Health Financia	al Systems	ST. JOSEPH HOSPITAL & F	HEALTH CENTER	In Lie	u of Form Cl	MS-2552-10
This report is	required by law (42 USC 1395)	g; 42 CFR 413.20(b)). Failu	ure to report can resul	t in all interim	FORM APPRO	VED
payments made	since the beginning of the co	st reporting period being o	deemed overpayments (42	USC 1395g).	OMB NO. 09	38-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COSUMMARY	OST REPORT CERTIFICATION	Provider CCN: 150010	Peri od: From 07/01/2015		Ī
				To 06/30/2016	11/22/2016	
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically filed	cost report		Date: 11/22/2	016 Time	: 2:42 pm
use only	2. [ ] Manually submitted co	st report				
	3. [ 0 ] If this is an amended 4. [ F ] Medicare Utilization.			esubmitted this co	ost report	
Contractor	5. [ 1 ]Cost Report Status			IPR Date:		
use only	(1) As Submitted	7. Contractor No.	11. 0	Contractor's Vendo	or Code:	4
		8. [ N ] Initial Report for	this Provider CCN 12. [			
	(3) Settled with Audit	9. [ N ] Final Report for the	nis Provider CCN	number of tim	ies reopened	d = 0-9.

## PART II - CERTIFICATION

(4) Reopened (5) Amended

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

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. JOSEPH HOSPITAL & HEALTH CENTER (150010) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 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.

(Si gned)		
	Officer or Administrator of Provider(	s)
	· ·	
T: +1 -		
Title		
Date		

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	88, 053	115, 914	25, 649	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	12, 512	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
12.00	CMHC I	0		0		0	12. 00
200.00	Total	0	100, 565	115, 914	25, 649	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150010 Peri od: Worksheet S-2 From 07/01/2015 Part I Date/Time Prepared: 06/30/2016 11/22/2016 2:42 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1907 WEST SYCAMORE STREET 1.00 PO Box: 1.00 State: IN 2.00 City: KOKOMO Zip Code: 46901 County: HOWARD 2.00 Payment System (P, Component Name CCN CBSA Provi der Date T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ST. JOSEPH HOSPITAL & 150010 29020 07/01/1966 Ν Р 0 3.00 1 HEALTH CENTER Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF ST. JOSEPH ACUTE REHAB 15T010 29020 5 07/01/2002 Ν Р 0 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 To: From: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2015 06/30/2016 20.00 21.00 Type of Control (see instructions) 1 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22 02 Is this a newly merged hospital that requires final uncompensated care payments to be N Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2, or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result 22.03 Ν Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no enter "Y" for yes or "N" <u>for no</u> 0ther In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days eligible unpai d paid days 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 327 24. 00 553 4.451 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 25 00 55 O 0 158 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.

	Financial Systems ST. JOSEPH HO AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		Provi der (	CCN: 150010	Period: From 07/01		Workshe Part I Date/Ti 11/22/2	et S-2 me Pre	pared:
					Urban/Ru		Date of	Geogr	, , , , , , , , , , , , , , , , , , ,
5. 00	Enter your standard geographic classification (not wac	ge) sta	itus at the beg	inning of th	1. 00 ne	1	2.0	00	26. 00
7. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wag reporting period. Enter in column 1, "1" for urban or	ge) sta	itus at the end		Ī	1			27. 00
5. 00	enter the effective date of the geographic reclassific If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35. 00
					Begi nni 1. 00		Endi ı 2. C		
. 00	Enter applicable beginning and ending dates of SCH sta of periods in excess of one and enter subsequent dates		Subscript line	36 for numbe	er				36. 00
	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the nu	·			0			37.0
	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)	yes o	or "N" for no.	(see	N				37. 0
3. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. 0
					Y/N		Y/I		
0.00	Does this facility qualify for the inpatient hospital	paymer	nt adjustment f	or low volum	1. 00 ne N	J	2. C		39. 00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii) or "N" for no. Does the facility meet the mileage requ CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes of	ui remer or "N"	nts in accordan for no. (see i	ce with 42 nstructions)			N.		40.00
7. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobeno in column 2, for discharges on or after October 1.	er 1. E	Enter "Y" for y				N		40.00
						1. 00	XVIII 2. 00	3. 00	
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment	for c	li sproporti opat	o share in a	ccordance	T N	Υ	N	45. 0
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excep pursuant to 42 CFR §412.348(f)? If yes, complete Wkst.	otion f	or extraordi na	ry circumsta	ances	N	N	N	46. 0
	Pt. III.  Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.  N N N  Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.  N N N								47. 0 48. 0
. 00	<u>Teaching Hospitals</u> Is this a hospital involved in training residents in a	approve	ed GME programs	? Enter "Y	for yes	N			56. 0
	or "N" for no. If line 56 is yes, is this the first cost reporting po GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "Y" "N", complete Wkst. D, Parts III & IV and D-2, Pt. II,	yes or of th , comp if ap	"N" for no in nis cost report blete Worksheet oplicable.	column 1. I ing period? E-4. If col	f column 1 Enter "Y" umn 2 is				57.0
	If line 56 is yes, did this facility elect cost reimbudefined in CMS Pub. 15-1, chapter 21, §2148? If yes, c			ns' services	s as				58.0
00 .	Are costs claimed on line 100 of Worksheet A? If yes,	compl	ete Wkst. D-2,			N Y			59.0
). 00	Are you claiming nursing school and/or allied health o provider-operated criteria under §413.85? Enter "Y" f	or yes	or "N" for no	. (see instr	uctions)	<u> </u>			60.0
		Y/N	I ME	Direct GME	E I IME		Di rect	GME	
00	Did a second	1.00	2. 00	3. 00	4.0		5. C		(1.0
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	61.0
. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.	00				61.0
02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.	00				61. C
03	ACA). (see instructions)  Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.	00				61.0
04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.	00				61.0
	current cost reporting period.(see instructions).  Enter the difference between the baseline primary		0.00	0.	00				61.0

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	ST. JOSEPH H EX IDENTIFICATION DA			CCN: 150010	Peri od: From 07/01/2015 To 06/30/2016	w of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 11/22/2016 2:	pared:
		Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4. 00	5. 00	
61.06 Enter the amount of ACA §5503 awa used for cap relief and/or FTEs t care or general surgery. (see ins	hat are nonprimary		0.00	0.	00		61. 06
		Pro	ogram Name	Program Cod	E Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3. 00	4.00	
61.10 Of the FTEs in line 61.05, specif specialty, if any, and the number for each new program. (see instrucolumn 1, the program name, enter program code, enter in column 3, unweighted count and enter in col FTE unweighted count.	of FTE residents ctions) Enter in in column 2, the the IME FTE umn 4, direct GME				0.00		61. 10
61. 20 Of the FTEs in line 61.05, specific program specialty, if any, and the residents for each expanded progrinstructions) Enter in column 1, enter in column 2, the program column 3, the IME FTE unweighted count a 4, direct GME FTE unweighted count	e number of FTE am. (see the program name, de, enter in column nd enter in column				0.00	0.00	61. 20
						1. 00	
ACA Provisions Affecting the Heal 62.00 Enter the number of FTE residents	that your hospital	trai ned			riod for which	0.00	62. 00
your hospital received HRSA PCRE 62.01 Enter the number of FTE residents during in this cost reporting per	that rotated from a iod of HRSA THC prog	a Teachi gram. (s	see instruction		o your hospital	0.00	62. 01
63.00 Has your facility trained residen "Y" for yes or "N" for no in colu	ts in nonprovider se	ettings	during this co			N	63. 00
				Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year	FTE Residents in No	nnrovi	der Settings	1.00	2.00	3.00	
64.00 Enter in column 1, if line 63 is in the base year period, the numb	<u>ly 1, 2009 and befor</u> yes, or your facilit er of unweighted nor	<u>re June</u> ty trair n-priman	30, 2010. ned residents ry care		00 0.00	, ,	64.00
resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	number of unweighted r hospital. Enter ir	d non-pr n column	imary care n 3 the ratio				
p. (co. s.m. ) divided by (co. dilli)	Program Name		ogram Code	Unwei ghted FTEs Nonprovi dei Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00		2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3				0.	00 0.00	0. 000000	n 65. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMP		HOSPITAL & HEALTH CEN NTA Provider	CCN: 150010 P	eriod: rom 07/01/201!	5 Date/Time Pre	pared:		
			Unwei ghted FTEs Nonprovi der Si	Unwei ghted FTEs in Hospi tal	11/22/2016 2:   Ratio (col. 1/   (col. 1 + col.   2))			
Section 5504 of the ACA Current		n Nonprovider Settin	1.00 gsEffective fo	2.00 or cost report	3.00 ing periods			
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima occurring in all nonpo unweighted non-prima cal. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	O. C	0. 000000	66. 00		
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	3.00	4.00 0.0	5. 00 0 0. 000000	67. 00		
				1. (	00 2.00 3.00			
Inpatient Psychiatric Facility F		IPF) or does it cont	tain an IPE subr	provi der? N		70. 00		
Enter "Y" for yes or "N" for no 71.00 If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF	Enter "Y" for yes or "N" for no.  1.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.  Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)							
75.00 Is this facility an Inpatient Results subprovider? Enter "Y" for yes	habilitation Facility	y (IRF), or does it o	contain an IRF	Y		75. 00		
76.00 If line 75 yes: Column 1: Did the recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Enterindicate which program year begans	ne facility have an a ling on or before Novo train residents in a er "Y" for yes or "N"	ember 15, 2004? Enter new teaching program for no. Column 3: I1	"Y" for yes or m in accordance f column 2 is Y,	"N" for with 42	N O	76. 00		
					1. 00			
80.00 Is this a long term care hospital PPS 81.00 Is this a LTCH co-located within "Y" for yes and "N" for no.  TEFRA Providers				period? Enter	N N	80. 00 81. 00		
85.00 Is this a new hospital under 42 86.00 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider or yes and "N" for no.	(excluded unit) under	42 CFR Section	1	N	85. 00 86. 00 87. 00		
87.00 Is this hospital a "subclause (I for yes or "N" for no.	i, Lion Crassified I	under Section 1880(0)	, ( I ) ( U ) ( I V ) ( I I ) ;		N	67.00		
				1. 00	XI X 2. 00			
70.00 Title V and XIX Services  90.00 Does this facility have title V	and/or XIX inpatient	hospital services? E	Enter "Y" for	N	Y	90.00		
yes or "N" for no in the applica 91.00 is this hospital reimbursed for	ıble column.	•		N	N	91. 00		
full or in part? Enter "Y" for y  92.00 Are title XIX NF patients occupy	es or "N" for no in	the applicable column	٦.		N	92. 00		
instructions) Enter "Y" for yes 93.00 Does this facility operate an IC	or "N" for no in the	applicable column.	, ,	N	N N	93. 00		
94.00 Does this facility operate an item.  "Y" for yes or "N" for no in the Does title V or XIX reduce capit applicable column.	applicable column.	•		N N	N N	94. 00		

