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: 14-0145 Worksheet S Peri od: From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: 1/24/2024 12:29 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 1/24/2024 Time: 12:29 pm Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. JOSEPHS HOSPITAL (14-0145) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SE	TTLEMENT SUMMARY						
1.00 HOSPITAL		0	-31, 976	-862	0	0	1.00
2. 00 SUBPROVI DER	· IPF	0	0	0		0	2.00
3. 00 SUBPROVI DER	- IRF	0	0	0		0	3.00
5.00 SWING BED - S	SNF	0	0	0		0	5.00
6.00 SWING BED - 1	IF	0				0	6.00
10.00 RURAL HEALTH	CLINIC I	0		31, 620		0	10.00
200. 00 TOTAL		0	-31, 976	30, 758	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.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX	ST. JOSEPHS		ler CC	CN: 14-0145	Peri od: From 07/01, To 06/30,	/2022	of For Workshe Part I Date/Ti	et S-2 me Pre	pared:
	1.00	2. 00		3. 00			4. 00	1/24/20)24 12:	29 pm
	Hospital and Hospital Health Care Co									
	Street: 9515 HOLY CROSS LANE	PO Box:	7: 01	- (22	20 0	t CLINTON				1.00
2. 00	Ci ty: BREESE	State: IL Component Name	Zip Cod	e: 622 CB:		unty: CLINTON ler Date	Davme	nt Syst	om (D	2.00
		Component Name	Number	Numl				0, or		
							V	XVIII		
		1. 00	2. 00	3. (00 4.00	5. 00	6.00	7. 00	8. 00	
2 00	Hospital and Hospital-Based Componer		140145	411	00 1	07/01/10//	N	P	0	2 00
3. 00 4. 00 5. 00 6. 00 7. 00	Hospital Subprovider - IPF Subprovider - IRF Subprovider - (Other) Swing Beds - SNF	ST. JOSEPHS HOSPITAL ST. JOSEPHS HOSPITAL	140145 14U145	411		07/01/1966		P	N	3. 00 4. 00 5. 00 6. 00 7. 00
11. 00 12. 00	Swing Beds - NF Hospital -Based SNF Hospital -Based NF Hospital -Based OLTC Hospital -Based HHA									8. 00 9. 00 10. 00 11. 00 12. 00
14. 00 15. 00	Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FOHC	ST. JOSEPHS HOSPITAL RHC	148503	411	80	01/01/2009	N	0	N	13. 00 14. 00 15. 00
17.00	Hospital-Based (CMHC) I Renal Dialysis					From		To		17. 00 18. 00 19. 00
						1.00		To 2. (
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					07/01/2		06/30/		20. 00 21. 00
					1.00	2. 00	1	3. (20	
	Inpatient PPS Information				1.00	2.00		0. (,,,	
22. 00	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section §	stment, in accordance w r yes or "N" for no. Is 412.106(c)(2)(Pickle am	ith 42 CF this		Y	N				22.00
22. 01	hospital?) In column 2, enter "Y" for Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting on cost reporting on coinstructions)	Ps, including supplemen column 1, "Y" for yes g period occurring prio "N" for no for the por	or "N" fo r to Octo	r no ber	Y	Y				22. 01
22. 02	Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in	? (see instructions) En e portion of the cost re column 2, "Y" for yes o	ter in co eporting r "N" for		N	N				22. 02
22. 03	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. Did this hospital receive a geographic reclassification from urban to 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							22.03		
22. 04	yes or "N" for no. Did this hospital receive a geographic reclassification from urban to 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						22.04			
	yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente	of admission, 2 if censor of identifying the days method used in the prio	us days, in this r cost	or 3		1 N				23. 00

Health Financial Systems ST. JOSEPHS HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0145 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 12:29 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 151 87 658 72 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν 48.00 Teachi ng Hospi tal s Is this a hospital involved in training residents in approved GME programs? For cost reporting Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, Ν 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or

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

Health Financial Systems ST. JOSEPHS HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0145 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 12: 29 pm XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	ST	JOSEPHS HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COM				eriod: com 07/01/2022	Worksheet S-2 Part I	
			To	06/30/2023	Date/Time Pre 1/24/2024 12:	pared: 29 pm
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovider Site	Hospi tal	col. 2))	
Section 5504 of the ACA Base Ye	ear ETE Posidonts in N	opprovidor Sottings	1.00	2. 00	3.00	
period that begins on or after	July 1, 2009 and befo	re June 30, 2010.				
64.00 Enter in column 1, if line 63 in the base year period, the nuresident FTEs attributable to resettings. Enter in column 2 th	mber of unweighted no otations occurring in e number of unweighte	n-primary care all nonprovider d non-primary care	0.00	0. 00	0. 000000	64.00
resident FTEs that trained in yof (column 1 divided by (column						
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovider	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1.00	2.00	Si te 3. 00	4.00	5. 00	
65.00 Enter in column 1, if line 63	1. 00	2. 00	0.00	4. 00	0. 000000	65. 00
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)			Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	1/ (col . 1 + col . 2))	
			Si te			
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Setting	1.00	2.00 or cost report	3.00	
beginning on or after July 1, 2	010		,	<u> </u>		
66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	occurring in all nonp unweighted non-prima tal. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0. 00	0. 000000	66.00
(2)	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovider	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1.00	2.00	Si te 3. 00	4.00	5. 00	
67.00 Enter in column 1, the program	1.00	2.00	0.00	4. 00 0. 00		67. 00
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)						

	Financial Systems ST. JOSEPHS HOSPITAL FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN	F	Period: From 07/01/2 To 06/30/2	2022	wof Form Workshee Part I Date/Tin	et S-2	
			0 00/30/2	2023	1/24/202	24 12:	pareu. 29 pm
					1. 00)	
68. 00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-490 For a cost reporting period beginning prior to October 1, 2022, did you ob MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final (August 10, 2022)?	tain permissi	on from yo		N		68. 00
				1. 00	2.00	3. 00	
70. 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it conta	nin an IPF sub	oprovi der?	N	<u> </u>		70. 00
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teachin recent cost report filed on or before November 15, 2004? Enter "Y" for ye 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for ye Column 3: If column 2 is Y, indicate which program year began during this (see instructions) Inpatient Rehabilitation Facility PPS	ng program in es or "N" for in a new tead es or "N" for	the most no. (see ching no.			0	71.00
75. 00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it co	ntain an IRF		N			75. 00
76. 00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teachin recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching program CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If indicate which program year began during this cost reporting period. (see	"Y" for yes of in accordance column 2 is \	or "N" for e with 42 /,			0	76. 00
					1. 00)	
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for n Is this a LTCH co-located within another hospital for part or all of the c "Y" for yes and "N" for no.		g period? E	nter	N N		80. 00 81. 00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter Did this facility establish a new Other subprovider (excluded unit) under			no.	N		85. 00 86. 00
	\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified u 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				N		87. 00
	Tool(d)(1)(b)(vi): Litter i for yes or in for no.		Approved Permaner Adjustme (Y/N) 1.00	nt	Number Approv Perman Adjustm 2.00	/ed ent ents	
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFR amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete co 89. (see instructions)		e			0	88. 00
	Column 2: Enter the number of approved permanent adjustments.	Wkst. A Line	Effectiv	10	Approv	rod.	
		No.	Date	76	Perman Adjustr Amount Discha	ent ment Per	
	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2.00		3. 00		89. 00
89 00		0. 0	٦			O	07.00
89. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.						
89. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the						
89. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		V 1.00		XI X 2. 00		
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the	iter "Y" for					90.00
90. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report	either in	1. 00		2. 00		90.00
90. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati	either in	1. 00 N		2. 00 Y		
90. 00 91. 00 92. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column.	either in on)? (see	1. 00 N		2. 00 Y N		91. 00
90. 00 91. 00 92. 00 93. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no	either in on)? (see I XIX? Enter	1. 00 N N		2. 00 Y N		91. 00 92. 00
90. 00 91. 00 92. 00 93. 00 94. 00 95. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column.	either in on)? (see IXIX? Enter o in the	1.00 N N		2. 00 Y N N)	91. 00 92. 00 93. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CO	°N: 14_0145	<u> </u>	Worksheet S	-2
	Provider Co		From 07/01/2022 To 06/30/2023	Part I Date/Time P	repared:
			V	1/24/2024 1 XIX	2:29 pm
			1. 00	2. 00	
8.00 Does title V or XIX follow Medicare (title XVIII) for the stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.			N	Y	98.00
8.01 Does title V or XIX follow Medicare (title XVIII) for the C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Υ	98.0
8.02 Does title V or XIX follow Medicare (title XVIII) for the bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			N	Y	98. 02
3.03 Does title V or XIX follow Medicare (title XVIII) for a cr reimbursed 101% of inpatient services cost? Enter "Y" for for title V, and in column 2 for title XIX.				N	98.03
3.04 Does title V or XIX follow Medicare (title XVIII) for a CA outpatient services cost? Enter "Y" for yes or "N" for no in column 2 for title XIX.			N	N	98.04
3.05 Does title V or XIX follow Medicare (title XVIII) and add Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.				Υ	98. 05
8.06 Does title V or XIX follow Medicare (title XVIII) when cos Pts. I through IV? Enter "Y" for yes or "N" for no in colucolumn 2 for title XIX.			N	Y	98.00
Rural Providers 05.00 Does this hospital qualify as a CAH?			N		105.00
06.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	l-inclusive met	hod of paymer	- 1		106.00
07.00 Column 1: If line 105 is Y, is this facility eligible for training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, disapproved medical education program in the CAH's excluded	mn 1. (see ins o you train I&R IPF and/or IRF	structions) Rs in an			107.0
Enter "Y" for yes or "N" for no in column 2. (see instruc 08.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	e CRNA fee sche				108. 0
	Physi cal 1.00	0ccupati ona 2.00	Speech 3.00	Respiratory 4.00	<u>/</u>
09.00 If this hospital qualifies as a CAH or a cost provider, and therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	е				109.00
10.00Did this hospital participate in the Rural Community Hospi				1 00	-
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.	"Y" for yes or	"N" for no.	If yes,	1. 00 N	110.0
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W	"Y" for yes or	"N" for no.	If yes, ough 215, as	N	110.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.	"Y" for yes or orksheet E-2, I the Frontier Cost reporting column 1 is Y, articipating in	community period? Enter the column 2.	If yes, ough 215, as		
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for	"Y" for yes or orksheet E-2, I the Frontier Cost reporting column 1 is Y, articipating in	Community period? Enter enter the column 2. s; and/or "C"	If yes, bugh 215, as	N 2. 00	110.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable.	"Y" for yes or orksheet E-2, I the Frontier Cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is i pating in the	community period? Enter the column 2.	If yes, ough 215, as	N	111.0
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes 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 provided.	"Y" for yes or orksheet E-2, I the Frontier Cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes	Community period? Enter enter the column 2. g; and/or "C"	If yes, bugh 215, as	N 2. 00	
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital constration. In column 3, enter the date the hospital constration in the demonstration, if applicable. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes 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 provid the definition in CMS Pub. 15-1, chapter 22, §2208. 1.	"Y" for yes or orksheet E-2, I the Frontier Cost reporting column 1 is Y, articipating ir additional beds alth Model reporting column 1 is i pating in the eased or "N" for no B, or E only) "93" percent (includes ers) based on	community period? Enter enter the column 2. grand/or "C"	If yes, bugh 215, as	N 2. 00	111.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes 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 provid the definition in CMS Pub. 15-1, chapter 22, §2208. 1.	"Y" for yes or orksheet E-2, I the Frontier Cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes ers) based on "for yes or	community period? Enter enter the column 2. grand/or "C" 1.00 N	If yes, bugh 215, as	N 2. 00	111.00

Health Financial Systems	ST. JOSEPHS H	OSPLTAL		In lie	ı of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I DENTI		Provi der CC		eri od:	Worksheet S	
				rom 07/01/2022 o 06/30/2023	Part I Date/Time P	repared:
			Donas i como		1/24/2024 1	2:29 pm
			Premi ums	Losses	Insurance	
			1. 00	2. 00	3. 00	
118.01 List amounts of malpractice premiums and	oaid Losses:		130, 165			26 118. 01
				1.00	2.00	
118.02 Are mal practice premiums and paid losses	reported in a cost of	center other	than the	1. 00 N	2. 00	118. 02
Administrative and General? If yes, subm						
and amounts contained therein. 119.00 DO NOT USE THIS LINE						119. 00
120.00 Is this a SCH or EACH that qualifies for				N	Υ	120.00
§3121 and applicable amendments? (see ins						
"N" for no. Is this a rural hospital with Hold Harmless provision in ACA §3121 and						
Enter in column 2, "Y" for yes or "N" for	no.	•	•			
121.00 Did this facility incur and report costs patients? Enter "Y" for yes or "N" for no		itable devices	s charged to	Y		121. 00
122.00 Does the cost report contain healthcare re	elated taxes as defi			Υ	5. 06	122. 00
Act?Enter "Y" for yes or "N" for no in co the Worksheet A line number where these to		is "Y", enter	r in column 2			
123.00 Did the facility and/or its subproviders		chase professi	i onal			123. 00
services, e.g., legal, accounting, tax pr	eparation, bookkeepi	ng, payroll,	and/or			
management/consulting services, from an unifor yes or "N" for no.	nrelated organizatio	on? In column	1, enter "Y"			
If column 1 is "Y", were the majority of						
professional services expenses, for services located in a CBSA outside of the main hos	ces purchased from u	unrelated orga	anizations			
"N" for no.	DITAL CBSA? III COLUI	ıın 2, enter	r for yes or			
Certified Transplant Center Information						
125.00 Does this facility operate a Medicare-cer and "N" for no. If yes, enter certification			"Y" for yes	N		125. 00
126.00 If this is a Medicare-certified kidney tr	ansplant program, er	nter the certi	ification date			126. 00
in column 1 and termination date, if appl 127.00 If this is a Medicare-certified heart tra			fication data			127. 00
in column 1 and termination date, if appl	cable, in column 2.	ter the certifi	ircation date			127.00
128.00 If this is a Medicare-certified liver tra			fication date			128. 00
in column 1 and termination date, if appl 129.00 If this is a Medicare-certified lung trans			ication date			129. 00
in column 1 and termination date, if appl	cable, in column 2.					
130.00 If this is a Medicare-certified pancreas date in column 1 and termination date, if			rti fi cati on			130. 00
131.00 If this is a Medicare-certified intestina			certi fi cati on			131.00
date in column 1 and termination date, if			fication data			122 00
132.00 f this is a Medicare-certified islet tra in column 1 and termination date, if appl			ircation date			132. 00
133.00 Removed and reserved		200	000			133.00
134.00 If this is a hospital-based organ procured in column 1 and termination date, if appl			ne OPO number			134.00
All Providers						
140.00 Are there any related organization or home chapter 10? Enter "Y" for yes or "N" for				Y	14H005	140. 00
are claimed, enter in column 2 the home of						
1.00 If this facility is part of a chain organ	2.00	inos 141 thro	ugh 142 tho n	3. 00	of the home	
office and enter the home office contract			ugii 143 the na	dille ariu auur ess	or the nome	
141.00 Name: HOSPITAL SISTERS HEALTH Cor	tractor's Name: NGS		Contractor	r's Number: 0013	1	141. 00
SYSTEMS 142.00Street: 4936 LAVERNA ROAD PO	Box:					142. 00
	ite: IL		Zi p Code:	6270	7	143.00
					1 00	_
144.00 Are provider based physicians' costs incl	uded in Worksheet A?	?			1. 00 Y	144. 00
				1.00	0.00	
145.00 If costs for renal services are claimed on	n Wkst. A. line 74	are the costs	s for	1. 00	2. 00	145. 00
inpatient services only? Enter "Y" for ye	s or "N" for no in o	column 1. If o	column 1 is			1.5.00
no, does the dialysis facility include Me period? Enter "Y" for yes or "N" for no		for this cost	reporti ng			
146.00 Has the cost allocation methodology change	ed from the previous			N		146. 00
Enter "Y" for yes or "N" for no in column	1. (See CMS Pub. 15					
yes, enter the approval date (mm/dd/yyyy)	TH COLUMN Z.					I

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPL		HOSPITAL Provider CC	N: 14-0145	Period:	/01/2022	Worksheet S-	-2552-1 -2
					/30/2023		repared: 2: 29 pm
						1. 00	_
47.00 Was there a change in the statist	ical basis? Enter "Y" for	yes or "N" for	no.			N	147.00
48.00 Was there a change in the order o						N	148. 00
49.00 Was there a change to the simplif	ied cost finding method? E					N	149.00
		Part A 1.00	Part B 2.00		tle V 3.00	Title XIX 4.00	
Does this facility contain a prov	ider that qualifies for ar						
or charges? Enter "Y" for yes or							
55. 00 Hospi tal	·	N	N		N	N	155. 0
56.00 Subprovi der - IPF		N	N		N	N	156. 0
57. 00 Subprovi der - I RF		N	N		N	N	157. 0
58. 00 SUBPROVI DER							158. 0
59. 00 SNF 60. 00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 00 160. 00
61. OOKMHC		IN IN	N N		N N	N N	161. 0
01. 00 OMITO					14	IV.	101.0
						1. 00	
Multicampus							
65.00 Is this hospital part of a Multic	ampus hospital that has on	ne or more camp	uses in dif	ferent CE	BSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	News	0	C+-+- -	7: CI-	CDCA	FTF /C	
	Name 0	County 1.00	2. 00	Zip Code 3.00	4. 00	FTE/Campus 5.00	_
66.00 f ine 165 is yes, for each	O .	1.00	2.00	3.00	4.00		00 166. 0
campus enter the name in column							
0, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	
Health Information Technology (HI	T) incentive in the Americ	can Recovery an	d Reinvestr	ment Act		1.00	
67.00 Is this provider a meaningful use						Υ	167. 0
68.00 If this provider is a CAH (line 1	05 is "Y") and is a meanin	ngful user (line		"), enter	the		168. 0
reasonable cost incurred for the							
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)					Ishi p		168. 0
69.00 If this provider is a meaningful					ntor the	0.1	00169. 0
transition factor. (see instructi		1 13 HOL & CAII	(Trie 105 i	3 N), C	inter the	0.	00107.0
				Beg	i nni ng	Endi ng	
					1.00	2. 00	
70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and ending	date for the re	eporti ng				170. 0
					1. 00	2. 00	
71.00 If line 167 is "Y", does this pro	vider have any days for in	ndi vi dual s enro	lled in		N	2.00	0171.0
section 1876 Medicare cost plans				.			
"Y" for yes and "N" for no in col							

Health Financial Systems ST. JOSEPHS HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-0145 Peri od: Worksheet S-2 From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 1/24/2024 12: 29 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Υ 5.00 those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 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 instructions) Was the cost report prepared using the PS&R Report for 11/01/2023 11/01/2023 17.00 Υ Υ 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 14-0145	Peri od: From 07/01/2022 To 06/30/2023	Worksheet Part II Date/Time 1/24/2024	Prepared
		Descr	iption	Y/N	Y/N	
			0	1.00	3. 00	
0. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.0
	The position of the state of th	Y/N	Date	Y/N	Date	
		1. 00	2.00	3.00	4. 00	
1. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0
				-	1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS	HOSPI TALS)		1.00	
2 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see) instructions				22. 0
3. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			ring the cost		23. 0
	Were new leases and/or amendments to existing leases entere If yes, see instructions	· ·				24.0
5. 00	Have there been new capitalized leases entered into during instructions.	•	.			25. 0 26. 0
5. 00 7. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions. Has the provider's capitalization policy changed during the	·	0 .			27.0
	copy. Interest Expense	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u> </u>	J		
	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.		Ü			28.0
9. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	ructions		ŕ		30.0
	instructions. Has debt been recalled before scheduled maturity without is	,	,	·		31. (
	instructions. Purchased Services					
	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app	ıcti ons.	•			32.0
	no, see instructions. Provider-Based Physicians					
4. 00	Were services furnished at the provider facility under an a	ırrangement wi	th provider-	based physicians?		34.0
5. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the	provi der-based		35. (
	phrysicians during the cost reporting period? If yes, see th	ISTI UCTI OIIS.		Y/N	Date	
	lu occ			1.00	2. 00	
4 00	Home Office Costs			V		24.6
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	epared by the	home office	? Y Y		36. 0 37. 0
3. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off			of N		38.0
9. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.			es, N		39. 0
0. 00		home office?	If yes, see	· N		40. 0
			00		20	
	Cost Report Preparer Contact Information	1.	00	2. (50	
1. 00		PATTY		RACHELL		41.0
2. 00		FORVI S				42.0
	preparer.					43.0

Heal th	Financial Systems ST. JOSE	PHS HOSPITAL In Lieu of Form C				of Form CMS-2	2552-10
HOSPI 1	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0145			Worksheet S-2 Part II Date/Time Pre 1/24/2024 12:	pared:
			3.00				
	Cost Report Preparer Contact Information		0.00				
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3 respectively.		MANAGING DIRECTOR				41. 00
42. 00	Enter the employer/company name of the cost report preparer.						42.00
43. 00	Enter the telephone number and email address of the cos report preparer in columns 1 and 2, respectively.	t					43.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 07/01/2022 | Part | | To 06/30/2023 | Date/Time Prepared: Health Financial Systems ST. JOHN HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-0145

				Т	o 06/30/2023	Date/Time Pre 1/24/2024 12:	
						1/P Days /	2 / piii
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.		Avai I abl e			
	DADT I CTATICTICAL DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	PART I - STATISTICAL DATA	30.00	46	1/ 700	0.00	0	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00	40	16, 790	0.00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)						2.00
3. 00	HMO IPF Subprovider						3.00
4. 00	HMO IRF Subprovider						4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF					Ö	6.00
7. 00	Total Adults and Peds. (exclude observation		46	16, 790	0. 00	_	7.00
,, 00	beds) (see instructions)				0.00		/
8. 00	INTENSIVE CARE UNIT	31.00	C		0.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		46	16, 790	0. 00	0	14.00
15.00	CAH visits					0	15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	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	20.00					24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC	00.00				_	25.00
26. 00 26. 25	RHC (CONSOLIDATED) FEDERALLY QUALIFIED HEALTH CENTER	88. 00 89. 00				0	26. 00 26. 25
27. 00	Total (sum of lines 14-26)	69.00	46			U	27. 00
28. 00	Observation Bed Days		40	'		0	28.00
29. 00	Ambulance Trips					U	29.00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Thisti detroit)						31.00
32. 00	Labor & delivery days (see instructions)		c				32.00
32. 01	Total ancillary labor & delivery room						32.01
52.01	outpatient days (see instructions)						02.01
33. 00				1			33. 00
33. 01	LTCH site neutral days and discharges						33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	C) c)	0	34.00
				-			

Health Financial Systems ST. JOHN HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-0145

				'	0 00/30/2023	1/24/2024 12:	
		I/P Days	/ O/P Visits	/ Trips	Full Time E		_ , p
		i,, bayo	, 0,1 110.10	,po		-qu. va. 00	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 491	63	3, 650			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	737	745				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	424	0	782			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	44			6.00
7.00	Total Adults and Peds. (exclude observation	1, 915	63	4, 476			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	0	0	0			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		88	997			13.00
14.00	Total (see instructions)	1, 915	151	5, 473	0.00	195. 05	14.00
15.00	CAH visits	0	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)			78			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RHC (CONSOLI DATED)	13, 426	3, 826	51, 517		17. 17	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0.00	1
27.00	Total (sum of lines 14-26)				0.00	212. 22	1
28. 00	Observation Bed Days		3	455			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			163			30.00
31. 00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	72	188			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

Provider CCN: 14-0145

					00/30/2023	1/24/2024 12:	
		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		0	442	25	1, 421	1.00
2. 00 3. 00 4. 00	for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider			210	290 0		2.00 3.00 4.00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF				Ö		5. 00
7. 00 8. 00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						7. 00 8. 00
9. 00 10. 00 11. 00 12. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						9. 00 10. 00 11. 00 12. 00 13. 00
13. 00 14. 00 15. 00 15. 10 16. 00 17. 00 18. 00 19. 00	NURSERY Total (see instructions) CAH visits REH hours and visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY	0.00	0	442	25	1, 421	
20. 00 21. 00 22. 00 23. 00 24. 00 24. 10	NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)						20. 00 21. 00 22. 00 23. 00 24. 00 24. 10
25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	CMHC - CMHC RHC (CONSOLIDATED) FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0.00 0.00 0.00					25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01 34. 00	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care			0			33. 00 33. 01 34. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 14-0145

						o 06/30/2023	Date/Time Pre	
		Wkst. A Line	Amount	Recl assi fi cat		Paid Hours	Average	29 piii
		Number	Reported	i on of Sal ari es	Salaries (col.2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col . 4	col . 5)	
		1. 00	2. 00	A-6) 3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA	1. 00	2. 00	0.00	1.00	0.00	0. 00	
1. 00	SALARIES Total salaries (see	200.00	14, 460, 337	Ιο	14, 460, 337	408, 470. 01	35. 40	1. 00
	instructions)	200.00						
2. 00	Non-physician anesthetist Part A		0	O	C	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		0	0	C	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		0	0	C	0. 00	0. 00	4. 00
4. 01	Physicians - Part A - Teaching		0	0	· ·	0.00	0.00	
5. 00	Physician and Non Physician-Part B		71, 950	O	71, 950	1, 155. 00	62. 29	5. 00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		58, 612	0	58, 612	1, 607. 75	36. 46	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	c	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0		_	0.00	0. 00	7. 01
7.01	residents (in an approved programs)		O			0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	C	0.00	0. 00	8. 00
9. 00	SNF	44.00	0	0	c	0. 00	0. 00	9. 00
10. 00	Excluded area salaries (see instructions)		265, 939	0	265, 939	10, 350. 09	25. 69	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		17, 093	O	17, 093	110. 28	155. 00	11.00
12. 00	Contract Labor: Top Level		0	o	C	0. 00	0. 00	12.00
	management and other management and administrative							
13. 00	services Contract Labor: Physician-Part		122, 807	0	122, 807	878. 98	139. 72	13. 00
14. 00	A - Administrative Home office and/or related		0	0	C	0. 00	0.00	14. 00
14.00	organization salaries and		O	Ĭ		0.00	0.00	14.00
14. 01	wage-related costs Home office salaries		3, 217, 644	0	3, 217, 644	78, 717. 74	40 88	14. 01
14. 02	Related organization salaries		0	0		0.00	0. 00	14. 02
15. 00	Home office: Physician Part A - Administrative		0	O		0. 00	0.00	15. 00
16. 00	Home office and Contract		0	О	C	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	c	0.00	0. 00	16. 01
16. 02	- Teaching Home office contract		0	0		0. 00	0.00	16. 02
10. 02	Physicians Part A - Teaching					0.00	0.00	10.02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		4, 552, 179	Ιο	4, 552, 179)		17. 00
18. 00	instructions) Wage-related costs (other)		,,,,,,					18. 00
	(see instructions)		10/ 27/		10/ 27/			
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		106, 274 0	0	106, 274 C)		19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	C			21. 00
22. 00	Physician Part A -		0	O	c)		22. 00
22. 01	Administrative Physician Part A - Teaching		0					22. 01
23. 00	Physician Part B		17, 192	0	17, 192			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		18, 691 0	0	18, 691			24. 00 25. 00
	approved program)		· ·					
25. 50	Home office wage-related (core)		1, 257, 718	0	1, 257, 718	3		25. 50
25. 51	Rel ated organization		0	0	C			25. 51
25. 52			0	0	c			25. 52
	- Administrative - wage-related (core)							
	130 10.0.00			ı	1	1	· · · · · · · · · · · · · · · · · · ·	

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0145 Peri od: Worksheet S-3 From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 1/24/2024 12:29 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of Sal ari es (col. 2 ± col. Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 0 0.00 0. 00 26.00 27.00 Administrative & General 5.00 559, 248 -754 558, 494 17, 777. 50 31. 42 27.00 28.00 Administrative & General under 301, 729 301, 729 2, 686. 12 112. 33 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 485, 504 0 485, 504 16, 771. 18 28. 95 30.00 31.00 Laundry & Linen Service 8.00 0.00 31.00 C 0.00 32.00 28, 620. 85 Housekeepi ng 9.00 492, 567 C 492, 567 17. 21 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 266, 493 -218, 894 47, 599 2, 721.81 17. 49 34.00 Dietary under contract (see 35.00 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 218, 894 218, 894 12, 532. 33 17. 47 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 0 Nursing Administration 13.00 52. 93 38.00 38.00 983, 306 Ω 983, 306 18, 576. 78 39.00 Central Services and Supply 14.00 C 0.00 0.00 39.00 8, 975. 15 40.00 Pharmacy 15.00 470, 498 0 470, 498 52. 42 40.00 Medical Records & Medical Records Library 41.00 16.00 0 0 0.00 0.00 41.00

-754

754

0

0

0.00

0.00

0.00 42.00

0.00 43.00

17.00

18.00

42.00

Social Service

43.00 Other General Service

Health Financial Systems

ST. JOSEPHS HOSPITAL

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0145 | Period: | Worksheet S-3

HOSPI 1	TAL WAGE INDEX INFORMATION			Provi der C		Period: From 07/01/2022 To 06/30/2023		
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		14, 631, 504	0	14, 631, 50	4 408, 393. 38	35. 83	1.00
	instructions)							
2.00	Excluded area salaries (see		265, 939	0	265, 93	9 10, 350. 09	25. 69	2.00
	instructions)							
3.00	Subtotal salaries (line 1		14, 365, 565	0	14, 365, 56	5 398, 043. 29	36. 09	3.00
	minus line 2)							
4. 00	Subtotal other wages & related		3, 357, 544	0	3, 357, 54	4 79, 707. 00	42. 12	4. 00
	costs (see inst.)							
5. 00	Subtotal wage-related costs		5, 809, 897	0	5, 809, 89	7 0.00	40. 44	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		23, 533, 006	0	23, 533, 00	6 477, 750. 29	49. 26	6.00
7.00	Total overhead cost (see		3, 558, 591	0	3, 558, 59	1 108, 661. 72	32. 75	7.00
	instructions)							

ST. JOSEPHS HOSPITAL	In Lieu of Form CMS-2552-10
Provi der CCN: 14-0145	
	From 07/01/2022 Part IV

	To 06/30/2023	B Date/Time Pre 1/24/2024 12:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	249, 616	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)	771, 513	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)	2, 569, 611	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9. 00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
	Accident Insurance (If employee is owner or beneficiary)	0	12.00
	Disability Insurance (If employee is owner or beneficiary)	18, 849	13.00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
	'Workers' Compensation Insurance	287, 894	15.00
	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	1
	Noncumulative portion)		
	TAXES	_	
17. 00	FICA-Employers Portion Only	867, 985	17. 00
18.00	Medicare Taxes - Employers Portion Only	209, 675	18.00
	Unemployment Insurance	-293, 347	
	State or Federal Unemployment Taxes	0	1
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
200	instructions))	1	
22.00	Day Care Cost and Allowances	0	22. 00
	Tui ti on Rei mbursement	12, 540	
	Total Wage Related cost (Sum of Lines 1 -23)	4, 694, 336	
250	Part B - Other than Core Related Cost	1, 27, 1, 000	55
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
	1	1	,

Health Financial Systems	ST. JOSEPHS HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 14-0145	Peri od: Worksheet S-3
		From 07/01/2022 Part V

		To 06/30/2023		
	Cost Center Description	Contract	Benefit Cost	
		Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	17, 093	4, 694, 336	1.00
2.00	Hospi tal	17, 093	4, 694, 336	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4.00
5. 00	Subprovi der - (Other)	0	0	5.00
6. 00	Swing Beds - SNF	0	0	6.00
7. 00	Swing Beds - NF	0	0	7.00
8. 00	SKILLED NURSING FACILITY			8. 00
9. 00	NURSING FACILITY			9. 00
	OTHER LONG TERM CARE I		 -	10.00
	Hospi tal -Based HHA			11.00
	AMBULATORY SURGICAL CENTER (D. P.) I		 -	12.00
	Hospi tal -Based Hospi ce			13.00
	Hospital-Based Health Clinic RHC	0	0	14.00
	Hospital-Based Health Clinic FQHC			15. 00
	Hospi tal -Based-CMHC			16.00
	RENAL DIALYSIS I			17.00
18. 00	Other	0	0	18. 00

	FAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 14-0145	Peri od:	eu of Form CMS- Worksheet S-8	
			Component	CCN: 14-8503	From 07/01/2022 To 06/30/2023		
					RHC I	Cost	_
					1	. 00	-
	Clinic Address and Identification				1.	. 00	
. 00	Street		1		VARI OUS		1.0
				<u>i ty</u> . 00	State 2.00	ZIP Code 3.00	
. 00	City, State, ZIP Code, County		VARI OUS	. 00		62230	2.
-00	HOCDITAL DACED FOLICE ONLY. Designation. Fort	"D"	-1 "!!"			1.00	\
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er k for rura	al or u for		nt Award	Date 0	3.
					1. 00	2. 00	
00	Source of Federal Funds						١.
i. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4. (5. (
. 00	Health Services for the Homeless (Section 34						6.0
. 00	Appal achi an Regional Commission						7.0
3. 00 9. 00	Look-Alikes OTHER (SPECIFY)						8. (9. (
. 00	JOHIER (SI EGITT)			1			7.
					1. 00	2. 00	
0. 00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operatio	ons in column	N	0	10.
	Tiour 5.)	Sun	day	M	londay	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1. 00	2.00	3.00	4. 00	5. 00	
1. 00	CLINIC			07: 00	18: 00	07: 00	11.
2. 00	Have you received an approval for an excepti	on to the produ	uctivity stand	dard?	1. 00 N	2. 00	12.
3.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section Y 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and						12.
	30.8? Enter "Y" for yes or "N" for no in col	umn 1. If yes,	enter in colu	umn 2 the	·	3	13.
	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	umn 1. If yes,	enter in colu	umn 2 the ders and Provi	ider name	CCN	3 13.
4.00	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	umn 1. If yes,	enter in colu	umn 2 the ders and Provi	ider name 1.00	CCN 2. 00	
4. 00 4. 01	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	umn 1. If yes,	enter in colu	umn 2 the ders and Provi	ider name 1.00	CCN	14.
	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	umn 1. If yes, List the names	enter in colu s of all provi	umn 2 the ders and Provi ST. JOSEPHS CLINTON CNTY NEW BADEN CLINTON CNTY CARLYLE RIV	ider name 1.00 HOSPITAL 'RURAL HEALTH 'RURAL HLTH-	CCN 2. 00 148503 148553 148570	14.
4. 01	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	umn 1. If yes, List the names	enter in colu s of all provi	The ders and Provi	i der name 1.00 HOSPI TAL ' RURAL HEALTH ' RURAL HLTH-	CCN 2. 00 148503 148553 148570 Total Visits	14. 14.
4. 01 4. 02	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN	umn 1. If yes, List the names	enter in colu s of all provi	umn 2 the ders and Provi ST. JOSEPHS CLINTON CNTY NEW BADEN CLINTON CNTY CARLYLE RIV	ider name 1.00 HOSPITAL 'RURAL HEALTH 'RURAL HLTH-	CCN 2. 00 148503 148553 148570	14. 14.
4. 01 4. 02	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	umn 1. If yes, List the names	enter in colu s of all provi	The ders and Provi	i der name 1.00 HOSPI TAL ' RURAL HEALTH ' RURAL HLTH-	CCN 2. 00 148503 148553 148570 Total Visits	14. 14.
4. 01	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	umn 1. If yes, List the names	enter in colus of all provi	The ders and Provi	i der name 1.00 HOSPI TAL ' RURAL HEALTH ' RURAL HLTH-	CCN 2. 00 148503 148553 148570 Total Visits	14. 14.

