions) raordinary circumstances (line 2)	κline 6)	0 1.00 0 0 0.00 0.00 0.00	4. 0 5. 0 1. 0 2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00 9. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary c Net program inpatient capital costs (line 1 minus I Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x I Percentage adjustment for extraordinary circumstance Adjustment to capital minimum payment level for ext Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12	4) ircumstances (see instructions) ine 2) ine 4) es (see instructions) raordinary circumstances (line 2 x	ŕ	0 1.00 0 0 0.00 0 0.00 0	1. CC 2. CC 3. CC 4. CC 5. CC 6. CC 7. CC 8. CC 9. CC
3. 00 4. 00 5. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00 9. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary c Net program inpatient capital costs (line 1 minus I Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x l Percentage adjustment for extraordinary circumstance Adjustment to capital minimum payment level for ext Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12 Current year comparison of capital minimum payment	4) ircumstances (see instructions) ine 2) ine 4) es (see instructions) raordinary circumstances (line 2 x as applicable) level to capital payments (line 8	less line 9)	0 1.00 0 0 0.00 0.00 0.00 0	1. C 2. C 3. C 4. C 5. C 6. C 7. C 8. C 9. C
3. 00 4. 00 5. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00 9. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary c Net program inpatient capital costs (line 1 minus I Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x I Percentage adjustment for extraordinary circumstance Adjustment to capital minimum payment level for ext Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12 Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level	4) ircumstances (see instructions) ine 2) ine 4) es (see instructions) raordinary circumstances (line 2 x as applicable) level to capital payments (line 8	less line 9)	0 1.00 0 0 0.00 0 0.00 0	4. (5. (1. (2. (3. (4. (5. (6. (7. (8. (9. (
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary c Net program inpatient capital costs (line 1 minus I Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x l Percentage adjustment for extraordinary circumstance Adjustment to capital minimum payment level for ext Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12 Current year comparison of capital minimum payment	arcumstances (see instructions) ine 2) ine 4) es (see instructions) raordinary circumstances (line 2 : as applicable) evel to capital payments (line 8 evel over capital payment (from pri	less line 9) or year	0 1.00 0 0 0.00 0.00 0.00 0	1. (2. (3. (4. (5. (6. (7. (8. (9. (10. (

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

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

17.00 Current year exception offset amount (see instructions)

15.00 Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)

0 12.00

0 13.00

0 14.00

0 15.00

0 16.00 0 17.00

13.00