Health Financial Systems ST. JOSEPH HOSPITAL						CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	F	eriod: rom 07/01/2 o 06/30/2	2015 P	orksheet art l ate/Time	S-2 Prepared:
					1/22/201	6 2: 42 pm
			1. 00		2. 00	
95.00 If line 94 is "Y", enter the reduction percentage in the apl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for year applicable column.			0. 00 N		0. 00 N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	olicable column	n.	0.00		0. 00	97. 00
105.00 Does this hospital qualify as a critical access hospital (C, 106.00 of this facility qualifies as a CAH, has it elected the all		nod of payment	N			105. 00 106. 00
for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, column reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see instr	ructions) If				107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sched	dul e? See 42	N			108. 00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	1	Respi rat 4.00	ory
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00	2.00	3.00		4.00	109. 00
					1.00	
110.00 Did this hospital participate in the Rural Community Hospitathe current cost reporting period? Enter "Y" for yes or "N"		on project (410	OA Demo)for		N	110. 00
				1. 00	2.00 3	3. 00
Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on	r "N" for no in	n column 1 lf	column 1	N		0 115.00
is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" percel psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208.1.	. If column 2 int for long ter	is "E", enter i rm care (includ	n column des			113.00
116.00 Is this facility classified as a referral center? Enter "Y"	-			N		116. 00
117.00 s this facility legally-required to carry malpractice insu		,		Y		117. 00
118.00 s the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 i	if the policy i	S	2		118. 00
		Premiums	Losses	,	Insuran	ce
		1.00	2.00		2.00	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 417, 040	2.00	0	3. 00	0 118. 01
			1. 00		2. 00	
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.	center other dule listing co	than the ost centers	N N		2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies the second seco	n column 1, "Y' ualifies for th	' for yes or ne Outpatient	N		N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no.  121.00Did this facility incur and report costs for high cost impli	•	ŕ	Y			121. 00
patients? Enter "Y" for yes or "N" for no.		Ü			F 00	
122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.			Y		5. 00	122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or ves and "N"	for no. If	l N			125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, en	,					126. 00
in column 1 and termination date, if applicable, in column 3	2.					
127.00 of this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 128.00 of this is a Medicare certified liver transplant center, en	2.					127. 00 128. 00
in column 1 and termination date, if applicable, in column 1 129.00 of this is a Medicare certified lung transplant center, entity	2.					129. 00
column 1 and termination date, if applicable, in column 2.  130.00 olf this is a Medicare certified pancreas transplant center,						130.00
date in column 1 and termination date, if applicable, in column 131.00  f this is a Medicare certified intestinal transplant center	umn 2.					131. 00
date in column 1 and termination date, if applicable, in col	umn 2.					
132.00  f this is a Medicare certified islet transplant center, en  in column 1 and termination date, if applicable, in column 3		cation date				132. 00

Health Financial Systems	ST. JOSEPH HOSPITAL	& HFALTH CENT	FR		In Lie	eu of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			CCN: 150010	Peri od:		Worksheet S-	
					7/01/2015		annorod.
				To 06	5/30/2016	Date/Time Pr 11/22/2016 2	
		<u> </u>					
					1. 00	2.00	
133.00 If this is a Medicare certified of			cation date	÷			133. 00
in column 1 and termination date, 134.00 If this is an organ procurement or			n column 1				134. 00
and termination date, if applicable		ne of a ridiliber i	ii corumii i				134.00
All Providers	.,						
140.00 Are there any related organization					Υ	15H046	140. 00
chapter 10? Enter "Y" for yes or "				S			
are claimed, enter in column 2 the	2.0		Trons)		3. 00		
If this facility is part of a chai			uah 143 the	name and		of the	
home office and enter the home off							
141.00 Name: ST. VINCENT HEALTH	Contractor's Name: WP	S	Contrac	tor's Nur	mber: 0810	01	141. 00
142.00 Street: 10330 NORTH MERIDIAN STREET			L				142. 00
143.00 Ci ty: I NDI ANAPOLI S	State: IN		Zi p Cod	e:	4629	90 T	143. 00
						1.00	
144.00 Are provider based physicians' cos	its included in Worksheet	A?				1.00 Y	144. 00
Trincopii o provi dei saesa prigerorano ess	TO THE GOOD THE WOLKSHOOT						111100
					1. 00	2.00	
145.00 If costs for renal services are cl					Υ		145. 00
inpatient services only? Enter "Y"							
no, does the dialysis facility inc period? Enter "Y" for yes or "N"		for this cost	reporting				
146.00 Has the cost allocation methodolog		usly filed cost	t report?		N		146. 00
Enter "Y" for yes or "N" for no ir				f	IN		140.00
yes, enter the approval date (mm/c		-,	, 3, .				
47 00 11 11 11 11 11						1.00	117.00
147.00 Was there a change in the statisti 148.00 Was there a change in the order of						N N	147. 00 148. 00
149.00 Was there a change to the simplifi				ır no		N N	149. 00
147. 00 was there a change to the simpiriti	ed cost finding method: El	Part A	Part B		tle V	Title XIX	147.00
		1.00	2.00		3.00	4.00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or "	N" for no for each compone			(See 42			155.00
155.00 Hospi tal 156.00 Subprovi der - TPF		N N	l N N		N N	N N	155. 00 156. 00
157. 00 Subprovi der - IRF		N N	l N		N	N N	157. 00
158. 00 SUBPROVI DER					••		158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N		N	N	160. 00
161. 00 CMHC			N		N	N	161. 00
161. 10 CORF			N		N	N	161. 10
						1.00	
Multicampus						1.00	
165.00 s this hospital part of a Multica	impus hospital that has one	e or more campu	uses in diff	erent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.		<u> </u>					
	Name	County		ip Code	CBSA	FTE/Campus	
1// 00  f line 1/F is yes for each	0	1. 00	2. 00	3. 00	4. 00	5. 00	20144 00
166.00 If line 165 is yes, for each campus enter the name in column						0.0	00 166. 00
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)	) incentive in the America	an Recovery and	d Reinvestme	ent Act		1.00	
167.00 Is this provider a meaningful user						Y	167. 00
168.00 If this provider is a CAH (line 10				), enter	the		0168.00
reasonable cost incurred for the H	IIT assets (see instruction	ns)					
168.01 If this provider is a CAH and is r					shi p		168. 01
exception under §413.70(a)(6)(ii)?					ntor the		E0140 00
169.00 If this provider is a meaningful utransition factor. (see instruction		is not a CAH (	TITHE TUS IS	ы), е	nter the	0.	50169. 00
priansi tron ractor. (See matractic						1	1

Health Financial Systems	u of Form CMS-	2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CCN: 150010	Peri od:	Worksheet S-2	
			From 07/01/2015	Part I	
			To 06/30/2016	Date/Time Pre	pared:
	11/22/2016 2:	42 pm			
			Begi nni ng	Endi ng	
	2.00				
170.00 Enter in columns 1 and 2 the EHR begins period respectively (mm/dd/yyyy)	12/31/2015	170. 00			
				1.00	1
171.00 If line 167 is "Y", does this prov	ider have any days for indivi	duals enrolled in secti	on 1876	N	171. 00
Medicare cost plans reported on Wk	st. S-3, Pt. I, line 2, col.	6? Enter "Y" for yes a	nd "N" for no.		
(see instructions)					

	Financial Systems ST. JOSEPH HOSPITA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			In Lie Period:	eu of Form CMS- Worksheet S-2	
1103F1 1	AL AND HOSPITAL HEALTH CARE RETWINDURSEMENT QUESTIONNAIRE	Frovider		From 07/01/2015 To 06/30/2016	Part II Date/Time Pre	epared:
				Y/N	11/22/2016 2: Date	42 pm
				1, 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO r	esponses. Ente			
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					_
1. 00	Has the provider changed ownership immediately prior to the	e heainnina of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in o					1.00
			Y/N	Date	V/I	
2 00		0.16	1.00	2. 00	3. 00	0.00
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum		N			2. 00
	voluntary or "I" for involuntary.					
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of		Y			3. 00
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of	of the board				
	of directors through ownership, control, or family and other	er similar				
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Cert		Y	A		4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date ava	ror compiled, ailable in				
	column 3. (see instructions) If no, see instructions.					
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit red	conciliation.		Y/N	Legal Oper.	
				1.00	2. 00	
	Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provider is	N		6. 00
7. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	netrueti one		Y		7. 00
8. 00	Were nursing school and/or allied health programs approved		d durina the	N		8.00
	cost reporting period? If yes, see instructions.		G			
9. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		the current	N		10.00
10.00	cost reporting period? If yes, see instructions.	or renewed in	the current			10.00
11. 00	Are GME cost directly assigned to cost centers other than I	I & Rin an Ap	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes				Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	oolicy change	during this co	st reporting	N	13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I	f ves. see ins	tructi ons.	N	14.00
	Bed Complement		<i>J</i>			
15. 00	Did total beds available change from the prior cost reporti	, , ,			N N	15. 00
		Y/N	rt A Date	Y/N	rt B 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?	Υ	10/03/2016	Υ	10/03/2016	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)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					1