Health Financial Systems	ST. JOSEPHS	HOSPITAL		In Lieu of Form CMS		2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provi der C		Period: From 07/01/2022	Worksheet S-8		
		Component	Component CCN: 14-8503		Date/Time Pre 1/24/2024 12:	pared: 29 pm
				RHC I	Cost	
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7.00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	07: 00	17: 00	07: 00	17: 00	11.00
	Fri	day	Sat	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	17: 00	07: 00	14: 00		11. 00

	Financial Systems ST. JOSEPHS HOSP TAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovi der CCN:	: 14-0145	Peri od:	u of Form CMS- Worksheet S-	
	THE GROOM ENGINES THIS TREE STATE STATE			From 07/01/2022		
				To 06/30/2023	Date/Time Pr 1/24/2024 12	epared : 29 pm
					1. 00	
	Uncompensated and indigent care cost computation					
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ided by line	e 202 colum	n 8)	0. 243490	1.0
	Medicaid (see instructions for each line)					
. 00	Net revenue from Medicaid				2, 304, 21	
. 00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.0
. 00	If line 3 is yes, does line 2 include all DSH and/or supplements			ai d'?	Υ	4.0
. 00 . 00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid charges	on wearcard			18, 140, 99 ⁹	
. 00	Medicaid cost (line 1 times line 6)				4, 417, 15	
00	Difference between net revenue and costs for Medicaid program (I	line 7 minus	s sum of li	nes 2 and 5: if	2, 112, 93	1
	< zero then enter zero)				_,,	
	Children's Health Insurance Program (CHIP) (see instructions for	r each line))			
. 00	Net revenue from stand-alone CHIP					9. (
	Stand-al one CHIP charges					10.
1.00	Stand-alone CHIP cost (line 1 times line 10)					11.
2. 00	Difference between net revenue and costs for stand-alone CHIP (lenter zero)	line ii mini	us line 9;	if < zero then	(12.
	Other state or local government indigent care program (see instr	ructions for	r each line)		
3. 00	Net revenue from state or local indigent care program (Not included in the				(13.
	Charges for patients covered under state or local indigent care					14.
	10)	1 3 4 (
5. 00	State or local indigent care program cost (line 1 times line 14))			(15.
5. 00		igent care ¡	program (li	ne 15 minus line	• (16.
	13; if < zero then enter zero)	D	// ! : ! :		/	
	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)	P and State	/rocar rndr	gent care progra	ms (see	
7 00	Private grants, donations, or endowment income restricted to fur	nding chari	ty care			17.
	Government grants, appropriations or transfers for support of he					18.
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent ca	are program	s (sum of lines	2, 112, 93	7 19.
	,		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci	i I i +v/	1, 464, 54	335, 793	1, 800, 33	20.
). 00	(see instructions)	iiity	1, 404, 34	333, 793	1, 600, 33,	20.
1. 00	Cost of patients approved for charity care and uninsured discour	nts (see	356, 60	335, 793	692, 394	1 21.
	instructions)	()				
2. 00	Payments received from patients for amounts previously written	off as		0 0	(22.
	charity care					
3. 00	Cost of charity care (line 21 minus line 22)		356, 60)1 335, 793	692, 39	1 23.
					1 00	
1. 00	Does the amount on line 20 column 2, include charges for patien	t days heyo	nd a Length	of stay limit	1. 00 N	24.
. 00	imposed on patients covered by Medicaid or other indigent care p		na a rengtii	or stay rriller	IV	24.
5. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit		care progra	m's length of	(25.
5. 00	Total bad debt expense for the entire hospital complex (see ins	tructions)			2, 124, 79	1 26.
7. 00	Medicare reimbursable bad debts for the entire hospital complex		uctions)		87, 89	
7. 01	Medicare allowable bad debts for the entire hospital complex (se			ļ	135, 22	
8. 00	Non-Medicare bad debt expense (see instructions)		- /		1, 989, 56	
9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (see i	nstructi ons)	531, 770	
	1016				1, 224, 16	1 30.
0. 00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line)			J	3, 337, 10	

	n Financial Systems	ST. JUSEPHS				u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		Peri od:	Worksheet A	
					From 07/01/2022 To 06/30/2023	Date/Time Pre	nared:
				'	00/30/2023	1/24/2024 12:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons (See	Trial Balance	
				. 5511 2)	A-6)	(col. 3 +-	
					,	col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		1, 314, 150	1, 314, 150	775, 688	2, 089, 838	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		1, 314, 130	1, 314, 130		1, 145, 661	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 667, 417	4, 667, 417		4, 665, 925	4.00
5. 01	00540 NONPATIENT TELEPHONES	0	66, 682	66, 682		88, 539	5. 01
5. 01	00550 DATA PROCESSING	0	00, 082	00, 002		00, 534	5. 02
	1 1	100 000	142, 569	_	-		5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	100, 989		243, 558		243, 484	
5. 04	00570 ADMITTING	0	5, 081	5, 081	-1, 823	3, 258	5.04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	10 004 054	44 0/0 046	000 050	0	5. 05
5.06	00590 ADMIN & GENERAL	458, 259	13, 804, 951	14, 263, 210		14, 484, 063	5.06
7. 00	00700 OPERATION OF PLANT	485, 504	1, 604, 659	2, 090, 163		2, 222, 849	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	146, 477	146, 477		146, 477	8.00
9. 00	00900 HOUSEKEEPI NG	492, 567	360, 474	853, 041		853, 041	
10. 00	01000 DI ETARY	266, 493	352, 630	619, 123		109, 659	10.00
11. 00	01100 CAFETERI A	0	0	(505, 488	505, 488	
13.00	01300 NURSI NG ADMI NI STRATI ON	983, 306	59, 689	1, 042, 995	-40	1, 042, 955	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	(0	0	14.00
15.00	01500 PHARMACY	470, 498	724, 292	1, 194, 790	-635, 017	559, 773	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	377	377	-339	38	16.00
17.00	01700 SOCI AL SERVI CE	-754	645	-109	109	0	17.00
19.00		ol	o	(709, 483	709, 483	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1	-				
30.00	03000 ADULTS & PEDIATRICS	3, 465, 002	352, 538	3, 817, 540	-1, 702, 432	2, 115, 108	30.00
31. 00	1 1	0	0	(0	31.00
43. 00	1 1	ő	-4, 382	-4, 382	223, 354	218, 972	43. 00
45.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	7, 302	7, 302	220, 004	210, 772	45.00
50.00	05000 OPERATING ROOM	1, 576, 455	2, 873, 751	4, 450, 206	-2, 262, 918	2, 187, 288	50.00
51.00	05100 RECOVERY ROOM	1, 370, 433	2, 673, 731	4, 430, 200		2, 107, 200	51.00
	1 1	- 1	-	_	-		
52.00	05200 DELIVERY ROOM & LABOR ROOM	543	51, 378	51, 921		1, 251, 737	52.00
53.00	05300 ANESTHESI OLOGY	1 040 004	743, 825	743, 825		-244	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 048, 334	586, 181	1, 634, 515		1, 387, 165	1
57. 00	05700 CT SCAN	0	40, 924	40, 924		-1, 176	
58. 00	1 1	85, 507	69, 293	154, 800		147, 101	
60.00	06000 LABORATORY	1, 119, 503	1, 674, 954	2, 794, 457		2, 725, 514	
63.00	06300 BLOOD STORING PROCESSING & TRA	0	127, 505	127, 505		127, 505	
65. 00	06500 RESPI RATORY THERAPY	498, 438	121, 311	619, 749	-119, 701	500, 048	
66. 00	06600 PHYSI CAL THERAPY	1, 450, 063	235, 313	1, 685, 376	-176, 409	1, 508, 967	66.00
69. 00	06900 ELECTROCARDI OLOGY	12, 046	20, 105	32, 151	-641	31, 510	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	73	73	-73	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	92, 486	123, 941	216, 427	2, 146, 911	2, 363, 338	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(563, 998	563, 998	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(690, 662	690, 662	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	166, 912	14, 674	181, 586	-9, 557	172, 029	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(ol		1
	OUTPATIENT SERVICE COST CENTERS				'		1
88. 00		130, 562	8, 840, 469	8, 971, 031	-978, 373	7, 992, 658	88. 00
90.00		0	n	2, 17 1, 00		0	90.00
90. 01	09001 CLINI C	ol o	0			0	90.01
90. 02	1 1	203, 530	28, 016	231, 546	-378	231, 168	1
91.00	1 1	1, 088, 155	1, 225, 452	2, 313, 607		2, 182, 787	1
91.00		1,000,133					
		٩	38, 646	38, 646	-4, 141	34, 505	
92. 00	· ·						92.00
400.0	OTHER REIMBURSABLE COST CENTERS				J al		
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	(0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
	0 11300 I NTEREST EXPENSE		325, 918				113. 00
118.00		14, 194, 398	40, 739, 978	54, 934, 376	366, 795	55, 301, 171	118.00
	NONREI MBURSABLE COST CENTERS						1
192.00	0 19200 PHYSICIANS PRIVATE OFFICES	234, 078	1, 843, 591	2, 077, 669	-409, 266	1, 668, 403	192.00
	0 07950 LI FELI NE	ol	o	(ol ol	0	194. 00
	1 07951 DEVELOPMENT	o	o	(ol ol	0	194. 01
	2 07952 VACANT SPACE	ol	36, 819	36, 819	43, 531		194. 02
	3 07953 TRANSPORTATI ON	31, 861	17, 661	49, 522			194. 03
200.00		14, 460, 337	42, 638, 049			57, 098, 386	
			, , - , - , - , - , - , - , - , -	, , , , , , , ,	, 9	,	

Provider CCN: 14-0145

				10 06/30/2023 Date/Time Pre 1/24/2024 12:	
	Cost Center Description	Adjustments	Net Expenses	77 2 17 202 1 121	27 0
	·	(See A-8)	For		
			Allocation		
		6. 00	7. 00		
4 00	GENERAL SERVICE COST CENTERS	171 057	4 047 004		
1.00	00100 CAP REL COSTS-BLDG & FIXT	-171, 857			1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	-4, 615			2. 00 4. 00
5. 01	00540 NONPATIENT TELEPHONES	-2, 819, 727 0	1, 846, 198 88, 539		5. 01
5. 02	00550 DATA PROCESSING	0	00, 537		5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	-1, 368			5. 02
5. 04	00570 ADMITTING	212, 947	216, 205		5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		5. 05
5.06	00590 ADMIN & GENERAL	-5, 487, 547	8, 996, 516		5.06
7.00	00700 OPERATION OF PLANT	-32, 470	2, 190, 379		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	-9, 261	137, 216		8. 00
9. 00	00900 HOUSEKEEPI NG	0	853, 041		9. 00
10.00	01000 DI ETARY	0			10.00
11.00	01100 CAFETERI A	-25, 285			11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION	-28 0	1, 042, 927 0		13. 00 14. 00
15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	-1, 583	-		15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	581, 745			16.00
17. 00	01700 SOCI AL SERVI CE	0 0	0		17. 00
19. 00		-709, 483	o o		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-6, 851	2, 108, 257		30.00
31.00	03100 INTENSIVE CARE UNIT	0			31.00
43.00		0	218, 972		43.00
50.00	ANCILLARY SERVICE COST CENTERS	100 55/	0.004.700		
50.00	05000 OPERATING ROOM	-182, 556			50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0 1, 251, 737		51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	-244		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-3, 945			54.00
57. 00	05700 CT SCAN	0, 710	-1, 176		57.00
58. 00	05800 MRI	Ō	147, 101		58. 00
60.00	06000 LABORATORY	-9, 210	2, 716, 304		60.00
63.00	06300 BLOOD STORING PROCESSING & TRA	0	127, 505		63.00
65.00	06500 RESPI RATORY THERAPY	0	500, 048		65.00
66. 00	06600 PHYSI CAL THERAPY	-1, 702			66.00
69. 00	06900 ELECTROCARDI OLOGY	-10, 747	20, 763		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 363, 338 563, 998		71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	690, 662		73.00
76. 97		-1, 175			76. 97
	1	0			77. 00
	OUTPATIENT SERVICE COST CENTERS				
		-27, 425	7, 965, 233		88. 00
	09000 CLI NI C	0	1		90.00
	09001 CLI NI C	0			90. 01
90. 02		-7, 103			90.02
	09100 EMERGENCY	-1, 030, 016			91.00
91. 01	09101 PRIORITY CARE CARLYLE 09200 OBSERVATION BEDS (NON-DISTINCT	0	34, 505		91. 01 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS				92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
	SPECIAL PURPOSE COST CENTERS				
	11300 I NTEREST EXPENSE	0			113. 00
118.00	3 /	-9, 749, 262	45, 551, 909		118. 00
	NONREI MBURSABLE COST CENTERS				
	19200 PHYSICIANS PRIVATE OFFICES	0	1, 668, 403		192.00
	07950 LI FELI NE	0	0		194.00
	107951 DEVELOPMENT	0	00 250		194. 01
	2 07952 VACANT SPACE 3 07953 TRANSPORTATI ON		80, 350 48, 462		194. 02 194. 03
200.00		-9, 749, 262			200.00
	,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1, 3, .2 1		

Health Financial Systems RECLASSIFICATIONS ST. JOSEPHS HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 14-0145 Peri od: Worksheet A-6 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

					10	ate/lime Prepared: /24/2024 12:29 pm_
	Cost Center 2.00	Increases Line # 3.00	Sal ary 4.00	0ther 5.00		
4.00	A - NONPHYSICAN ANESTHETISTS					1.00
1. 00	NONPHYSI CI AN ANESTHETI STS 0	1900	0	70 <u>9, 4</u> 83 709, 483		1.00
1. 00	B - TO RECLASS CAFETERIA COST CAFETERIA O	1100	21 <u>8, 8</u> 94 218, 894	28 <u>6, 5</u> 94 286, 594		1.00
1. 00	D - RECLASS SOCIAL SERVICE SALA SOCIAL SERVICE	.RY 17. 00		O O		1.00
1. 00	E - PHARMACY RECLASS DRUGS CHARGED TO PATIENTS	73. 00	ol	690, 662		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 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 8. 00		0. 00 0. 00	o	0		7. 00 8. 00
9. 00		0. 00	Ö	0		9.00
10. 00	0	0.00	- — — 0	0 690, 662		10.00
1. 00	F - PLANT OP RECLASS OPERATION OF PLANT	7. 00	0	203, 284		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 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 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
8.00	0			203, 284		8.00
1. 00	G - TELEPHONE RECLASS NONPATIENT TELEPHONES	5. 01	0	21, 857		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4.00		0. 00	o	0		4.00
5. 00 6. 00		0. 00 0. 00	0	0 0		5. 00 6. 00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
	0 I - SUPPLY & IMPLANTS RECLASS		0	21, 857		
1.00	PHARMACY	15. 00	0	27, 097		1.00
2. 00	MEDICAL SUPPLIES CHARGED TO PAT	71. 00	0	2, 172, 813		2.00
3. 00 4. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00 0. 00	0	563, 998 0		3. 00 4. 00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7.00		0. 00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12.00		0. 00	0	0		12.00
13. 00 14. 00		0. 00 0. 00	0	0		13. 00 14. 00
15. 00 16. 00		0. 00 0. 00	o	0		15. 00 16. 00
10.00	0	0.00		2, 763, 908		10.00
1. 00	J - DEPRECIATION RECLASS CAP REL COSTS-BLDG & FIXT	1. 00	0	448, 924		1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00	0	1, 145, 661 0		2. 00 3. 00
4.00		0. 00	0	0		4. 00
5. 00 6. 00		0. 00 0. 00	0	0 0		5. 00 6. 00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0. 00	0	0		9. 00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12. 00		0. 00	0	0		12.00

Health Financial Systems RECLASSIFICATIONS ST. JOSEPHS HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 14-0145

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

						 1/24/2024 12:29 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17. 00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	O	0		21.00
22.00		0.00	O	0		22.00
23.00		0.00	O	0		23.00
24.00		0.00	О	0		24.00
25.00		0.00	О	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	O	0		27.00
	0 — — — — —			1, 594, 585		
	K - TO RECLASS INTEREST EXPER	NSE			1	
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	326, 764		1.00
2.00		0.00	o	. 0		2.00
3.00		0.00	o	0		3.00
4.00		0.00	o	0		4.00
	TOTALS			326, 764		
	L - SALARY CORRECTION RECLASS	S			•	
1.00	NURSERY	43.00	255, 648	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 246, 302	0		2.00
	0		1, 501, 950	$\frac{0}{0}$	1	
	P - OVERHEAD PHYSICIAN EXPENS	SES			"	
1.00	ADULTS & PEDIATRICS	30.00	0	7, 485		1.00
2. 00		0.00	o	0		2. 00
	TOTALS					
	R - RHC ADMTTTING PERSONNEL			.,		
1.00	ADMIN & GENERAL	5. 06	0	500, 455		1.00
	0			500, 455		
	S - ADVERTISING & SPONSORSHII	P RECLASS				
1.00	ADMIN & GENERAL	5. 06	0	132	ı	1.00
2. 00	Nomin W & GENERALE	0.00	0	0		2.00
2.00	TOTALS — — — —			<u></u> 132		2.00
	T - CCRHC-GTOWN CLOSING RECLA	ASS	<u> </u>	132	1	
1. 00	RADI OLOGY-DI AGNOSTI C	54.00	O	5, 000		1.00
2. 00	PHYSI CAL THERAPY	66. 00	0	11, 507		2.00
3. 00	VACANT SPACE	194. 02	0	65, 091		3.00
3.00	TOTALS	— — 1 74. 02	— — — ;	<u>05, 09 1</u> 81, 598		3.00
500 00	Grand Total: Increases		1, 721, 598	7, 186, 807		500.00
300.00	pranu rotar. Thereases	1	1, 121, 598	1, 180, 807	T .	J 500. 00

Health Financial Systems RECLASSIFICATIONS

	,				10	06/30/2023 Date/lime F 1/24/2024 1	
	Coat Contar	Decreases	Callany	Othor Wil	(at A 7 Daf		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther Wk	10.00		
	A - NONPHYSICAN ANESTHETISTS	7100	0, 00	71 00	10.00		
1.00	ANESTHESI OLOGY	<u>53.</u> 00		709, 483	0		1.00
	B - TO RECLASS CAFETERIA COST	Γ	0	709, 483			
1. 00	DI ETARY	10.00	218, 894	286, 594	0		1.00
	0 — — — — —		218, 894	286, 594			
	D - RECLASS SOCIAL SERVICE SA						
1. 00	ADMI N & GENERAL		<u>754</u> 754	0	0		1.00
	E - PHARMACY RECLASS		754	U			
1.00	PHARMACY	15. 00	0	656, 412	0		1.00
2.00	ADULTS & PEDIATRICS	30. 00	0	1, 611	0		2. 00
3.00	OPERATING ROOM	50.00	0	21, 087	0		3.00
4. 00 5. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52. 00 54. 00	0	1, 677 4, 558	0		4. 00 5. 00
6. 00	LABORATORY	60. 00	o	173	o		6.00
7.00	RESPI RATORY THERAPY	65. 00	0	394	0		7. 00
8. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	3, 082	0		8. 00
9. 00	PAT OUTPATIENT PSYCHIATRIC	90. 02	o	76	0		9. 00
10.00	EMERGENCY	91.00	o	1. 592	o		10.00
	0 — — — — —			690, 662			
1 00	F - PLANT OP RECLASS	22.25		=,,	al		
1. 00 2. 00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	0	566 168	0		1. 00 2. 00
3. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	168	0		3.00
4. 00	PHYSI CAL THERAPY	66.00	Ö	28	o		4.00
5.00	RURAL HEALTH CLINIC	88. 00	0	10, 743	0		5. 00
6. 00	EMERGENCY	91.00	0	232	0		6.00
7. 00 8. 00	PHYSICIANS PRIVATE OFFICES VACANT SPACE	192. 00 194. 02	0	175, 091 16, 288	0		7. 00 8. 00
0.00	0		0	203, 284	-		0.00
	G - TELEPHONE RECLASS						
1.00	ADMIN & GENERAL	5. 06	0	1, 953	0		1.00
2. 00 3. 00	OPERATION OF PLANT RADIOLOGY-DIAGNOSTIC	7. 00 54. 00	0	1, 577 35	0		2. 00 3. 00
4. 00	LABORATORY	60. 00	o	111	o		4.00
5.00	PHYSI CAL THERAPY	66. 00	O	258	0		5.00
6.00	RURAL HEALTH CLINIC	88. 00	0	3, 294	0		6.00
7. 00 8. 00	PHYSICIANS PRIVATE OFFICES TRANSPORTATION	192. 00 194. 03	0	13, 569 1, 060	0		7. 00 8. 00
0.00	0	174.03	 _	21, 857	-		0.00
	I - SUPPLY & IMPLANTS RECLASS						
1. 00 2. 00	ADULTS & PEDIATRICS NURSERY	30. 00 43. 00	0	142, 014 31, 861	0		1. 00 2. 00
3. 00	OPERATING ROOM	50. 00	0	2, 046, 385	0		3.00
4. 00	DELIVERY ROOM & LABOR ROOM	52. 00	Ö	36, 933	Ö		4. 00
5.00	ANESTHESI OLOGY	53. 00	0	15, 078	О		5.00
6. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	68, 686	0		6.00
7. 00 8. 00	CT SCAN MRI	57. 00 58. 00	0	9, 333 7, 670	0		7. 00 8. 00
9. 00	RESPI RATORY THERAPY	65. 00	Ö	113, 674	ő		9. 00
10.00	PHYSI CAL THERAPY	66. 00	0	179, 999	0		10.00
11.00	ELECTROCARDI OLOGY	69.00	0	641	0		11.00
12. 00 13. 00	ELECTROENCEPHALOGRAPHY CARDI AC REHABI LI TATI ON	70. 00 76. 97	0	73 2, 218	0		12. 00 13. 00
14. 00	OUTPATIENT PSYCHIATRIC	90. 02	Ö	302	ő		14. 00
15.00	EMERGENCY	91. 00	0	105, 761	0		15.00
16. 00	PRI ORI TY CARE CARLYLE	91.01	0	3, 280	0		16. 00
	U - DEPRECIATION RECLASS		0	2, 763, 908			+
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 492	9		1.00
2.00	ADMITTING	5. 04	O	1, 823	9		2. 00
3.00	ADMIN & GENERAL	5.06	0	274, 477	0		3.00
4. 00 5. 00	OPERATION OF PLANT DIETARY	7. 00 10. 00	0	68, 912 3, 976	0		4. 00 5. 00
6. 00	NURSING ADMINISTRATION	13. 00	0	3, 976	0		6.00
7.00	PHARMACY	15. 00	ō	767	o		7. 00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	339	0		8.00
9. 00 10. 00	SOCIAL SERVICE ADULTS & PEDIATRICS	17. 00 30. 00	0	645 63, 776	0		9. 00 10. 00
10.00	NURSERY	43. 00	0	433	0		11.00
12. 00	OPERATING ROOM	50. 00	O	195, 255	О		12. 00
13. 00	DELIVERY ROOM & LABOR ROOM	52. 00	o	7, 876	О		13.00

Health Financial Systems		ST. JOSEPHS	ST. JOSEPHS HOSPITAL			In Lieu of Form CMS-2552-1		
	SIFI CATIONS			Provi der (CCN: 14-0145	Peri od:	Worksheet A-	6
						From 07/01/2022	Data (Time D	
						To 06/30/2023	Date/Time Pr 1/24/2024 12	epared: · 29 nm
		Decreases					, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7 7 7
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Rei	÷.		
	6. 00	7. 00	8. 00	9. 00	10.00			
14.00	ANESTHESI OLOGY	53. 00	0	19, 508		0		14.00
15.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	178, 903		0		15.00
16.00	CT SCAN	57. 00	0	32, 767		0		16. 00
17.00	MRI	58. 00	0	29		0		17.00
18.00	LABORATORY	60.00	0	68, 659		0		18. 00
19.00	RESPI RATORY THERAPY	65. 00	0	5, 633		0		19.00
20.00	PHYSI CAL THERAPY	66. 00	0	7, 631		0		20.00
21. 00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	22, 820		0		21.00
22.00	CARDIAC REHABILITATION	76. 97	0	7, 339		0		22. 00
23.00	RURAL HEALTH CLINIC	88. 00	0	381, 748		0		23. 00
24.00	EMERGENCY	91.00	0	23, 235		0		24.00
25.00	PRIORITY CARE CARLYLE	91. 01	0	624		0		25. 00
26.00	PHYSICIANS PRIVATE OFFICES	192. 00	0	220, 606		0		26. 00
27.00	VACANT SPACE	194. 02	0	5, 272		0		27. 00
	0		0	1, 594, 585				
	K - TO RECLASS INTEREST EXPE	NSE						
1. 00	PURCHASING RECEIVING AND	5. 03	0	74	-	11		1. 00
	STORES							
2. 00	RURAL HEALTH CLINIC	88. 00	0	535		0		2.00
3. 00	PRIORITY CARE CARLYLE	91. 01	0	237		0		3. 00
4. 00	INTEREST EXPENSE	113.00	•	325, 918		<u>o</u> l		4. 00
	TOTALS		0	326, 764				_
4 00	L - SALARY CORRECTION RECLAS		4 504 050					1 00
1.00	ADULTS & PEDIATRICS	30.00	1, 501, 950	0		0		1.00
2.00		0.00	0	$ \frac{0}{0}$		Ō		2. 00
	P - OVERHEAD PHYSICIAN EXPEN:	CEC	1, 501, 950	0				
1. 00	ADMIN & GENERAL	5. 06	O	2, 550		0		1.00
2. 00	•	l I		4, 935				2.00
2.00	PHARMACY	1500				<u> </u>		2.00
	R - RHC ADMTTTING PERSONNEL		U	7, 485				-
1. 00	RURAL HEALTH CLINIC	88. 00		500, 455		0		1.00
1.00	O LINIC		0	<u>500, 455</u> 500, 455		4		1.00
	S - ADVERTISING & SPONSORSHI	D DECLASS	UU	300, 433				
1. 00	OPERATION OF PLANT	7.00	O	109		0		1.00
2. 00	OPERATING ROOM	50.00		23		0		2.00
2.00	TOTALS	30.00				9		2.00
	T - CCRHC-GTOWN CLOSING RECL	L	<u> </u>	132				
1. 00	RURAL HEALTH CLINIC	88. 00	O	81, 598		0		1.00
2. 00	INDIVIDE HEALTH OF INIO	0.00	0	01, 340		0		2.00
3. 00		0.00	0	0		o l		3. 00
3. 00	TOTALS — — — —	- 0.00	— —)	 81, 598		7		3.00
500 00	Grand Total: Decreases		1, 721, 598	7, 186, 807				500.00
300.00	por and Total . Decircuses	I I	1, 721, 570	7, 100, 007	I	I		1 300. 00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS ST. JOSEPHS HOSPITAL

Period: Worksheet A-7
From 07/01/2022 Part I Provider CCN: 14-0145

				-	To 06/30/2023	Date/Time Pre 1/24/2024 12:	pared: 29 pm
				Acqui si ti ons	•		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	1, 704, 211	0	(0 (0	1.00
2.00	Land Improvements	5, 059, 795	23, 568		0 23, 568		2.00
3.00	Buildings and Fixtures	52, 978, 116	1, 011, 976	(0 1, 011, 976		3.00
4.00	Building Improvements	1, 146, 389	0	(0	95, 997	4.00
5.00	Fi xed Equipment	0	0	(0	0	5.00
6.00	Movable Equipment	29, 160, 081	2, 333, 051	(0 2, 333, 051	0	6. 00
7. 00	HIT designated Assets	0	0	(0 (0	7.00
8.00	Subtotal (sum of lines 1-7)	90, 048, 592	3, 368, 595	(3, 368, 595		8. 00
9.00	Reconciling Items	1, 403, 287	0	(0 (106, 546	9. 00
10.00	Total (line 8 minus line 9)	88, 645, 305	3, 368, 595	(3, 368, 595	-10, 549	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		_				
1. 00	Land	1, 704, 211	0				1.00
2.00	Land Improvements	5, 083, 363	0				2.00
3. 00	Buildings and Fixtures	53, 990, 092	0				3.00
4. 00	Building Improvements	1, 050, 392	0				4.00
5.00	Fi xed Equi pment	0	0				5.00
6. 00	Movable Equipment	31, 493, 132	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	93, 321, 190	0				8.00
9.00	Reconciling Items	1, 296, 741	0				9.00
10. 00	Total (line 8 minus line 9)	92, 024, 449	0				10.00

Heal th	n Financial Systems	ST. JOSEPHS	HOSPI TAL		In Lieu of Form CMS-2552-10			
	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 14-0145	Period: From 07/01/2022	Worksheet A-7		
						Date/Time Pre 1/24/2024 12:		
			SU	IMMARY OF CAP	ITAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
					,	instructions)		
					instructions)			
		9. 00	10. 00	11. 00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FLXT	1, 314, 150	0		0	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00	
3.00	Total (sum of lines 1-2)	1, 314, 150	0		0 0	0	3.00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	Other	Total (1)					
	·	Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)	,					
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 314, 150				1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
0 00	T. I. I. (C. I 1. O.)	1	4 044 450				2 22	

0 0 0

1, 314, 150

1.00 2.00 3.00

3.00 Total (sum of lines 1-2)

Health Financial Systems	ST. JOSEPHS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 07/01/2022 To 06/30/2023	Worksheet A-7 Part III Date/Time Prep 1/24/2024 12:2	
	COMF	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	·
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1. 00	2.00	col . 2) 3.00	4.00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT	61, 828, 058		61, 828, 05	0. 662530	0	1. 00
2. 00 CAP REL COSTS-MVBLE EQUIP	31, 493, 132	l .				2. 00
3.00 Total (sum of lines 1-2)	93, 321, 190		93, 321, 19			3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
·		Capi tal -Rel at	col s. 5	'		
		ed Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1. 00 CAP REL COSTS-BLDG & FIXT	0	1	ł	0 1, 917, 981	0	1. 00
2. 00 CAP REL COSTS-MVBLE EQUIP	0	1)	0 1, 141, 046		2.00
3.00 Total (sum of lines 1-2)	0		<u>l</u> JMMARY OF CAPI	3, 059, 027	0	3. 00
		50	JININARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
·		(see	instructions)	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C			·I		1 017 001	
1.00 CAP REL COSTS-BLDG & FIXT	0		1	0	1, 917, 981	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	1	1	0 0	1, 141, 046	2.00
3.00 Total (sum of lines 1-2)	1	ı	'I	U _I U	3, 059, 027	3. 00

From 07/01/2022 06/30/2023 Date/Time Prepared: 1/24/2024 12:29 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL -326, 764 CAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) OCAP REL COSTS-MVBLE EQUIP 2.00 Investment income - CAP REL 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 5.00 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0 00 7.00 stations excluded) (chapter 8.00 Television and radio service -3, 734 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 -1, 248, 895 10.00 Provi der-based physici an 10.00 A-8-2 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization -382, 829 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 13.00 Laundry and linen service 0.00 Cafeteria-employees and guests -25, 285 CAFETERI A 14.00 11.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 В 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than В 0.00 17.00 pati ents Sale of medical records and OMEDICAL RECORDS & LIBRARY 18.00 R 16.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY 24.00 A - 8 - 366.00 therapy costs in excess of limitation (chapter 14) Utilization review 0 *** Cost Center Deleted *** 25.00 25.00 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant -709, 483 NONPHYSI CI AN ANESTHETI STS 28.00 19.00 Α 28.00 29 00 0.00 29 00 Adjustment for occupational 0 *** Cost Center Deleted *** 30.00 30.00 A-8-3 67.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions)