19.00

but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems ST. JOSEPH HOSPITA	L & HEALTH CENT	ER	In Lie	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 150010	Peri od: From 07/01/2015 To 06/30/2016	Worksheet S-: Part II Date/Time Pro 11/22/2016 2	epared:
			pti on	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R	(	)	1. 00 N	3. 00 N	20. 00
20.00	Report data for Other? Describe the other adjustments:			IN IN	IN	20.00
		Y/N	Date	Y/N	Date	
21 00	Weether and according to the considerate	1.00	2.00	3.00	4. 00	21.00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)	-		
00.00	Capital Related Cost					
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		als made dur	ing the cost		22. 00 23. 00
25. 00	reporting period? If yes, see instructions.	due to apprais	ars made dur	ring the cost		25.00
24. 00	Were new leases and/or amendments to existing leases enterollifyes, see instructions	ed into during	this cost re	porting period?		24. 00
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see		25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the state of the second seco	he cost reporti	ng period? I	f yes, see		26. 00
27. 00	instructions. Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	yes, submit		27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or letters of credit e	ntered into dur	ing the cost	reporting		28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		· ·			29. 00
30. 00	treated as a funded depreciation account? If yes, see insti Has existing debt been replaced prior to its scheduled matu		debt? If yes	, see		30. 00
31. 00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	, see		31. 00
	instructions. Purchased Services					
32. 00	Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru	rvices furnishe uctions.	d through co	ntractual		32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appling, see instructions.		g to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an allf yes, see instructions.	rrangement with	provi der-ba	sed physi ci ans?		34. 00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ts with the	provi der-based		35. 00
	, , , , , , , , , , , , , , , , , , ,			Y/N	Date	
	ll 066: 0t-			1. 00	2. 00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?			Υ		36. 00
37. 00	If line 36 is yes, has a home office cost statement been pullf yes, see instructions.	repared by the	home office?			37. 00
38. 00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end			N		38. 00
39. 00				, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
		1	00		00	
	Cost Report Preparer Contact Information	1.	00	2.	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,					
42. 00	respectively. Enter the employer/company name of the cost report	ST VINCENT HEA	LTH			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost	317-583-3234		RONALD. HELMS@S7	TVI NCENT. ORG	43. 00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems	ST. JOSEPH HOSPITAL	TAL & HEALTH CENTER				In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMEN	Γ QUESTI ONNAI RE	Prov	ider CCM	N: 150010	Peri		Worksheet S-2	<u>)</u>	
						To	m 07/01/2015	Part II   Date/Time Pre	nared:	
						10	007 307 2010	11/22/2016 2:	42 pm	
				3.00						
	Cost Report Preparer Contact Information									
41.00	Enter the first name, last name and the		REIMBURSE	MENT MAN	IAGER				41. 00	
	held by the cost report preparer in colu	ımns 1, 2, and 3,								
	respecti vel y.									
42.00	Enter the employer/company name of the c	cost report							42. 00	
	preparer.									
	Enter the telephone number and email add								43. 00	
	report preparer in columns 1 and 2, resp	ecti vel y.								

Heal th Financial Systems ST. JOSEPH HOSPITAL & HEALTH CENTER
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 07/01/2015 | Part I | Date/Time Prepared: | Provi der CCN: 150010

					''	00/30/2010	11/22/2016 2:	
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1.00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		94	34, 404	0.00		1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			94	34, 404	0. 00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		13	4, 758	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)	40.00						12.00
13.00	NURSERY	43. 00		407			0	13. 00
14.00	Total (see instructions)			107	39, 162	0. 00		14.00
15.00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF	44.00		10	/ 500			16.00
17. 00	SUBPROVI DER - I RF	41. 00		18	6, 588		0	
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE							20. 00 21. 00
		101. 00					o	22.00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. )	101.00					U	23. 00
24. 00	HOSPICE							24.00
24. 00	HOSPICE (non-distinct part)	30.00						24. 00
25. 00	CMHC - CMHC	99. 00					0	25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26. 00	RURAL HEALTH CLINIC	77. 10					U	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			125				27. 00
28. 00	Observation Bed Days			123			0	28. 00
29. 00	Ambulance Trips						J	29. 00
30. 00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31.00
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room			O				32. 00
JZ. 01	outpatient days (see instructions)							32.01
33. 00	LTCH non-covered days							33. 00
· · · · ·	1	'	'		1		'	

Heal th Financial Systems ST. JOSEPH HOSPITAL & HEALTH CENTER
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN

Provider CCN: 150010

						11/22/2016 2:	42 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	8, 064	416	17, 645		10.00	1. 00
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4 500					
2.00	HMO and other (see instructions)	1, 592	4, 451				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	293	158				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	O	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	8, 064	416	17, 645			7. 00
8.00	INTENSIVE CARE UNIT	1, 497	196	2, 331			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		280	1, 974			13. 00
14.00	Total (see instructions)	9, 561	892	21, 950	0.00	652.04	14. 00
15. 00	CAH visits	0	0	0			15. 00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	2, 780	55	3, 553	0.00	21. 19	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	0	0	0	0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	o	o	0			24. 10
25.00	CMHC - CMHC	o	o	0	0.00	0.00	25. 00
25. 10	CMHC - CORF	O	o	0	0.00	0.00	25. 10
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27.00	Total (sum of lines 14-26)				0.00	673. 23	27. 00
28.00	Observation Bed Days		o	735			28. 00
29.00	Ambul ance Trips	2, 286					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF		İ	0			31. 00
32. 00	Labor & delivery days (see instructions)	0	o	445			32.00
32. 01	Total ancillary labor & delivery room		ĭ	0			32. 01
52. 51	outpatient days (see instructions)			O			32.01
33.00		o					33. 00
	•	. '	'		•		

Heal th Financial Systems ST. JOSEPH HOSPITAL & HEALTH CENTER

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN

					00/30/2010	11/22/2016 2:	
		Full Time		Di sch	arges		
		Equi val ents			,		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12. 00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	2, 063	302	6, 006	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)			3	1, 487		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				22		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	I NTENSI VE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY			0.040			13.00
14.00	Total (see instructions)	0. 00	0	2, 063	302	6, 006	
15.00	CAH visits						15. 00
16.00	SUBPROVI DER - I PF	0.00		0.40	4.0	20.4	16.00
17. 00	SUBPROVI DER - I RF	0. 00	0	249	10	324	
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	0.00					21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC	0.00					25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						33. 00
33. 00	LTCH non-covered days	1					33.UU

| Peri od: | Worksheet S-3 | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: | Provider CCN: 150010

					To	06/30/2016	Date/Time Pre 11/22/2016 2:	
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries	Adj usted Sal ari es		Average Hourly	
		Li ne Number	керог геа	(from	(col.2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
		1.00	2. 00	Worksheet A-6) 3.00	3) 4. 00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	0.00	
	SALARI ES	222 22	10.010.557		10.040.553	1 100 000 00	1 00 /4	
1. 00	Total salaries (see instructions)	200. 00	40, 068, 557	0	40, 068, 557	1, 400, 323. 00	28. 61	1. 00
2.00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	2. 00
3. 00	A  Non-physician anesthetist Part		0	0	0	0. 00	0.00	3. 00
	В							
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0. 00	4. 00
4. 01	Physicians - Part A - Teaching		0	0	0	0.00	1	
5. 00 6. 00	Physician-Part B Non-physician-Part B		304, 009 0	0	304, 009 0	2, 091. 00 0. 00	l .	
7. 00	Interns & residents (in an	21. 00	0	Ö	Ö	0. 00	1	
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0.00	7. 01
	residents (in an approved		J			0.00	0.00	'''
8. 00	programs) Home office personnel		0	0	0	0. 00	0.00	8. 00
9. 00	SNF	44. 00	0	O	0	0.00	0. 00	9. 00
10. 00	Excluded area salaries (see instructions)		2, 218, 616	270, 739	2, 489, 355	60, 372. 00	41. 23	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		191, 702	0	191, 702	3, 285. 00	58. 36	11. 00
12. 00	Contract Labor: Top Level		0	0	0	0.00	0. 00	12. 00
	management and other management and administrative							
40.00	servi ces		222 5/4		000 5/4			
13. 00	Contract Labor: Physician-Part A - Administrative		229, 561	0	229, 561	4, 752. 00	48. 31	13. 00
14. 00	Home office salaries &		13, 273, 126	0	13, 273, 126	281, 936. 00	47. 08	14. 00
15. 00	wage-related costs Home office: Physician Part A		0	0	0	0.00	0.00	15. 00
16. 00	- Administrative Home office and Contract		0	_	0	0. 00	0. 00	16. 00
10.00	Physicians Part A - Teaching				Ŭ	0.00	0.00	10.00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		12, 490, 602	l 0	12, 490, 602		I	17. 00
	instructions)							40.00
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19.00	Excluded areas		691, 611	0	691, 611			19.00
20. 00	Non-physician anesthetist Part A		0	0	0			20. 00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		0	О	0			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00	1 7		94, 769	ő	94, 769			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC)		0	0	0			24. 00 25. 00
23.00	approved program)							23.00
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	89, 585	Γο	89, 585	8, 258. 00	10. 85	26. 00
27. 00	1 ' '	5. 00	8, 145, 951	l				
28. 00	Administrative & General under contract (see inst.)		122, 527	0	122, 527	569. 00	215. 34	28. 00
29. 00	Maintenance & Repairs	6. 00	0	О	0	0.00	0. 00	29. 00
30.00	Operation of Plant	7. 00	280, 066	0	280, 066	15, 039. 00 0. 00		
31. 00 32. 00	Laundry & Linen Service Housekeeping	8. 00 9. 00	0		0	0.00	l .	ı
33. 00	Housekeeping under contract		1, 507, 475	0	1, 507, 475	70, 898. 00	21. 26	33. 00
34. 00	(see instructions) Dietary	10. 00	0	0	0	0.00	0.00	34.00
35. 00	Di etary under contract (see		497, 941	0	497, 941	20, 312. 00	24. 51	35. 00
36. 00	i nstructi ons) Cafeteri a	11. 00	0	o	О	0.00	0. 00	36. 00
37. 00 38. 00	1	12. 00 13. 00	0 761, 326	0	761, 326	0. 00 22, 140. 00		37. 00 38. 00
39. 00	g .	14. 00	701, 320 0	0		22, 140.00 0.00		39.00
40. 00	Pharmacy	15. 00	1, 489, 154	О О	1, 489, 154	36, 501. 00	40. 80	40. 00

Health Financial Systems	JOSEPH HOSPITAL & HEALTH CENTER			In Lieu of Form CMS-2552-10			
HOSPITAL WAGE INDEX INFORMATION	Pro		Provi der		Peri od:	Worksheet S-3	
					From 07/01/2015		
					To 06/30/2016	Date/Time Pre 11/22/2016 2:	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1. 00	2.00	3.00	4.00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	531, 540	0	531, 54	0 36, 401. 00	14. 60	41.00
Records Library							
42.00 Social Service	17. 00	C	0		0.00	0.00	42.00
43.00 Other General Service	18. 00	C	0		0.00	0.00	43. 00

instructions)