Provider Con: 14-0145 | Worksheet A-8 | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared:

				'	0 00/30/2023	1/24/2024 12:	
				Expense Classification on	Worksheet A		•
				To/From Which the Amount is			
Cos	t Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	,	(2)				Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
31.00 Adjustmer	nt for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31.00
	costs in excess of						
	on (chapter 14)						
	Adjustment for		0		0. 00	0	32.00
	tion and Interest						
	PENSION ADJUSTMENT	A	-508, 391	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33.00
	NEOUS INCOME	В		PURCHASING RECEIVING AND	5. 03	0	33. 01
			,	STORES			
33. 02 MI SCELLAN	NEOUS INCOME	В	44, 395	ADMIN & GENERAL	5. 06	0	33. 02
	NEOUS INCOME	В		OPERATION OF PLANT	7. 00	0	33. 03
	NEOUS INCOME	В		PHYSI CAL THERAPY	66. 00	0	33. 04
	NEOUS INCOME	B		RURAL HEALTH CLINIC	88. 00	0	33. 05
	NEOUS INCOME	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	33.06
•	NEOUS INCOME	B		ADULTS & PEDIATRICS	30. 00	0	33. 07
33. 08 LOBBYI NG		A		ADMIN & GENERAL	5. 06	0	33. 08
	& COMMUNITY BENEFIT	A		ADMIN & GENERAL	5. 06	0	33. 09
SALARY	a comment it better it		0,000	A SENERALE	0.00	Ü	00.07
	& COMMUNITY BENEFIT	A	-544	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 10
BENEFI	, a comment :: BENE: : :	, ,	0	Emileo de Bener Pro Berviit ment	00	ŭ	00.10
	& COMMUNITY BENEFIT	A	-147 537	ADMIN & GENERAL	5. 06	0	33. 11
OTHER	, a comment :	,,	117,007	A SENERULE	0.00	ŭ	00
33. 12 MEDI CAI D	PROVI DER TAX	A	-2, 320, 401	ADMIN & GENERAL	5. 06	0	33. 12
33. 13 ALCOHOL E		A		ADMIN & GENERAL	5. 06	0	33. 13
	SELF-I NSURANCE	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	35.00
	TAX OFFSET	A	·	ADMIN & GENERAL	5. 06	0	35. 01
	VABLE EXPENSE	A		ADMIN & GENERAL	5. 06	0	36.00
37. 00 BUI LDI NG		A		CAP REL COSTS-BLDG & FLXT	1. 00	9	37.00
•	RELIFING	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	38.00
39. 00 RENTAL IN		B		OPERATION OF PLANT	7. 00	Ó	39.00
39. 01 HSHS MED		A		ADMIN & GENERAL	5. 06	0	39. 01
•	JRSABLE EXPENSE	Ä		ADMIN & GENERAL	5. 06 5. 06	0	39. 02
	JRSABLE EXPENSE	A		NURSING ADMINISTRATION	13. 00	0	39.02
	RECRUITMENT EXPENSE	A		ADMIN & GENERAL	5. 06	0	39.03
	P RHC ADVERTISING	A		RURAL HEALTH CLINIC	88. 00	0	39.04
	ım of lines 1 thru 49)		-9, 749, 262		88.00	U	50.00
	to Worksheet A,		-7, 147, 202				30.00
	line 200.)						
•	all chapter referen	l	lump pontoin t	- CMC Dub. 1E 1			

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

OFFICE COSTS

Provider CCN: 14-0145

Worksheet A-8-1 From 07/01/2022

				To 06/30/2023	Date/Time Pre 1/24/2024 12:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	27 piii
			'	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	F TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1. 00	•	EMPLOYEE BENEFITS DEPARTMENT				1. 00
2. 00	•		INFORMATION SYSTEMS ISC M	2, 529, 637	1, 900, 548	2.00
3.00	•		CASHI ER/AR SB0	813, 670	0	3.00
4. 00	5. 04	ADMITTI NG	ADMITTING SBO	212, 947	0	4.00
4. 01	5. 06	ADMIN & GENERAL	ADMI N-SBO	0	2, 804, 940	4. 01
4. 02	16.00	MEDICAL RECORDS & LIBRARY	MED REC-SBO	581, 745	0	4. 02
4.03	4. 00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS - HUMAN RE	85, 190	274, 151	4.03
4.04	5. 06	ADMIN & GENERAL	ADMIN CONTRACTED SVCS	1, 456, 264	1, 874, 568	4.04
4.05	5. 06	ADMIN & GENERAL	ADMIN PURCHASED SVCS	0	117, 735	4.05
4.06	5. 06	ADMIN & GENERAL	IL - A&G	533, 526	684, 047	4.06
4. 07	15. 00	PHARMACY	IL - SHARED PHARMACIST	63, 515	65, 098	4.07
4. 08	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	137, 216	146, 477	4. 08
4.09	5. 06	ADMIN & GENERAL	IL - LIBRARY	14, 488	16, 271	4.09
4. 10	5. 06	ADMIN & GENERAL	RHC - MED GROUP MANAGEMENT F	1, 073, 813	ı o	4. 10
5.00	TOTALS (sum of lines 1-4).			10, 656, 827	11, 039, 656	5.00
	Transfer column 6, line 5 to				1	
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office	
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	TED 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	100. 00 HSHS 100. 0	6.00
7. 00		0.00	7.00
8. 00		0.00	8.00
9. 00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

Heal th I	Financial Syste	ems		ST. JOSEPH	S HOSPITAL		In Lie	u of Form CMS	-2552-10
STATEME OFFICE		SERVICES FROM	RELATED ORGAN	IIZATIONS AND HO	ME Provider	CCN: 14-0145	Peri od: From 07/01/2022 To 06/30/2023	Worksheet A- Date/Time Pr 1/24/2024 12	epared:
	Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref. 7.00			'				
	A. COSTS INCUR OFFICE COSTS:	RED AND ADJUSTM	MENTS REQUIRED) AS A RESULT OF	TRANSACTI ONS	WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
1. 00 2. 00 3. 00 4. 00 4. 01 4. 02 4. 03 4. 04 4. 05 4. 06 4. 07 4. 08 4. 09	-1, 005 629, 089 813, 670 212, 947 -2, 804, 940 581, 745 -188, 961 -418, 304 -117, 735 -150, 521 -1, 583 -9, 261 -1, 783	0 0 0 0 0 0 0							1. 00 2. 00 3. 00 4. 00 4. 01 4. 02 4. 03 4. 04 4. 05 4. 06 4. 07 4. 08 4. 09
4. 10	1, 073, 813	1 0							4. 10

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

5.00

1103 110	t been posted to worksheet A,	cordinas i and/or 2, the amount arrowable should be mareated in cordina 4 or this part	·
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	CORPORATE OFFICE		6.00
7.00			7.00
8.00			8.00
9. 00 10. 00			9.00
10.00		1	10.00
100.00		10	00.00

- (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.
- 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.

5.00

-382, 829

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0145

Peri od: Worksheet A-8-2 From 07/01/2022 06/30/2023 Date/Time Prepared:

1/24/2024 12:29 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er der Component Remuneration Component Component Hours 1.00 3. 00 5.00 2 00 4 00 6 00 7 00 1.00 30. 00 ADULTS & PEDIATRICS 22, 989 2, 250 20, 739 211,500 171 1.00 2.00 50. 00 OPERATING ROOM 182, 556 182, 556 246, 400 0 2.00 1, 300 3.00 54. 00 RADI OLOGY-DI AGNOSTI C 1, 300 239, 400 0 3.00 60. 00 LABORATORY 70, 030 260, 300 486 4.00 4 00 70.030 0 5.00 66. 00 PHYSI CAL THERAPY 8,000 Ω 8,000 211, 500 67 5.00 6.00 69. 00 ELECTROCARDI OLOGY 10, 747 211, 500 10, 747 0 6.00 7.00 76. 97 CARDIAC REHABILITATION 1, 988 1, 988 211, 500 8 7.00 0 90. 02 OUTPATIENT PSYCHIATRIC 8.00 147 8.00 22,050 0 22,050 211, 500 9.00 91. 00 EMERGENCY 1, 030, 016 1, 030, 016 211, 500 0 9.00 10.00 0.00 0 10.00 1, 349, 676 879 122, 807 200.00 200.00 1, 226, 869 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Li mi t Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col Insurance Education 12.00 12 1.00 2.00 8. 00 9.00 13.00 14. 00 1.00 30. 00 ADULTS & PEDIATRICS 17, 388 869 0 1.00 2.00 50. 00 OPERATING ROOM 0 0 0 2.00 0 3.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 3.00 0 0 0 0 60. 00 LABORATORY 3.041 4 00 60.820 4 00 5.00 66. 00 PHYSI CAL THERAPY 6,813 341 0 0 5.00 69. 00 ELECTROCARDI OLOGY 0 6.00 0 0 0 0 6.00 0 76. 97 CARDIAC REHABILITATION 0 0 7 00 813 41 7 00 90. 02 OUTPATIENT PSYCHIATRIC 0 8.00 14, 947 747 0 8.00 9.00 91. 00 EMERGENCY 0 0 9.00 0 0 10.00 0.00 0 0 0 10.00 100, 781 o 5,039 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Li mi t Di sal I owance Share of col. 14 1.00 17.00 18.00 2.00 15.00 16.00 1.00 30. 00 ADULTS & PEDIATRICS 0 17, 388 3, 351 5, 601 1.00 50. 00 OPERATING ROOM 0 182, 556 2.00 0 2.00 3.00 54. OORADI OLOGY-DI AGNOSTI C 0 3.00 1 300 0 0 60. 00 LABORATORY 4.00 60,820 9, 210 9, 210 4.00 5.00 66. 00 PHYSI CAL THERAPY 0 6, 813 1, 187 1, 187 5.00 6.00 69. 00 ELECTROCARDI OLOGY 0 10,747 6.00 0 76. 97 CARDIAC REHABILITATION 0 1, 175 7 00 813 1 175 7 00 90. 02 OUTPATIENT PSYCHIATRIC 0 8.00 14, 947 7, 103 7, 103 8.00 9.00 91. 00 EMERGENCY o 0 1, 030, 016 9.00 0 10.00 0.00 10.00

100, 781

22, 026

1, 248, 895

200.00

200.00

Period: Worksheet B From 07/01/2022 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 14-0145

					To	o 06/30/2023	Date/Time Pre	pared:
				CAPLTAL RE	LATED COSTS		1/24/2024 12:	29 pm
		Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	NONPATI ENT	
			for Cost Allocation			BENEFITS DEPARTMENT	TELEPHONES	
			(from Wkst A			DEFAITIMENT		
			col. 7)					
	CENED	AL CEDIVICE COST CENTERS	0	1.00	2. 00	4. 00	5. 01	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	1, 917, 981	1, 917, 981				1. 00
2. 00	00200	CAP REL COSTS-MVBLE EQUIP	1, 141, 046		1, 141, 046			2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	1, 846, 198		1, 596	1, 851, 721		4. 00
5. 01		NONPATIENT TELEPHONES DATA PROCESSING	88, 539	0	0	0	88, 539 0	5. 01 5. 02
5. 02 5. 03		PURCHASING RECEIVING AND STORES	242, 116	28, 492	0	12, 932	640	5. 02
5. 04		ADMI TTI NG	216, 205	31, 459		0	640	5. 04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	_	0	0	5. 05
5. 06 7. 00		ADMIN & GENERAL OPERATION OF PLANT	8, 996, 516 2, 190, 379	489, 734 134, 028		58, 586 62, 171	14, 586 2, 943	5. 06 7. 00
8. 00		LAUNDRY & LINEN SERVICE	137, 216	32, 131		02, 171	128	8. 00
9. 00	00900	HOUSEKEEPI NG	853, 041	15, 854		63, 076	896	9. 00
10.00		DI ETARY	109, 659			6, 095	1, 024	10.00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	480, 203 1, 042, 927	17, 181 5, 391		28, 030 125, 917	0 640	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	1,042,927	5, 391		125, 917	040	14.00
15. 00	1	PHARMACY	558, 190	_	_	60, 250	640	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	581, 783	10, 526		0	3, 838	16. 00
17. 00 19. 00		SOCIAL SERVICE	0	1, 784 0		0	768 0	17. 00 19. 00
19.00		NONPHYSICIAN ANESTHETISTS LENT ROUTINE SERVICE COST CENTERS	0	0	0	U	U	19.00
30.00	03000	ADULTS & PEDIATRICS	2, 108, 257	126, 349	43, 017	251, 381	16, 249	30. 00
31.00		INTENSIVE CARE UNIT	0	0	-	0	0	31.00
43. 00		NURSERY LARY SERVICE COST CENTERS	218, 972	7, 727	463	32, 737	0	43.00
50. 00		OPERATING ROOM	2, 004, 732	156, 280	238, 314	201, 873	6, 269	50. 00
51.00		RECOVERY ROOM	0	0	0	0	0	51.00
52.00		DELIVERY ROOM & LABOR ROOM	1, 251, 737	25, 772		159, 665	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	-244 1, 383, 220	1, 552 31, 843		0 134, 244	128 2, 815	53. 00 54. 00
57. 00		CT SCAN	-1, 176	3, 671		0	2, 013	57. 00
58.00	05800		147, 101	5, 807		10, 950	0	58. 00
60.00	1	LABORATORY	2, 716, 304	17, 645 0		143, 358	2, 431	60. 00 63. 00
63. 00 65. 00		BLOOD STORING PROCESSING & TRA RESPIRATORY THERAPY	127, 505 500, 048	8, 679	_	63, 827	0 1, 407	65.00
66. 00		PHYSI CAL THERAPY	1, 507, 265	76, 356		185, 688	3, 199	
69. 00	1	ELECTROCARDI OLOGY	20, 763	0	0	1, 543	0	69.00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PAT	0 2, 363, 338	0 6, 783	0 24, 415	0 11, 843	0	70. 00 71. 00
71.00	1	IMPL. DEV. CHARGED TO PATIENTS	563, 998	0, 783		11, 643	0	71.00
73.00		DRUGS CHARGED TO PATIENTS	690, 662	0	0	0	0	73. 00
		CARDI AC REHABI LI TATI ON	170, 854				512	
77. 00		ALLOGENEIC HSCT ACQUISITION TIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
88. 00		RURAL HEALTH CLINIC	7, 965, 233	194, 091	111, 264	16, 719	0	88. 00
90.00		CLINIC	0	0	0	0	0	90. 00
90. 01		CLINIC	0	12 242	0	0	1 525	90. 01
90. 02 91. 00		OUTPATIENT PSYCHIATRIC EMERGENCY	224, 065 1, 152, 771	12, 262 43, 801		26, 063 139, 344	1, 535 2, 303	90. 02 91. 00
91. 01		PRI ORI TY CARE CARLYLE	34, 505	0		0	0	91. 01
92.00		OBSERVATION BEDS (NON-DISTINCT						92.00
102.00	OTHER	REIMBURSABLE COST CENTERS OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
102.00		AL PURPOSE COST CENTERS	0	0	0	U	0	102.00
113.00		INTEREST EXPENSE						113. 00
118.00	-	SUBTOTALS (SUM OF LINES 1 through 117)	45, 551, 909	1, 540, 822	1, 112, 408	1, 817, 666	63, 591	118. 00
192 00		IMBURSABLE COST CENTERS PHYSICIANS PRIVATE OFFICES	1, 668, 403	266, 472	28, 638	29, 975	24, 948	192 00
194.00	07950	LI FELI NE	0 ., 555, 405	200, 472	0	27, 773	0	194.00
		DEVELOPMENT	0	0	0	0		194. 01
		VACANT SPACE TRANSPORTATION	80, 350 48, 462		0	0 4, 080		194. 02 194. 03
200.00		Cross Foot Adjustments	40, 402	١		4, 080		200. 00
201.00		Negative Cost Centers		0	0	О	0	201. 00
202.00)	TOTAL (sum lines 118 through 201)	47, 349, 124	1, 917, 981	1, 141, 046	1, 851, 721	88, 539	202. 00

Peri od: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared: 1/24/2024 12:29 pm

						1/24/2024 12:	29 pm
	Cost Center Description	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMITTI NG	CASHI ERI NG/AC COUNTS RECEI VABLE	Subtotal	
		5. 02	5. 03	5. 04	5. 05	5A. 05	
	GENERAL SERVICE COST CENTERS	3. 02	3.03	3.04	5.05	JA. 03	
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 17. 00	GENERAL SERVICE COST CENTERS O0100	0 0 0 0 0 0 0 0 0 0 0	284, 180 161 0 3, 649 5, 375 0 1, 065 0 0 0 0 0	250, 415 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	9, 801, 183 2, 465, 243 169, 475 933, 932 148, 044 525, 414 1, 175, 184 0 628, 798 596, 512 3, 242	8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>		<u> </u>		17.00
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	0 0 0	0	7, 044 0 1, 385	0	2, 556, 712 0 261, 520	31.00
FO 00	ANCILLARY SERVICE COST CENTERS		0.1/0	20 777	ما	2 (4(414	F0 00
90. 01 90. 02 91. 00 91. 01	09000 CLI NI C 09001 CLI NI C 09002 OUTPATI ENT PSYCHI ATRI C 09100 EMERGENCY 09101 PRI ORI TY CARE CARLYLE	000000000000000000000000000000000000000	0 241 136 3, 409 2, 243 207 32, 211 6, 285 165 543 430 0 111, 247 27, 801 34, 044 154 0 0 0 38 698	30, 777 0 6, 752 7, 613 25, 796 32, 689 9, 570 46, 944 1, 134 3, 067 13, 213 3, 449 0 5, 347 3, 832 12, 249 337 0 17, 819 0 907 20, 449 42	0 0 0 0 0 0 0 0 0 0 0	0 0 264, 870 1, 399, 123 34, 550	51. 00 52. 00 53. 00 54. 00 57. 00 60. 00 63. 00 66. 00 70. 00 71. 00 72. 00 73. 00 76. 97 77. 00 88. 00 90. 01 90. 02 91. 00 91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS					0	92.00
	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
113. 00 118. 00	11300 NTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	283, 047	250, 415	0	45, 085, 976	113. 00 118. 00
194. 00 194. 00 194. 02	D 19200 PHYSICIANS PRIVATE OFFICES D 07950 LIFELINE 1 07951 DEVELOPMENT 2 07952 VACANT SPACE 3 07953 TRANSPORTATION Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0	0 0 0 5	0 0 0 0 0 0 250, 415	0 0 0 0 0	0 191, 037 52, 547 0 0	194. 00 194. 01 194. 02 194. 03 200. 00 201. 00

				11	0 06/30/2023	Date/IIme Pre 1/24/2024 12:	
	Cost Center Description	ADMIN &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	p
		GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
	GENERAL SERVICE COST CENTERS	5. 06	7. 00	8. 00	9. 00	10. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATIENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5.03	00560 PURCHASING RECEIVING AND STORES						5. 03
5.04	00570 ADMITTING						5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 ADMIN & GENERAL	9, 801, 183					5.06
7. 00	00700 OPERATION OF PLANT	643, 505	3, 108, 748				7. 00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	44, 238	81, 187	294, 900	4 047 775		8.00
9.00	00900 HOUSEKEEPI NG	243, 785	40, 058		1, 217, 775	074 447	9.00
10.00	01000 DI ETARY	38, 644	68, 252	0	16, 476	271, 416	1
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	137, 149 306, 759	43, 413 13, 622	0	0 220	0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	300, 739	13, 622] 0 0	8, 238	0	14.00
15. 00	01500 PHARMACY	164, 136	21, 626	0	30, 205	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	155, 708	26, 597	0	5, 492	0	16.00
17. 00	01700 SOCIAL SERVICE	846	4, 507	o o	5, 492	0	17.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	-		- 1		
30.00	03000 ADULTS & PEDIATRICS	667, 381	319, 250	129, 169	214, 184	240, 239	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300 NURSERY	68, 265	19, 524	0	16, 476	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	690, 796	394, 879	61, 447	197, 709	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	378, 742	65, 119	0	10, 984	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	11, 029 469, 711	3, 921 80, 459	36, 324	60, 411	0	53. 00 54. 00
57. 00	05700 CT SCAN	9, 770	9, 277	0 30, 324	10, 984	0	57.00
58. 00	05800 MRI	45, 332	14, 673		5, 492	0	58.00
60.00	06000 LABORATORY	786, 792	44, 585	112	19, 222	0	60.00
63. 00	06300 BLOOD STORING PROCESSING & TRA	35, 219	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	152, 371	21, 929	0	10, 984	0	65.00
66.00	06600 PHYSI CAL THERAPY	468, 575	192, 933	5, 190	19, 222	0	66.00
69.00	06900 ELECTROCARDI OLOGY	6, 835	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	658, 574	17, 139	0	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	155, 478	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	192, 368	0	0	0	0	73.00
76. 97	07697 CARDIAC REHABILITATION	56, 674	40, 745		10, 984	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	2, 178, 377	490, 416	847	141, 362	0	88. 00
90.00	09000 CLINIC	2, 170, 377	470, 410	047	141, 302	0	90.00
	09001 CLI NI C	Ö	0	0	0	0	
		69, 139	30, 983	Ō	o	0	90. 02
91.00	09100 EMERGENCY	365, 214	110, 674		109, 838	10, 492	91.00
91. 01	09101 PRI ORI TY CARE CARLYLE	9, 019	0	0	5, 492	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113.00
118.00	5 /	9, 210, 431	2, 155, 768	282, 688	899, 247	250, 731	118.00
400.00	NONREI MBURSABLE COST CENTERS	F07.4(0	(70,000	40.040	240 500	20 (05	100 00
	19200 PHYSICIANS PRIVATE OFFICES	527, 169	673, 303	12, 212	318, 528	20, 685	
	007950 LI FELI NE 107951 DEVELOPMENT	0	0		0		194. 00 194. 01
	207952 VACANT SPACE	49, 867	279, 677	0	0		194.01
	3 07953 TRANSPORTATION	13, 716	279, U//	0	0		194. 02
200. 00		13, 710	J		٩	O	200.00
201.00		0	0	0	n	0	201.00
202.00		9, 801, 183	3, 108, 748	294, 900	1, 217, 775	271, 416	
						•	

Peri od: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Ti me Prepared: 1/24/2024 12:29 pm

				00/30/2023	1/24/2024 12:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	•
		ADMI NI STRATI O	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS				,		
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00540 NONPATI ENT TELEPHONES						5. 01
5. 02 00550 DATA PROCESSING 5. 03 00560 PURCHASING RECEIVING AND STORES						5. 02 5. 03
5. 04 00570 ADMI TTI NG						5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06 00590 ADMI N & GENERAL						5.06
7.00 OO700 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	705 074					10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	705, 976 36, 322	1, 540, 125				11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	30, 322	1, 540, 125	0			14.00
15. 00 01500 PHARMACY	17, 530	84, 413	Ö	946, 708		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	784, 309	16.00
17. 00 01700 SOCIAL SERVICE	o	0	0	0	0	17.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
INPATIENT ROUTINE SERVICE COST CENTERS	404 044	===1		20	70/ 0//	
30. 00 03000 ADULTS & PEDI ATRI CS	106, 361	511, 664	0	23	706, 864	30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	11, 755	56, 573	0	0 341	0 44, 777	31. 00 43. 00
ANCILLARY SERVICE COST CENTERS	11, 755	50, 573	U	341]	44,777	43.00
50. 00 05000 OPERATING ROOM	72, 196	347, 182	0	371	5, 069	50. 00
51.00 05100 RECOVERY ROOM	O	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	57, 513	276, 556	0	0	7, 885	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	52, 754	0	0	0	282	54.00
57. 00 05700 CT SCAN	0	0	0	0	0	57.00
58. 00 05800 MRI 60. 00 06000 LABORATORY	4, 149 75, 125	0	0	0	0 282	58. 00 60. 00
63. 00 06300 BLOOD STORING PROCESSING & TRA	75, 125	0	0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	26, 926	ő	Ö	o	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	85, 578	0	0	0	1, 126	66.00
69. 00 06900 ELECTROCARDI OLOGY	651	3, 179	0	0	282	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	8, 908	0	0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	455 170	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDI AC REHABILI TATION	7, 972	38, 402	0	455, 179	0	73. 00 76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	7, 972	30, 402	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS		<u> </u>	<u> </u>	<u> </u>		77.00
88. 00 08800 RURAL HEALTH CLINIC	66, 014	0	0	490, 794	0	88. 00
90. 00 09000 CLINIC	0	o	0	0	0	90.00
90. 01 09001 CLI NI C	0	0	0	0	0	90. 01
90. 02 09002 OUTPATI ENT PSYCHI ATRI C	9, 802	0	0	0	0	90. 02
91. 00 09100 EMERGENCY	46, 205	222, 156	0	0	17, 742	91.00
91. 01 09101 PRI ORI TY CARE CARLYLE 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT	U	O	0	U	0	91. 01 92. 00
OTHER REIMBURSABLE COST CENTERS						92.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	-,	-,	-,	-1		
113. 00 11300 NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	685, 761	1, 540, 125	0	946, 708	784, 309	118. 00
NONREI MBURSABLE COST CENTERS		_1	_1			
192. 00 19200 PHYSICIANS PRIVATE OFFICES	16, 514	0	0	0		192.00
194. 00 07950 LI FELI NE 194. 01 07951 DEVELOPMENT	0	0	0	0		194. 00 194. 01
194. 01 07951 DEVELOPMENT 194. 02 07952 VACANT SPACE	0	0	0	0		194. 01 194. 02
194. 03 07953 TRANSPORTATI ON	3, 701	ol O	0	0		194. 02
200.00 Cross Foot Adjustments	2, . 0 .	Ĭ	J	٦		200. 00
201.00 Negative Cost Centers	o	o	0	О		201. 00
202.00 TOTAL (sum lines 118 through 201)	705, 976	1, 540, 125	0	946, 708	784, 309	202. 00

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0145 Peri od: Worksheet B From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 12:29 pm Cost Center Description SOCI AL NONPHYSI CI AN Subtotal Intern & Total SERVI CE **ANESTHETISTS** Resi dents Cost & Post Stepdown Adjustments 17. 00 19.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00590 ADMIN & GENERAL 5.06 5.06 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 14.087 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 14, 087 5, 465, 934 5, 465, 934 30.00 31 00 03100 INTENSIVE CARE UNIT C 0 31 00 0 0 0 43.00 04300 NURSERY 0 0 479, 231 0 479, 231 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 50.00 4, 416, 063 4, 416, 063 05100 RECOVERY ROOM 0 51 00 Ω 0 51 00 0 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 2, 247, 745 2, 247, 745 52.00 05300 ANESTHESI OLOGY 0 0 53.00 0000 57, 202 57, 202 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 2, 499, 387 0 0 2, 499, 387 54.00 05700 CT SCAN 67, 458 67, 458 57 00 0 57 00 58.00 05800 MRI 0 243, 312 243, 312 58.00 06000 LABORATORY 3, 940, 289 0 60.00 3, 940, 289 60.00 63.00 06300 BLOOD STORING PROCESSING & TRA 00000 0 170, 143 0 0 170.143 63.00 06500 RESPIRATORY THERAPY 795, 938 795, 938 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 2, 567, 718 2, 567, 718 66.00 69 00 06900 ELECTROCARDI OLOGY 37, 132 0 0 37, 132 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 3, 207, 594 3, 207, 594 71.00 Ω 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 751, 109 0 751, 109 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 1, 384, 502 73.00 0 1.384.502 73.00 07697 CARDIAC REHABILITATION 76.97 Ω 371, 893 0 371, 893 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 0 0 11, 713, 056 0 11, 713, 056 0 0 90.00 09000 CLI NI C 0 0 0 90.00 09001 CLI NI C 0 0 90.01 90.01 09002 OUTPATIENT PSYCHIATRIC 0 0 90.02 0 374, 794 374, 794 90.02 09100 EMERGENCY 0 2, 331, 043 0 91.00 0 2.331.043 91.00 91.01 09101 PRI ORI TY CARE CARLYLE 0 C 49,061 0 49,061 91.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 0 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 43, 170, 604 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 14.087 0 43, 170, 604 118.00 0 NONREI MBURSABLE COST CENTERS 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 3, 587, 975 0 3, 587, 975 192. 00 194. 00 07950 LI FELI NE 0 0 0 0 0 194.00 194. 01 07951 DEVELOPMENT 0 Ω 0 0 0 194.01 194. 02 07952 VACANT SPACE 0 0 0 520, 581 520, 581 194. 02 194. 03 07953 TRANSPORTATION 0 0 69, 964 0 69, 964 194. 03 200.00 Cross Foot Adjustments 0 0 ol 0 200.00 201 00 0 201.00 Negative Cost Centers 0 0 0 202.00 TOTAL (sum lines 118 through 201) 14, 087 47, 349, 124 47, 349, 124 202. 00

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Provider CCN: 14-0145

					To	06/30/2023	Date/Time Pre	
				CAPI TAL REI	ATED COSTS		1/24/2024 12:	29 piii
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New Capital				BENEFITS DEPARTMENT	
			Related Costs				DELAKTIMENT	
			0	1. 00	2.00	2A	4. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS MARIE FOLL D						1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	0	3, 927	1, 596	5, 523	5, 523	2. 00 4. 00
5. 01	1	NONPATI ENT TELEPHONES	0	0, 727	0	0, 323	0, 323	5. 01
5. 02		DATA PROCESSING	0	0	0	o	0	5. 02
5. 03	1	PURCHASING RECEIVING AND STORES	93, 457	28, 492		121, 949	39	5. 03
5.04		ADMITTING	0	31, 459		33, 409	0	5.04
5. 05 5. 06		CASHIERING/ACCOUNTS RECEIVABLE ADMIN & GENERAL	636, 917	0 489, 734	-	0 1, 364, 763	175	5. 05 5. 06
7. 00	1	OPERATION OF PLANT	030, 717	134, 028		204, 375	185	7. 00
8.00		LAUNDRY & LINEN SERVICE	8, 164	32, 131	0	40, 295	0	8. 00
9. 00		HOUSEKEEPI NG	0	15, 854		15, 854	188	9. 00
10. 00 11. 00	1	DIETARY	0	27, 012	4, 254	31, 266	18	10.00
13.00		CAFETERIA NURSING ADMINISTRATION	0	17, 181 5, 391	309	17, 181 5, 700	84 376	11. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	0	0,371	0	0, 700	0	14. 00
15.00	1	PHARMACY	0	8, 559	1, 159	9, 718	180	15.00
16. 00		MEDICAL RECORDS & LIBRARY	0	10, 526		10, 889	0	16.00
17.00	1	SOCIAL SERVICE	0	1, 784		2, 474	0	17.00
19. 00		NONPHYSICIAN ANESTHETISTS ENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	19. 00
30. 00		ADULTS & PEDIATRICS	1, 380	126, 349	43, 017	170, 746	748	30. 00
31. 00		INTENSIVE CARE UNIT	0	0		0	0	31.00
43.00		NURSERY	0	7, 727	463	8, 190	98	43.00
FO 00		LARY SERVICE COST CENTERS	150 (04	15/ 200	220 214	FF4 100	(00	FO 00
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	159, 604	156, 280 0		554, 198 0	602	50. 00 51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0	25, 772		32, 551	476	52.00
53.00	1	ANESTHESI OLOGY	0	1, 552		34, 619	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	7, 650	31, 843	218, 119	257, 612	400	54.00
57. 00		CT SCAN	0	3, 671	0	3, 671	0	57.00
58. 00 60. 00	05800	MRI LABORATORY	2, 974	5, 807 17, 645		5, 838 75, 897	33 428	58. 00 60. 00
63.00	1	BLOOD STORING PROCESSING & TRA	2, 7/4	17,043	1	75, 647	420	63.00
65. 00		RESPI RATORY THERAPY	0	8, 679	6, 535	15, 214	190	65. 00
66. 00		PHYSI CAL THERAPY	11, 582	76, 356	8, 830	96, 768	554	66. 00
69.00		ELECTROCARDI OLOGY	0	0	0	0	5	69.00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PAT	0	6, 783	24, 415	31, 198	0 35	70. 00 71. 00
71.00		IMPL. DEV. CHARGED TO PATIENTS	0	0, 783	24, 413	31, 170	0	71.00
73. 00	1	DRUGS CHARGED TO PATIENTS	0	0	0	ō	0	73. 00
76. 97	1	CARDI AC REHABILI TATION	0	16, 126	7, 759	23, 885	64	76. 97
77. 00		ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	17, 727	194, 091	111, 264	323, 082	50	88. 00
90.00		CLINIC	0	0	0	0	0	90.00
90. 01		CLINIC	0	0	0	o	0	90. 01
90. 02		OUTPATIENT PSYCHIATRIC	0	12, 262		12, 262	78	90. 02
91.00		EMERGENCY	0	43, 801	1	83, 558	416	
91. 01 92. 00		PRIORITY CARE CARLYLE OBSERVATION BEDS (NON-DISTINCT	34, 436	0	0	34, 436 0	0	91. 01 92. 00
92.00		REIMBURSABLE COST CENTERS				<u> </u>		92.00
102.00		OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
		AL PURPOSE COST CENTERS						
		INTEREST EXPENSE	070 004	4 540 000	4 440 400	0 (07 101		113.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	973, 891	1, 540, 822	1, 112, 408	3, 627, 121	5, 422	118. 00
192 00		PHYSICIANS PRIVATE OFFICES	n	266, 472	28, 638	295, 110	89	192. 00
		LIFELINE	0	0	0	273, 110		194. 00
194. 01	07951	DEVELOPMENT	0	0	0	О	0	194. 01
		VACANT SPACE	61, 385	110, 687	0	172, 072		194. 02
194. 03 200. 00		TRANSPORTATION Cross Foot Adjustments	0	0	0	0		194. 03 200. 00
200.00	1	Negative Cost Centers		n	n	O O		200. 00 201. 00
202.00	1	TOTAL (sum lines 118 through 201)	1, 035, 276	1, 917, 981	1, 141, 046	4, 094, 303		202.00
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In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared:
1/24/2024 12:29 pm