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 150010 Peri od: From 07/01/2015 To 06/30/2016 11/22/2016 2:42 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . col. 5) Salaries in (from Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 41, 892, 491 41, 892, 491 1, 490, 011. 00 28. 12 1.00 instructions) 2.00 Excluded area salaries (see 2, 218, 616 270, 739 2, 489, 355 60, 372. 00 41. 23 2.00 instructions) 3.00 Subtotal salaries (line 1 39, 673, 875 -270, 739 39, 403, 136 1, 429, 639. 00 27. 56 3.00 minus line 2) 4.00 Subtotal other wages & related 13, 694, 389 13, 694, 389 289, 973. 00 47.23 4.00 costs (see inst.) Subtotal wage-related costs 5.00 12, 490, 602 Ω 12, 490, 602 0.00 31.70 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 65, 858, 866 -270, 739 65, 588, 127 1, 719, 612. 00 38 14 7.00 Total overhead cost (see 13, 425, 565 13, 425, 565 460, 366. 00 29. 16 7.00

Health Financial Systems	ST. JOSEPH HOSPITAL & F	HEALTH CENTER	In Lieu of Form CMS-2552-10		
HOSPITAL WAGE RELATED COSTS		Provi der CCN: 150010	Peri od: From 07/01/2015	Worksheet S-3 Part IV	

			From 07/01/2015 To 06/30/2016		oared:
				11/22/2016 2:	
				Amount	
				Reported	
				1. 00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			2, 084, 618	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)			476, 610	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)			4, 906, 837	8. 00
9.00	Prescription Drug Plan			1, 167, 961	9. 00
10.00	Dental, Hearing and Vision Plan			90, 703	
11. 00	Life Insurance (If employee is owner or beneficiary)			0	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)			30, 669	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			317, 166	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			32, 154	
15.00	'Workers' Compensation Insurance			380, 598	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraor	dinary accrual required	by FASB 106.	0	16. 00
	Non cumulative portion)				
	TAXES				
	FICA-Employers Portion Only			2, 944, 208	
18. 00	Medicare Taxes - Employers Portion Only			0	18. 00
19. 00	Unemployment Insurance			0	19. 00
20. 00	State or Federal Unemployment Taxes			50	20.00
	OTHER				
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Rep	orted on lines 1 throug	h 4 above. (see	0	21. 00
	instructions))			_	
22. 00	Day Care Cost and Allowances			0	22. 00
23. 00	Tuition Reimbursement			59, 028	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)			12, 490, 602	24. 00
05.60	Part B - Other than Core Related Cost				05.00
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25. 00

Health Financial Systems	ST. JOSEPH HOSPITAL & F	HEALTH CENTER	In Lieu of Form CMS-25		
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provi der CCN: 150010	From 07/01/2015	Worksheet S-3 Part V Date/Time Prepared:	

		Т	o 06/30/2016	Date/Time Prep 11/22/2016 2:	
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1. 00	Total facility's contract labor and benefit cost		191, 702	12, 490, 602	1. 00
2.00	Hospi tal		191, 702	12, 490, 602	2.00
3.00	Subprovi der - IPF				3.00
4. 00	Subprovi der - I RF		0	0	4.00
5.00	Subprovi der - (Other)		0	0	5.00
6. 00	Swing Beds - SNF		0	0	6.00
7. 00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF				8. 00
9.00	Hospi tal -Based NF				9. 00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	11. 00
12. 00	Separately Certified ASC				12.00
13. 00	Hospi tal -Based Hospi ce				13.00
14. 00	Hospital-Based Health Clinic RHC				14.00
15. 00	Hospital-Based Health Clinic FQHC				15.00
16. 00	Hospi tal -Based-CMHC		0	0	16.00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
17. 00	Renal Dialysis		0	0	17.00
18. 00	Other		0	0	18.00

	Financial Systems ST. JOSEPH HOSPITAL & HEALTH			u of Form CMS-2			
HOSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA Provi	der CCN: 150010	Peri od: From 07/01/2015	Worksheet S-10	0		
			To 06/30/2016				
				11/22/2016 2:	42 pm		
				1. 00			
	Uncompensated and indigent care cost computation						
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided b Medicaid (see instructions for each line)	y line 202 colum	nn 8)	0. 250416	1.00		
2.00	Net revenue from Medicaid			6, 938, 807	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00		
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payme	nts from Medicai	d?		4.00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medic	ai d		0	5. 00		
6.00	Medi cai d charges			68, 723, 240			
7.00	Medicaid cost (line 1 times line 6)			17, 209, 399			
8.00	Difference between net revenue and costs for Medicaid program (line 7	minus sum of li	nes 2 and 5; if	10, 270, 592	8.00		
	<pre>&lt; zero then enter zero) Chata Children   Market   Ma</pre>						
0 00	State Children's Health Insurance Program (SCHIP) (see instructions f Net revenue from stand-alone SCHIP	or each rine)		0	0.00		
9. 00 10. 00	Stand-alone SCHIP charges			0			
11. 00	Stand-alone SCHIP cost (line 1 times line 10)			0			
12. 00	Difference between net revenue and costs for stand-alone SCHIP (line	11 minus line 9.	if < zero then	0			
12.00	lenter zero)	TI IIII III 7,	11 ( 2010 (11011	o o	12.00		
	Other state or local government indigent care program (see instruction	ns for each line	9)		İ		
13.00	Net revenue from state or local indigent care program (Not included o	9)	0	13.00			
14.00	Charges for patients covered under state or local indigent care progr	am (Not included	d in lines 6 or	0	14.00		
	10)			0	15. 00		
15. 00							
16. 00							
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)						
17. 00	Private grants, donations, or endowment income restricted to funding	charity care		0	17. 00		
18. 00	Government grants, appropriations or transfers for support of hospita			0	18.00		
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local indi		ams (sum of lines	10, 270, 592			
	8, 12 and 16)	g pg	(				
		Uni nsured		Total (col. 1			
		pati ents		+ col . 2)			
	I=	1.00	2. 00	3. 00			
20. 00	Total initial obligation of patients approved for charity care (at fu		236 3, 855, 706	10, 787, 942	20. 00		
21. 00	charges excluding non-reimbursable cost centers) for the entire facil Cost of initial obligation of patients approved for charity care (lin		943 965, 530	2, 701, 473	21. 00		
22. 00	times line 20) Partial payment by patients approved for charity care	200, (	028 50, 516	250, 544	22. 00		
23. 00	1 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1, 535,	·	2, 450, 929			
23.00	cost of charity care (fine 2) minus fine 22)	1, 555,	713 713,014	2,430,727	23.00		
				1. 00			
	Does the amount in line 20 column 2 include charges for patient days		of stay limit	N	24. 00		
24. 00	imposed on patients covered by Medicaid or other indigent care program?						
25. 00	If line 24 is "yes," charges for patient days beyond an indigent car		gtir or stay rimit	7 500 200	26 00		
25. 00 26. 00	If line 24 is "yes," charges for patient days beyond an indigent car Total bad debt expense for the entire hospital complex (see instructi	ons)	gtil of Stay IIIII t	7, 599, 209			
25. 00 26. 00 27. 00	If line 24 is "yes," charges for patient days beyond an indigent car Total bad debt expense for the entire hospital complex (see instructi Medicare bad debts for the entire hospital complex (see instructions)	ons)	gtir or stay rriiir t	7, 599, 209 342, 518	27. 00		
25. 00 26. 00 27. 00 28. 00	If line 24 is "yes," charges for patient days beyond an indigent car Total bad debt expense for the entire hospital complex (see instructi Medicare bad debts for the entire hospital complex (see instructions) Non-Medicare and non-reimbursable Medicare bad debt expense (line 26	ons) minus line 27)		7, 599, 209 342, 518 7, 256, 691	27. 00 28. 00		
25. 00 26. 00 27. 00	If line 24 is "yes," charges for patient days beyond an indigent car Total bad debt expense for the entire hospital complex (see instructi Medicare bad debts for the entire hospital complex (see instructions) Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (	ons) minus line 27)		7, 599, 209 342, 518	27. 00 28. 00 29. 00		

	Financial Systems ST. SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	JOSEPH HOSPITAL F EXPENSES			In Lie eriod:	u of Form CMS- Worksheet A	2552-10
					rom 07/01/2015 o 06/30/2016	Date/Time Pre 11/22/2016 2:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	42 piii
		1.00	2. 00	3. 00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS						
1. 00 4. 00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	89, 585	4, 926, 053 7, 842, 656				
5. 00	00500 ADMINISTRATIVE & GENERAL	8, 145, 951	18, 655, 127				
7.00	00700 OPERATION OF PLANT	280, 066	5, 992, 582			6, 265, 941	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	_		544, 032	1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	2, 255, 851 2, 544, 616				
11. 00	01100 CAFETERI A		2, 344, 010				1
13.00	01300 NURSING ADMINISTRATION	761, 326	225, 470		-104, 920	881, 876	
15.00	01500 PHARMACY	1, 489, 154	4, 323, 198				
16. 00 23. 00	01600 MEDICAL RECORDS & LIBRARY 02300 SCHOOL OF RADIOLOGY-ALLIED HEALTH	531, 540 84, 966	564, 439 19, 401			1, 091, 983 395, 779	
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	04, 700	17, 401	104, 307	271, 412	373, 117	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	6, 276, 676	1, 077, 132		144, 331	7, 498, 139	30.00
31.00	03100   I NTENSI VE CARE UNI T	1, 425, 779	281, 130				
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	1, 154, 831	139, 097 0			1, 266, 981 433, 994	
43.00	ANCI LLARY SERVI CE COST CENTERS	ı o	0		433, 774	433, 774	43.00
50.00	05000 OPERATI NG ROOM	3, 681, 169	7, 775, 988	11, 457, 157	-4, 569, 869	6, 887, 288	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 050, 756	450, 713			1, 066, 145	
53.00	05300 ANESTHESI OLOGY	0	20, 572			20, 572	1
54. 00 54. 01	05400   RADI OLOGY-DI AGNOSTI C   03630   ULTRA SOUND	1, 512, 879 325, 304	1, 232, 707 72, 053			2, 389, 354 366, 053	
57. 00	05700 CT SCAN	319, 074	33, 511			349, 448	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	285, 984	61, 950	347, 934	-25, 954	321, 980	
59.00	05900 CARDI AC CATHETERI ZATI ON	69, 217	114, 400			139, 515	
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0 1, 244, 450	5, 853, 083 302, 550				
66. 00	06600 PHYSI CAL THERAPY	3, 073, 351	1, 069, 838				
67.00	06700 OCCUPATI ONAL THERAPY	0	0				
68. 00	06800 SPEECH PATHOLOGY	0	177			232, 998	
69. 00 70. 00	06900   ELECTROCARDI OLOGY   07000   ELECTROENCEPHALOGRAPHY	887, 086 333, 862	360, 191 210, 700	1, 247, 277 544, 562		1, 056, 870 454, 255	
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	252, 574	460, 645			2, 691, 331	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	· ·			
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	_	-,		
74. 00 76. 00	07400 RENAL DI ALYSI S 03950 BEHAVI ORAL HEALTH SERVI CES	1 200 254	153, 234			150, 123	
76. 00 76. 01	03480 ONCOLOGY	1, 398, 356 996, 601	304, 241 15, 864, 669			1, 675, 298 5, 050, 983	
	03330 ENDOSCOPY	201, 202	254, 864			387, 279	
76. 03	03951 WOUND CARE	227, 155	775, 670	1, 002, 825	-78, 694	924, 131	76. 03
00 00	OUTPATIENT SERVICE COST CENTERS					0	00.00
90. 00 91. 00	09000   CLI NI C   09100   EMERGENCY	1, 990, 844	529, 580	2, 520, 424	-205, 399	0 2, 315, 025	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,770,011	027,000	2,020,121	200, 077	2,010,020	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	758, 670	177, 372	936, 042	-36, 165	899, 877	
98. 00 99. 00	09850 OTHER REIMBURSABLE COST CENTERS		0		0	0	
	09910 CORF		0	Ö	0	0	
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300   NTEREST EXPENSE		505, 365	505, 365	-505, 365	0	113. 00
118.00	1	39, 848, 408	85, 430, 825				
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	19200   PHYSI CLANS'   PRI VATE   OFFI CES   19201   ASC-MOB	0	642, 682 12, 799			642, 682 12, 799	
	19202 EDUCATION CENTER		12, 744				192. 02
	19300 NONPALD WORKERS		0	0			193. 00
	07950 FOUNDATION	0	0	0	-		194. 00
	07951 ASPR BIOTERRORISM GRANT	220 140	14, 861	14, 861			194. 01
	07952 CLINIC OF HOPE 07953 MARKETING	220, 149	63, 134 0			283, 283 0	194. 02
200.00		40, 068, 557	86, 177, 236				
				-	. '		•