			10	00/30/2023	1/24/2024 12:	
Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	
	TELEPHONES	PROCESSI NG	RECEIVING AND		COUNTS	
	5.01		STORES		RECEI VABLE	
GENERAL SERVICE COST CENTERS	5. 01	5. 02	5. 03	5. 04	5. 05	
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 00540 NONPATI ENT TELEPHONES	О					5. 01
5. 02 00550 DATA PROCESSING	О	0				5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES	0	0	121, 988			5. 03
5. 04 00570 ADMI TTI NG	0	0	69	33, 478		5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	0	0	5. 05
5. 06 00590 ADMI N & GENERAL	0	0	1, 566	0	0	5.06
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	0	0	2, 307	0	0	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	0	0 457	0	0	8. 00 9. 00
10. 00 01000 DI ETARY	0	0	437	0	0	10.00
11. 00 01100 CAFETERI A	0	0	0	0	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	Ö	0	o o	0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 01500 PHARMACY	0	0	0	0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	1	0	0	16. 00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS	٥	0	1 005	0.42	0	30.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	0	0		943 0	0	31.00
43. 00 04300 NURSERY	o	0		185	0	
ANCI LLARY SERVI CE COST CENTERS	<u> </u>		101	100	<u> </u>	10.00
50. 00 05000 OPERATING ROOM	0	0	3, 506	4, 120	0	50.00
51.00 05100 RECOVERY ROOM	О	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	104	904	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		1, 019	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1, 463	3, 453	0	54.00
57. 00 05700 CT SCAN	0	0	963 89	4, 375	0	57.00
58. 00 05800 MRI 60. 00 06000 LABORATORY	0	0	13, 827	1, 281 6, 242	0	58. 00 60. 00
63. 00 06300 BLOOD STORING PROCESSING & TRA	0	0	2, 698	152	0	63.00
65. 00 06500 RESPIRATORY THERAPY	Ö	0	71	410	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	233	1, 769	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	184	462	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	47, 757	716	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	11, 934	513	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	,	1, 640	0	73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON 77. 00 O7700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	66	45 0	0	76. 97 77. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	0	U	0	17.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	17, 222	2, 385	0	88. 00
90. 00 09000 CLI NI C	О	0		0	0	
90. 01 09001 CLI NI C	О	0	0	0	0	90. 01
90. 02 09002 OUTPATI ENT PSYCHI ATRI C	0	0	16	121	0	90. 02
91. 00 09100 EMERGENCY	0	0	300	2, 737	0	
91. 01 09101 PRI ORI TY CARE CARLYLE	0	0	1	6	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 0I D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	0	U	U	0	102.00
113. 00 11300 NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	О	0	121, 502	33, 478	0	118.00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0	484	0		192. 00
194. 00 07950 LI FELI NE	0	0	0	0		194.00
194. 01 07951 DEVELOPMENT	0	0	0	0		194. 01
194. 02 07952 VACANT SPACE 194. 03 07953 TRANSPORTATI ON	O	0		0		194. 02 194. 03
200.00 Cross Foot Adjustments	۷	Ü		U		200.00
201.00 Negative Cost Centers	0	0	0	n	n	200.00
202.00 TOTAL (sum lines 118 through 201)	0	0		33, 478		202.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-1	_	, , , , , , ,			

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 07/01/2022 | Part II | Date/Time Prepared: 1/24/2024 12:29 pm

				'	0 00/30/2023	1/24/2024 12:	
	Cost Center Description	ADMIN &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
	GENERAL SERVICE COST CENTERS	5. 06	7. 00	8. 00	9. 00	10. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5. 03
5.04	00570 ADMI TTI NG						5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 ADMIN & GENERAL	1, 366, 504					5.06
7.00	00700 OPERATION OF PLANT	89, 720	296, 587				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	6, 168	7, 746	54, 209	l .		8. 00
9. 00	00900 HOUSEKEEPI NG	33, 990	3, 822	0			9. 00
10.00	01000 DI ETARY	5, 388	6, 512	0	735	43, 919	10.00
11. 00	01100 CAFETERI A	19, 122	4, 142	0	0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	42, 770	1, 300	0	367	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	22, 884	2, 063	0	1, 347	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	21, 709	2, 538	0	245	0	16.00
17. 00 19. 00	01900 NONPHYSICIAN ANESTHETISTS	118	430 0	0	245	0	17. 00 19. 00
19.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	l d	U		l d	U	19.00
30. 00	03000 ADULTS & PEDIATRICS	93, 049	30, 458	23, 744	9, 552	38, 874	30.00
31. 00	03100 I NTENSI VE CARE UNI T	75, 047	0, 430	0	7, 332	0	31.00
43. 00	04300 NURSERY	9, 518	1, 863	0	· - 1	0	43.00
10.00	ANCILLARY SERVICE COST CENTERS	7,010	., 555		, 33		10.00
50.00	05000 OPERATING ROOM	96, 314	37, 673	11, 295	8, 818	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	l ' '	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	52, 806	6, 213	0	490	0	52.00
53.00	05300 ANESTHESI OLOGY	1, 538	374	0	o	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	65, 489	7, 676	6, 677	2, 694	0	54.00
57.00	05700 CT SCAN	1, 362	885	0	490	0	57.00
58. 00	05800 MRI	6, 320	1, 400	0	245	0	58. 00
60.00	06000 LABORATORY	109, 698	4, 254	21	857	0	60.00
63. 00	06300 BLOOD STORING PROCESSING & TRA	4, 910	0	0	0	0	63.00
65. 00	06500 RESPI RATORY THERAPY	21, 244	2, 092	0		0	65.00
66.00	06600 PHYSI CAL THERAPY	65, 331	18, 407	954	857	0	66.00
69.00	06900 ELECTROCARDI OLOGY	953	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	01 021	1 425	0	0	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 IMPL. DEV. CHARGED TO PATIENTS	91, 821	1, 635 0) 	0	0	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	21, 677 26, 821	0	0	0	0	73.00
76. 97	07697 CARDIAC REHABILITATION	7, 902	3, 887	0	490	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	7, 702	3, 007	0	970	0	77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	١	J		١		77.00
88. 00	08800 RURAL HEALTH CLINIC	303, 700	46, 788	156	6, 305	0	88. 00
90.00	09000 CLI NI C	0	0	0		0	90.00
90. 01	09001 CLI NI C	o	0	0	o	0	90. 01
90. 02	09002 OUTPATIENT PSYCHIATRIC	9, 640	2, 956	0	0	0	90. 02
91.00	09100 EMERGENCY	50, 920	10, 559	9, 117	4, 899	1, 698	91.00
91. 01	09101 PRI ORI TY CARE CARLYLE	1, 257	0	0	245	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT						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						113. 00
118.00		1, 284, 139	205, 673	51, 964	40, 106	40, 572	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS PRIVATE OFFICES	73, 500	64, 232	2, 245	14, 205		192.00
	07950 LI FELI NE	0	0	0	0		194.00
	07951 DEVELOPMENT	0	0	0			194. 01
	207952 VACANT SPACE	6, 953	26, 682	0	Ĭ		194. 02
	3 O7953 TRANSPORTATION	1, 912	O	0	0	0	194. 03
200.00				_		^	200. 00 201. 00
201. 00 202. 00		1, 366, 504	0 296, 587	54, 209	54, 311	43, 919	
202.00	TOTAL (Sum Times 110 through 201)	1, 300, 304	270, 307	J4, 209	J4, J11	43, 717	1202.00

			10	06/30/2023	Date/IIme Pre 1/24/2024 12:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	2 / piii
		ADMI NI STRATI O	SERVICES &		RECORDS &	
	11. 00	N 13. 00	SUPPLY 14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
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 00540 NONPATI ENT TELEPHONES						5. 01
5. 02 00550 DATA PROCESSING						5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES 5. 04 00570 ADMITTING						5.03
5. 04 00570 ADMI TTI NG 5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04 5. 05
5. 06 00590 ADMI N & GENERAL						5. 06
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	40, 529					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	2, 085	52, 598				13.00
14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY	1 004	2 002	0	40, 001		14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	1, 006 0	2, 883	0	40, 081 0	35, 382	16.00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	ő	0	Ö	0	19. 00
INPATIENT ROUTINE SERVICE COST CENTERS	-	- 1	- 11	-		
30. 00 03000 ADULTS & PEDIATRICS	6, 105	17, 473	0	1	31, 887	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43. 00 04300 NURSERY	675	1, 932	0	14	2, 020	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 O5000 OPERATING ROOM	4, 145	11, 857	0	16	229	50. 00
51. 00 05100 RECOVERY ROOM	4, 145	11,657	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 302	9, 445	0	o	356	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 029	0	0	0	13	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58. 00 05800 MRI	238	0	0	0	0	58.00
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORING PROCESSING & TRA	4, 313 0	0	0	0	13 0	60. 00 63. 00
65. 00 06500 RESPIRATORY THERAPY	1, 546	0	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	4, 913	Ö	0	0	51	66. 00
69. 00 06900 ELECTROCARDI OLOGY	37	109	0	o	13	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	О	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	511	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	19, 271	0	73.00
76.97 O7697 CARDIAC REHABILITATION 77.00 O7700 ALLOGENEIC HSCT ACQUISITION	458 0	1, 312 0	0	0	0	76. 97 77. 00
OUTPATIENT SERVICE COST CENTERS	U	U U	U	U	0	77.00
88. 00 08800 RURAL HEALTH CLINIC	3, 790	ol	0	20, 779	0	88. 00
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 09001 CLI NI C	0	0	0	0	0	90. 01
90. 02 09002 OUTPATI ENT PSYCHI ATRI C	563	0	0	0	0	90. 02
91. 00 09100 EMERGENCY	2, 653	7, 587	0	0	800	91.00
91. 01 09101 PRI ORI TY CARE CARLYLE 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT	U	U	0	U	0	91. 01 92. 00
OTHER REIMBURSABLE COST CENTERS						92.00
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 SUBTOTALS (SUM OF LINES 1 through 117)	39, 369	52, 598	0	40, 081	35, 382	118. 00
NONREI MBURSABLE COST CENTERS	0.40	ما				100.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES 194. 00 07950 LI FELI NE	948 0	0	0	0		192. 00 194. 00
194. 01 07950 LI FELI NE 194. 01 07951 DEVELOPMENT	0	٥	0	0		194. 00 194. 01
194. 02 07952 VACANT SPACE	0	n	0	0		194. 01
194. 03 07953 TRANSPORTATI ON	212	ol	o	ől		194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	О	0	О		201. 00
202.00 TOTAL (sum lines 118 through 201)	40, 529	52, 598	0	40, 081	35, 382	202. 00

Heal th Financial Systems ST. JOSEPHS HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0145 Period: Worksheet B

ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der Co		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown	1/24/2024 12: Total	29 pm
		17. 00	19. 00	24. 00	Adjustments 25.00	26. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 ADMIN & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	3, 267 0	0				1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	3, 267		428, 74	2 0	428, 742	30.00
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	0		25, 33	o	0 25, 331	31. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS						43.00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	l .	732, 77	0 0	732, 773 0	50. 00 51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	ő		106, 64	-	106, 647	52.00
53.00	05300 ANESTHESI OLOGY	0		37, 60		37, 608	53.00
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	0		348, 50 11, 74	1	348, 506 11, 746	54. 00 57. 00
58. 00	05800 MRI	Ö		15, 44		15, 444	58.00
60.00	06000 LABORATORY	0		215, 55	1	215, 550	60.00
63. 00 65. 00	06300 BLOOD STORING PROCESSING & TRA 06500 RESPIRATORY THERAPY	0		7, 76 41, 25	1	7, 760 41, 257	63. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0		189, 83	1	189, 837	66.00
69. 00	06900 ELECTROCARDI OLOGY	0		1, 76	1	1, 763	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 IMPL. DEV. CHARGED TO PATIENTS	0		173, 67 34, 12		173, 673 34, 124	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	Ö		62, 34	1	62, 346	73.00
	07697 CARDI AC REHABI LI TATI ON	0	l	38, 10			76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0			0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	0		724, 25	7 0	724, 257	88. 00
90.00	09000 CLI NI C	0			0	0	90.00
90. 01 90. 02	09001 CLI NI C 09002 OUTPATI ENT PSYCHI ATRI C	0		25, 63		0 25, 636	90. 01 90. 02
91.00	09100 EMERGENCY	Ö		175, 24	1	175, 244	1
91. 01	09101 PRI ORI TY CARE CARLYLE	0		35, 94	5 0	35, 945	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS				0		92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0			O	0	102.00
	SPECIAL PURPOSE COST CENTERS			I			
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	2 247		2 422 20		2 422 200	113.00
118.00	NONREIMBURSABLE COST CENTERS	3, 267	0	3, 432, 29	3 0	3, 432, 298	1118.00
	19200 PHYSICIANS PRIVATE OFFICES	0		454, 16	0	454, 160	
	07950 LI FELI NE 07951 DEVELOPMENT	0			0		194. 00 194. 01
	07951 DEVELOPMENT 07952 VACANT SPACE			205, 70	7 0	205, 707	
	07953 TRANSPORTATI ON	Ö		2, 13	1		194. 03
200.00	Cross Foot Adjustments		0		o o	0	200. 00
201.00		0	0	4 004 30	0 3		201.00
202.00	TOTAL (sum lines 118 through 201)	3, 267	0	4, 094, 30	اح اح	4, 074, 303	₁ 202. UU

Heal th	Finan	icial Systems	ST. JOSEPHS	HOSPI TAL		In Lie	u of Form CMS-	2552-10
		TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
						From 07/01/2022 To 06/30/2023	Dato/Timo Bro	narod:
						10 00/30/2023	Date/Time Pre 1/24/2024 12:	29 pm
			CAPI TAL REL	ATED COSTS				
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	NONPATI ENT	DATA	
			(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT	TELEPHONES (PHONES)	PROCESSING (TIME SPENT)	
				VALUE)	(GROSS	(THONES)	(TIME SIENT)	
					SALARI ES)			
			1. 00	2. 00	4.00	5. 01	5. 02	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	239, 784	1 0// 401				1.00
2. 00 4. 00		EMPLOYEE BENEFITS DEPARTMENT	491	1, 066, 491 1, 492	14, 460, 33	7		2. 00 4. 00
5. 01		NONPATI ENT TELEPHONES	0	1, 472	14, 400, 33	, 0 692		5. 01
5. 02		DATA PROCESSING	Ö	0		0 0	100	
5.03	00560	PURCHASING RECEIVING AND STORES	3, 562	0	100, 98	9 5	0	
5. 04		ADMITTING	3, 933	1, 823	1	0 5	0	
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		0 0	0	
5. 06 7. 00		ADMIN & GENERAL OPERATION OF PLANT	61, 226	222, 554 65, 751			100 0	
8. 00		LAUNDRY & LINEN SERVICE	16, 756 4, 017	05, 751	485, 50	0 1	0	
9. 00		HOUSEKEEPI NG	1, 982	0	492, 56	-	0	1
10.00		DI ETARY	3, 377	3, 976			0	10.00
11.00		CAFETERI A	2, 148	0	218, 89	4 0	0	11.00
13.00		NURSING ADMINISTRATION	674	289	983, 30		0	1
14. 00		CENTRAL SERVICES & SUPPLY	0	0		0	0	
15.00		PHARMACY	1, 070	1, 083			0	10.00
16.00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	1, 316	339		0 30	0	
17. 00 19. 00		NONPHYSI CI AN ANESTHETI STS	223	645 0		0 6	0	
17.00		IENT ROUTINE SERVICE COST CENTERS	<u> </u>			0	<u> </u>	17.00
30.00		ADULTS & PEDIATRICS	15, 796	40, 206	1, 963, 05	2 127	0	30.00
31.00		INTENSIVE CARE UNIT	o	0		0 0	0	31.00
43.00		NURSERY	966	433	255, 64	0 8	0	43.00
EO 00		LARY SERVICE COST CENTERS OPERATING ROOM	10 520	222 742	1 574 45	5 49	0	1 50 00
50. 00 51. 00		RECOVERY ROOM	19, 538 0	222, 743 0		0 0	0	
52. 00		DELIVERY ROOM & LABOR ROOM	3, 222	6, 336	1		0	1
53. 00		ANESTHESI OLOGY	194	30, 906		0 1	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	3, 981	203, 867	1, 048, 33	4 22	0	54.00
57.00	1	CT SCAN	459	0		0	0	
58.00	05800		726	29			0	
60. 00 63. 00		LABORATORY BLOOD STORING PROCESSING & TRA	2, 206	51, 666	1, 119, 50	3 19 0 0	0	
65.00		RESPIRATORY THERAPY	1, 085	6, 108	498, 43		0	65.00
66. 00		PHYSI CAL THERAPY	9, 546	8, 253			0	66.00
69.00		ELECTROCARDI OLOGY	0	0	12, 04		0	69.00
70.00		ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
		MEDICAL SUPPLIES CHARGED TO PAT	848	22, 820	92, 48		0	
		IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73. 00 76. 97		DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	2, 016	7, 252	166, 91	2 4	0	
		ALLOGENEIC HSCT ACQUISITION	2,010	7, 232	100, 91	0 0	0	1
		TIENT SERVICE COST CENTERS	-1			-		1
88. 00	08800	RURAL HEALTH CLINIC	24, 265	103, 994	130, 56		0	
90.00		CLINIC	0	0		0	0	
90. 01		CLINIC	0	0	200 50	0 0	0	
90.02		OUTPATIENT PSYCHIATRIC EMERGENCY	1, 533	27 150	203, 53		0	
91. 00 91. 01		PRIORITY CARE CARLYLE	5, 476 0	37, 159 0	1, 088, 15	5 18 0 0	0	
		OBSERVATION BEDS (NON-DISTINCT	Ĭ	O			0	92.00
		REIMBURSABLE COST CENTERS			l .			1
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		0 0	0	102. 00
		AL PURPOSE COST CENTERS						
	1	INTEREST EXPENSE	100 (00	4 000 704	14 104 00	407	100	113.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	192, 632	1, 039, 724	14, 194, 39	8 497	100	118.00
192 00		PHYSICIANS PRIVATE OFFICES	33, 314	26, 767	234, 07	8 195	0	192. 00
		LIFELINE	0	0	20.707	0 0		194.00
		DEVELOPMENT	o	0		0 0		194. 01
		VACANT SPACE	13, 838	0		0 0		194. 02
		TRANSPORTATION	0	0	31, 86	1 0	0	194. 03
200.00		Cross Foot Adjustments						200.00
201. 00 202. 00		Negative Cost Centers Cost to be allocated (per Wkst. B,	1, 917, 981	1, 141, 046	1, 851, 72	1 88, 539	^	201. 00 202. 00
202. UC	1	Part I)	1, 717, 701	1, 141, 040	1,001,72	00, 339		202.00
203.00	o	Unit cost multiplier (Wkst. B, Part I)	7. 998786	1. 069907	0. 12805	5 127. 946532	0. 000000	203.00
	•	, , ,						•

Heal th Fina	ncial Systems	ST. JOSEPHS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Period: From 07/01/2022	Worksheet B-1	
					To 06/30/2023	Date/Time Pre 1/24/2024 12:	
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATI ENT TELEPHONES (PHONES)	DATA PROCESSING (TIME SPENT)	
		1. 00	2. 00	4.00	5. 01	5. 02	
204. 00	Cost to be allocated (per Wkst. B, Part II)			5, 52	3 0	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00038	2 0.000000	0. 000000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST A	LLOCATION - STATISTICAL BASIS		Provi der Co	CN: 14-0145 PE	eri od:		
					rom 07/01/2022	Worksheet B-1	
				10	06/30/2023	Date/Time Pre 1/24/2024 12:	
	Cost Center Description	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	Reconciliatio	ADMIN &	,
		RECEI VI NG AND	(GROSS	COUNTS	n	GENERAL	
		STORES	CHARGES)	RECEI VABLE		(ACCUM. COST)	
		(SUPPLY EXP)		(GROSS CHARGES)			
		5. 03	5. 04	5. 05	5A. 06	5. 06	
	GENERAL SERVICE COST CENTERS	3.33		2.22			
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 5. 02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG						5. 01 5. 02
5. 02 5. 03	00560 PURCHASING RECEIVING AND STORES	5, 765, 268					5.03
5. 04	00570 ADMI TTI NG	3, 258	177, 299, 602				5.04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	177, 299, 602			5.05
5.06	00590 ADMIN & GENERAL	74, 027	0	0	-9, 801, 183		5.06
7.00	00700 OPERATION OF PLANT	109, 041	0	0	0	2, 465, 243	7.00
8. 00 9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG	21, 600	0	0	0	169, 475 933, 932	8. 00 9. 00
10.00	01000 DI ETARY	21,000	0	0	0	148, 044	10.00
11. 00	01100 CAFETERI A	o	0	0	0	525, 414	11.00
13. 00	01300 NURSING ADMINISTRATION	o	0	0	0	1, 175, 184	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00	01500 PHARMACY	0	0	0	0	628, 798	
	01600 MEDICAL RECORDS & LIBRARY	38	0	0	0	596, 512	16.00
17. 00 19. 00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	3, 242 0	17. 00 19. 00
19.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	l o	U	0] 19.0C
30. 00	03000 ADULTS & PEDIATRICS	89, 575	4, 988, 808	4, 988, 808	0	2, 556, 712	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0		0	,	31.00
43.00	04300 NURSERY	4, 778	980, 899	980, 899	0	261, 520	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	165, 721	21, 796, 738		0	2, 646, 414	50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 4, 892	4, 781, 961	0 4, 781, 961	0	0 1, 450, 946	51.00 52.00
53.00	05300 ANESTHESI OLOGY	2, 756	5, 391, 366		0	42, 252	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	69, 153	18, 269, 155		ő	1, 799, 446	
57. 00	05700 CT SCAN	45, 511	23, 150, 701		0	37, 427	
58. 00	05800 MRI	4, 197	6, 777, 902		0	173, 666	
60.00	06000 LABORATORY	653, 480	33, 198, 323		0	3, 014, 171	
63.00	06300 BLOOD STORING PROCESSING & TRA	127, 505	803, 146 2, 171, 923		0	134, 924 583, 728	63. 00 65. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 349 11, 023	9, 357, 713		0	1, 795, 094	
69.00	06900 ELECTROCARDI OLOGY	8, 717	2, 442, 945		0	26, 185	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	2, 256, 947	3, 786, 952	3, 786, 952	0	2, 522, 973	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	563, 998	2, 714, 130		0	595, 631	
	07300 DRUGS CHARGED TO PATIENTS	690, 662	8, 674, 782			1	
	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION	3, 129	238, 666	238, 666	0	217, 116 0	76. 97 77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	١	0	<u> </u>		0	77.00
88. 00	08800 RURAL HEALTH CLINIC	813, 923	12, 619, 420	12, 619, 420	0	8, 345, 246	88. 00
90.00	09000 CLI NI C		0	0	0	0	90.00
90. 01	09001 CLI NI C	0	0	0	0	0	90. 01
90. 02	09002 OUTPATIENT PSYCHIATRIC	771	642, 083		0	264, 870	90.02
91.00	09100 EMERGENCY	14, 164	14, 482, 037		0	1, 399, 123	91.00
	09101 PRIORITY CARE CARLYLE 09200 OBSERVATION BEDS (NON-DISTINCT	69	29, 952	29, 952	O	34, 550	91. 01 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						92.0C
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	, , ,	5, 742, 284	177, 299, 602	177, 299, 602	-9, 801, 183	35, 284, 793	118.00
	NONREI MBURSABLE COST CENTERS	20.070		I al	ما	0.010.5/4	
	19200 PHYSICIANS PRIVATE OFFICES	22, 879	0	· -	0	2, 019, 564	
	07950 LI FELI NE 07951 DEVELOPMENT		0	0	0		194. 00 194. 01
	07952 VACANT SPACE		0	0	0	191, 037	
	07953 TRANSPORTATION	105	0	l ő	ől	52, 547	
200.00					-	,	200.00
201. 00	Negative Cost Centers						201. 00
202. 00		284, 180	250, 415	0		9, 801, 183	202.00
	Part I)	0.040000	0 001410	0.000000		0.0/1001	202 00
202 00	Unit cost multiplier (Wkst. B, Part I)	0. 049292	0. 001412			0. 261031 1, 366, 504	
203. 00 204. 00	Cost to be allocated (per Wkst. B,	121, 988	33, 478				

Heal th Finar	ncial Systems	ST. JOSEPHS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 07/01/2022 To 06/30/2023	Date/Time Pre 1/24/2024 12:	
	Cost Center Description	PURCHASI NG	ADMITTI NG		Reconciliatio		
		RECEIVING AND	(GROSS	COUNTS	n	GENERAL	
		STORES	CHARGES)	RECEI VABLE		(ACCUM. COST)	
		(SUPPLY EXP)		(GROSS			
				CHARGES)			
		5. 03	5. 04	5. 05	5A. 06	5. 06	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 021159	0. 000189	0. 00000	0	0. 036394	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	Financial Systems LOCATION - STATISTICAL BASIS	ST. JOSEPHS		CN: 14 O14E D		u of Form CMS-	
CUST ALI	LUCATION - STATISTICAL BASIS		Provi der Co		eriod: rom 07/01/2022 o 06/30/2023	Worksheet B-1 Date/Time Pre	
	Cost Contor Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	1/24/2024 12:	29 pm
	Cost Center Description	PLANT	LI NEN SERVI CE	(HOURS OF	(MEALS	CAFETERIA (FTES SERV	
		(SQUARE FEET)	(POUNDS OF	SERVI CE)	SERVED)	ED)	
		7. 00	LAUNDRY) 8. 00	9. 00	10.00	11. 00	
G	ENERAL SERVICE COST CENTERS	7.00	8.00	7.00	10.00	11.00	
	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES						4. 00 5. 01
	00550 DATA PROCESSING						5. 02
1	00560 PURCHASING RECEIVING AND STORES						5. 03
	00570 ADMI TTI NG						5. 04
	00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 ADMIN & GENERAL						5. 05 5. 06
	00700 OPERATION OF PLANT	153, 816					7.00
	00800 LAUNDRY & LINEN SERVICE	4, 017	200, 863				8. 00
1	00900 HOUSEKEEPI NG	1, 982	0	11, 087			9.00
1	01000 DI ETARY 01100 CAFETERI A	3, 377 2, 148	0	150	17, 202 0	17, 357	10.00
	11300 NURSING ADMINISTRATION	674	0	75	0	893	1
1	01400 CENTRAL SERVICES & SUPPLY	0	0	0	o	0	1
	1500 PHARMACY	1, 070	0	275	0	431	1
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 316 223	0	50 50	O O	0	16. 00 17. 00
	11900 NONPHYSICIAN ANESTHETISTS	223	0	0	0	0	1
_	NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			<u> </u>		1
	03000 ADULTS & PEDIATRICS	15, 796	87, 980	1, 950	15, 226	2, 615	1
	03100 INTENSIVE CARE UNIT	0 966	0	0	0	0	
	04300 NURSERY NCILLARY SERVICE COST CENTERS	900	0	150	0	289	43.00
	05000 OPERATING ROOM	19, 538	41, 853	1, 800	0	1, 775	50.00
	05100 RECOVERY ROOM	0	0	0	0	0	
	05200 DELIVERY ROOM & LABOR ROOM	3, 222	0	100	0	1, 414	1
1	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	194 3, 981	24, 741	0 550	0	0 1, 297	
1	05700 CT SCAN	459	0	100	Ö	0	I
1	05800 MRI	726	0	50	0	102	1
	06000 LABORATORY	2, 206	76		0	1, 847	1
1	06300 BLOOD STORING PROCESSING & TRA 06500 RESPIRATORY THERAPY	0 1, 085	0	0 100	0	0 662	
	06600 PHYSI CAL THERAPY	9, 546	3, 535	175	o	2, 104	1
1	06900 ELECTROCARDI OLOGY	0	0	0	0	16	
1	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 IMPL. DEV. CHARGED TO PATIENTS	848	0	0	0	219 0	
	07300 DRUGS CHARGED TO PATIENTS	0	Ō	Ö	o	0	1
	07697 CARDIAC REHABILITATION	2, 016	0		0		76. 97
	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
	08800 RURAL HEALTH CLINIC	24, 265	577	1, 287	0	1, 623	88. 00
	09000 CLI NI C	0	0	0	Ō	0	1
	99001 CLI NI C	0	0	0	0	0	
	09002 OUTPATIENT PSYCHIATRIC	1, 533 5, 476		0	0	241	
	19100 EMERGENCY 19101 PRI ORI TY CARE CARLYLE	0,476	33, 783 0	1, 000 50	665 0	1, 136 0	91. 00 91. 01
	99200 OBSERVATION BEDS (NON-DISTINCT				J	J	92.00
	THER REIMBURSABLE COST CENTERS						
	0200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
	PECIAL PURPOSE COST CENTERS 1300 INTEREST EXPENSE						113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	106, 664	192, 545	8, 187	15, 891	16, 860	118.00
N	ONREI MBURSABLE COST CENTERS						
192.001	9200 PHYSICIANS PRIVATE OFFICES	33, 314	8, 318	2, 900	1, 311		192.00
	07950 LI FELI NE 07951 DEVELOPMENT	0) 0	0	0	0	194. 00 194. 01
	07952 VACANT SPACE	13, 838	0	o o	Ö		194. 02
	07953 TRANSPORTATI ON	0	0	0	0	91	194. 03
200.00	Cross Foot Adjustments						200.00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	3, 108, 748	294, 900	1, 217, 775	271, 416	705, 976	201.00
202.00	Part I)	3, 100, 740	274, 300	1,217,773	2,1,410	103, 710	
203. 00	Unit cost multiplier (Wkst. B, Part I)	20. 210823			15. 778165	40. 673849	
204. 00	Cost to be allocated (per Wkst. B,	296, 587	54, 209	54, 311	43, 919	40, 529	204.00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	1. 928193	0. 269880	4. 898620	2. 553133	2. 335023	205 00
200.00	II)	,231,73	3. 20,000		2.000.00	2.000020	[
					·		

Health Finar	ncial Systems	ST. JOSEPHS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 07/01/2022	D. I. (T' D	
					To 06/30/2023	Date/Time Pre 1/24/2024 12:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(HOURS OF	(MEALS	(FTES SERV	
		(SQUARE FEET)	(POUNDS OF	SERVI CE)	SERVED)	ED)	
			LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
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)						

	ancial Systems ATION - STATISTICAL BASIS	ST. JOSEPHS	Provi der CO		eriod: rom 07/01/2022	u of Form CMS-: Worksheet B-1 Date/Time Pre	
	Cost Center Description	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	1/24/2024 12: SOCI AL SERVI CE (TI ME SPENT)	
locus	The office of the order of the	13. 00	14. 00	15. 00	16.00	17. 00	
1. 00 0010 2. 00 0020 4. 00 0054 5. 01 0055 5. 03 0056 5. 04 0057 5. 05 0058 5. 06 0059 7. 00 0070 8. 00 0090 10. 00 0100 11. 00 0110 13. 00 0130 14. 00 0140 15. 00 0150	RAL SERVICE COST CENTERS OC CAP REL COSTS-BLDG & FIXT OCAP REL COSTS-MVBLE EQUIP OCEMPLOYEE BENEFITS DEPARTMENT OCNONPATIENT TELEPHONES OCOPIES OF PURCHASING RECEIVING AND STORES OCOPIES OC	163, 749 0 8, 975 0	0 0 0	1, 318, 121 0			1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 11. 00 11. 00 14. 00 15. 00
1	OO SOCIAL SERVICE OO NONPHYSICIAN ANESTHETISTS	0	0	0		100 0	1
30. 00 0300 31. 00 0310	INTERPOLATION AND THE STATE OF	54, 401 0 6, 015	0 0	32 0 475	2, 510 0	100	30.00 31.00
ANCI	LLARY SERVICE COST CENTERS OO OPERATING ROOM	36, 913	0			0	
51. 00 0510 52. 00 0520 53. 00 0530 54. 00 0540 57. 00 0570	O PERATTING ROOM OO RECOVERY ROOM OO DELI VERY ROOM & LABOR ROOM OO ANESTHESI OLOGY OO RADI OLOGY-DI AGNOSTI C OCT SCAN OO MRI	30, 713 0 29, 404 0 0	0 0 0 0 0	0	0 28 0 1 0	0 0 0 0 0	51. 00 52. 00 53. 00 54. 00 57. 00
63. 00 0630 65. 00 0650 66. 00 0660 69. 00 0690	OL LABORATORY OLO BLOOD STORI NG PROCESSI NG & TRA OLO RESPI RATORY THERAPY OLO PHYSI CAL THERAPY OLO ELECTROCARDI OLOGY OLO ELECTROENCEPHALOGRAPHY	0 0 0 0 338 0	0 0 0 0 0	0 0 0 0 0	0 0 4	0 0 0 0 0	63. 00 65. 00 66. 00 69. 00
72. 00 0720 73. 00 0730 76. 97 0769 77. 00 0770	MEDICAL SUPPLIES CHARGED TO PAT MINDL. DEV. CHARGED TO PATIENTS DO DRUGS CHARGED TO PATIENTS TO CARDIAC REHABILITATION MINDLE AC REHABILITATION MATIENT SERVICE COST CENTERS	0 0 0 4, 083 0	0 0 0 0	0	0	0 0 0 0	72. 00 73. 00 76. 97
90. 00 0900 90. 01 0900 90. 02 0900 91. 00 0910 91. 01 0910	OO RURAL HEALTH CLINIC OO CLINIC OI CLINIC OUTPATIENT PSYCHIATRIC OO EMERGENCY OI PRIORITY CARE CARLYLE OO OBSERVATION BEDS (NON-DISTINCT	0 0 0 0 23, 620 0	0 0 0 0 0	683, 342 0 0 0 0 0	0 0 0 0 63 0	0 0 0 0 0	90. 00 90. 01 90. 02 91. 00
	R REIMBURSABLE COST CENTERS OO OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPEC 113. 00 1130 118. 00	IAL PURPOSE COST CENTERS OF INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) ELIMBURSABLE COST CENTERS	163, 749	0				113. 00 118. 00
192. 00 1920 194. 00 0795 194. 01 0795 194. 02 0795 194. 03 0795 200. 00 201. 00	DO PHYSICIANS PRIVATE OFFICES DO LIFELINE DI DEVELOPMENT DO VACANT SPACE SI TRANSPORTATION Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 0	0 0 0 0 0	0 0 0 0 0	0 0 0 0	0 0 0 0	192. 00 194. 01 194. 02 194. 03 200. 00 201. 00
202. 00 203. 00 204. 00	Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	1, 540, 125 9. 405401 52, 598	0. 000000 0	946, 708 0. 718225 40, 081	281. 619031	14, 087 140. 870000 3, 267	