Health FinancialSystemsST.JOSEPH HOSPRECLASSIFICATIONAND ADJUSTMENTS OF TRIALBALANCE OF EXPENSES

Provider CCN: 150010 Period: From 07/01/2

Peri od: Worksheet A From 07/01/2015 To 06/30/2016 Date/Time Prepared: 11/22/2016 2: 42 pm

				11/22/2016 2:	42 pm
	Cost Center Description		Net Expenses		
			or Allocation		
	OFFICE A SERVICE ASST SERVED	6. 00	7. 00		
1 00	GENERAL SERVICE COST CENTERS	22 452	/ 244 775		1 00
1.00	00100 CAP REL COSTS-BLDG & FLXT	-23, 452 734, 471	6, 344, 775		1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		8, 657, 312		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	540, 794	27, 166, 912		5. 00
7.00	00700 OPERATION OF PLANT	-240, 633	6, 025, 308		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	544, 032		8. 00
9. 00	00900 HOUSEKEEPI NG	0	1, 767, 248		9. 00
10. 00	01000 DI ETARY	-13, 015	676, 883		10.00
11. 00	01100 CAFETERI A	-642, 614	1, 211, 345		11. 00
13.00	01300 NURSING ADMINISTRATION	0	881, 876		13. 00
15.00	01500 PHARMACY	-21, 765	17, 779, 663		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-684	1, 091, 299		16. 00
23.00	02300 SCH00L OF RADIOLOGY-ALLIED HEALTH	O	395, 779		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			
30.00	03000 ADULTS & PEDIATRICS	-2,073	7, 496, 066		30.00
31.00	03100 INTENSIVE CARE UNIT	O	1, 557, 905		31.00
41. 00	04100 SUBPROVI DER - I RF	O	1, 266, 981		41.00
43. 00	04300 NURSERY	o	433, 994		43. 00
10.00	ANCILLARY SERVICE COST CENTERS	9	100/ // 1		1 .0.00
50.00	05000 OPERATING ROOM	-8, 000	6, 879, 288		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-69	1, 066, 076	i e e e e e e e e e e e e e e e e e e e	52. 00
53. 00	05300 ANESTHESI OLOGY	0	20, 572	1	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-45, 582		1	54.00
	03630 ULTRA SOUND	1	2, 343, 772		1
54. 01	l l	0	366, 053	i e	54. 01
57. 00	05700 CT SCAN	0	349, 448	l e e e e e e e e e e e e e e e e e e e	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	-17	321, 963		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	139, 515		59. 00
60.00	06000 LABORATORY	-2, 010	5, 746, 945		60.00
65. 00	06500 RESPI RATORY THERAPY	0	1, 521, 861		65. 00
66.00	06600 PHYSI CAL THERAPY	-39, 330	2, 503, 665		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	997, 346		67. 00
68.00	06800 SPEECH PATHOLOGY	0	232, 998		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	1, 056, 870		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	O	454, 255		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	2, 691, 331		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	4, 119, 596		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	3, 606	l e e e e e e e e e e e e e e e e e e e	73. 00
74. 00	07400 RENAL DIALYSIS		150, 123		74. 00
76. 00	03950 BEHAVI ORAL HEALTH SERVI CES	-161, 053	1, 514, 245		76.00
76. 01	03480 ONCOLOGY	-95, 744	4, 955, 239		76. 01
76. 01	03330 ENDOSCOPY	0	387, 279		76. 02
	03951 WOUND CARE				1
70.03		U U	924, 131		76. 03
90. 00	OUTPATIENT SERVICE COST CENTERS			1	1 00 00
	09000 CLINIC	0	0	i e	90.00
91.00	09100 EMERGENCY	-47	2, 314, 978		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
05.00	OTHER REIMBURSABLE COST CENTERS	ا ما	202 277	,I	
	09500 AMBULANCE SERVICES	0	899, 877		95. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0	i e	98. 00
	09900 CMHC	0	0	i e	99. 00
	09910 CORF	0	0	1	99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100 HOME HEALTH AGENCY	0	0		101. 00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	0	0		113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-20, 823	125, 258, 410		118. 00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	642, 682		192. 00
192.0	1 19201 ASC-MOB	0	12, 799		192. 01
	19202 EDUCATION CENTER	0	12, 935		192. 02
	19300 NONPALD WORKERS		0	l .	193. 00
	07950 FOUNDATION		0		194. 00
	107951 ASPR BIOTERRORISM GRANT		14, 861		194. 00
	2 07952 CLINIC OF HOPE		283, 283	·	194. 01
	3 07953 MARKETI NG	821, 324	821, 324		194. 02
200.00		800, 501	127, 046, 294		200.00
200.00	TOTAL (SUM OF LINES 110-177)	000, 501	121,040,294	TI	1200.00

Health Financial Systems RECLASSIFICATIONS ST. JOSEPH HOSPITAL & HEALTH CENTER

Provi der CCN: 150010 In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: | Worksnee. . . | From 07/01/2015 | Date/Ti me Prepared: | 11/22/2016 2: 42 pm

		Increases				: 42 piii
	Coot Conton	Increases	Calami	Othon		
	Cost Center 2.00	Li ne # 3.00	<u>Sal ary</u> 4. 00	0ther 5.00		
	A - BUILDING RENTAL RECLASS	3.00	4.00	5.00		
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	383, 933		1. 00
2.00	CAL REE COSTS-BEDG & TTAT	0.00	0	0 303, 733		2. 00
3.00		0.00	0			3. 00
4. 00		0.00	0	o o		4. 00
5.00		0.00	0	-		5. 00
3.00	TOTALS — — — —		— — <u> </u>			3.00
	B - EQUI PMENT RENTAL EXPENSE			303, 733		+
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	417, 271		1. 00
2.00	CAI NEE COSTS-BEDG & TTAT	0.00	0			2. 00
3.00		0.00	0			3. 00
4.00		0.00	0			4. 00
5.00		0.00	0			5. 00
6.00		0.00	0			6. 00
7. 00		0.00	0			7. 00
8.00		0.00	0	_		8. 00
9. 00		0.00	0			9. 00
10. 00		0.00	0			10.00
11. 00		0.00	0			1
			0			11.00
12.00		0.00	0			12. 00 13. 00
13.00		0.00	-			1
14.00		0.00	0			14. 00
15.00		0.00	0			15. 00
16.00		0.00	0			16. 00
17. 00		0.00	0			17. 00
18.00		0.00	0			18. 00
19. 00		0.00	0	-		19. 00
20.00		0.00	0	0		20. 00
21. 00		0.00	0	-		21. 00
22. 00		0.00	0	-		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	L		24. 00
	TOTALS		0	417, 271		_
	C - DRUGS CHARGED TO PATIENTS					
1.00	PHARMACY	15. 00	0	,		1. 00
2.00		0.00	0			2. 00
3.00		0.00	0			3. 00
4.00		0.00	0			4. 00
5.00		0.00	0	_		5. 00
6.00		0.00	0			6. 00
7.00		0.00	0	_		7. 00
8.00		0.00	0			8. 00
9.00		0.00	0			9. 00
10. 00		0.00	0			10. 00
11. 00		0.00	0			11. 00
12.00		0.00	0			12. 00
13.00		0.00	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	0	0		21. 00
22.00		0.00	0	0		22. 00
	TOTALS		0	377, 608		_
	D - REAL ESTATE TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0			1. 00
	TOTALS		0	50, 729		_
	E - LAUNDRY DEPARTMENT RECLAS	S				
1.00	LAUNDRY & LINEN SERVICE	8. 00	0	544, 032		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
	TOTALS			544, 032		
	F - CAPITAL INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	93, 865		1. 00
	TOTALS					1
	G - CAFETERIA_DIETARY RECLASS					1
1.00	CAFETERI A	11.00	0			1. 00
	TOTALS — — — —					1
		· ·		٠		•

RECLASSI FI CATIONS

ST. JOSEPH HOSPITAL & HEALTH CENTER

Provi der CCN: 150010

Period: From 07/01/2015 To 06/30/2016

Worksheet A-6 5 Date/Time Prepared:

11/22/2016 2:42 pm Increases Cost Center Sal ary 0ther Line # 2.00 3.00 4.00 5.00 - MEDICAL SUPPLIES CHARGED TO PATIENTS 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 2, 011, 150 1.00 PATI ENTS 2.00 0.00 0 0 2.00 3.00 0 0.00 0 3 00 4.00 0.00 0 0 4.00 5.00 0 0.00 5.00 0 6.00 0.00 0 6.00 0 0 7.00 0.00 7.00 8.00 0.00 0 0 8.00 9.00 0.00 0 0 9.00 0 0 10.00 0.00 10.00 11.00 0.00 0 0 11.00 12.00 0.00 0 0 12.00 0 0 13.00 13.00 0.00 0 14.00 0.00 14.00 15.00 0.00 0 0 15.00 0 0 16.00 0.00 16.00 0 0.00 0 17.00 17.00 0 0 18.00 0.00 18.00 19.00 0.00 0 19.00 0 20.00 0.00 0 20.00 O 0 21.00 0.00 21.00 22.00 0.00 0 0 22.00 23.00 0.00 0 0 23.00 0 24.00 0.00 0 24.00 0 25.00 0.00 0 25.00 26.00 0.00 0 0 26.00 27.00 0.00 27.00 TOTALS 2.011.150 - PT\_OT\_ST RECLASS 1.00 OCCUPATIONAL THERAPY 67.00 739, 815 257, 531 1.00 2.00 SPEECH PATHOLOGY 68.00 157, 276 54, 748 2.00 TOTALS 897, 091 312, 279 J - IMPLANTABLE SUPPLY RECLASS 1.00 IMPL. DEV. CHARGED TO 72. 00 0 4, 117, 249 1.00 PATI ENTS 2.00 ADMINISTRATIVE & GENERAL 5.00 0 22, 500 2.00 0 3.00 0.00 0 3.00 4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 0 6.00 6.00 0.00 0 0 7.00 0.00 0 7 00 8.00 0.00 0 8.00 9.00 0.00 0 9.00 0 10.00 0.00 0 10.00 11.00 0.00 0 0 11.00 12.00 0.00 0 12.00 0 13.00 0.00 0 13.00 14.00 0.00 0 0 14.00 15.00 0.00 15.00 TOTALS 4, 139, 749 K - CHEMOTHERAPY PHARMACY RECLASS 1.00 PHARMACY <u>15.</u>00 <u>11, 729, 1</u>87 1.00 TOTALS 11, 729, 187 L - RADIOLOGY SCHOOL PRECEPTING RECLASS 1.00 SCHOOL OF RADIOLOGY-ALLIED 23.00 270, 739 20, 673 1.00 HEALTH TOTALS 270, 739 20, 673 M - LABOR AND DELIVERY ROOM RECLASS ADULTS & PEDIATRICS 388, 409 85, 364 1.00 30.00 1.00 2.00 NURSERY 43.00 355, 797 78, 197 2.00 3.00 OPERATING ROOM 50.00 254, 062 55, 837 3.00 4.00 ULTRA SOUND 54.01 3.840 844 4.00 4, 408 5.00 II ABORATORY 60.00 20,056 5 00 6.00 RESPIRATORY THERAPY 65.00 18, 457 4,056 6.00 SPEECH PATHOLOGY 17,050 3, 747 7.00 68.00 7.00 MEDICAL SUPPLIES CHARGED TO 71.00 5, 192 8.00 8.00 23, 623 PATI ENTS 9.00 IMPL. DEV. CHARGED TO 72.00 1, 924 423 9.00 PATI ENTS 10.00 DRUGS CHARGED TO PATIENTS 73.00 2, 956 10.00 TOTALS 1, 086, 174 238, 718

Health Financial Systems	ST. JOSEPH HOSPITAL & F	HEALTH CENTER	In Lie	u of Form CMS-2552-10
RECLASSI FI CATI ONS		Provider CCN: 150010	Peri od: From 07/01/2015	Worksheet A-6
				Date/Time Prepared: 11/22/2016 2:42 pm
	Increases		•	

					11/22/2016 2	:42 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	N - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	496, 376		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	8, 989		2. 00
	TOTALS		0	505, 365		
500.00	Grand Total: Increases		2, 254, 004	22, 678, 518		500.00

Health Financial Systems
RECLASSIFICATIONS

	Provi der	CCN:	150010	07/01/2015	Worksheet A-6 Date/Time Pre 11/22/2016 2:	epared:	
<u></u>							

		Decreases				11/22/2016 2	. 42 piii
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - BUILDING RENTAL RECLASS						4
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1, 500			1.00
2.00 3.00	RADI OLOGY-DI AGNOSTI C PHYSI CAL THERAPY	54. 00 66. 00	0	7, 01 <sup>2</sup> 290, 017			2. 00 3. 00
4.00	ELECTROENCEPHALOGRAPHY	70. 00	0	58, 168			4. 00
5. 00	BEHAVIORAL HEALTH SERVICES	76.00	Ö	27, 234			5. 00
	TOTALS			383, 933			
	B - EQUIPMENT RENTAL EXPENSE						Ī
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 507			1. 00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	52, 237			2.00
3. 00 4. 00	OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	0	6, 707 323			3. 00 4. 00
5. 00	DI ETARY	10.00	0	327			5. 00
6. 00	NURSING ADMINISTRATION	13.00	Ö	102, 400			6. 00
7.00	PHARMACY	15. 00	0	107, 610			7. 00
8.00	MEDICAL RECORDS & LIBRARY	16. 00	0	3, 872	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	8, 843			9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	325			10.00
11.00	SUBPROVI DER - I RF	41.00	0	1, 106			11. 00
12. 00 13. 00	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	50. 00 52. 00	0	4, 648 1, 751			12. 00 13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	16, 735			14. 00
15. 00	LABORATORY	60.00	0	1, 429			15. 00
16.00	RESPIRATORY THERAPY	65.00	0	46, 758			16.00
17.00	PHYSI CAL THERAPY	66. 00	0	7, 050	o		17. 00
18. 00	ELECTROCARDI OLOGY	69. 00	0	1, 106			18. 00
19. 00	ELECTROENCEPHALOGRAPHY	70.00	0	4, 886			19. 00
20. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	35, 978	0		20. 00
21. 00	ONCOLOGY	76. 01	0	1, 423	ol ol		21. 00
22. 00	WOUND CARE	76. 03	Ö	3, 963			22. 00
23. 00	EMERGENCY	91.00	0	5, 964			23. 00
24.00	AMBULANCE_SERVICES	95. 00	0	323	B 0		24. 00
	TOTALS		0	417, 271			
1 00	C - DRUGS CHARGED TO PATIENTS		0	7 (00			1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADULTS & PEDIATRICS	4. 00 30. 00	0	7, 609 21, 41 <i>6</i>			1. 00 2. 00
3.00	INTENSIVE CARE UNIT	31.00	0	6, 268			3. 00
4. 00	SUBPROVI DER - I RF	41.00	0	496			4. 00
5.00	OPERATING ROOM	50.00	0	65, 394			5. 00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	9, 194	ı o		6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	8, 409			7. 00
8.00	CT SCAN	57. 00	0	13			8. 00
9. 00	MAGNETIC RESONANCE IMAGING	58. 00	0	24, 634	0		9. 00
10. 00	(MRI)  CARDIAC CATHETERIZATION	59. 00	0	5, 314	ıl ol		10. 00
11. 00	LABORATORY	60.00	Ö	6, 013			11. 00
12.00	RESPIRATORY THERAPY	65.00	0	854	0		12.00
13.00	PHYSI CAL THERAPY	66. 00	0	15, 095	0		13. 00
14.00	ELECTROCARDI OLOGY	69. 00	0	166, 941			14. 00
15. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	9, 488	0		15. 00
16. 00	PATIENTS RENAL DIALYSIS	74. 00	0	1, 304	0		16. 00
17. 00	BEHAVIORAL HEALTH SERVICES	76.00	0	1, 302			17. 00
18. 00	ONCOLOGY	76. 01	0	2, 385			18. 00
19. 00	ENDOSCOPY	76. 02	0	3, 042			19. 00
20.00	WOUND CARE	76. 03	0	7, 250	o		20. 00
21. 00	EMERGENCY	91.00	0	6, 896			21. 00
22. 00	AMBULANCE SERVICES	95.00	0	9, 528			22. 00
	TOTALS		0	377, 608	3		-
1.00	D - REAL ESTATE TAXES ADMINISTRATIVE & GENERAL	5. 00	0	50, 729	13		1. 00
1.00	TOTALS		— — <u> </u>	50, 72			1.00
	E - LAUNDRY DEPARTMENT RECLAS	SS	<u> </u>	30, 72	'		1
1.00	HOUSEKEEPI NG	9.00	0	488, 132	2 0		1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 134			2. 00
3.00	PHYSICAL THERAPY	66. 00	0	46, 062			3. 00
4.00	ELECTROENCEPHALOGRAPHY	<u></u>	9				4. 00
	TOTALS  F - CAPITAL INSURANCE RECLASS		0	544, 032	<u>'</u>		4
1.00	ADMINISTRATIVE & GENERAL	5.00	0	93, 865	512		1. 00
1.00	TOTALS		— — <u> </u>				1.00
	•	'	-1	,	'		•