Heal th Finar	ncial Systems	ST. JOSEPHS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provi der Co		Period: From 07/01/2022		
					To 06/30/2023	Date/Time Pre 1/24/2024 12:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	SERVI CE	
		N	SUPPLY	REQUI S.)	LI BRARY	(TIME SPENT)	
		(DI RECT	(COSTED		(TIME SPENT)		
		NRSING HRS)	REQUIS.)				
		13. 00	14. 00	15. 00	16.00	17. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 321211	0. 000000	0. 03040	8 12. 704488	32. 670000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health FinancialSystemsST. JOSEPHS HOSPITALIn Lieu of Form CMS-2552-10COST ALLOCATION - STATISTICAL BASISProvider CCN: 14-0145Period:Worksheet B-1

From 07/01/2022 06/30/2023 Date/Time Prepared: 1/24/2024 12:29 pm Cost Center Description NONPHYSI CI AN **ANESTHETI STS** (ASSI GNED TIME) 19.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00590 ADMIN & GENERAL 5.06 5.06 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0 31.00 43.00 04300 NURSERY 0 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 53. 00 | 05300 | ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 00000000000 54.00 57 00 05700 CT SCAN 57 00 58.00 05800 MRI 58.00 60.00 06000 LABORATORY 60.00 63.00 06300 BLOOD STORING PROCESSING & TRA 63.00 06500 RESPIRATORY THERAPY 65 00 65 00 06600 PHYSI CAL THERAPY 66.00 66.00 06900 ELECTROCARDI OLOGY 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 07697 CARDIAC REHABILITATION 76. 97 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 09000 CLI NI C 0 90.00 90.00 90.01 09001 CLI NI C 90 01 90.02 09002 OUTPATIENT PSYCHIATRIC 0 90.02 0 91.00 09100 EMERGENCY 91.00 09101 PRI ORI TY CARE CARLYLE 91.01 0 91.01 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 118.00 118.00 NONREIMBURSABLE COST CENTERS 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 194. 00 07950 LI FELI NE 0 194.00 0 194. 01 07951 DEVELOPMENT 194.01 194. 02 07952 VACANT SPACE 0 194 02 194. 03 07953 TRANSPORTATI ON 0 194.03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 203.00 0.000000 204.00 Cost to be allocated (per Wkst. B, 204.00 Part II) 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 II)

Heal th Finar	ncial Systems	ST. JOSEPHS	HOSPI TAL		In Lieu	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der (CCN: 14-0145	Peri od:	Worksheet B-1	
					From 07/01/2022 To 06/30/2023	Date/Time Pre 1/24/2024 12:	
	Cost Center Description	NONPHYSI CI AN					
		ANESTHETI STS					
		(ASSI GNED					
		TIME)					
		19. 00					
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems		ST.	JOSEPHS HO	SPI TAL		In Lieu	of Form C	MS-2552-10
COMPUTATION OF RATIO OF CO	STS TO CHARGES			Provi der	CCN: 14-0145	7/01/2022	Worksheet Part I Date/Time	Prepared:

Total Cost						To 06/30/2023	Date/Time Pre 1/24/2024 12:	pared: 29 pm
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 3.00 3.00 4.00 5.00 1.00 3.00 3.00 4.00 5.00 1.00 3.				Title	XVIII	Hospi tal		
CFrom West: Acid Disal Lowance Repart						Costs		
INPATLENT ROUTINE SERVICE COST CENTERS		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00		·	(from Wkst.	Adj.		Di sal I owance		
INPATI ENT ROUTI NE SERVICE COST CENTERS			B, Part I,	•				
IMPATIENT ROUTINE SERVICE COST CENTERS			col . 26)					
30.00 03000 ADULTS & PEDIATRICS 5,465,934 5,465,934 3,351 5,469,285 30.00 31.00 33.00 343.			1. 00	2.00	3.00	4. 00	5. 00	
33.00 03100 INTERNSIVE CARE UNIT 479,231 479,231 0 479,231 4	I NI	PATIENT ROUTINE SERVICE COST CENTERS						
479, 231 479, 231	30. 00 03	000 ADULTS & PEDIATRICS	5, 465, 934		5, 465, 934	3, 351	5, 469, 285	30.00
ANCILLARY SERVICE COST CENTERS	31. 00 03	100 INTENSIVE CARE UNIT	0		(0	0	31.00
50.00	43.00 04	300 NURSERY	479, 231		479, 231	0	479, 231	43.00
51.00 05100 DECOVERY ROOM & LABOR ROOM 2, 247, 745 2, 247, 745 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 247, 745 52.00 05300 DELIVERY ROOM & LABOR ROOM 2, 247, 745 52.00 05300 ANESTHESI OLOGY 57, 202 57, 202 57, 202 053.00 57, 202 53.00 54.00 05400 RADIOLOGY-DI AGNOSTIC 2, 499, 387 2, 499, 387 0 2, 499, 387 54.00 57.00 05700 CT SCAN 67, 458 67, 458 0 60, 0 6000 0 6000 0 6000 0 6000 0 6000 0 60, 0 6000 0 6000 0 60, 0 6000 0 6000 0 60, 0 6000 0 6000 0 60, 0	ANG	CILLARY SERVICE COST CENTERS						
S2.00 05200 DELIVERY ROOM & LABOR ROOM 2, 247, 745 52.00 53.00 05300 ANESTHESIOLOGY 57.202 57.202 0 57.202 53.00 57.202 53.00 57.202 53.00 57.202 53.00 57.202 53.00 57.202 53.00 57.202 53.00 57.202 53.00 57.202 53.00 57.00 5	50.00 050	OOO OPERATING ROOM	4, 416, 063		4, 416, 063	0	4, 416, 063	50.00
53.00 05300 AMESTHESI OLOGY 57, 202 57, 202 57, 202 58.00 54.00 5400 RADI OLOGY-DI AGNOSTI C 2, 499, 387 2, 499, 387 0 2, 499, 387 57.00	51.00 05	100 RECOVERY ROOM	0		(0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 499, 387 2, 499, 387 0 2, 499, 387 57. 00 5700 CT SCAN 67, 458 67, 458 67, 458 0 67, 458 58. 00 05800 MRI 243, 312 243, 312 0 243, 312 58. 00 0600 0.00	52. 00 05:	200 DELIVERY ROOM & LABOR ROOM	2, 247, 745		2, 247, 745	0	2, 247, 745	52.00
57. 00 05700 CT SCAN 67, 458 67, 458 0 67, 458 0 05800 MRI 243, 312 243, 312 0 243, 312 0 243, 312 0 243, 312 0 243, 312 0 243, 312 0 243, 312 0 243, 312 0 243, 312 0 243, 312 0 243, 312 0 3, 949, 99 60. 00 60. 00 06000 LABDRATORY 79, 938 0 795, 938 0	53. 00 05	300 ANESTHESI OLOGY	57, 202		57, 202	<u>2</u> o	57, 202	53.00
58. 00 05800 MRI 243, 312 243, 312 0 243, 312 58. 00 60. 00 60000 LABORATORY 3,940, 289 3,940, 289 3,940, 289 0. 00 3,940, 499 60. 00	54.00 05	400 RADI OLOGY-DI AGNOSTI C	2, 499, 387		2, 499, 387	0	2, 499, 387	54.00
60. 00 06000 LABORATORY 3,940,289 3,940,289 9,210 3,949,499 60. 00 63. 00 06300 BLODD STORING PROCESSING & TRA 170,143 170,143 0 170,143 63. 00 65. 00 06500 RESPIRATORY THERAPY 795,938 0 795,938 0 795,938 0 795,938 0 795,938 65. 00 66. 00 06600 PHYSI CAL THERAPY 2,567,718 0 2,567,718 1,187 2,568,905 66. 00 06900 ELECTROCARDI OLOGY 37,132 37,132 0 37,132 0 0 0 0 0 0 0 0 0	57. 00 05	700 CT SCAN	67, 458		67, 458	s o	67, 458	57.00
63.00 06300 BLOOD STORING PROCESSING & TRA 170, 143 170, 143 0 170, 143 63.00 65.00 06500 RESPIRATORY THERAPY 795, 938 0 795, 938 0 795, 938 65.00 66.00 06600 PHYSI CAL THERAPY 2, 567, 718 0 2, 567, 718 1, 187 2, 568, 905 66.00 69.00 06900 ELECTROCARDI OLOGY 37, 132 37, 132 0 37, 132 0 0 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 3, 207, 594 3, 207, 594 0 3, 207, 594 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 1, 384, 502 1, 384, 502 0 751, 109 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1, 384, 502 1, 384, 502 0 1, 384, 502 73.00 74.97 07697 CARDI AC REHABI LI TATI ON 371, 893 371, 893 1, 175 373, 068 76.97 77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 88.00 08800 RURAL HEALTH CLINI C 11, 713, 056 11, 713, 056 0 11, 713, 056 88.00 90.01 09000 CLI NI C 0 0 0 0 0 0 90.01 09000 CLI NI C 0 0 0 0 0 91.01 09101 EMERGENCY 2, 331, 043 2, 331, 043 0 2, 331, 043 91.00 91.01 09101 PRI ORITY CARE CARLYLE 49, 061 49, 061 0 49, 061 92.00 92.00 09002 OUTPATI ENT PSYCHI ATRI C 605, 236 605, 236 605, 236 200.00 102.00 01000 DITEATMENT PROGRAM 0 0 0 0 102.00 01000 DITEATMENT PROGRAM 0 0 0 0 102.00 01000 INTEREST EXPENSE 113, 00 103.00 13000 INTEREST EXPENSE 113, 00 103.00 13000 INTEREST EXPENSE 130, 00 200.00 0000 Subtrotal (see instructions) 43, 775, 840 0 43, 775, 840 605, 236 605, 236 605, 236 201.00 201.00 02000 DISES OSSE OST CENTERS 133, 00 00 0 0 0 201.00 0000 00000 000000 0000000000	58. 00 05	800 MRI	243, 312		243, 312	<u>2</u> o	243, 312	58. 00
65. 00 06500 RESPIRATORY THERAPY 795, 938 0 795, 938 0 795, 938 65. 00 66. 00 06600 PHYSI CAL THERAPY 2,567, 718 0 2,567, 718 1,187 2,568, 905 66. 00 06900 ELECTROCARDIO LOGY 37, 132 37, 132 0 3, 207, 594 0 3	60.00 06	000 LABORATORY	3, 940, 289		3, 940, 289	9, 210	3, 949, 499	60.00
66. 00 06600 PHYSICAL THERAPY 2,567,718 0 2,567,718 1,187 2,566,905 66. 00 6900 ELECTROCARDI OLOGY 37, 132 37, 132 0 37, 132 0 37, 132 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 3, 207, 594 3, 207, 594 0 3, 207, 594 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 751, 109 751, 109 0 751, 109 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 384, 502 1, 384, 502 0 1, 384, 502	63.00 06	300 BLOOD STORING PROCESSING & TRA	170, 143		170, 143	sl ol	170, 143	63.00
69. 00 06900 ELECTROCARDI OLOGY 37, 132 0 37, 132 0 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0	65. 00 06	500 RESPI RATORY THERAPY	795, 938	0	795, 938	s o	795, 938	65.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70. 00	66. 00 06	600 PHYSI CAL THERAPY	2, 567, 718	0	2, 567, 718	1, 187	2, 568, 905	66.00
71. 00	69. 00 06	900 ELECTROCARDI OLOGY	37, 132		37, 132	0	37, 132	69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 751, 109 751, 109 0 751, 109 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 1,384,502 1,384,502 0 1,384,502 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 371,893 371,893 1,175 373,068 76. 97 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0UTPATIENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 11,713,056 11,713,056 0 11,713,056 88. 00 90. 00 09000 CLINI C 0 0 0 0 0 90. 01 09001 CLINI C 0 0 0 0 0 90. 02 09002 0UTPATIENT PSYCHIATRI C 374,794 374,794 7,103 381,897 90.02 91. 00 09100 EMERGENCY 2,331,043 2,331,043 0 2,331,043 91.00 91. 01 09101 PRI ORI TY CARE CARLYLE 49,061 49,061 0 49,061 91.01 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT 605,236 605,236 605,236 605,236 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 43,775,840 22,026 43,797,866 200.00 201. 00 Less Observati on Beds 605,236 605,236 605,236 201.00	70.00 070	000 ELECTROENCEPHALOGRAPHY	0			ol ol	0	70.00
73. 00	71.00 07	100 MEDICAL SUPPLIES CHARGED TO PAT	3, 207, 594		3, 207, 594	ı ol	3, 207, 594	71.00
76. 97 07697 CARDI AC REHABILITATION 371, 893 371, 893 1, 175 373, 068 76. 97 77. 00 0700 ALLOGENEIC HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0	72. 00 07:	200 IMPL. DEV. CHARGED TO PATIENTS	751, 109		751, 109	el o	751, 109	72.00
77. 00	73. 00 07	300 DRUGS CHARGED TO PATIENTS	1, 384, 502		1, 384, 502	2 0	1, 384, 502	73.00
SERVICE COST CENTERS SERVICE COST CENTERS	76. 97 07	697 CARDI AC REHABI LI TATI ON	371, 893		371, 893	1, 175	373, 068	76. 97
88. 00	77. 00 07	700 ALLOGENEIC HSCT ACQUISITION	1				0	
90. 00 09000 CLINIC 0 0 0 0 0 90. 00 90. 01 90. 01 90. 01 90. 01 90. 02 90. 02 90. 02 09002 OUTPATIENT PSYCHIATRIC 374, 794 374, 794 7, 103 381, 897 90. 02 91. 00 09100 EMERGENCY 2, 331, 043 2, 331, 043 0 2, 331, 043 91. 00 91. 01 09101 PRI ORI TY CARE CARLYLE 49, 061 49, 061 0 49, 061 91. 01 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 605, 236 605, 236 605, 236 92. 00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPIOLD TREATMENT PROGRAM 0 0 0 102. 00 OTHER PROGRAM 0 0 0 102. 00 OTHER PROGRAM 0 0 0 0 0 0 0 0 0	OU ⁻	TPATIENT SERVICE COST CENTERS				'		
90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 02			11, 713, 056		11, 713, 056	0	11, 713, 056	88. 00
90. 02	90.00 09	DOO CLINIC	0			ol ol		
91. 00 09100 EMERGENCY 2, 331, 043 2, 331, 043 0 2, 331, 043 91. 00 91. 01 09101 PRI ORI TY CARE CARLYLE 49, 061 49, 061 0 49, 061 0 91. 01 09200 0BSERVATI ON BEDS (NON-DI STI NCT 605, 236 605, 236 605, 236 0 092. 00 09200	90. 01 09	001 CLI NI C	o			ol ol	0	90. 01
91. 00 09100 EMERGENCY 2, 331, 043 2, 331, 043 0 2, 331, 043 91. 00 91. 01 09101 PRI ORI TY CARE CARLYLE 49, 061 49, 061 0 49, 061 0 91. 01 09200 0BSERVATI ON BEDS (NON-DI STI NCT 605, 236 605, 236 605, 236 0 092. 00 09200	90. 02 090	002 OUTPATIENT PSYCHIATRIC	374, 794		374, 794	7, 103	381, 897	90. 02
91. 01			2, 331, 043		2, 331, 043		-	91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT 605, 236 605, 236 605, 236 92. 00 0THER REIMBURSABLE COST CENTERS 102. 00 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (see instructions) 43,775,840 0 43,775,840 22,026 43,797,866 200. 00 201. 00 Less Observation Beds 605,236 605,236 605,236 201. 00	91. 01 09	101 PRI ORI TY CARE CARLYLE						
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM O O O 102.00			1				-	
102. 00 10200 OPI OI D TREATMENT PROGRAM O O O 102. 00			222, 200		, , , , , , , , , , , , , , , , , , , ,		2227 222	
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 43,775,840 0 43,775,840 22,026 43,797,866 200.00 201.00 Less Observation Beds 605,236 605,236 605,236 201.00			0		(0	102.00
113. 00 11300 INTEREST EXPENSE	SPI	ECIAL PURPOSE COST CENTERS	<u>'</u>		<u>'</u>	<u>'</u>		1
201.00 Less Observation Beds 605, 236 605, 236 605, 236 605, 236								113.00
201.00 Less Observation Beds 605, 236 605, 236 605, 236 605, 236			43, 775, 840	0	43, 775, 840	22, 026	43, 797, 866	200.00
			1 1					
	202. 00	Total (see instructions)	43, 170, 604	0	43, 170, 604	22, 026	43, 192, 630	202.00

Health Financial Systems	ST. JOSEPHS HOSPITAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-01				
		From 07/01/2022 Part			

Cost Center Description					1	From 07/01/2022 To 06/30/2023	Part I Date/Time Pre 1/24/2024 12:	
Inpati ent					XVIII	Hospi tal	PPS	
NPATLENT ROUTINE SERVICE COST CENTERS		Cost Center Description	I npati ent				I npati ent	
30. 00 03000 ADULTS & PEDI ATRICS 4,252,988 4,252,988 30. 00 31. 00			6. 00	7.00	8. 00	9. 00	10.00	
31. 00 03100 INTENSIVE CARE UNIT 980,899 980,899 980,899 31. 00 43. 00 03000 NURSERY 990,899 980,899 980,899 50. 00 00. 000000 00. 00.		INPATIENT ROUTINE SERVICE COST CENTERS						
43.00			4, 252, 988		4, 252, 988	3		
ANCILLARY SERVICE COST CENTERS Service Cost Center Cost Cost Cost Cost Cost Cost Cost Cost			0					
50.00			980, 899		980, 899	9		43.00
51.00								
52.00 05200 05200 05200 05200 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 0540								
53.00 05300 ABESTHESI OLOGY 2, 105, 641 3, 285, 725 5, 391, 366 0, 010610 0, 000000 53.00 54.00 05400 RADIOLOGY-DI AGNOSTI C 1, 235, 290 17, 033, 865 18, 269, 155 0, 136809 0, 000000 57.00 58.00 05700 CT SCAN 3, 107, 909 20, 042, 792 23, 150, 701 0, 002914 0, 000000 57.00 58.00 05800 MRI 376, 749 6, 401, 153 6, 777, 902 0, 035898 0, 000000 60.00 60.00 6000 LABORATORY 5, 862, 737 27, 335, 586 33, 198, 323 0, 118689 0, 000000 60.00 63.00 06300 BLOOD STORI NG PROCESSI NG & TRA 402, 150 400, 996 803, 146 0, 211846 0, 000000 63.00 65.00 05600 RESPI RATORY THERAPY 950, 550 1, 221, 373 2, 171, 923 0, 366467 0, 000000 66.00 66.00 06600 PHYSI CAL THERAPY 1, 093, 628 8, 644, 085 9, 357, 713 0, 274396 0, 000000 66.00 67.00 07000 07000 LECTROCARDI OLOGY 367, 786 2, 075, 159 2, 442, 945 0, 015200 0, 000000 69.00 67.00 07000 LECTROCARDI OLOGY 367, 786 2, 075, 159 2, 442, 945 0, 015200 0, 000000 71.00 67.00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 1, 127, 995 2, 658, 957 3, 786, 952 0, 847012 0, 000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 620, 990 2, 093, 140 2, 714, 130 0, 276740 0, 000000 73.00 76.97 07400 07597 CARDI AC REHABI LI TATI ON 328 238, 338 238, 666 1, 558215 0, 000000 76.97 77.00 07700 ALDGENEIC HSCT ACQUI SITI ON 0 0 0, 000000 0, 0000				-	1			
S4.00 OS400 RADI OLOGY-DI AGNOSTI C 1, 235, 290 17, 033, 865 18, 269, 155 0, 136809 0, 000000 54, 000 0570. 00 0570. 00 0570. 00 05800 MRI 376, 749 6, 401, 153 6, 777, 902 0.035898 0.000000 58, 00 0600 0.00000 0.000000								
57. 00 05700 CT SCAN 3, 107, 909 20, 042, 792 23, 150, 701 0.002014 0.000000 57. 00		· ·						
58. 00 05800 MR 376, 749 6, 401, 153 6, 777, 902 0. 035898 0. 000000 58. 00 60. 00 06000 LABORATORY 5, 862, 737 27, 335, 586 33, 198, 323 0. 118689 0. 000000 60. 00 65. 00 65. 00 06500 RESPI RATORY THERAPY 950, 550 1, 221, 373 2, 171, 923 0. 366467 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 093, 628 8, 264, 085 9, 357, 713 0. 274396 0. 000000 66. 00 06900 ELECTROCARDI OLOGY 367, 786 2, 075, 159 2, 442, 945 0. 015200 0. 000000 70. 00 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 70. 00 70. 00 0. 000000 0. 000000 70. 00 70. 00 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 70. 00 70. 00 0. 000000 0. 000000 70. 00 70. 00 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 70. 00 70. 00 0. 000000 0. 000000 70. 00 70. 00 0. 000000 0. 000000 70. 00 70. 00 0. 000000 0. 000000 70. 00 70. 00 0. 000000 0. 000000 70. 00 0. 000000 70. 00 70. 00 0. 000000 70. 000000 70. 00 0. 000000 70. 000000 70. 000000 70. 000								
60.00 06000 LABORATORY 5, 862, 737 27, 335, 586 33, 198, 323 0. 118689 0. 000000 60. 00 63. 00 63. 00 63. 00 63. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 66.								
63. 00 06300 BLOOD STORING PROCESSING & TRA 402, 150 400, 996 803, 146 0. 211846 0. 000000 63. 00 65. 00 06500 RESPIRATORY THERAPY 950, 550 1, 221, 373 2, 171, 923 0. 366467 0. 000000 65. 00 66. 00 06600 PHYSIC CAL THERAPY 1, 093, 628 8, 264, 085 9, 357, 713 0. 274396 0. 000000 66. 00 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000								
65.00 06500 RESPIRATORY THERAPY 950, 550 1, 221, 373 2, 171, 923 0. 366467 0. 000000 65.00 66.00 06600 PHYSI CAL THERAPY 1, 093, 628 8, 264, 085 9, 357, 713 0. 274396 0. 000000 66.00 69.00 06900 ELECTROCARDI OLOGY 367, 786 2, 075, 159 2, 442, 945 0. 015200 0. 0000000 69.00 0. 000000 70.00 0. 000000 70.00 0. 000000 70.00 71.00 0. 0100000 0. 000000 70.00 71.00 0. 01000000 71.00 0. 000000 71.00 0. 000000 71.00 0. 000000 72.00 0. 000000 0. 000000 72.00 0. 0000000 0. 0000000 0. 0000000 0. 00000000			1 ' ' 1					
66. 00 06600 PHYSI CAL THERAPY 1,093,628 8,264,085 9,357,713 0.274396 0.000000 66.00 69.00 0.000000 0.000000 69.00 0.0000000 0.000000 0.0000000 0.0000000 0.00000000								
69. 00 06900 CLECTROCARDI OLOGY 367, 786 2,075,159 2,442,945 0.015200 0.000000 69. 00 70. 00 07000 CLECTROENCEPHALOGRAPHY 0 0 0 0 0 0.000000 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 1,127,995 2,658,957 3,786,952 0.847012 0.00000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 620,990 2,093,140 2,714,130 0.276740 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 2,844,887 5,829,895 8,674,782 0.159601 0.000000 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 328 238,338 238,666 1.558215 0.000000 76. 97 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0.000000 0.000000 77. 00 00TPATI ENT SERVI CE COST CENTERS 88. 00 88. 00 08800 RURAL HEALTH CLI NI C 0 12,619,420 0.000000 0.000000 90. 00 90. 01 09001 CLI NI C 0 0 0 0 0.000000 0.000000 90. 00 90. 01 09001 CLI NI C 0 642,083 642,083 0.583716 0.000000 90. 01 90. 02 09002 0UTPATI ENT PSYCHI ATRI C 0 642,083 642,083 0.583716 0.000000 90. 02 91. 00 09100 EMERGENCY 2,088,398 12,393,639 14,482,037 0.160961 0.000000 91. 01 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT 223,673 512,147 735,820 0.82533 0.000000 92. 00 0THER REIMBURSABLE COST CENTERS 113. 00 1000 0 0 0 0THER REIMBURSABLE COST CENTERS 113. 00 1000 0 0 0 0 0THER REIMBURSABLE COST CENTERS 113. 00 1000 0 0 0 0 0 0 0								
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0								
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 1, 127, 995 2, 658, 957 3, 786, 952 0. 847012 0. 000000 71. 00 72. 00 72. 00 1MPL. DEV. CHARGED TO PATIENTS 620, 990 2, 093, 140 2, 714, 130 0. 276740 0. 000000 72. 00 73. 00 73. 00 73. 00 70. 00 DRUGS CHARGED TO PATIENTS 2, 844, 887 5, 829, 895 8, 674, 782 0. 159601 0. 000000 73. 00 76. 97 7			1 .1					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 620, 990 2, 093, 140 2, 714, 130 0. 276740 0. 000000 72. 00 73. 00 73. 00 73. 00 73. 00 74. 00			1 9	ŭ	-			
73. 00			1 ' ' 1					
76. 97			1					
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0								
SB. 00			1					
88. 00			١			0.000000	0.000000	77.00
90. 00			0	12, 619, 420	12, 619, 420			88.00
90. 01			o				0.000000	
90. 02			o	0				
91. 00	90. 02	09002 OUTPATIENT PSYCHIATRIC	0	642, 083	642, 083			
91. 01 09101 PRI ORI TY CARE CARLYLE 0 29, 952 29, 952 1. 637987 0. 000000 91. 01 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT 223, 673 512, 147 735, 820 0. 822533 0. 000000 92. 00			2, 088, 398					
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O	91. 01	09101 PRIORITY CARE CARLYLE		29, 952			0. 000000	91.01
102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O	92.00	09200 OBSERVATION BEDS (NON-DISTINCT	223, 673	512, 147	735, 820	0. 822533	0.000000	92.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 34,412,653 142,886,949 177,299,602 200.00 201.00 Less Observation Beds 201.00		OTHER REIMBURSABLE COST CENTERS						
113.00	102.00	10200 OPIOID TREATMENT PROGRAM	0	0	()		102.00
200.00 Subtotal (see instructions) 34,412,653 142,886,949 177,299,602 200.00 Less Observation Beds 200.00	Ī	SPECIAL PURPOSE COST CENTERS						
201.00 Less Observation Beds 201.00	113. 00							
			34, 412, 653	142, 886, 949	177, 299, 602	2		
202.00 Total (see instructions) 34,412,653 142,886,949 177,299,602 202.00	201.00	Less Observation Beds						
	202. 00	Total (see instructions)	34, 412, 653	142, 886, 949	177, 299, 602	2		202. 00

Heal th Financial Systems

ST. JOSEPHS HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0145

From 07/01/2022
To 06/30/2023
Date/Time Prepared:
1/24/2024 13: 20 pm

			10 06/30/2023	Date/II me Prepared: 1/24/2024 12:29 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 202602			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 470047			52.00
53. 00 05300 ANESTHESI OLOGY	0. 010610			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 136809			54.00
57. 00 05700 CT SCAN	0. 002914			57.00
58. 00 05800 MRI	0. 035898			58.00
60. 00 06000 LABORATORY	0. 118967			60.00
63.00 06300 BLOOD STORING PROCESSING & TRA	0. 211846			63.00
65. 00 06500 RESPI RATORY THERAPY	0. 366467			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 274523			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 015200			69. 00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 847012			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 276740			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 159601			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	1. 563138			76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88.00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 CLI NI C	0. 000000			90. 01
90. 02 09002 0UTPATI ENT PSYCHI ATRI C	0. 594778			90. 02
91. 00 09100 EMERGENCY	0. 160961			91.00
91. 01 09101 PRI ORI TY CARE CARLYLE	1. 637987			91. 01
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT	0. 822533			92. 00
OTHER REIMBURSABLE COST CENTERS				
102.00 10200 OPIOID TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)	1			202. 00

Health Financial Systems	ST. JOSEPHS HOSPITAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-0145	Peri od: Worksheet C From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared:			

				1	o 06/30/2023	Date/Time Pre 1/24/2024 12:	
			Ti tl	e XIX	Hospi tal	Cost	27 piii
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	, and the second	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	,				
		col . 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 465, 934		5, 465, 934	3, 351	5, 469, 285	30.00
31.00	03100 INTENSIVE CARE UNIT	0		(0	0	31.00
43.00	04300 NURSERY	479, 231		479, 231	0	479, 231	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 416, 063		4, 416, 063	0	4, 416, 063	
51.00	05100 RECOVERY ROOM	0		(- 1	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 247, 745		2, 247, 745	0	2, 247, 745	
53.00	05300 ANESTHESI OLOGY	57, 202		57, 202		57, 202	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 499, 387		2, 499, 387	' 이	2, 499, 387	54.00
57.00	05700 CT SCAN	67, 458		67, 458	0	67, 458	
58. 00	05800 MRI	243, 312		243, 312		243, 312	
60.00	06000 LABORATORY	3, 940, 289		3, 940, 289	9, 210	3, 949, 499	
63.00	06300 BLOOD STORING PROCESSING & TRA	170, 143		170, 143		170, 143	
65.00	06500 RESPI RATORY THERAPY	795, 938	0	795, 938	0	795, 938	65.00
66.00	06600 PHYSI CAL THERAPY	2, 567, 718	0	2, 567, 718	1, 187	2, 568, 905	
69. 00	06900 ELECTROCARDI OLOGY	37, 132		37, 132	2 0	37, 132	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		(0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	3, 207, 594		3, 207, 594	ا ا	3, 207, 594	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	751, 109		751, 109	0	751, 109	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 384, 502		1, 384, 502		1, 384, 502	
	07697 CARDI AC REHABI LI TATI ON	371, 893		371, 893	1, 175	373, 068	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		(0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	11, 713, 056		11, 713, 056	0	11, 713, 056	
90. 00	09000 CLI NI C	0		(0	0	90.00
90. 01	09001 CLI NI C	0		(0	0	90. 01
90. 02	09002 OUTPATI ENT PSYCHI ATRI C	374, 794		374, 794		381, 897	
	09100 EMERGENCY	2, 331, 043		2, 331, 043		2, 331, 043	
91. 01	09101 PRI ORI TY CARE CARLYLE	49, 061		49, 061		49, 061	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	605, 236		605, 236		605, 236	92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0		()	0	102.00
	SPECIAL PURPOSE COST CENTERS	ı					
	11300 I NTEREST EXPENSE						113. 00
200.00	, ,	43, 775, 840	0	,		43, 797, 866	
201.00		605, 236		605, 236		605, 236	
202.00	Total (see instructions)	43, 170, 604	0	43, 170, 604	22, 026	43, 192, 630	202.00

Health Financial Systems	ST. JOSEPHS HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-0145	Period: Worksheet C
		From 07/01/2022 Part I
		T- 0/ /20/2022 D-+- /T: D

				-	From 07/01/2022 To 06/30/2023	Part I Date/Time Pre 1/24/2024 12:	
				e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 252, 988		4, 252, 988	3		30.00
31.00	03100 INTENSIVE CARE UNIT	0		()		31.00
43.00	04300 NURSERY	980, 899		980, 899	9		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 009, 528	18, 787, 210	21, 796, 738	0. 202602	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	(0. 000000	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 760, 527	1, 021, 434	4, 781, 96°	0. 470047	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	2, 105, 641	3, 285, 725	5, 391, 366	0. 010610	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 235, 290	17, 033, 865	18, 269, 15	0. 136809	0.000000	54.00
57.00	05700 CT SCAN	3, 107, 909	20, 042, 792	23, 150, 70 ⁻	0. 002914	0.000000	57.00
58.00	05800 MRI	376, 749	6, 401, 153	6, 777, 902	0. 035898	0.000000	58.00
60.00	06000 LABORATORY	5, 862, 737	27, 335, 586	33, 198, 323	0. 118689	0.000000	60.00
63.00	06300 BLOOD STORING PROCESSING & TRA	402, 150	400, 996			0. 000000	63.00
65.00	06500 RESPI RATORY THERAPY	950, 550	1, 221, 373	2, 171, 92	0. 366467	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	1, 093, 628	8, 264, 085	9, 357, 713	0. 274396	0. 000000	66.00
69.00	06900 ELECTROCARDI OLOGY	367, 786	2, 075, 159	2, 442, 945	0. 015200	0. 000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000	0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1, 127, 995	2, 658, 957	3, 786, 952	0. 847012	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	620, 990	2, 093, 140	2, 714, 130	0. 276740	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 844, 887	5, 829, 895	8, 674, 782	0. 159601	0. 000000	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	328	238, 338	238, 666	1. 558215	0. 000000	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	o	0		0. 000000	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	12, 619, 420	12, 619, 420	0. 928177	0.000000	88. 00
90.00	09000 CLI NI C	0	0	(0. 000000	0.000000	90.00
90. 01	09001 CLI NI C	o	0	(0. 000000	0.000000	90. 01
90. 02	09002 OUTPATIENT PSYCHIATRIC	o	642, 083	642, 083	0. 583716	0.000000	90.02
91.00	09100 EMERGENCY	2, 088, 398	12, 393, 639	14, 482, 03	0. 160961	0.000000	91.00
91. 01	09101 PRI ORI TY CARE CARLYLE	O	29, 952	29, 952	1. 637987	0.000000	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	223, 673	512, 147	735, 820		0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS				•		
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	(102.00
	SPECIAL PURPOSE COST CENTERS	· '					
113.00	11300 I NTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	34, 412, 653	142, 886, 949	177, 299, 602	2		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	34, 412, 653	142, 886, 949	177, 299, 602	2		202.00

Heal th Financial Systems

ST. JOSEPHS HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0145
From 07/01/2022
To 06/30/2023
Date/Time Prepared:

			10 06/30/2023	Date/II me Prepared: 1/24/2024 12:29 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57. 00 05700 CT SCAN	0. 000000			57. 00
58. 00 05800 MRI	0. 000000			58.00
60. 00 06000 LABORATORY	0. 000000			60.00
63. 00 06300 BLOOD STORING PROCESSING & TRA	0. 000000			63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT	0. 000000			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000			76. 97 77. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0. 000000			//.00
	0.000000			98.00
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC	0. 000000 0. 000000			88. 00 90. 00
90. 00 09000 CEI NI C 90. 01 09001 CLI NI C	0. 000000			90.00
90. 01 09001 CETNI C 90. 02 09002 OUTPATI ENT PSYCHI ATRI C	0. 000000			90.01
91. 00 09100 EMERGENCY	0. 000000			91.00
91. 01 09101 PRI ORI TY CARE CARLYLE	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	0.000000			72.00
102. 00 10200 OPI OI D TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS	1			
113. 00 11300 NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	ST. JOSEPHS	HOSPI TAL	OSPITAL In Lieu		u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provi der Co	Provi der CCN: 14-0145		Worksheet D Part I Date/Time Pre 1/24/2024 12:	pared:
		Title	XVIII	Hospi tal	PPS	2, p
Cost Center Description	Capital Related Cost (from Wkst. B, Part II,	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 -	Total Patient Days	Per Diem (col. 3 / col. 4)	
	col . 26) 1.00	2.00	col . 2) 3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT	428, 742 0	695	428, 04	7 4, 105 0 0	104. 27 0. 00	30. 00 31. 00
43. 00 NURSERY	25, 331		25, 33 ⁻	1 997	25. 41	43.00
200.00 Total (lines 30 through 199)	454, 073		453, 378	5, 102		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6) 7.00				
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 43.00 NURSERY 200.00 Total (lines 30 through 199)	1, 491 0 0 1, 491	0				30. 00 31. 00 43. 00 200. 00

Cost Center Description	Health Financial Systems	ST. JOSEPHS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Capit al Related Cost (from Wkst. B, Part II, col. 8)	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS		F	From 07/01/2022 To 06/30/2023	Part II Date/Time Pre 1/24/2024 12:	
Related Cost							
ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00	Cost Center Description						
B. Part II, col. 26					9		
COL 26 COL 26 COL 26 COL 26 COL 20 C					Charges	column 4)	
1.00 2.00 3.00 4.00 5.00			col. 8)	col. 2)			
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATING ROOM 732, 773 21, 796, 738 0.033618 996, 326 33, 494 50. 00 51. 00 0 0 0.000000 0 0 0 51. 00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 106, 647 4, 781, 961 0.022302 0 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 106, 647 4, 781, 961 0.022302 0 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 106, 647 4, 781, 961 0.022302 0 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 106, 647 4, 781, 961 0.022302 0 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 106, 647 4, 781, 961 0.022302 0 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 106, 647 4, 781, 961 0.022302 0 0 0.0000507 1, 556, 471 789 57. 00 05700 CT SCAN 11, 746 23, 150, 701 0.000507 1, 556, 471 789 57. 00 05700 CT SCAN 11, 744 23, 150, 701 0.000507 1, 556, 471 789 57. 00 05800 MRI 15, 444 6, 777, 902 0.002279 165, 030 376 58. 00 06900 LABORATORY 215, 550 33, 198, 323 0.006493 2, 426, 073 15, 752 60. 00 06300 BLOOD STORING PROCESSING & TRA 7, 760 803, 146 0.009662 47, 509 4459 63. 00 65. 00 06500 RESPI RATORY THERAPY 41, 257 2, 171, 923 0.018996 427, 208 8, 115 65. 00 66. 00 06600 PHYSI CAL THERAPY 189, 837 9, 357, 713 0.020287 367, 314 7, 452 66. 00 06900 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0 0 0.000000 0		1. 00	2.00	3.00	4.00	5. 00	
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0		700 770			201 201	20.404	
52.00 05200 DELI VERY ROOM & LABOR ROOM 106, 647 4, 781, 961 0. 022302 0 0 0 52.00 53.00 05300 AMESTHES LOGY 37, 608 5, 391, 366 0. 00600676 189, 828 1, 324 53.00 54.00 05400 RADIO LOGY-DI AGNOSTI C 348, 506 18, 269, 155 0. 019076 643, 994 12, 285 54.00 57.00 05700 CT SCAN 11, 746 23, 150, 701 0. 000507 1, 556, 471 789 57.00 60.00 06000 LABORATORY 215, 555 33, 198, 323 0. 006493 2, 426, 073 15, 752, 60.00 63.00 63.00 06300 BLOOD STORI NG PROCESSI NG & TRA 7, 760 803, 146 0. 009662 47, 509 459 63.00 66.00 06600 PHYSI CAL THERAPY 41, 257 2, 171, 923 0. 018996 427, 208 8, 115 65.00 66.00 06600 PHYSI CAL THERAPY 419, 257 2, 171, 923 0. 018996 427, 303 73.14 7, 452 66.00 <td></td> <td>1</td> <td>l .</td> <td></td> <td></td> <td></td> <td></td>		1	l .				
53.00 0 5300 ANESTHESI OLOGY 37,608 5,391,366 0.006976 189,828 1,324 53.00 13,24 53.00 53.00 0 5000 RADI OLOGY-DI AGNOSTI C 348,506 18,269,155 0.019076 643,994 12,285 54.00 12,285 54.00 54.00 57.00 0 5700 CT SCAN 11,746 23,150,701 0.000507 1,556,471 789 57.00 58.00 0 5800 MRI 15,544 6,777,902 0.002279 165,030 376 58.00 360.00 0 6000 LABDRATORY 215,550 33,198,323 0.006493 2,426,073 15,752 60.00 33.198,323 0.006493 2,426,073 15,752 60.00 450.00 0 6300 BLOOD STORI NG PROCESSI NG & TRA 7,760 803,146 0.009662 47,509 459 63.00 36.00 0 6300 BLOOD STORI NG PROCESSI NG & TRA 7,760 803,146 0.009662 47,509 459 63.00 36.00 0 6500 RESPI RATORY THERAPY 189,837 9,357,713 0.020287 367,314 7,452 66.00 45.00 47,509 459 63.00 36.00 0 6600 PHYSI CAL THERAPY 189,837 9,357,713 0.020287 367,314 7,452 66.00 37.314 7,452 66.00 36.00 0 6600 PHYSI CAL THERAPY 189,837 9,357,713 0.020287 367,314 7,452 69.00 37.00 37.0		· ·	ı			_	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 348, 506 18, 269, 155 0.019076 643, 994 12, 285 54. 00 57. 00 05700 CT SCAN 11, 746 23, 150, 701 0.000507 1, 556, 471 789 57. 00 60. 00 06000 LABORATORY 215, 550 33, 198, 323 0.006493 2, 426, 073 15, 752 60. 00 63. 00 06300 BLOOD STORI NG PROCESSI NG & TRA 7, 760 803, 146 0.009662 47, 509 459 63. 00 65. 00 06500 RESPI RATORY THERAPY 41, 257 2, 171, 923 0.018996 427, 208 8, 115 65. 00 66. 00 06600 PHYSI CAL THERAPY 18, 837 9, 357, 713 0.020287 367, 314 7, 452 66. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 763 2, 442, 945 0.000722 196, 973 142 69. 00 70. 00 07000 ELECTROCARCEPHALOGRAPHY 0 0.000000 0.000000 0 0.7000 0.000000 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>_</td> <td></td>						_	
57. 00 05700 CT SCAN 11, 746 23, 150, 701 0.000507 1, 556, 471 789 57. 00 5800 MRI 15, 444 6, 777, 902 0.002279 165, 003 376 58. 00 60. 00 6000 LABORATORY 215, 550 33, 198, 323 0.006493 2, 426, 073 15, 752 60. 00 60. 00 6000 LABORATORY 41, 257 2, 171, 923 0.018996 427, 208 8, 115 65. 00 6500 RESPIRATORY THERAPY 41, 257 2, 171, 923 0.018996 427, 208 8, 115 65. 00 66. 00 6600 PHYSI CAL THERAPY 189, 837 9, 357, 713 0.020287 367, 314 7, 452 66. 00 69. 00 6900 ELECTROCARDI OLOGY 1, 763 2, 442, 945 0.000722 196, 973 142 69. 00 70. 00 7000 ELECTROCARDI OLOGY 1, 763 2, 442, 945 0.000722 196, 973 142 69. 00 70. 00 7000 MEDI CAL SUPPLI ES CHARGED TO PAT 173, 673 3, 786, 952 0.045861 475, 590 21, 811 71. 00 7000 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 34, 124 2, 714, 130 0.012573 431, 425 5, 424 72. 00 73. 00 70300 DRUGS CHARGED TO PATI ENTS 34, 124 2, 714, 130 0.012573 431, 425 5, 424 72. 00 7400 MPL. DEV. CHARGED TO PATI ENTS 62, 346 8, 674, 782 0.007187 1, 038, 661 7, 465 73. 00 7697 CARDI AC REHABI LI TATI ON 38, 109 238, 666 0.159675 163 26 76. 97 77. 00 7700 ALLOGENEI C HSCT ACQUI SI TI ON 0 70. 00 0.000000 0 0 0.000000 0 0 0.000000							
58. 00 05800 MRI 15, 444 6, 777, 902 (0.002279) 165, 030 (0.00279) 165, 030 (0.00277) 376 (0.00277) 58. 00 (0.002279) 165, 030 (0.00277) 376 (0.002279) 165, 030 (0.002279) 15, 550 (0.002279) 165, 030 (0.002279) 165, 030 (0.002279) 165, 030 (0.002279) 165, 030 (0.002279) 165, 030 (0.002279) 165, 030 (0.002279) 165, 030 (0.002279) 459 (63, 00) 63, 00 660, 00 169, 00 459, 50 (0.002277) 452 (0.002277) 452 (0.002277) 452 (0.002277) 452 (0.002277) 452 (0.002277) 452 (0.002277) 452 (0.002277) 452 (0.002277) 452 (0.002277) 452 (0.002277) 452 (0.002277)							
60. 00							
63. 00	· · · · · · · · · · · · · · · · · · ·						
65. 00	· · · · · · · · · · · · · · · · · · ·						
66. 00					· ·		
69. 00 06900 ELECTROCARDI OLOGY 1, 763 2, 442, 945 0. 000722 196, 973 142 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0. 000000 0 0 0. 000000 0 0 0. 000000 0 0 0. 000000 0 0 0. 000000 0 0 0. 000000 0 0 0. 000000 0 0 0. 000000 0 0 0. 000000 0 0 0. 000000 0 0 0. 000000 0 0 0. 000000 0 0 0. 000000 0 0. 0000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 0000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 0000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 00000000							
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 173, 673 3,786,952 0.045861 475,590 21,811 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 34,124 2,714,130 0.012573 431,425 5,424 72.00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 62,346 8,674,782 0.007187 1,038,661 7,465 73.00 76. 97 CARDI AC REHABI LI TATI ON 38,109 238,666 0.159675 163 26 76.97 70. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0.000000 0 0 0 0 0 0 0 0 77.00 0							
71. 00	, , , , , , , , , , , , , , , , , , ,						
72. 00						_	
73. 00 07300 DRUGS CHARGED TO PATIENTS 62, 346 8, 674, 782 0. 007187 1, 038, 661 7, 465 73. 00 76. 97 CARDI AC REHABILITATION 38, 109 238, 666 0. 159675 163 26 76. 97 77. 00 0.000000 0 0 0 0 0 0	· · · · · · · · · · · · · · · · · · ·				· ·		
76. 97					· ·		
77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 0 0	· · · · · · · · · · · · · · · · · · ·						
SECTION SUPPRITIENT SERVICE COST CENTERS SECTION SEC							
88. 00 08800 RURAL HEALTH CLINIC 724, 257 12, 619, 420 0.057392 0 0 088.00 09000 0 0 000000 0 0 0				0.00000	<u>) </u>	U	17.00
90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0		724 257	12 610 420	0.05730	0	0	88 00
90. 01 09001 CLINI C 0 0.000000 0 0 90. 01 90. 02 000000 0 0 90. 02 000000 0 90. 02 000000 0 90. 02 0000000 0 90. 02 0000000 0 90. 02 000000000 0 90. 02 000000000 0 90. 02 0000000000 0 90. 02 00000000000 0 90. 02 0000000000000 0 90. 02 00000000000000000000000000000000		1	1			_	
90. 02 09002 0UTPATI ENT PSYCHI ATRI C 25, 636 642, 083 0. 039926 0 0 90. 02 0 91. 00 0 91. 00 0 91. 01 0 91. 01 0 0 0 0 0 0 0 0 0		0	0				
91. 00 09100 EMERGENCY 175, 244 14, 482, 037 0. 012101 1, 048, 077 12, 683 91. 00 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT 47, 445 735, 820 0. 064479 106, 496 6, 867 92. 00 93. 01 94. 00 94. 01 94.		25 636	642 083	•			
91. 01 09101 PRI ORI TY CARE CARLYLE 35, 945 29, 952 1. 200087 0 0 91. 01 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT 47, 445 735, 820 0. 064479 106, 496 6, 867 92. 00							
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT 47,445 735,820 0.064479 106,496 6,867 92. 00			l '				
				•		_	
				•			

Health Financial Systems	ST. JOSEPHS	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS		<u> </u>	Period: From 07/01/2022 Fo 06/30/2023	Worksheet D Part III Date/Time Pre 1/24/2024 12:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)	,	
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0	4, 105	5 0.00	1, 491	30.00
31.00 03100 INTENSIVE CARE UNIT		0	(0.00	0	31.00
43. 00 04300 NURSERY		0	99	7 0.00	0	43.00
200.00 Total (lines 30 through 199)		0	5, 102	2	1, 491	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	*					

 Heal th Financial
 Systems
 ST. JOSEPHS HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 14-0145
 In Lieu of Form CMS-2552-10

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

				10 00/30/2023	1/24/2024 12:	29 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	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
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
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
57. 00 05700 CT SCAN	0	0		0	0	57.00
58. 00 05800 MRI	0	0		0	0	58. 00
60. 00 06000 LABORATORY	0	0		0	0	60.00
63. 00 06300 BLOOD STORING PROCESSING & TRA	0	0		0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	
77. 00 O7700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	1 0		I			00.00
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC	0	0		0 0	0	88. 00 90. 00
90. 00 09000 CLI NI C 90. 01 09001 CLI NI C	0	0		0	Ĭ.	
90. 01 09001 CLINI C 90. 02 09002 OUTPATI ENT PSYCHI ATRI C	0	0		0	0	90. 01 90. 02
	0	0		0	0	
91. 00 09100 EMERGENCY 91. 01 09101 PRI ORI TY CARE CARLYLE		0			0	91.00
				0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT		_			0	92.00
200.00 Total (lines 50 through 199)	1 0	0	l	0	0	200. 00

Health Financial Systems	ST. JOSEPHS HOSPITAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 14-0145	Peri od:	Worksheet D

From 07/01/2022 Part IV To 06/30/2023 Date/Time Prepared: THROUGH COSTS 1/24/2024 12:29 pm Title XVIII Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 4. 00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 21, 796, 738 0.000000 50.00 05100 RECOVERY ROOM 0 0 0.000000 51.00 51.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 4, 781, 961 52.00 52.00 0 05300 ANESTHESI OLOGY 0 0 53.00 5, 391, 366 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 18, 269, 155 0.000000 54.00 57.00 05700 CT SCAN 0 23, 150, 701 0.000000 57.00 0 58.00 05800 MRI 0 6, 777, 902 0.000000 58.00 06000 LABORATORY 0 60.00 0 33, 198, 323 0.000000 60.00 63.00 06300 BLOOD STORING PROCESSING & TRA 803, 146 0.000000 63.00 2, 171, 923 9, 357, 713 06500 RESPIRATORY THERAPY 0 0 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 0 0 0.000000 66.00 66.00 69.00 06900 ELECTROCARDI OLOGY 0 2, 442, 945 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0.000000 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 0 3, 786, 952 0.000000 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 2, 714, 130 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 8, 674, 782 0.000000 73.00 07697 CARDIAC REHABILITATION 0 76. 97 0 238, 666 0.000000 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0.000000 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 12, 619, 420 0.000000 88.00 0 90.00 09000 CLI NI C 0 0 0 0 0 0 0.000000 90.00 0 09001 CLI NI C 90 01 0 0.000000 90 01 0 09002 OUTPATIENT PSYCHIATRIC 90.02 0 642, 083 0.000000 90.02 91.00 09100 EMERGENCY 0 0 14, 482, 037 0.000000 91.00 29, 952 91. 01 09101 PRI ORI TY CARE CARLYLE 0 0 0.000000 91.01

0

0

0

735, 820

172, 065, 715

0.000000

92.00

200.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT

Total (lines 50 through 199)

200.00

Health Financial Systems	ST. JOSEPHS HOSPITAL	In Lieu o	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 1		orksheet D
THROUGH COSTS		From 07/01/2022 P	art IV

THROUG	H COSTS				rom 07/01/2022 o 06/30/2023		
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col . 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS	T		ı			
	05000 OPERATING ROOM	0. 000000	996, 326	[C	3, 882, 759	0	00.00
	05100 RECOVERY ROOM	0. 000000	0	C	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	C	0	0	52.00
	05300 ANESTHESI OLOGY	0. 000000	189, 828		655, 945	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	643, 994		4, 477, 577	0	54.00
	05700 CT SCAN	0. 000000	1, 556, 471		6, 945, 339	0	57.00
	05800 MRI	0. 000000	165, 030		1, 774, 635	0	58. 00
	06000 LABORATORY	0. 000000	2, 426, 073		2, 763, 063	0	60.00
	06300 BLOOD STORING PROCESSING & TRA	0. 000000	47, 509		43, 330	0	63.00
	06500 RESPI RATORY THERAPY	0. 000000	427, 208	[C	376, 991	0	65.00
	06600 PHYSI CAL THERAPY	0. 000000	367, 314	C	91, 520	0	66.00
	06900 ELECTROCARDI OLOGY	0. 000000	196, 973	C	641, 967	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	C	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000	475, 590	C	482, 888	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	431, 425	C	526, 043	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 038, 661	C	1, 518, 696	0	73.00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	163	C	84, 507	0	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	C	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0	C	0	0	88. 00
90.00	09000 CLI NI C	0. 000000	0	C	0	0	90.00
	09001 CLI NI C	0. 000000	0	C	0	0	90. 01
90. 02	09002 OUTPATIENT PSYCHIATRIC	0. 000000	0	C	407, 642	0	90. 02
91.00	09100 EMERGENCY	0. 000000	1, 048, 077	C	2, 878, 287	0	91.00
91.01	09101 PRI ORI TY CARE CARLYLE	0. 000000	0	C	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000	106, 496	[C	244, 213	0	92.00
200.00	Total (lines 50 through 199)		10, 117, 138	(27, 795, 402	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 14-0145 Peri od: Worksheet D From 07/01/2022 Part V 06/30/2023 Date/Time Prepared: 1/24/2024 12: 29 pm Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 202602 3, 882, 759 786, 655 50.00 05100 RECOVERY ROOM 0 0.000000 51.00 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0.470047 0 52.00 53.00 05300 ANESTHESI OLOGY 0.010610 655, 945 0 6,960 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.136809 4, 477, 577 0 612, 573 54.00 0 0.002914 6, 945, 339 57 00 05700 CT SCAN 0 20, 239 57.00 0 58.00 05800 MRI 0.035898 1, 774, 635 0 63, 706 58.00 60.00 06000 LABORATORY 0.118689 2, 763, 063 18, 482 o 327, 945 60.00 0 63.00 06300 BLOOD STORING PROCESSING & TRA 43, 330 0 9, 179 0.211846 63.00 06500 RESPIRATORY THERAPY 376, 991 0 65.00 0.366467 138, 155 65.00 66.00 06600 PHYSI CAL THERAPY 0.274396 91, 520 0 25, 113 66.00 06900 ELECTROCARDI OLOGY 0 69.00 0.015200 641, 967 0 9, 758 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70 00 0 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0.847012 482, 888 0 0 409, 012 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 276740 526, 043 0 0 145, 577 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 159601 1, 518, 696 0 4, 353 242, 385 73.00 07697 CARDIAC REHABILITATION 0 76. 97 1 558215 84, 507 131, 680 76. 97 0 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0.000000 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 90 00 09000 CLI NI C 0.000000 Ω 0 0 90.00 0 90.01 09001 CLI NI C 0.000000 0 90.01 09002 OUTPATIENT PSYCHIATRIC 0.583716 407, 642 0 237, 947 90.02 90.02 09100 EMERGENCY 0. 160961 59 91.00 91.00 2, 878, 287 0 463, 292 09101 PRI ORI TY CARE CARLYLE 1. 637987 91.01 0 91.01 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 0.822533 244, 213 0 200, 873 92.00 3, 831, 049 200.00 Subtotal (see instructions) 27, 795, 402 18.482 4.412 200.00 201.00 Less PBP Clinic Lab. Services-Program 201. 00

27, 795, 402

18, 482

4, 412

3, 831, 049 202. 00

Only Charges

Net Charges (line 200 - line 201)

202.00

Health Financial Systems	ST.		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCII	NE COST Provider	CCN: 14-0145 Peri		sheet D
				07/01/2022 Part	

	WOOTHE GOST	Trovider o	J. 17 0110	From 07/01/2022 To 06/30/2023	Part V Date/Time Prepared: 1/24/2024 12:29 pm
			XVIII	Hospi tal	PPS
		sts	1		
Cost Center Description	Cost	Cost			
	Rei mbursed	Rei mbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.				
	(see inst.)	(see inst.)	-		
ANOULL ARV. OFFILE OF COOT, OFFITFING	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0	0	<u>'</u>		50.00
51. 00 05100 RECOVERY ROOM	0	0	2		51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	2		52.00
53. 00 05300 ANESTHESI OLOGY	0	0	2		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	2		54.00
57. 00 05700 CT SCAN	0	0	2		57. 00
58. 00 05800 MRI	0	0	?		58.00
60. 00 06000 LABORATORY	2, 194	0)		60.00
63.00 06300 BLOOD STORING PROCESSING & TRA	0	0	2		63.00
65. 00 06500 RESPIRATORY THERAPY	0	0	2		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	2		66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	2		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	?		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	2		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	695	1		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	1		76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	9		77. 00
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92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT	2 104	704	'		
200.00 Subtotal (see instructions)	2, 194	704	1		200.00
201.00 Less PBP Clinic Lab. Services-Program					201.00
Only Charges 202.00 Net Charges (line 200 - line 201)	2, 194	704			202.00
202.00 Net Gliarges (Title 200 - Title 201)	2, 194	1 /04	1		J202. 00

Health Financial Systems	ST. JOSEPHS HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0145	Peri od: From 07/01/2022	Worksheet D-1	
			Date/Time Pre 1/24/2024 12:	
	Title XVIII	Hospi tal	PPS	

DARK 1 - ALL PROVIDER CORPONENTS PART 1 - ALL PROVIDER CORPONENTS			Title XVIII	Hooni tal	1/24/2024 12: PPS	29 pm	
DWART I - ALL PROVIDER COMPONENTS 1.00		Cost Center Description	TI LIE XVIII	Hospi tal	PPS		
Impartiest days (including private room days and sering-bed days, excluding newborn)							
Inpatient days (including private room days and swing-bed days, excluding newborn)							
Inipatient days (including private room days, excluding sking-bed and newborn days) 4,105 2,00	1. 00		4, 931	1.00			
do not complete this line. 4. 00 Semi-private room days (excluding swing-bed and observation bed days) 5. 00 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost reporting period (if culendar year, enter 0 on this line) 7. 00 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost reporting period (if culendar year, enter 0 on this line) 7. 00 Total swing-bed SM type inpatient days (including private room days) through December 31 of the cost reporting period (if culendar year, enter 0 on this line) 8. 01 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost reporting period cost and bed SM type inpatient days (including private room days) after December 31 of the cost reporting period cost in the swing swing-bed cost reporting							
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PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) O 28.00 29.00 Pri vate room charges (excluding swing-bed charges) Semi-pri vate room charges (excluding swing-bed charges) O 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) O 29.00 Average pri vate room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) O 28.00 O 29.00 O 30.00 O 0 0 30.00 O 0 0 30.00 O 0 0 30.00 O 0 0 0 30.00 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			(line 21 minus line 26)				
29.00 30.00 Private room charges (excluding swing-bed charges) 29.00 30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.00 32.00 Average private room per diem charge (line 29 ÷ line 3) 0.00 32.00 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 32.00 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 460, 417) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1, 330.19 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 330.19 38.00 1, 983, 313 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			(11110 21 111110 11110 21)		57 1007 111		
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 5, 460, 417) 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 0.00 000 32.00 32.00 33.00 32.00 33.00 33.00 33.00 34.00 35.00 35.00 36.00 37.00 Frogram general inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 5, 460, 417) 38.00 Average per diem private room cost differential (line 5, 460, 417) 38.00 Average per diem private room cost differential (line 5, 460, 417) 38.00 Average per diem private room cost per diem (see instructions) 39.00 Average per diem private room cost differential (line 5, 460, 417) 39.00 Average per diem private room cost differential (line 5, 460, 417) 37.00 Average per diem private room cost differential (line 5, 460, 417) 37.00 Average per diem private room cost differential (line 5, 460, 417) 38.00 Average per diem private room cost differential (line 5, 460, 417) 39.00 Average per diem private room cost differential (line 5, 460, 417) 39.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 39.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructi			d and observation bed ch	narges)			
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 5, 460, 417) 37.00 PART II - HOSPITAL AND SUBPROVI DERS 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 32.00 0 0 32.00 32.00 32.00 32.00 32.00 34.00 35.00 36.00 37.00 36.00 37.00 37.00 38.00 39.00 40.00							
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 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 460, 417) 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 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32			. Lino 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 5, 460, 417) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 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 33.00 37.00 35.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 37.00 38.00 37.00 39.00 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)		,	- Title 20)				
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 5, 460, 417) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 37.00 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 34.00 35.00 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 38.00 37.00 39.00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 330.19 1, 983, 313 39.00 40.00						•	
36.00 37.00 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 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 36.00 37.00 37.00 37.00 37.00			nus line 33)(see instru	ctions)		•	
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) 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 1, 460, 417 37.00			ne 31)				
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 40.00			and neture+ " "	fforort: -1 ()			
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 40.00	37.00					37.00	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 330.19 38.00 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 40.00							
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) 1,983,313 39.00 40.00			USTMENTS				
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			,				
			•			•	
41.00 Total Trogram general Tripatrent routine service cost (Trie 39 + Trie 40)							
	41.00	Trotal Trogram general impatrient routine service cost (Title 39	1 11116 40 <i>)</i>		1, 703, 313	1 41.00	

COMPLIT	Financial Systems ATION OF INPATIENT OPERATING COST	31. JUSEFIIS	HOSPI TAL Provi der (CCN: 14-0145	Peri od:	u of Form CMS-: Worksheet D-1	
	ATTOM OF THE ATTEM OF ENAMENO GOOD				From 07/01/2022 To 06/30/2023	Date/Time Pre 1/24/2024 12:	epared:
	Cost Center Description	Total	Ti tl Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient	Inpatient	Di em (col.		(col. 3 x	
		Cost	Days	÷ col . 2)	4.00	col . 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 Uni	ts					
43.00	INTENSIVE CARE UNIT	0	(0.0	00	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (-		1, 806, 057	
48. 01	Program inpatient cellular therapy acquisi				, column 1)	2 700 270	
49. 00	Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	S 41 through 48.C))(see instru	uctions)		3, 789, 370	49. 00
50.00	Pass through costs applicable to Program i	npatient routine	services (fro	om Wkst. D, su	m of Parts I and	155, 467	50.00
51. 00		nnationt ancillar	sy sorvicos (1	From Wkst D	cum of Darte II	134, 464	51.00
31.00	and IV)	пратгент ансттаг	y services (i	TOIII WKSt. D,	Sum of Parts II	134, 404	31.00
52.00	Total Program excludable cost (sum of line					289, 931	1
53. 00	Total Program inpatient operating cost exc medical education costs (line 49 minus lin		elated, non-ph	nysician anest	hetist, and	3, 499, 439	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	e 52)					
	Program di scharges					0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
55. 02	Adjustment amount per discharge (contracto	r use only)				0.00	1
56.00	Target amount (line 54 x sum of lines 55,	55. 01, and 55. 02)				0	1
57.00	Difference between adjusted inpatient oper	0	1				
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54	0 0. 00					
	updated and compounded by the market baske						
60.00	Expected costs (lesser of line 53 ÷ line 5	4, or line 55 fro	om prior year	cost report,	updated by the	0. 00	60.00
61. 00	market basket) Continuous improvement bonus payment (if line $53 \div 1$ line 54 is less than the lowest of lines 55 plus 55.01 , or line 59 , or line 60 , enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54×60), or 1% of the target amount (line 56), otherwise						61.00
62.00	enter zero. (see instructions) Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive pa PROGRAM INPATIENT ROUTINE SWING BED COST	yment (see instru	ictions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	osts through Dece	ember 31 of th	ne cost report	ing period (See	0	64. 00
65.00	Medicare swing-bed SNF inpatient routine c	osts after Decemb	per 31 of the	cost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rou	tine costs (line	64 plus line	65)(title XVI	ll only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31	of the cost r	enorting period	0	67. 00
	(line 12 x line 19)	· ·					
68. 00	Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)	ine costs after L	ecember 31 of	f the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER	t routine costs ((line 67 + lir ′ AND LCE/LLE	ne 68) ONLY		0	69. 00
70.00	Skilled nursing facility/other nursing fac	ility/ICF/IID rou	ıtine service	cost (line 37)		70.00
71.00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x lin Medically necessary private room cost appl		n (line 14 x l	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine se	rvice costs (line	e 72 + line 73	3)			74.00
75. 00	Capital-related cost allocated to inpatien 26, line 45)	t routine service	e costs (from	Worksheet B,	Part II, column		75. 00
76.00	Per diem capital -related costs (line 75 ÷						76.00
77. 00 78. 00	Program capital-related costs (line 9 x li Inpatient routine service cost (line 74 mi						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exc	ess costs (from p					79.00
80.00	Total Program routine service costs for co	•	cost limitatio	on (line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem li Inpatient routine service cost limitation		1)				81. 00 82. 00
83.00	Reasonable inpatient routine service costs	(see instruction	•				83.00
84.00	Program inpatient ancillary services (see		,,,,				84.00
	Utilization review - physician compensatio	n (see instructio					85.00
85.00		um of lines 83 th	rough 85)				1 86.00
	Total Program inpatient operating costs (s PART IV - COMPUTATION OF OBSERVATION BED P. Total observation bed days (see instruction	ASS THROUGH COST	nrough 85)			455	86. 00 87. 00

Health Financial Systems	ST. JOSEPHS HOSPITAL In Lieu			u of Form CMS-2	2552-10		
COMPUTATION OF INPATIENT OPERATING COST	ST Pr			Peri od:	Worksheet D-1		
				From 07/01/2022 To 06/30/2023			
		Title	XVIII	Hospi tal	PPS	PPS	
Cost Center Description							
					1.00		
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			605, 236	89.00	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line	column 2	Observati on	Bed Pass		
		21)		Bed Cost	Through Cost		
				(from line	(col. 3 x		
				89)	col. 4) (see		
					instructions)		
	1. 00	2.00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST						
90.00 Capital -related cost	428, 742	5, 469, 285	0. 07839	1 605, 236	47, 445	90.00	
91.00 Nursing Program cost	0	5, 469, 285	0.00000	0 605, 236	0	91.00	
92.00 Allied health cost	0	5, 469, 285	0.00000	0 605, 236	0	92.00	
93.00 All other Medical Education	o	5, 469, 285	0. 00000	0 605, 236	0	93.00	

Health Financial Systems ST. JC INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	OSEPHS HOSPITAL Provider C	CN: 14 014E	Peri od:	u of Form CMS-: Worksheet D-3	
INPATTENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 14-0145	From 07/01/2022		5
			To 06/30/2023	Date/Time Pre 1/24/2024 12:	
	Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	2. 00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			1, 479, 947		30.00
31. 00 03100 NTENSI VE CARE UNI T			0		31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS				•	
50. 00 05000 OPERATING ROOM		0. 2026	02 996, 326	201, 858	50.00
51.00 05100 RECOVERY ROOM		0.0000		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4700		_	
53. 00 05300 ANESTHESI OLOGY		0. 0106			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1368			
57. 00 05700 CT SCAN		0. 0029		4, 536	
58. 00 05800 MRI		0. 0358			
60.00 06000 LABORATORY 63.00 06300 BLOOD STORING PROCESSING & TRA		0. 1189 0. 2118			
65.00 06500 RESPIRATORY THERAPY		0. 3664	· ·		
66. 00 06600 PHYSI CAL THERAPY		0. 2745			
69. 00 06900 ELECTROCARDI OLOGY		0. 0152			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000			1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 8470		402, 830	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2767			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1596	01 1, 038, 661	165, 771	73.00
76. 97 O7697 CARDIAC REHABILITATION		1. 5631		255	
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.0000		0	
90. 00 09000 CLI NI C		0.0000		· -	
90. 01 09001 CLINI C		0.0000		0	
90. 02 09002 0UTPATI ENT PSYCHI ATRI C 91. 00 09100 EMERGENCY		0. 5947 0. 1609		0 168, 700	
91. 00 09100 EMERGENCY 91. 01 09101 PRI ORI TY CARE CARLYLE		1. 6379			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT		0. 8225			
200.00 Total (sum of lines 50 through 94 and 96 through	n 98)	0.0225	10, 117, 138		
201.00 Less PBP Clinic Laboratory Services-Program only			10, 117, 130	1,000,037	201.00
202.00 Net charges (line 200 minus line 201)	, 900 (01)	1	10, 117, 138		202.00

	ncial Systems	ST. JOSEPHS HOSPITAL			u of Form CMS-2	
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-0145	Peri od:	Worksheet D-3	
		Component	CCN: 14-U145	From 07/01/2022 To 06/30/2023		
		Ti +1 c	· XVIII	Swing Beds - SNF	1/24/2024 12: PPS	29 pm
	Cost Center Description	11116	Ratio of Cos		Inpati ent	
	cost center bescription		To Charges		Program Costs	
			10 onar ges	Charges	(col. 1 x	
				Criai ges	col . 2)	
			1.00	2. 00	3.00	
I NPAT	TENT ROUTINE SERVICE COST CENTERS		•	<u> </u>		
30.00 03000	ADULTS & PEDIATRICS					30.00
31.00 03100	INTENSIVE CARE UNIT					31.00
43.00 04300	NURSERY					43.00
ANCI L	LARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 2026	02 0	0	50.00
	RECOVERY ROOM		0.0000		0	
	DELIVERY ROOM & LABOR ROOM		0. 4700	47 0	0	52.00
	ANESTHESI OLOGY		0. 0106		0	
	RADI OLOGY-DI AGNOSTI C		0. 1368		1, 411	
	CT SCAN		0. 0029		84	
58.00 05800			0. 0358		0	
	LABORATORY		0. 1189			•
	BLOOD STORING PROCESSING & TRA		0. 2118		595	
	RESPI RATORY THERAPY		0. 3664			
	PHYSI CAL THERAPY		0. 2745			
•	ELECTROCARDI OLOGY		0. 0152		l .	69.00
	ELECTROENCEPHALOGRAPHY		0.0000		0	
	MEDICAL SUPPLIES CHARGED TO PAT		0. 8470		16, 116	
	I MPL. DEV. CHARGED TO PATIENTS		0. 2767		0	
	DRUGS CHARGED TO PATIENTS		0. 1596		l	
	CARDI AC REHABI LI TATI ON		1. 5631		0	
	ALLOGENEIC HSCT ACQUISITION TIENT SERVICE COST CENTERS		0.0000	00 0	0	77.00
	RURAL HEALTH CLINIC		0.0000	00	0	1 88. 00
	CLINIC		0.0000		0	
	CLINIC		0.0000		0	1
	1		1		1	1
	OUTPATIENT PSYCHIATRIC EMERGENCY		0. 5947 0. 1609		0 324	
	PRIORITY CARE CARLYLE		1. 6379		324	1
	OBSERVATION BEDS (NON-DISTINCT		0. 8225		0	
200. 00	Total (sum of lines 50 through 94 and	96 through 98)	0.0223	595, 187	1	1
201.00	Less PBP Clinic Laboratory Services-Pi		1	373, 167		201.00

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

Net charges (line 200 minus line 201)

595, 187

201. 00 202. 00

201.00

202.00

Health Financial Systems	ST. JOSEPHS HOSPITAL	In Lieu of Form CMS-2552			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0145	From 07/01/2022	Worksheet E Part A Date/Time Prepared: 1/24/2024 12:29 pm		
	Ti tl a YVIII	Hospi tal	DDS		

		Title XVIII	Hospi tal	1/24/2024 12: PPS	29 pm
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring p instructions)	rior to October 1 (see	0 736, 878	1. 00 1. 01
1. 02	Instructions) DRG amounts other than outlier payments for discharges occurring of instructions)	n or after October	1 (see	2, 846, 334	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for di 1 (see instructions)	scharges occurring	prior to October	0	1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for di October 1 (see instructions)	scharges occurring	on or after	0	1.04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see	instructions)		0	2. 03
2. 04 3. 00 4. 00	Outlier payments for discharges occurring on or after October 1 (s Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting	0 0 42. 28	3. 00		
	Indirect Medical Education Adjustment				
5. 00 5. 01	FTE count for allopathic and osteopathic programs for the most record before 12/31/1996. (see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAA 2			0. 00	5. 00 5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the cr new programs in accordance with 42 CFR 413.79(e)			0.00	•
6. 26	Rural track program FTE cap limitation adjustment after the cap-bu the CAA 2021 (see instructions)	ilding window close	ed under §127 of	0. 00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under ACA § 5503 reduction amount to the IME cap as specified under 42 C			0. 00 0. 00	7. 00 7. 01
7. 02	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track programs with a rural track for Medicare GME affiliated progrand 87 FR 49075 (August 10, 2022) (see instructions)	9	` '	0. 00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) 1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots u report straddles July 1, 2011, see instructions.	nder § 5503 of the	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots funder \S 5506 of ACA. (see instructions)			0. 00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots u instructions)		,	0.00	
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	•	0. 00	
11. 00 12. 00	FTE count for allopathic and osteopathic programs in the current y FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)	ear from your recor	us	0. 00	11. 00 12. 00
13.00	Total allowable FTE count for the prior year.			0. 00	13.00
	Total allowable FTE count for the penultimate year if that year en otherwise enter zero.	ded on or after Sep	otember 30, 1997,		14.00
16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program (see inst	ructions)		0. 00	15. 00 16. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count			0.00	17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0. 000000 0. 000000	ı
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	21.00
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0	ı
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of Number of additional allopathic and osteopathic IME FTE resident c		CFR 412 105	0.00	
24. 00	<pre>(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)</pre>			0. 00	
25. 00	If the amount on line 24 is greater than -O-, then enter the lower instructions)	of line 23 or line	e 24 (see	0. 00	1
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000	
28. 00	IME add-on adjustment amount (see instructions)			0	28.00
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)			0	28. 01 29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	1
	Percentage of SSI recipient patient days to Medicare Part A patien	t days (see instruc	ctions)	1. 17	•
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			19. 37 20. 54	•
	Allowable disproportionate share percentage (see instructions)				33. 00

Heal th	Financial Systems ST. JOSEPHS H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0145	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A	pared:
		Title XVIII	Hospi tal	PPS	
24.00	Discourantianata alama adi naturata (ana inaturatiana)			1. 00	24.00
34.00	Disproportionate share adjustment (see instructions)		Prior to 10/1	55, 182 On/After 10/1	34.00
			1.00	2. 00	
	Uncompensated Care Payment Adjustment		1 =		
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		7, 192, 008, 710 0. 000041065	6, 874, 403, 459 0. 000044936	1
35. 02	Hospital UCP, including supplemental UCP (Ifline 34 is zero (see instructions)	308, 906	1		
35. 03 36. 00	Pro rata share of the hospital UCP, including supplemental U Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	CP (see instructions)	74, 441 305, 486	231, 045	35. 03 36. 00
	Additional payment for high percentage of ESRD beneficiary di	ischarges (lines 40 thro	ugh 46)		
40. 00	Total Medicare discharges (see instructions)		Before 1/1	On/After 1/1	40. 00
			1.00	1. 01	
41.00	Total ESRD Medicare discharges (see instructions)		0	0	•
41. 01 42. 00	Total ESRD Medicare covered and paid discharges (see instruc Divide line 41 by line 40 (if less than 10%, you do not qual		0.00	0	41. 01 42. 00
43. 00	Total Medicare ESRD inpatient days (see instructions)	rry for adjustment)	0.00		42.00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44. 00
45.00	Average weekly cost for dialysis treatments (see instruction		0. 00	0. 00	ł
46.00	Total additional payment (line 45 times line 44 times line 4	1. 01)	0 3, 943, 880		46.00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,		47. 00 48. 00		
	only. (see instructions)	·		A	
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions	s)		3, 943, 880	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a)	268, 656	1
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Pt Direct graduate medical education payment (from Wkst. E-4, I			0	51. 00 52. 00
53.00	Nursing and Allied Health Managed Care payment	The 47 See Thistructions)	•	0	53.00
54.00	Special add-on payments for new technologies			6, 310	•
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	40)		0	54. 01 55. 00
55. 01	Cellular therapy acquisition cost (see instructions)	07)		0	55. 01
56.00	Cost of physicians' services in a teaching hospital (see int			0	56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt.	The state of the s	through 35).	0	57.00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	TV, Cot. 11 Time 200)		0 4, 218, 846	58. 00 59. 00
60.00	Primary payer payments			0	60.00
	Total amount payable for program beneficiaries (line 59 minus	s line 60)		4, 218, 846	
62.00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			537, 152 5, 200	ı
64.00	Allowable bad debts (see instructions)			62, 594	1
65.00	Adjusted reimbursable bad debts (see instructions)			40, 686	1
66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63)	tructions)		57, 885 3, 717, 180	1
68. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (see instructions)		68.00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)			0	69. 00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tration) adjustment (acc	inatruationa)	0	70.00
70. 50 70. 75	Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions)	tration) adjustment (see	rnstructions)	0	70. 50 70. 75
70. 87	Demonstration payment adjustment amount before sequestration			Ö	70.87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89 70. 90	Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions)	tructions)		0	70. 89 70. 90
70. 90	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 90
70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 92
70. 93	HVBP payment adjustment amount (see instructions)			0 130	70. 93
70. 94 70. 95	HRR adjustment amount (see instructions) Recovery of accelerated depreciation			-9, 128 0	70. 94 70. 95
,. , ,	, J			0	

Heal th	Financial Systems ST. JOSEPHS H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 14-0145	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Pre 1/24/2024 12:	pared: 29 pm
		Title	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period prior to 10/1)			2022	171, 766	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			2023	663, 135	70. 97
70. 98	Low Volume Payment-3			0	0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			4, 542, 953	
71. 01	Sequestration adjustment (see instructions)				90, 859	
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
	Interim payments				4, 484, 070	
	Interim payments-PARHM				_	72. 01
73.00	Tentative settlement (for contractor use only)				0	73.00
73. 01 74. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and				-31, 976	73. 01 74. 00
7. 0.	73)					7. 0.
74. 01 75. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	ance with			283, 930	74. 01 75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			1		
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
91. 00	plus 2.04 (see instructions)				0	91. 00
91.00	Capital outlier from Wkst. L, Pt. I, line 2 Operating outlier reconciliation adjustment amount (see instr	suctions)			0	91.00
	Capital outlier reconciliation adjustment amount (see instru				0	93.00
	The rate used to calculate the time value of money (see instruc				0. 00	
95. 00	Time value of money for operating expenses (see instructions)				0.00	
96. 00	Time value of money for capital related expenses (see instructions)				0	
70.00	Trine varies of money for capital for a tea expenses (see first ac	2013)	1	Prior to 10/1		70.00
				1.00	2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	ns)		0	0	102.00
103.00	HRR adjustment factor (see instructions)			0.0000	0.0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instructions	s)		0		104.00
	Rural Community Hospital Demonstration Project (§410A Demonst		ustment	-1		
200.00	Is this the first year of the current 5-year demonstration po					200. 00
	Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir	ne 49)				201.00
	Medicare discharges (see instructions)	,				202. 00
	Case-mix adjustment factor (see instructions)					203. 00
	Computation of Demonstration Target Amount Limitation (N/A ir	n first year	of the curre	nt 5-year demons	trati on	
	peri od)					
204.00	Medicare target amount					204. 00
205.00	Case-mix adjusted target amount (line 203 times line 204)					205.00

	IO BE COMPLETED BY CONTRACTOR (Times 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90.00		
	plus 2.04 (see instructions)					
91.00			0			
92. 00	, , , , , , , , , , , , , , , , , , ,		0			
93. 00			0			
94.00			0.00	94.00		
95.00			0			
96. 00	Time value of money for capital related expenses (see instructions)		0	96.00		
		Prior to 10/1				
		1. 00	2. 00			
	HSP Bonus Payment Amount		_			
100.00	HSP bonus amount (see instructions)	0	0	100. 00		
	HVBP Adjustment for HSP Bonus Payment	T				
	HVBP adjustment factor (see instructions)	0. 000000000				
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00		
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)	0.0000				
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00		
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st			200.00		
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00		
	Medicare discharges (see instructions)			202. 00 203. 00		
	Computation of Demonstration Target Amount Limitation (N/A in first year of the cur	rent 5-year demons	tration			
204.00	peri od)			204 00		
	Medicare target amount			204.00		
	Case-mix adjusted target amount (line 203 times line 204)			205.00		
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00		
207.00	Adjustment to Medicare Part A Inpatient Reimbursement			207 00		
	Program reimbursement under the §410A Demonstration (see instructions)			207.00		
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00		
	Adjustment to Medicare IPPS payments (see instructions)			209.00		
	Reserved for future use			210.00		
211.00	Total adjustment to Medicare IPPS payments (see instructions)		<u> </u>	211. 00		
212 00	Comparision of PPS versus Cost Reimbursement			212 00		
	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00		
	D Low-volume adjustment (see instructions)			213. 00 218. 00		
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218.00		
	(line 212 minus line 213) (see instructions)		j	I		

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 07/01/2022 Part A Exhibit 4 To 06/30/2023 Date/Time Prepared: 1/24/2024 12:29 pm Provider CCN: 14-0145

					10	06/30/2023	1/24/2024 12:	
	,	l			XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After	Total (Col 2 through 4)	
		Title	E, Part A)	EIILI LI ellleiil	10 10/01	10/01	tili ougii 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1.00
4 04	payments	1 01	70/ 070		70/ 070		70, 070	1 01
1. 01	DRG amounts other than outlier payments for discharges	1. 01	736, 878	0	736, 878		736, 878	1. 01
	occurring prior to October 1							
1. 02	DRG amounts other than outlier	1. 02	2, 846, 334	0		2, 846, 334	2, 846, 334	1. 02
	payments for discharges							
	occurring on or after October							
1. 03	DRG for Federal specific	1. 03	o	0	o		0	1.03
	operating payment for Model 4							
	BPCI occurring prior to							
1. 04	October 1 DRG for Federal specific	1. 04	0	0		0	0	1.04
1.04	operating payment for Model 4	1.04		J		O .	9	1.04
	BPCI occurring on or after							
2 00	October 1 Outlier payments for	2 00						2.00
2. 00	discharges (see instructions)	2. 00						2.00
2. 01	Outlier payments for	2. 02	O	0	0	0	0	2. 01
	discharges for Model 4 BPCI							
2. 02	Outlier payments for discharges occurring prior to	2. 03	0	0	0		0	2. 02
	October 1 (see instructions)							
2. 03	Outlier payments for	2. 04	0	0		0	0	2.03
	discharges occurring on or							
	after October 1 (see instructions)							
3. 00	Operating outlier	2. 01	0	0	0	0	0	3.00
	reconciliation							
4. 00	Managed care simulated	3. 00	0	0	0	0	0	4.00
	payments Indirect Medical Education Adj	L ustment						
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
	A, line 21 (see instructions)		_	_		_	_	
6. 00	IME payment adjustment (see instructions)	22. 00	0	O	0	0	0	6.00
6. 01	IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see							
	instructions)		- 1-1-1 6 6-					
7. 00	Indirect Medical Education Adj	27.00	0. 000000	0.00000	0. 000000	0. 000000		7.00
7.00	(see instructions)	27.00	0.00000	0. 000000	0.00000	0.00000		7.00
8.00	IME adjustment (see	28. 00	o	0	0	0	0	8. 00
0.01	instructions)	28. 01		0	0	0	0	8. 01
8. 01	IME payment adjustment add on for managed care (see	28.01	U	U	U	Ü	0	8.01
	instructions)							
9. 00	Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed	29. 01	0	0	0	0	0	9. 01
,. 01	care (sum of lines 6.01 and					O		/. 0
	8. 01)							
10. 00	Disproportionate Share Adjustm Allowable disproportionate	ent 33.00	0. 0616	0. 0616	0. 0616	0. 0616		10.00
10.00	share percentage (see	33.00	0.0010	0.0010	0.0010	0.0010		10.00
	instructions)							
11. 00	Disproportionate share	34. 00	55, 182	0	11, 348	43, 834	55, 182	11.00
11. 01	adjustment (see instructions) Uncompensated care payments	36.00	305, 486	0	74, 441	231, 045	305, 486	11 01
	Additional payment for high pe				,]
12. 00	Total ESRD additional payment	46. 00	0	0	0	0	0	12.00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	3, 943, 880	0	822, 667	3, 121, 213	3, 943, 880	13 00
14. 00	Hospital specific payments	47.00	3, 743, 000 N	0	022, 007 N	J, 1∠1, ∠13 N	3, 743, 080 N	14.00
55	(completed by SCH and MDH,				S	9		
	small rural hospitals only.)							
15. 00	(see instructions) Total payment for inpatient	49. 00	3, 943, 880	0	822, 667	3, 121, 213	3, 943, 880	15 00
15.00	operating costs (see	47.00	3, 743, 080	U	022,007	3, 121, 213	3, 743, 680	15.00
	instructions)							

LOW VC	OLUME CALCULATION EXHIBIT 4			Provi der C		Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/24/2024 12:29 pm		
				Title	XVIII	Hospi tal	PPS		
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2		
		line	E, Part A)	Entitlement	to 10/01	On/After	through 4)		
						10/01			
		0	1. 00	2. 00	3.00	4. 00	5. 00		
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	268, 656	0	56, 47	4 212, 182	268, 656	16. 00	
17. 00	new technologies	54. 00	6, 310	0		0 6, 310	6, 310	17.00	
17. 01	Net organ aquisition cost							17. 01	
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0		0	0	17. 02	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		O	0		0 0	0	18. 00	
19. 00	SUBTOTAL			0	879, 14	1 3, 339, 705	4, 218, 846	19.00	
		W/S L, line	(Amounts from		,		,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
		,	L)						
		0	1. 00	2.00	3.00	4. 00	5. 00		
20. 00	Capital DRG other than outlier		268, 656	0	56, 47	4 212, 182	268, 656	20.00	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0	0	20. 01	
21.00	Capital DRG outlier payments	2. 00	O	0		0	0	21.00	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0	0	21. 01	
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.000	0. 0000		22. 00	
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0	0	23. 00	
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0. 0000		24. 00	
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0	0	25. 00	
26. 00	Total prospective capital payments (see instructions)	12. 00	268, 656	0	56, 47	4 212, 182	268, 656	26. 00	
		W/S E, Part A	(Amounts to						
		l i ne	E, Part A)						
	T	0	1. 00	2. 00	3. 00	4. 00	5. 00		
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 19537 171, 76		171, 766	27. 00 28. 00	
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				663, 135	663, 135	29. 00	
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00	

| Peri od: | Worksheet E | From 07/01/2022 | Part A Exhibit 5 | To 06/30/2023 | Date/Time Prepared: Health Financial Systems ST. JOSEPHS HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provi der CCN: 14-0145

				Т	o 06/30/2023	Date/Time Pre 1/24/2024 12:	
			Title	XVIII	Hospi tal	PPS	<u> </u>
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (col s.	
		A, line	Wkst. E, Pt.	10/01	after 10/01	2 and 3)	
		0	A) 1. 00	2. 00	3. 00	4. 00	
1. 00	DRG amounts other than outlier payments	1. 00	1.00	2.00	3.00	4.00	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	736, 878	736, 878		736, 878	1. 01
1. 02	DRG amounts other than outlier payments for	1. 02	2, 846, 334		2, 846, 334	2, 846, 334	1. 02
1. 03	discharges occurring on or after October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	C		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	C	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	0	С		0	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	0		0	0	2. 03
3.00	Operating outlier reconciliation	2. 01	0	C	0	0	3.00
4.00	Managed care simulated payments	3. 00	0	C	0	0	4. 00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0. 000000	0. 000000		5. 00
	(see instructions)	00.00				0	
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	0	C C	0	0	6. 00 6. 01
	instructions) Indirect Medical Education Adjustment for the	a Add on for So	action 122 of t	the MMA			
7. 00	IME payment adjustment factor (see	27. 00	0. 000000		0. 000000		7. 00
7.00	instructions)	27.00	0. 000000	0.00000	0.00000		7.00
8.00	IME adjustment (see instructions)	28. 00	0	C	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	C	0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0	C	0	0	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01	0	C	0	0	9. 01
	lines 6.01 and 8.01)						
10. 00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33. 00	0. 0616	0. 0616	0. 0616		10.00
10.00	(see instructions)	33.00	0.0010	0.0010	0.0010		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	55, 182	11, 348	43, 834	55, 182	11. 00
11. 01	Uncompensated care payments	36. 00	305, 486	74, 441	231, 045	305, 486	11. 01
	Additional payment for high percentage of ESF	RD beneficiary	di scharges				
12. 00	Total ESRD additional payment (see	46. 00	0	C	0	0	12. 00
13. 00	instructions) Subtotal (see instructions)	47. 00	3, 943, 880	822, 667	3, 121, 213	3, 943, 880	13 00
	Hospital specific payments (completed by SCH		0, 743, 000			0, 743, 666	
	and MDH, small rural hospitals only.) (see					_	
15. 00	instructions) Total payment for inpatient operating costs	49. 00	3, 943, 880	822, 667	3, 121, 213	3, 943, 880	15. 00
16. 00	(see instructions) Payment for inpatient program capital (from	50. 00	268, 656	56, 474	212, 182	268, 656	16. 00
17. 00	Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	54. 00	6, 310	С	6, 310	6, 310	17.00
17. 01 17. 02	Net organ acquisition cost Credits received from manufacturers for	68. 00	0	С	0	0	17. 01 17. 02
18. 00	replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment	93. 00	0	C	0	0	18. 00
19. 00	amount (see instructions) SUBTOTAL			879, 141	3, 339, 705	4, 218, 846	19. 00

Heal th	Financial Systems	ST. JOSEPHS	HOSPLTAL		In lie	u of Form CMS-:	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA				Period: From 07/01/2022 Fo 06/30/2023	Worksheet E Part A Exhibi	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	268, 656	56, 47	4 212, 182	268, 656	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	0	(0	0	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(0	0	21.01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	(0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	268, 656	56, 47	212, 182	268, 656	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00 28. 00	Low volume adjustment prior to October 1	70. 96	171, 766	171, 76	5	171, 766	27. 00 28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	663, 135	,,	663, 135	· ·	
30.00	HVBP payment adjustment (see instructions)	70. 93	0	(0	000,100	1
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	Ö	(0	0	
31.00	HRR adjustment (see instructions)	70. 94	-9, 128	(-9, 128	-9, 128	31.00
31. 01	HRR adjustment for HSP bonus payment (see linstructions)	70. 91	0	(0	0	
	- /					() +	

0 70. 99

32.00 HAC Reduction Program adjustment (see instructions)
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

1.00

Ν

2.00

0

3.00

0

(Amt. to Wkst. E, Pt. A) 4.00

32.00

100.00

Health Financial Systems	ST. JOSEPHS HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0145	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 1/24/2024 12:29 pm
	T		550

No. PART S MEDICAL MODOTHER HEALTH SERVICES 1.00			1/24/2024 12:	29 pm
More		Title XVIII Hospital	PPS	
More			1 00	
Medical and other services (see instructions) 2,886 1.00		PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
3.70 3.00 3.75.331 3.00 4.00 3.175.331 3.00 4.00 3.175.331 3.00 4.00 3.00 3.00 3.00 4.00 3.00 3.00 3.00 4.00 3.00	1.00	Medical and other services (see instructions)	2, 898	1.00
Dutilier payment (see instructions)		· · · · · · · · · · · · · · · · · · ·		
Outlier reconstitution amount (see instructions)			1	
Enter the hospit follows: Color				1
Sam of Fines 3, 4, and 4.01, divided by Fine 6 0.00 7.00		· · · · · · · · · · · · · · · · · · ·		1
Transitional corridor payment (see instructions) 0 0 0 0 0 0 0 0 0		Line 2 times line 5		
And I larry service other pass through costs from West. D. Pt. IV. col. 13, line 200 0 9 0.00			ı	1
10.00 Organ acquisitions 2,808 11.00				1
1.00				
Reasonable Charges 22,894 12,00 Another year vice charges 22,894 13,00 Organ acquistion charges (sum of lines 12 and 13) 13,00 Organ acquistion charges (sum of lines 12 and 13) 13,00 13,00 13,00 13,00 15,00 1			2, 898	
12.00 Ancillary service charges 72.894 12.00 13.00 Organ acquist it on charges (From Wist: D-4, Pt. III, col. 4, line 69) 22.804 14.00 13.00 Organ acquist it on charges (sum of lines 12 and 13) 14.00 15.00				
13.00 Organ acquisition charges (cfrom Wists. D-4, Pt. III. col. 4, line 69) 0.13.00 Costomary charges (cum of Itines 12 and 13) 22,894 14.00 Total reasonable charges (cum of Itines 12 and 13) 15.00 Aggregate amount actually collected from patients Hable for payment for services on a charge basis 0.15.00 Aggregate amount actually collected from patients Hable for payment for services on a charge basis 0.15.00 Aggregate amount actually collected from patients Hable for payment for services on a charge basis 0.15.00 Aggregate amount actually collected from patients Hable for payment for services on a charge basis 0.15.00 Aggregate amount actually collected from patients Hable for payment for services on a charge basis 0.15.00 Aggregate amount actually collected from patients Hable for payment for services on a charge basis 0.15.00 Aggregate amount actually collected from patients Hable for payment for services on a charge basis 0.15.00 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	12.00		22.004	12.00
14.00			22, 894	
Constrainty charges Constrainty Constr			22, 894	
16.00 AnSounts that would have been realized from patients Iable for payment for services on a chargebasis 0 16.00 National payment been made in accordance with 42 CFR §43. 13(e) 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.0000000 77.00 0.000000 77.00 0.0000000 0.0000000000		Customary charges		
had such payment been made in accordance with 42 CFR \$413.13(e)				
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00	16. 00		0	16.00
18.00 Total customary charges (see instructions) 22,894 18.00 19.00 Excess of customary charges over reasonable cost (complete only If line 18 exceeds line 18) (see 19.996 19.00 19	17. 00		0. 000000	17. 00
Instructions			1	1
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00 instructions) 2,898 21.00 22.00 1.00 22.00 1.00 22.00 23.00 23.00 25.00	19. 00		19, 996	19. 00
instructions 2,898 21.00	20.00			20.00
21.00 Lesser of cost or charges (see instructions) 2,998 21.00 02.00	20.00			20.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 3,725,831 24.00 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 3,725,831 24.00 25.00 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 3,725,831 24.00 25.00 25.00 26.00 Deductible sand coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 729,842 26.00 26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2,998,887 27.00 27.00 28.00 29.00 29.00 28.00 29.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00 29.00 28.00 29.	21. 00		2, 898	21.00
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 3,725,831 24. 00				
COMPUTATION OF RELIBERISSMENT SETTLEMENT				1
25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0 25.00	24.00		3, 725, 831	24.00
26. 00 Doductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 729, 842 26. 00	25. 00		0	25.00
Instructions				
28. 00 Direct graduate medical education payments (From Wkst. E-4, line 50) 28. 00 28. 00 29. 00 29. 00 28. 00 29	27. 00		2, 998, 887	27. 00
28. 50 REH facility payment amount 28. 50 29. 90 ESRD direct medical education costs (from Wkst. E-4, line 36) 2. 998, 887 30. 00 3	20 00			20 00
29.00 ESRD direct medical education costs (from West. E-4, line 36) 29.00 29.0				
31.00 Subtotal (line 30 minus line 31) 2,998,722 32.00 20.00			0	
Subtotal (1 ine 30 minus line 31)				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 72.633 34.00 34.00 All owable bad debts (see instructions) 72.633 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 63.157 36.00 37.00 Subtotal (see instructions) 33.00 37.00 Subtotal (see instructions) 33.00 38.00 MSP-LCC reconciliation amount from PS&R 38.00 MSP-LCC reconciliation amount from PS&R 38.00 38.00 MSP-LCC reconciliation amount from PS&R 38.00 97.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 97.00 97.			1	1
33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 72.633 34.00 35.00 Allowable bad debts (see instructions) 47.211 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 63,157 36.00 37.00 38	32.00	,	2, 998, 122	32.00
35.00	33.00		0	33.00
36.00				
37.00 Subtotal (see instructions) 3,045,933 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 39.00 39.00 39.50 39.00 39.50 39.9				
38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 00 39. 00 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 75 39. 97 Demonstration payment adjustment amount (see instructions) 0 39. 75 39. 97 Demonstration payment adjustment amount before sequestration 0 39. 97 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00				
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 39.97 39.98 39.50 39.			1	
39. 75 N95 respirator payment adjustment amount (see instructions) 0 39. 75 39. 97 Demonstrati on payment adjustment amount before sequestration 0 39. 98 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 3,045, 933 40. 00 40. 01 Demonstration payment adjustment amount after sequestration 0 40. 01 40. 02 Sequestration adjustment-PARHM pass-throughs 0 40. 02 41. 00 Interim payments-PARHM 40. 03 41. 01 Interim payments-PARHM (for contractors use only) 41. 01 42. 01 Tentative settlement (for contractor use only) 42. 01 43. 00 Balance due provider/program (see instructions) 43. 01 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 0 70 BE COMPLETED BY CONTRACTOR 0 90. 00 90. 00 Original outlier amount (see instructions) 0 90. 00 90. 00 The rate used to calcula			0	39.00
39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 39.98 39.99 39.99 39.99 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 3			_	
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 3, 045, 933 40. 00 40. 01 Sequestration adjustment (see instructions) 60, 919 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 2, 985, 876 41. 00 41. 01 Interim payments-PARHM 41. 01 42. 00 Tentative settlement (for contractors use only) 0 42. 01 43. 00 Bal ance due provider/program (see instructions) -862 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 44. 00 Forested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 90. 00 Original outlier amount (see instructions) 0 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 90. 00 92. 00 The		, , , , , , , , , , , , , , , , , , , ,		
39. 99 40. 00 5ubtotal (see instructions) 30. 045, 933 40. 00 40. 01 5equestration adjustment (see instructions) 5equestration payment adjustment amount after sequestration 5equestration adjustment—PARHM pass-throughs 60, 919 40. 02 40. 03 5equestration adjustment—PARHM pass-throughs 61. 00 61. 01 62. 985, 876 63. 03 64. 00 64. 01 65. 985, 876 65. 985, 876 67. 00				
40.00 Subtotal (see instructions) 3,045,933 40.00 40.01 Sequestration adjustment (see instructions) 60,919 40.01 40.02 00 00 00.02 00.03 00.			1	
40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 51. 52 TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 94. 00 93. 00 95. 00 Time Value of Money (see instructions) 96. 00 97. 00 97. 00 97. 00 Time Value of Money (see instructions) 98. 00 Time Value of Money (see instructions) 99. 00 93. 00	40.00		3, 045, 933	40.00
40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Og 93.00			1	
41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 80.00 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 O 93.00			0	
41.01			2, 985, 876	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.01 42.01 43.00 43.01 44.00 95.01 90.02 90.03 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00				
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 43.01 95.00 44.00 96.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00			0	
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 The rate used to calculate the Time Value of Money 0 Time Value of Money (see instructions) 0 93.00		,	010	1
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\ \text{9115.2}\$ \[\text{TO BE COMPLETED BY CONTRACTOR} \] 90.00 Original outlier amount (see instructions) 0 Utlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 1 ime Value of Money (see instructions) 1 o 93.00 93.00 Time Value of Money (see instructions) 2 d4.00 Adv. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$0 Adv. 00 Adv. 00 Pub. 15-2, chapter 1, \$0 Adv.		, , , , , , , , , , , , , , , , , , , ,	-862	
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 value reconciliation adjustment amount (see instructions) 0 value of Money 0.00 P1.00 1 The rate used to calculate the Time Value of Money 1 me Value of Money (see instructions) 0 value of Money (see instructions) 0 value of Money (see instructions) 0 value of Money (see instructions)		, , , , , , , , , , , , , , , , , , , ,	0	
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00	55	§115. 2	<u> </u>]
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00				
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00		, ,		
93.00 Time Value of Money (see instructions) 0 93.00		, , , , , , , , , , , , , , , , , , , ,	1	1
94.00 Total (sum of lines 91 and 93) 0 94.00		· · · · · · · · · · · · · · · · · · ·	1	
	94. 00	Total (sum of lines 91 and 93)	0	94.00

Health Financial Systems ST.	٠. ا	JOSEPHS HO	SPI TAL		In Lieu	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provi der	CCN: 14-0145	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Pre 1/24/2024 12:	
			Ti tl	e XVIII	Hospi tal	PPS	
						1. 00	
MEDICARE PART B ANCILLARY COSTS							
200.00 Part B Combined Billed Days		-				0	200. 00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-0145 Period: Worksheet E-1

From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 1/24/2024 12:29 pm Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 4.00 1.00 2.00 3.00 1.00 Total interim payments paid to provider 4, 476, 075 3, 018, 497 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 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 02/22/2023 7, 995 3.01 3.02 0 3.02 C 3 03 0 0 3 03 3.04 0 0 3.04 3.05 3.05 0 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 02/22/2023 32, 621 3.50 3.51 3.51 0 0 3.52 0 3.52 3 53 0 0 3 53 3.54 0 3.54 0 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 7, 995 -32, 621 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4, 484, 070 2, 985, 876 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 0 5.02 0 5.02 5.03 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 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5. 50-5. 98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.01 SETTLEMENT TO PROGRAM 31, 976 6.02 862 6.02 4, 452, 094 7.00 Total Medicare program liability (see instructions) 2, 985, 014 7.00

Contractor

Number

1.00

NPR Date

(Mo/Day/Yr)

2.00

8.00

8.00 Name of Contractor

Health Financial Systems ST ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED ST. JOSEPHS HOSPITAL

				0 00, 00, 2020	1/24/2024 12:	29 pm
		Title	XVIII S	ving Beds - SNF		
		I npati en	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		278, 785		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)					ļ
2 01	Program to Provider				0	2 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER		0		0	3. 01 3. 02
3. 02					0	3.02
3. 03					0	3.03
3. 04					0	3.04
3.05	Provider to Program				U	3.05
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51	ABSOSTWENTS TO TROOMAW		٥		Ö	3.51
3. 52			ĺ		Ö	3. 52
3. 53			0		0	3.53
3. 54			0		Ö	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		278, 785		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		T	T		
5. 00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER		0		0	5. 01
5. 01	TENTATIVE TO PROVIDER				0	5.02
5. 02					0	5. 02
5. 05	Provider to Program		·			0.00
5. 50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			Ö		Ö	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		278, 785		0	7.00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
0.00	Name of Contractor)	1.00	2. 00	0.00
8. 00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-0145 From 07/01/2022 From 07/01/2022 To 06/30/2023 Title XVIII Hospital Provider CCN: 14-0145 From 07/01/2022 To 06/30/2023 Title XVIII Hospital Provider CCN: 14-0145 From 07/01/2022 To 06/30/2023 Title XVIII Hospital Provider CCN: 14-0145 From 07/01/2022 To 06/30/2023 Title XVIII Hospital Provider CCN: 14-0145 From 07/01/2022 To 06/30/2023 Title XVIII Hospital 1.00 To BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days (see instructions) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days (see instructions) 4.00 Total hospital charges from Wkst. C, Pt. I, col. 8 line 200 5.00 Total hospital charges from Wkst. S-10, col. 3 line 20 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 Ine 168 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial /interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify) 32.00 Bal ance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	Heal th	Financial Systems ST. JOSEPHS	S HOSPITAL	In Lie	u of Form CMS-	2552-10
To 06/30/2023 Date/Time Prepared: 1/24/2024 12: 29 pm Title XVIII Hospital PPS Title XVIII Hospital PPS TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days (see instructions) 2.00 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days (see instructions) 4.00 5.00 Total hospital charges from Wkst. C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 10.01 Initial/Interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 14-0145			1
Title XVIII Hospital PPS Title XVIII Hospital Title XVIII Hospital PPS						
Title XVIII Hospital PPS To BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days (see instructions) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days (see instructions) 4.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I rouline 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Total interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 31.00				10 06/30/2023		
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days (see instructions) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase o			Ti +l o YV/III	Hospi tal		29 piii
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 1.00 Medicare days (see instructions) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 31.00			THE AVIII	1103pi tai	113	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 1.00 Medicare days (see instructions) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I rine 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 Inpatient HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Thitial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 31.00					1 00	
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days (see instructions) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (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)		TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	
Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days (see instructions) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 Line 168 8.00 Calculation of the HIT incentive payment (see instructions) Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify)						1
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 Total inpatient days (see instructions) Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 31.00 Other Adjustment (specify)	1.00			ie 14		1.00
4.00 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (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	2.00					2.00
4.00 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (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	3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 1.00 Iline 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 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)	4.00					4.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 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 Other Adjustment (specify) 31.00	5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	l e e e e e e e e e e e e e e e e e e e			5.00
Iine 168	6.00	Total hospital charity care charges from Wkst. S-10, col.	3 line 20			6.00
8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify)	7.00	CAH only - The reasonable cost incurred for the purchase of	f certified HIT technology	Wkst. S-2, Pt. I		7.00
9.00 Sequestration adjustment amount (see instructions) 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) 31.00 Other Adjustment (specify)		line 168				
10.00 Calculation of the HIT incentive payment after sequestration (see instructions) INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify)	8.00	Calculation of the HIT incentive payment (see instructions)			8. 00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 31.00	9.00	Sequestration adjustment amount (see instructions)				9.00
30.00 Initial/interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify) 30.00	10.00	Calculation of the HIT incentive payment after sequestrati	on (see instructions)			10.00
31.00 Other Adjustment (specify)		INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 32.00						31.00
	32.00	Balance due provider (line 8 (or line 10) minus line 30 an	d line 31) (see instructio	ns)		32.00

Health Financial Systems	ST.	JOSEPHS HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 14-0145	Period: Worksheet E-2 From 07/01/2022
		Component CCN: 14-U145	

		Component CCN: 14-U145	To 06/30/2023	Date/Time Pre 1/24/2024 12:	
		Title XVIII	Swing Beds - SNF	PPS	
			Part A 1.00	Part B 2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
1.00	Inpatient routine services - swing bed-SNF (see instructions)		290, 938	0	
2. 00	Inpatient routine services - swing bed-NF (see instructions)			_	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin		0	0	3.00
	instructions)	ig-bed pass-till ough, see			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0. 00	4. 00
5. 00	instructions) Program days		424	0	5.00
6. 00	Interns and residents not in approved teaching program (see i	nstructions)	424	0	
7.00	Utilization review - physician compensation - SNF optional me	thod only	0		7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		290, 938	0	
9. 00 10. 00	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		290, 938	0	
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	290, 936	0	11.00
	professional services)	to pulper or all		_	
12.00	Subtotal (line 10 minus line 11)		290, 938	0	12.00
13. 00	Coinsurance billed to program patients (from provider records) for physician professional services)) (excl ude coi nsurance	6, 463	0	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14.00
15. 00	Subtotal (see instructions)		284, 475	0	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Prioneer ACO demonstration payment adjustment (see instructions				16.50
16. 55	Rural community hospital demonstration project (§410A Demonstration project (§410A Demonstrations)	atton) payment	U		16. 55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	
18. 00 19. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	ructions)	284, 475	0	
19. 00	Sequestration adjustment (see instructions)		5, 690	0	
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs			_	19. 03
19. 25 20. 00	Sequestration for non-claims based amounts (see instructions) Interim payments		278, 785	0	
20. 00	Interim payments Interim payments-PARHM		270, 703	O	20.00
21. 00	Tentative settlement (for contractor use only)		0	0	
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02) Balance due provider/program-PARHM (see instructions)	2, 19.25, 20, and 21)	0	0	
22. 01 23. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	0	0	22. 01
20.00	chapter 1, §115.2	100 111 111 01110 1 421 10 27			20.00
	Rural Community Hospital Demonstration Project (§410A Demonstr				
200.00	Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	riod under the 21st			200.00
	Cost Reimbursement				-
201.00	Medicare swing-bed SNF inpatient routine service costs (from N	Wkst. D-1, Pt. II, line			201.00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from 200 (title XVIII swing-bed SNF))	m Wkst. D-3, col. 3, lin	9		202. 00
203.00	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons	trati on	
205.00	period) Medicare swing-bed SNF target amount				205.00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see inst	•			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2 and 3)	2, col. 1, sum of lines	1		208. 00
209. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
	Reserved for future use	, 			210.00
045.55	Comparision of PPS versus Cost Reimbursement	200 .1 . 11 . 212) (045 05
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2 instructions)	209 plus line 270) (see			215. 00
	1.1.00. 400. 510)		ı l		I

Heal th	Financial Systems ST. JOSEPHS HO	OSPI TAL	In Lie	u of Form CMS-2	552-10
OUTLI E				Worksheet E-5	
				Date/Time Prep 1/24/2024 12:2	oared: 29 pm
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see	instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instr	ructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instruc	ctions)		0	4.00
5.00 The rate used to calculate the time value of money (see instructions)				0.00	5.00
6.00 Time value of money for operating expenses (see instructions)				0	6.00
7.00	Time value of money for capital related expenses (see instruc	ctions)		0	7.00

lealth Financial Systems ST. JOSEPHS HOSPITAL In Lieu of Form CMS-2552-10

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

Provider CCN: 14-0145

Period: Worksheet G From 07/01/2022 To 06/30/2023 Date/Time Prepared: 1/24/2024 12: 29 pm

		General Fund	Speci fi c	Endowment	Plant Fund	29 pili
			Purpose Fund	Fund		
	QUIDDENT ACCETS	1.00	2. 00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	787, 168	0	O	0	1.00
2. 00	Temporary investments	0		0	0	2.00
3. 00	Notes receivable	0	Ö	o	0	3. 00
4.00	Accounts receivable	15, 027, 402		0	0	4.00
5.00	Other recei vabl e	229, 305	0	0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable		0	0	0	6.00
7. 00 8. 00	Inventory Prepai d expenses	749, 773		O O	0	7. 00 8. 00
9. 00	Other current assets	346, 125 3, 854, 849		0	0	9.00
10.00	Due from other funds	15, 929		Ö	0	10.00
11.00	Total current assets (sum of lines 1-10)	13, 947, 530		0	0	11.00
	FI XED ASSETS					
12.00	Land	1, 704, 211	0	0	0	12.00
13.00	Land improvements	5, 083, 363		0	0	13.00
14. 00 15. 00	Accumulated depreciation Buildings	-3, 803, 610 32, 464, 258		0	0	14. 00 15. 00
16. 00	Accumulated depreciation	-17, 109, 914		0	0	16.00
17. 00	Leasehold improvements	267, 301	Ö	o	0	17. 00
18.00	Accumul ated depreciation	-267, 301	0	0	0	18. 00
19. 00	Fi xed equipment	21, 001, 635		0	0	19.00
20.00	Accumulated depreciation	-14, 021, 038		0	0	20.00
21. 00 22. 00	Automobiles and trucks Accumulated depreciation	0	0	O O	0	21. 00 22. 00
23. 00	Major movable equipment	31, 503, 681	0	0	0	23.00
24. 00	Accumulated depreciation	-24, 367, 850	0	0	0	24.00
25. 00	Minor equipment depreciable	0	Ö	Ō	0	25. 00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable	U 22 454 724	0	0	0	29. 00 30. 00
30.00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	32, 454, 736	<u> </u>	<u> </u>	U	30.00
31.00	Investments	167, 757, 892	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2, 328, 538		0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	170, 086, 430 216, 488, 696		0	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	210, 400, 090	<u> </u>	<u>U</u>	U	30.00
37.00	Accounts payable	1, 588, 764	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3, 487, 949		0	0	38. 00
39.00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	2, 214, 668		0	0	40.00
41.00	Deferred income	67, 895	0	U	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	331, 059	0	0	0	42. 00 43. 00
44. 00	Other current liabilities	803, 600		0	0	44.00
		8, 493, 935		Ō	0	
	LONG TERM LIABILITIES					
46.00	Mortgage payable	12, 117, 715		0	0	
47.00	Notes payable	0	0	0	0	47.00
48. 00	Unsecured Loans Other Long term Liabilities	0 -510, 538	0	0	0	48.00
49. 00 50. 00	Total long term Habilities (sum of lines 46 thru 49)	11, 607, 177		0	0	49. 00 50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	20, 101, 112		ol	0	51.00
	CAPI TAL ACCOUNTS		-1	-,		
52.00	General fund balance	196, 387, 584				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			٩	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion				· ·	
59. 00	Total fund balances (sum of lines 52 thru 58)	196, 387, 584		0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	216, 488, 696	0	0	0	60.00
	[59]	I	I I	ļ		I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES ST. JOSEPHS HOSPITAL In Lieu of Form CMS-2552-10

| Peri od: | Worksheet G-1 | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: Provider CCN: 14-0145

					To	06/30/2023	Date/Time Pre 1/24/2024 12:	
		Genera	Fund	Speci al	Pur	pose Fund	Endowment	
							Fund	
		1, 00	2.00	3.00	_	4. 00	5. 00	
1. 00	Fund balances at beginning of period		179, 062, 611			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		20, 208, 457					2.00
3.00	Total (sum of line 1 and line 2)		199, 271, 068			0		3. 00
4. 00	Additions (credit adjustments) (specify)	0			0		0	
5. 00		0			0		0	
6.00		0			0		0	
7. 00 8. 00		0			0		0	
9. 00		0			0			
10. 00	Total additions (sum of line 4-9)	٩	0		U	0	_	10.00
11. 00	Subtotal (line 3 plus line 10)		199, 271, 068			o		11.00
12.00	NET TRANSFERS	2, 883, 484	, , , , , , , , , , , , , , , , , , , ,		0		o	12.00
13.00		o			0		0	13.00
14.00		0			0		0	
15.00		0			0		0	
16.00		0			0		0	
17.00	T-+-1 d-dusting (of lines 12 17)	O	2 002 404		O		0	
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		2, 883, 484 196, 387, 584			0		18. 00 19. 00
17.00	sheet (line 11 minus line 18)		170, 307, 304			U		17.00
	Janear (Title 11 millias Title 10)	Endowment	PI ant	Fund				
		Fund						
			7.00	0.00				
1. 00	Fund balances at beginning of period	6. 00	7. 00	8.00	0			1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)				U			2.00
3. 00	Total (sum of line 1 and line 2)	o			0			3.00
4. 00	Additions (credit adjustments) (specify)	-	0		-			4.00
5.00			0	1				5.00
6. 00			0					6. 00
7. 00			0					7. 00
8. 00			0	1				8.00
9.00	T-+-1		0	1	_			9.00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0			0			10. 00 11. 00
12.00	NET TRANSFERS	٥	0		U			12.00
13. 00	INCI TRANSPERS		0					13.00
14. 00			0	ı				14.00
15.00			0					15.00
16.00			0					16.00
17. 00			0					17. 00
18.00	Total deductions (sum of lines 12-17)	0			0			18.00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)	l l		I	ļ			1

ST. JOSEPHS HOSPITAL

Health Financial Systems
STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-0145

			То	06/30/2023	Date/Time Pre 1/24/2024 12:	
	Cost Center Description	I npati ent		Outpati ent	Total	2 7 PIII
	oost contor bescription	1, 00		2.00	3. 00	
	PART I - PATIENT REVENUES	1.00		2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	4, 995, 3	01		4, 995, 301	1.00
2. 00	SUBPROVI DER - I PF	",""	-		.,,	2.00
3.00	SUBPROVIDER - IRF					3.00
4. 00	SUBPROVI DER					4.00
5. 00	Swing bed - SNF	376, 8	98		376, 898	5.00
6. 00	Swing bed - NF	21, 2			21, 207	6.00
7. 00	SKILLED NURSING FACILITY	2.,,=	0,		2.,20.	7.00
8. 00	NURSING FACILITY					8.00
9. 00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5, 393, 4	06		5, 393, 406	1
	Intensive Care Type Inpatient Hospital Services	0,0,0,	00		0,070,100	
11. 00	INTENSIVE CARE UNIT		0		0	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)	5, 393, 4	06		5, 393, 406	17.00
18. 00	Ancillary services	27, 469, 9		119, 725, 769	147, 195, 693	1
19. 00	Outpati ent services	2, 318, 4		13, 759, 643	16, 078, 043	1
20.00	RURAL HEALTH CLINIC		0	12, 619, 420	12, 619, 420	1
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	o	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26. 00	HOSPI CE					26.00
27. 00	PRO FEES	50, 6	73	248, 168	298, 841	27.00
27. 01	VACANT SPACE		0	342	342	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 35, 232, 4	03	146, 353, 342	181, 585, 745	28. 00
	G-3, line 1)			, ,	,	
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			57, 098, 386		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			o		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38.00			0			38. 00
39.00			0			39.00
40.00			0			40.00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)			o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	ransfer		57, 098, 386		43.00
	to Wkst. G-3, line 4)					

	· · · · · · · · · · · · · · · · · · ·	ST. JOSEPHS HOSPITAL		u of Form CMS-2	
STATEM	IENT OF REVENUES AND EXPENSES	Provi der CCN: 14-0145	Peri od: From 07/01/2022	Worksheet G-3	
			To 06/30/2023		nared.
			10 00/00/2020	1/24/2024 12:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I,			181, 585, 745	
2.00	Less contractual allowances and discounts on pat	ients' accounts		113, 809, 278	
3.00	Net patient revenues (line 1 minus line 2)			67, 776, 467	
4.00	Less total operating expenses (from Wkst. G-2, P	art II, line 43)		57, 098, 386	
5.00	Net income from service to patients (line 3 minu	s line 4)		10, 678, 081	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			6, 367, 310	7. 00
8.00	Revenues from telephone and other miscellaneous	communication services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			25, 285	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical suppli	es to other than patients		1, 368	16.00
17.00	Revenue from sale of drugs to other than patient	S		0	17.00
18.00	Revenue from sale of medical records and abstrac	ts		0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)		0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and c	anteen		0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			500, 140	22. 00
23.00	Governmental appropriations			3, 897	23.00
	MISC INCOME			345, 752	24.00
24.50	COVI D-19 PHE Funding			22, 230	24. 50
	Total other income (sum of lines 6-24)			7, 265, 982	
	Total (line 5 plus line 25)			17, 944, 063	
	PENSI ON			-2, 264, 420	
	DOLINDI NC				27 01

26 27. 01 -2, 264, 394 28. 00 20, 208, 457 29. 00

27.01 ROUNDING
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)

Heal th	Financial Systems ST. JOSEPHS F	INT ID201	Inlia	u of Form CMS-2	2552_10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 14-0145	Peri od: From 07/01/2022 To 06/30/2023	Worksheet L Parts I-III	pared:
		Title XVIII	Hospi tal	PPS	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			268, 656	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			0	•
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost r	eporting period (see ins	tructions)	10. 96	3.00
4.00	Number of interns & residents (see instructions)			0. 00	
5.00	Indirect medical education percentage (see instructions)			0.00	1
6. 00	Indirect medical education adjustment (multiply line 5 by th 1.01)(see instructions)			0	
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet	E, part A line	0. 00	7. 00
8.00	Percentage of Medicaid patient days to total days (see instr	ructions)		0.00	
9. 00	Sum of lines 7 and 8			0.00	
10.00	Allowable disproportionate share percentage (see instruction	s)		0.00	1
11.00	Disproportionate share adjustment (see instructions)			0	
12. 00	Total prospective capital payments (see instructions)			268, 656	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2. 00 3. 00	Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2)	ices (see instructions)		0	2. 00 3. 00
4. 00	Applicable exception percentage (see instructions)			0. 00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
6. 00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	
7. 00	Adjustment to capital minimum payment level for extraordinar		x line 6)	0	1
8.00	Capital minimum payment level (line 5 plus line 7)		,	0	8. 00
9.00	Current year capital payments (from Part I, line 12, as appl	i cabl e)		0	9.00
10.00	Current year comparison of capital minimum payment level to		,	0	
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payment (from pr	ior year	0	11. 00
12.00	Net comparison of capital minimum payment level to capital p			0	
13.00	Current year exception payment (if line 12 is positive, ente			0	
14. 00	Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	capital payment for the	following period	0	14. 00
15. 00	Current year allowable operating and capital payment (see in	structions)		0	
16.00				0	
17. 00	Current year exception offset amount (see instructions)		l	0	17. 00

	Financial Systems	ST. JOSEPHS		ON 14 0145		u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	JN: 14-0145	Peri od: From 07/01/2022	Worksheet M-1	
			Component	CCN: 14-8503	To 06/30/2023	Date/Time Pre 1/24/2024 12:	pared: 29 pm
					RHC I	Cost	
		Compensati on	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1. 00	Physi ci an	0	2, 662, 055		·		1
2.00	Physician Assistant	0	349, 490		·		
3. 00	Nurse Practitioner	71, 950	1, 752, 786	1, 824, 73	-5, 490		
4.00	Visiting Nurse	0	0		0 0	0	1
5.00	Other Nurse	17, 922	1, 730, 008	1, 747, 93	30 0	1, 747, 930	
6. 00	Clinical Psychologist	0	0		0	0	
7.00	Clinical Social Worker	0	0		0	0	
8.00	Laboratory Technician	0	0		0	0	
9.00	Other Facility Health Care Staff Costs	00.070	(404 000	, 504.04	0 0	0	
10.00	Subtotal (sum of lines 1 through 9)	89, 872	6, 494, 339	6, 584, 21	-53, 400		
11.00	Physician Services Under Agreement	0	0		0	0	
12.00	Physician Supervision Under Agreement	0	0		0	0	
13.00	Other Costs Under Agreement	0	0		0	0	13. 00 14. 00
14. 00 15. 00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	116, 716	11/ 71	0	-	1
16. 00	Transportation (Health Care Staff)	0	110, /10	116, 71	0	116, 716 0	
17. 00	Depreciation (Hearth Care Starr)	0	0		0	0	1
18. 00	Professional Liability Insurance	0	0		0	0	18.00
19. 00	Other Health Care Costs	0	692, 111	692, 11	0	692, 111	
20.00	Allowable GME Costs	U	072, 111	072, 11	0	092, 111	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	808, 827	808, 82	0.7	808, 827	
22. 00	Total Cost of Health Care Services (sum of	89, 872	7, 303, 166				
22.00	lines 10, 14, and 21)	07, 072	7, 303, 100	7, 373, 00	33, 400	7, 337, 030	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
25. 01	Tel eheal th	0	0		0 53, 400	53, 400	25. 01
25.02	Chronic Care Management	0	0		0 0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27. 00	Nonallowable GME costs	-					27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 53, 400	53, 400	28.00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	496, 395				29. 00
30.00	Administrative Costs	40, 690	1, 040, 908	1, 081, 59	98 -504, 696	576, 902	30.00

496, 395 1, 040, 908 1, 537, 303

8, 840, 469

40, 690

40, 690

130, 562

496, 395 1, 081, 598

1, 577, 993

8, 971, 031

-504, 696 -978, 373

-978, 373

22, 718 576, 902 599, 620

7, 992, 658

30.00

31.00

32.00

30.00 Administrative Costs

31.00

32.00

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	ST. JOSEPHS HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0145	Period: Worksheet M-1 From 07/01/2022
	Component CCN: 14-8503	To 06/30/2023 Date/Time Prepared:

			Component CCN: 14-850)3 10	06/30/2023	Date/IIME Pre 1/24/2024 12:	
					RHC I	Cost	Ζ γ μιι
		Adjustments	Net Expenses		1010	0031	
		riaj astiliorres	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7.00				
	FACILITY HEALTH CARE STAFF COSTS	5. 77					
1.00	Physi ci an	0	2, 616, 175				1.00
2. 00	Physician Assistant	0	347, 460				2.00
3. 00	Nurse Practitioner	0	1, 819, 246				3.00
4.00	Visiting Nurse	0	O				4.00
5. 00	Other Nurse	0	1, 747, 930				5.00
6. 00	Clinical Psychologist	0	0				6.00
7. 00	Clinical Social Worker	0	ol				7.00
8. 00	Laboratory Techni ci an	0	ol				8.00
9. 00	Other Facility Health Care Staff Costs	0	ol				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	6, 530, 811				10.00
11. 00	Physician Services Under Agreement	0	0				11.00
12. 00	9	0	o				12.00
	Other Costs Under Agreement	0					13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0				14.00
	Medical Supplies	0	116, 716				15.00
16. 00		0	0				16.00
	Depreciation-Medical Equipment	0	Ö				17.00
18. 00		0	o				18.00
	Other Health Care Costs	0	692, 111				19.00
20. 00	Allowable GME Costs	U	072, 111				20.00
21. 00	1	0	808, 827				21.00
22. 00	Total Cost of Health Care Services (sum of	0	7, 339, 638				22. 00
22.00	lines 10, 14, and 21)	O	7, 337, 030				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23 00	Pharmacy	0	O				23.00
24. 00		0	Ö				24.00
25. 00	4	0	o o				25. 00
25. 01	Tel eheal th	0	53, 400				25. 01
25. 02		0	0				25. 02
26. 00	All other nonreimbursable costs	0	0				26.00
27. 00	Nonal Lowable GME costs	J	o _l				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	53, 400				28. 00
20.00	through 27)	O	33, 400				20.00
	FACILITY OVERHEAD						
29 00	Facility Costs	0	22, 718				29.00
30.00	Admi ni strati ve Costs	-27, 425	549, 477				30.00
31. 00	Total Facility Overhead (sum of lines 29 and		572, 195				31.00
31.00	30)	-21,425	372, 173				31.00
32. 00	Total facility costs (sum of lines 22, 28	-27, 425	7, 965, 233				32.00
52.00	and 31)	27, 423	., 700, 200				32.00
	=::= =:/	۱ ا	I				1

	Financial Systems	ST. JOSEPHS				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Period: From 07/01/2022	Worksheet M-2	
			Component		To 06/30/2023	Date/Time Pre 1/24/2024 12:	
					RHC I	Cost	27 piii
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2.00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	6. 31					1.00
2. 00	Physici an Assistant	1. 45					2.00
3. 00	Nurse Practitioner	9. 41					3.00
4. 00	Subtotal (sum of lines 1 through 3)	17. 17			49, 308	·	4.00
5. 00	Visiting Nurse	0.00	l .)		0	5.00
6. 00	Clinical Psychologist	0.00	l .)		0	6.00
7. 00	Clinical Social Worker	0.00	l .)		0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00)		0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0. 00	1)		0	7. 02
0 00	only)	17 17	F4 F45	,		F1 F17	0.00
8. 00	Total FTEs and Visits (sum of lines 4	17. 17	51, 517			51, 517	8.00
9. 00	through 7) Physician Services Under Agreements					0	9.00
9.00	Priysi ci aii sei vi ces undei Agi eemerits			ή		U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SE	RVI CES			
10. 00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			7, 339, 638	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			53, 400	11.00
12. 00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			7, 393, 038	12.00
13. 00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			0. 992777	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet.	M-1, col. 7, I	ine 31)		572, 195	14.00
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)			3, 747, 823	15.00
16. 00	Total overhead (sum of lines 14 and 15)					4, 320, 018	
17. 00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					4, 320, 018	
	Overhead applicable to hospital-based RHC/FC					4, 288, 815	
20. 00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	0 and 19)		11, 628, 453	20.00

llool +b	Financial Systems ST. JOSEPHS HOSPI	TAI	la li o	of Form CMC 2	DEE2 10
	Financial Systems ST. JOSEPHS HOSPI ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC Pro		Peri od:	u of Form CMS-2 Worksheet M-3	2332-10
SERVI C	ES	mponent CCN: 14-8503	From 07/01/2022 To 06/30/2023	Date/Time Prep 1/24/2024 12:2	
		Title XVIII	RHC I	Cost	
				1 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from W	kst. M-2, line 20)		11, 628, 453	1.00
2.00	Cost of injections/infusions and their administration (from Wkst.			711, 626	2.00
3. 00	Total allowable cost excluding injections/infusions (line 1 minus	s line 2)		10, 916, 827	3. 00
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8)	o 0)		51, 517 0	4. 00 5. 00
6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, line Total adjusted visits (line 4 plus line 5)	e 9)		51, 517	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			211. 91	7. 00
			Calculation	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(07/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	06/30/2023) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	230. 66	239. 43	8. 00
9. 00	Rate for Program covered visits (see instructions)		211. 91	211. 91	9. 00
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from co	ntractor records)	6, 831	6, 595	10. 00
11. 00	Program cost excluding costs for mental health services (line 9:		1, 447, 557	1, 397, 546	11.00
12.00	Program covered visits for mental health services (from contractor	,	0	0	12.00
13. 00	Program covered cost from mental health services (line 9 x line	12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instructions) Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and	4 3) *	0	2, 845, 103	15. 00 16. 00
16. 01	Total program charges (see instructions) (from contractor's record	,	ı	2, 439, 498	16. 01
16. 02	Total program preventive charges (see instructions) (from provide	-		21, 297	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times li			24, 838	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 at	nd 18) times .80)		2, 053, 144	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		o	2, 077, 982	16. 05
17. 00	Primary payer amounts			130	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (fi	rom contractor		253, 835	18.00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instructions)	(from contractor		426, 850	19. 00
	records)				
20.00	Net Medicare cost excluding vaccines (see instructions)	4 11 4/		2, 077, 852	20.00
21. 00 22. 00	Program cost of vaccines and their administration (from Wkst. M- Total reimbursable Program cost (line 20 plus line 21)	4, TINE 16)		118, 174 2, 196, 026	
23. 00	Allowable bad debts (see instructions)			2, 170, 020	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24.00	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)		0	24.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25. 50	Prioneer ACO demonstration payment adjustment (see instructions)			0	25. 50 25. 99
25. 99 26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			2, 196, 026	25. 99 26. 00
26. 01	Sequestration adjustment (see instructions)			43, 921	26. 01
26. 02	Demonstration payment adjustment amount after sequestration			0	26. 02
27. 00	Interim payments			2, 120, 485	
28. 00	,	27 20)		0	28. 00
29. 00 30. 00	Balance due component/program (line 26 minus lines 26.01, 26.02, Protested amounts (nonallowable cost report items) in accordance			31, 620 0	29. 00 30. 00
30.00	chapter I, §115. 2	with ows rub. 15-11,			30.00

OMPUT	Financial Systems ST. JOSEPHS ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider CC	N: 14-0145	Peri od:	Worksheet M-4	
		Component C	CN: 14-8503	From 07/01/2022 To 06/30/2023	Date/Time Pre	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
. 00 . 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health	6, 530, 811 0. 006137	6, 530, 8° 0. 0101		6, 530, 811 0. 000000	1. 0 2. 0
. 00	care staff time Injection/infusion health care staff cost (line 1 x line 2)	40, 080	66, 43	5, 976	0	3. (
. 00	Injections/infusions and related medical supplies costs (from your records)	278, 136	58, 53	0	0	4. (
. 00	Direct cost of injections/infusions (line 3 plus line 4)	318, 216	124, 97	71 5, 976	0	5.
00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	7, 339, 638	7, 339, 63		7, 339, 638	6.
00	Total overhead (from Wkst. M-2, line 19)	4, 288, 815	4, 288, 8		4, 288, 815	7.
00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 043356	0. 01702		0. 000000	8.
00	Overhead cost - injection/infusion (line 7 x line 8)	185, 946	73, 02		0	9.
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	504, 162	197, 99		0	
1. 00	Total number of injections/infusions (from your records)	1, 315	2, 18		0	
2. 00	Cost per injection/infusion (line 10/line 11)	383. 39	90.8		0. 00	
3.00	Number of injection/infusion administered to Program beneficiaries	187	48		0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	74 (04	40. 7	0 705	0	
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	71, 694	43, 7	75 2, 705	0	14.
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
				4.00	N	
00	Tatal and as initiation /infortant and their activities of	+- (1. 00	2.00	15
	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			711, 626	15.
. 00	Total Program cost of injections/infusions and their admin	istration costs	(sum of		118, 174	16

Health Financial Systems	ST. JOSEPHS HO	SPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 14-0145 Component CCN: 14-8503	From 07/01/2022	Worksheet M-5 Date/Time Prepared: 1/24/2024 12: 29 pm

		Component Con. 14-0303	10 00/30/2023	1/24/2024 12: 3	
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			2, 024, 855	1.
2. 00	Interim payments payable on individual bills, either submitt			0	2.
	the contractor for services rendered in the cost reporting p	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3.
	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				
. 01			02/22/2023	88, 046	3.
. 02			02/22/2023	7, 584	3.
. 03				o	3.
. 04				l ol	3.
. 05				l ol	3.
	Provider to Program		<u>'</u>		
. 50				0	3.
. 51				l ol	3.
52				0	3.
53				0	3.
. 54				0	3
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9	987		95, 630	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transf			2, 120, 485	4.
. 00	27)	er to worksheet w 5, Time		2, 120, 403	٦.
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after desk	review Also show date of	5		5.
. 00	each payment. If none, write "NONE" or enter a zero. (1)	t row out rules ellen date el			"
	Program to Provider				
. 01				0	5.
02				0	5.
. 03				0	5.
	Provider to Program				
50				0	5.
51				l ol	5.
				0	5.
52					
	Subtotal (sum of lines 5 01-5 49 minus sum of lines 5 50-5 9	98)		1 ()1	ו ה
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9			0	
. 99 . 00	Determined net settlement amount (balance due) based on the				6.
. 99 . 00 . 01	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER			31, 620	6. 6.
. 99 . 00 . 01 . 02	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			31, 620 0	6. 6.
. 99 . 00 . 01 . 02	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER		Contractor	31, 620 0 2, 152, 105	6. 6. 6.
. 99 . 00 . 01 . 02	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		Contractor	31, 620 0 2, 152, 105 NPR Date	6. 6. 6.
5. 52 5. 99 5. 00 5. 01 5. 02 7. 00	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		Contractor Number 1.00	31, 620 0 2, 152, 105	5. 6. 6. 7.