Heal th	Financial Systems	ST	JOSEPH HOSPI TAL	. & HEALTH CEI	NTER	In Lieu	u of Form CMS-2552-10
RECLAS	SIFICATIONS			Provi dei		Peri od:	Worksheet A-6
						From 07/01/2015 To 06/30/2016	Date/Time Prepared:
						10 00/30/2010	11/22/2016 2: 42 pm
		Decreases				1	
	Cost Center	Li ne #	Salary	Other 0.00	Wkst. A-7 Ref.		
	6. 00 G - CAFETERIA DIETARY RECLASS	7.00	8. 00	9. 00	10. 00		
1. 00	DI ETARY	10.00	ol	1, 853, 959	9 0		1.00
1.00	TOTALS — — — —	10.00	<del> </del>	1, 853, 959			1.00
	H - MEDICAL SUPPLIES CHARGED	TO PATIENTS	<u> </u>	1,000,70	<u> </u>		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	284	4 0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	8, 118			2. 00
3. 00	HOUSEKEEPI NG	9.00	0	148			3.00
4.00	DIETARY	10.00	0	432			4.00
5.00	NURSI NG ADMI NI STRATI ON	13.00	0	2, 520			5. 00
6. 00 7. 00	PHARMACY MEDICAL RECORDS & LIBRARY	15. 00 16. 00	0	9, 938 124			6. 00 7. 00
8. 00	ADULTS & PEDIATRICS	30.00	o	298, 730			8.00
9. 00	INTENSIVE CARE UNIT	31.00	o	141, 989			9.00
10. 00	SUBPROVI DER - I RF	41.00	o	25, 345			10.00
11. 00	OPERATING ROOM	50.00	o	729, 084			11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	99, 331			12. 00
13.00	RADI OLOGY-DI AGNOSTI C	54.00	O	31, 391	1 0		13. 00
14.00	ULTRA SOUND	54. 01	0	35, 988	3 0		14.00
15.00	CT SCAN	57.00	0	3, 124			15. 00
16. 00	MAGNETIC RESONANCE I MAGING	58.00	0	1, 320	0		16. 00
47.00	(MRI)			0.4.07			17.00
17. 00	CARDI AC CATHETERI ZATI ON	59.00	0	24, 970			17. 00
18.00	LABORATORY	60.00	0	121, 150			18.00
19. 00 20. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	0	32, 600 22, 31 <i>6</i>			19. 00 20. 00
21. 00	ELECTROCARDI OLOGY	70.00	0	18, 549		1	21. 00
22. 00	RENAL DIALYSIS	74. 00	0	1, 807			22. 00
23. 00	ONCOLOGY	76. 01	0	77, 262			23. 00
24.00	ENDOSCOPY	76. 02	0	64, 287			24. 00
25. 00	WOUND CARE	76. 03	0	42, 186			25. 00
26.00	EMERGENCY	91.00	0	191, 875	5 0		26. 00
27. 00	AMBULANCE SERVICES	95.00		2 <u>6, 2</u> 82			27. 00
	TOTALS		0	2, 011, 150	0		
1 00	I - PT_OT_ST_RECLASS	// 00	007 001	212 276	9 0	1	1 00
1. 00 2. 00	PHYSI CAL THERAPY	66. 00 0. 00	897, 091 0	312, 279			1.00
2.00	TOTALS — — — —		897, 091	312, 27			2.00
	J - IMPLANTABLE SUPPLY RECLAS	SS	3777 3711	0.12/27	<u> </u>		
1.00	PHARMACY	15. 00	0	171	1 0		1. 00
2.00	ADULTS & PEDIATRICS	30.00	0	453			2. 00
3.00	INTENSIVE CARE UNIT	31.00	0	422		1	3. 00
4.00	OPERATING ROOM	50.00	0	4, 080, 642			4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	156			5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54. 00 59. 00	0	137			6. 00 7. 00
7. 00 8. 00	CARDI AC CATHETERI ZATI ON RESPI RATORY THERAPY	65. 00	0	13, 818 40			8.00
9. 00	ELECTROCARDI OLOGY	69.00	o	44		1	9. 00
10. 00	MEDICAL SUPPLIES CHARGED TO	71.00	o o	16, 387			10.00
	PATI ENTS			,			
11.00	ONCOLOGY	76. 01	0	30	0		11.00
12.00	ENDOSCOPY	76. 02	0	1, 458			12.00
13. 00	WOUND CARE	76. 03	0	25, 295			13. 00
14. 00	EMERGENCY	91.00	0	664		1	14. 00
15. 00	AMBULANCE SERVICES	95.00		32		1	15. 00
	TOTALS		0	4, 139, 749	7		
1.00	K - CHEMOTHERAPY PHARMACY RECONCOLOGY	76. 01	ol	11, 729, 187	7 0		1.00
1.00	TOTALS	70.01		11, 729, 187			1.00
	L - RADI OLOGY SCHOOL PRECEPTI	ING RECLASS	<u> </u>	11,727,107	<u>'                                     </u>		
1. 00	RADI OLOGY-DI AGNOSTI C	54.00	270, 739	20, 673	3 0		1.00
	TOTALS		270, 739	20, 673		Ī	
	M - LABOR AND DELIVERY ROOM F	RECLASS			·		
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 086, 174	238, 718	3 0		1.00
2.00		0.00	0	(	0		2. 00
3.00		0.00	0	(	0		3.00
4.00		0.00	0	(	0	1	4.00
5.00		0.00	0	(	0		5. 00
6. 00 7. 00		0.00	O	(	0		6. 00 7. 00
7. 00 8. 00		0.00	0	(			8.00
9. 00		0.00	0	(			9. 00
10. 00		0.00	ol	(	o o		10.00
	TOTALS — — — — —	T +	1, 086, 174	238, 718		1	
		·	,				·

Heal th Financial Systems ST. JOSEPH HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 150010
Period: Worksheet A-6
From 07/01/2015
To 06/30/2016
Date/Time Prepared:

						11/22/2016 2:	:42 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	N - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113. 00	0	505, 365	5 11		1. 00
2.00		0.00	0	(			2. 00
	TOTALS		0	505, 365	5		
500.00	Grand Total: Decreases		2, 254, 004	22, 678, 518	3	1	500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 150010 Peri od: Worksheet A-7 From 07/01/2015 Part I 06/30/2016 Date/Time Prepared: 11/22/2016 2:42 pm Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 722, 779 1.00 0 1.00 1, 764, 978 0 2.00 Land Improvements 0 2.00 0 3.00 55, 107, 232 777, 309 18, 987 3.00 Buildings and Fixtures 777, 309 0 4.00 Building Improvements 9, 712, 068 0 4.00 5.00 Fixed Equipment 21, 774, 546 0 5.00 36, 998, 569 0 18, 985 6.00 Movable Equipment 1, 518, 934 1, 518, 934 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 126, 080, 172 2, 296, 243 2, 296, 243 37, 972 8.00 9.00 Reconciling Items 0 9.00 126, 080, 172 2, 296, 243 37, 972 Total (line 8 minus line 9) 10.00 0 2, 296, 243 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 722, 779 0 1.00 2.00 Land Improvements 1, 764, 978 0 2.00 3.00 Buildings and Fixtures 55, 865, 554 0 3.00 0 4.00 Building Improvements 9, 712, 068 4.00 5.00 Fi xed Equipment 21, 774, 546 0 5.00 Movable Equipment 38, 498, 518 0 6.00 6.00 7.00 HIT designated Assets 0 7.00

128, 338, 443

128, 338, 443

0

0

Heal th	Financial Systems	ST. JOSEPH HOSPITA	L & HEALTH CENT	TER	In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150010	Peri od:	Worksheet A-7		
					From 07/01/2015 To 06/30/2016	Part II   Date/Time Pre	nared.	
					10 00, 00, 2010	11/22/2016 2:		
			Sl	JMMARY OF CAP	TTAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
					instructions)			
		9. 00	10.00	11. 00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FRO	M WORKSHEET A, COLUN	MN 2, LINES 1 a	nd 2				
1.00	1.00 CAP REL COSTS-BLDG & FLXT		0		0 0	0	1.00	
3.00	Total (sum of lines 1-2)	4, 926, 053	0		0 0	0	3. 00	
		SUMMARY C	F CAPITAL					
			T					
	Cost Center Description	Other	Total (1) (sum					
		Capi tal -Relate						
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FRO	M WORKSHEET A, COLUN	MN 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FLXT	C	4, 926, 053				1.00	
3.00	Total (sum of lines 1-2)	c	4, 926, 053				3. 00	

Health Financial Systems	ST. JOSEPH HOS	SPITAL & HEALTH CEN	ITER	In Lie	u of Form CMS-2	552-10	
RECONCILIATION OF CAPITAL COSTS CENT	ERS	Provi der	F	Period: From 07/01/2015	Worksheet A-7 Part III		
			'	o 06/30/2016	Date/Time Prep 11/22/2016 2:4		
		COMPUTATION OF RA	ATI OS	ALLOCATION OF		iz piii	
			Ta	5 (			
Cost Center Description	Gross Ass	sets   Capitalized Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance		
		Leases	(col. 1 - col.				
			2)				
	1.00	2. 00	3.00	4. 00	5. 00		
PART III - RECONCILIATION OF	CAPITAL COSTS CENTERS	<u> </u>	•				
1.00 CAP REL COSTS-BLDG & FIXT	128, 338	8, 443	0 128, 338, 443	1.000000	0	1.00	
3.00 Total (sum of lines 1-2)	128, 338	3, 443	0 128, 338, 443	1. 000000	0	3. 00	
	AL	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
cost center bescription	Taxes	Capi tal -Rel at		Depi eci ati on	Lease		
		d Costs	through 7)				
	6.00	7. 00	8.00	9. 00	10.00		
PART III - RECONCILIATION OF	CAPITAL COSTS CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT		0	0 0	4, 938, 705	801, 204	1.00	
3.00 Total (sum of lines 1-2)		0	o c	4, 938, 705	801, 204	3. 00	
		5	SUMMARY OF CAPIT	ΓAL			
Cost Center Description	Interes	st Insurance (se	e Taxes (see	Other	Total (2) (sum		
· ·		instructions)	instructions)				
				d Costs (see	through 14)		
				instructions)			
	11.00	12. 00	13. 00	14. 00	15. 00		
	CAPITAL COSTS CENTERS					1. 00	
1.00 CAP REL COSTS-BLDG & FLXT 460, 272 93, 865 50, 729 0 6, 344, 77							
3.00  Total (sum of lines 1-2)	460	0, 272 93, 86	50, 729	0	6, 344, 775	3. 00	

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 150010 Peri od: Worksheet A-8 From 07/01/2015 To 06/30/2016 Date/Time Prepared:

Expense Classification on Nortscheet A						06/30/2016	Date/lime Prep 11/22/2016 2:	
Dest Center Description								
100   Investment Income   CAP   FT   100   2,00   3,00   4.00   5.00   1.00					Io/From Which the Amount is	to be Adjusted		
100   Investment Income   CAP   FT   100   2,00   3,00   4.00   5.00   1.00								
100   Investment Income   CAP   FT   100   2,00   3,00   4.00   5.00   1.00								
100   Investment Income   CAP   FT   100   2,00   3,00   4.00   5.00   1.00		Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
2				2.00	3.00	4. 00	5. 00	
1.0003   1.0004   1	1. 00			0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
CRISTS MINIT FOUR (Chapter 2)   0	2.00			0	*** Cost Center Deleted ***	2.00	0	2. 00
Chapter 2)  Chapter 2)  Chapter 2)  Chapter 3)  Chapter 4)  Chapter 4)  Chapter 3)  Chapter 4)  Chapter 4)  Chapter 4)  Chapter 4)  Chapter 4)  Chapter 5)  Chapter 4)  Chapter 5)  Chapter 5)  Chapter 5)  Chapter 6)  Chapter 10)	2.00	COSTS-MVBLE EQUIP (chapter 2)		· ·		2.00		
Trade, quantity, and time   0   0.00   0.4.00   0.5.00	3.00			0		0.00	0	3. 00
1   1   2   2   2   2   2   2   2   2	4. 00			0		0.00	0	4. 00
6.00 expenses (chapter 8) 6.00 Rental of provider space by suppliers (chapter 6) 7.00 Suppliers (chapter 6) 7.00 Suppliers (chapter 6) 7.00 Suppliers (chapter 6) 7.00 Suppliers (chapter 6) 8.00 Television and radio service (chapter 72) 8.00 Television and radi		di scounts (chapter 8)						
Rental of provider space by Suppliers (Cehapter 8) Suppliers (Ceha	5. 00			0		0. 00	0	5. 00
Telephone services (pay stations excluded) (chapter 21)   Sale of the service   Comparison of the service   Comp	6. 00			0		0. 00	0	6. 00
Stations excluded) (Chapter 2)	7.00			0.540				7.00
17	7.00		В	-9, 540	ADMINISTRATIVE & GENERAL	5.00	O	7. 00
Chapter 21)								
Parking lot (chapter 21)   A-8-2   -683,991   Description of the state of the sta	8.00			0		0. 00	0	8. 00
10.00   Provider-based physician   A-8-2   -683,091     0   10.00	9. 00			0		0.00	0	9. 00
11.00 Saile of scrap, waste, etc. (chapter 23) 12.00 Related organization Related organization A-8-1 A-8-3 A		Provi der-based physician	A-8-2	-683, 091		2. 30		
Chapter 23)	11 00			^		0.00		11 00
12.00   Related organization   transactions (chapter 10)   13.00   Laundry and I linen service   0   0   0   0   0   13.00   15.00	11.00			Ü		0.00		11.00
13.00   Laundry and I inen service   0   0.00   0.13.00   13.00   15	12.00	Related organization	A-8-1	7, 203, 612			0	12. 00
14. 00   Caffeteria-employees and guests   B   -642, 614 (AFETRIA   11. 00   0   14. 00   0   15. 00   0   16. 00   0   17. 00   0   18. 00   0   19. 00   0	12 00	` ' '		0		0.00	0	12 00
15.00   Rental of quarters to employee and others   0   0   0   15.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   17.00   0   17.00   0   17.00   0   17.00   0   18.00   0   19.00   0   19.00   0   19.00   0   19.00   0   19.00   0   19.00   0   19.00   0   19.00   0   19.00   0   19.00   0   19.00   0   19.00   0   19.00   0   19.00   0   19.00   0   19.00   0   10.00   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00			В	-642, 614	CAFETERI A			
16.00   Sale of medical and surgical states   0   0.00   0   16.00   0   17.00   0   17.00   0   17.00   0   17.00   0   17.00   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   19.00	15. 00	Rental of quarters to employee		0				15. 00
Supplies to other than	16 00			0		0.00	0	16 00
17. 00   Sale of drugs to other than patients   B   -21,765  PHARIMACY   15.00   0   17.00   patients   18.00   Sale of medical records and abstracts   0   0   0   0   0   0   0   0   0	10.00			0		0.00	J	10.00
patients	17.00	patients	D	21 7/5	DUADMACY	15.00		17.00
abstracts	17.00		В	-21, 700	PHARWACY	15.00	0	17.00
19.00   Nursing school (tuition, fees, books, etc.)   20.00   Vending machines   B	18. 00		В	-684	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
books_ etc.)   Vending machines   B   -13,015 DIETARY   10.00   0.20.00	19. 00	•		0		0.00	0	19. 00
21.00   Income from imposition of interest, finance or penalty charges (chapter 21)   Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and present of the pay Medicare overpay Medicare overpay description of the pay Medicare overpay Medicare overpay Medicare		books, etc.)						
Interest, finance or penal ty charges (chapter 21)			В	-13, 015	DI ETARY			
22.00   Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments   0	21.00			0		0.00	J	21.00
Overpayments and borrowings to repay Medicare overpayments								
Page   Page	22. 00	·		0		0.00	O	22. 00
therapy costs in excess of limitation (chapter 14) 24. 00 Adj ustment for physical therapy costs in excess of limitation (chapter 21) 25. 00 Utilization review - physicans' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT								
I mi tation (chapter 14)	23. 00		A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00       Adjustment for physical therapy costs in excess of limitation (chapter 14)       A-8-3       0 PHYSICAL THERAPY       66.00       24.00         25. 00       Utilization review - physicians' compensation (chapter 21)       0 *** Cost Center Deleted ***       114.00       25.00         26. 00       Depreciation - CAP REL COSTS-BLDG & FIXT       0 CAP REL COSTS-BLDG & FIXT       1.00       0 26.00         27. 00       Depreciation - CAP REL COSTS-MNBLE EQUIP       0 *** Cost Center Deleted ***       2.00       0 27.00         28. 00       Non-physician Anesthetist       0 *** Cost Center Deleted ***       19.00       28.00         29. 00       Physicians' assistant       0 *** Cost Center Deleted ***       19.00       28.00         29. 00       Adjustment for occupational therapy costs in excess of limitation (chapter 14)       A-8-3       0 OCCUPATIONAL THERAPY       67.00       30.00         30. 99       Instructions)       Adjustment for speech       A-8-3       OSPEECH PATHOLOGY       68.00       31.00         31. 00       CAH HIT Adjustment for Depreciation and Interest       0 ODO       0 ODO       0 ODO       0 ODO         33. 00       REHAB RECYCLING REVENUE       B       -40 PHYSICAL THERAPY       66.00       0 0 33.00								
1 imitation (chapter 14)   Utilization review - physicians' compensation (chapter 21)   25.00   Depreciation - CAP REL   OCAP REL COSTS-BLDG & FIXT   1.00   0.26.00   COSTS-BLDG & FIXT   1.00   0.26.00   COSTS-BLDG & FIXT   1.00   0.27.00   COSTS-BLDG & FIXT   1.00   0.27.00   COSTS-MVBLE EQUIP   COSTS-	24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25.00   Utilization review - physicians' compensation (chapter 21)   26.00   Depreciation - CAP REL COSTS-BLDG & FIXT   1.00   0 26.00   CAP REL COSTS-BLDG & FIXT   1.00   0 26.00   CAP REL COSTS-BLDG & FIXT   1.00   0 26.00   CAP REL COSTS-BLDG & FIXT   1.00   0 26.00   CAP REL COSTS-BLDG & FIXT   1.00   0 26.00   CAP REL COSTS-BLDG & FIXT   2.00   0 27.00   CAP REL COSTS-MVBLE EQUIP   28.00   Non-physician Anesthetist   0 *** Cost Center Deleted ***   19.00   28.00   29.00   Adjustment for occupational therapy costs in excess of limitation (chapter 14)   A-8-3   0   OCCUPATIONAL THERAPY   67.00   30.00   30.99   Hospice (non-distinct) (see instructions)   A-8-3   OSPEECH PATHOLOGY   68.00   31.00   Adjustment for speech pathology costs in excess of limitation (chapter 14)   A-8-3   OSPEECH PATHOLOGY   68.00   31.00   32.00   CAP REL COSTS-BLDG & FIXT   1.00   CAP REL COSTS-B								
physicians' compensation (chapter 21)   26.00   Depreciation - CAP REL   OCAP REL COSTS-BLDG & FIXT   1.00   0 26.00   COSTS-BLDG & FIXT   1.00   0 26.00   COSTS-BLDG & FIXT   1.00   0 26.00   COSTS-BLDG & FIXT   1.00   0 26.00   COSTS-BLDG & FIXT   1.00   0 26.00   COSTS-BLDG & FIXT   1.00   0 27.00   COSTS-MVBLE EQUIP   COSTS-MVBLE   COSTS-MVBLE EQUIP   COSTS-MVBLE   COSTS-MVBL	25. 00			0	*** Cost Center Deleted ***	114.00		25. 00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT  27.00 Depreciation - CAP REL COSTS-BLDG & FIXT  27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP  28.00 Non-physician Anesthetist  28.00 Physicians' assistant  30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)  30.99 Hospice (non-distinct) (see instructions)  31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32.00 CAP REL COSTS-BLDG & FIXT  1.00 O 26.00  0 27.00  0 27.00  28.00  0 *** Cost Center Deleted ***  19.00 O 28.00  0 0 0 0 29.00  30.00  10 CCUPATIONAL THERAPY  10 ADULTS & PEDIATRICS  10 ADULTS & PEDIATRICS  11 O O SPEECH PATHOLOGY  12 O O O O O O O O O O O O O O O O O O O								
COSTS-BLDG & FIXT   Depreciation - CAP REL   COSTS-MVBLE EQUIP   COSTS-MVBLE	26 00			Λ	CAP REL COSTS-BLDG & FLYT	1 00	0	26 00
COSTS-MVBLE EQUIP   Non-physician Anesthetist   O **** Cost Center Deleted ***   19.00   28.00		COSTS-BLDG & FLXT						
28.00   Non-physician Anesthetist   0 **** Cost Center Deleted ***   19.00   28.00   29.00   Physicians' assistant   0.00   0 29.00   30.00   Adjustment for occupational therapy costs in excess of limitation (chapter 14)   Hospice (non-distinct) (see instructions)   31.00   Adjustment for speech pathology costs in excess of limitation (chapter 14)   A-8-3   0   SPEECH PATHOLOGY   68.00   31.00   31.00   Adjustment for speech pathology costs in excess of limitation (chapter 14)   32.00   CAH HIT Adjustment for Depreciation and Interest   B   -40   PHYSICAL THERAPY   66.00   0 33.00	27. 00			0	*** Cost Center Deleted ***	2. 00	0	27. 00
29. 00       Physicians' assistant       0       0.00       0       29. 00         30. 00       Adjustment for occupational therapy costs in excess of limitation (chapter 14)       A-8-3       0 OCCUPATIONAL THERAPY       67. 00       30. 00         30. 99       Hospice (non-distinct) (see instructions)       0 ADULTS & PEDIATRICS       30. 00       30. 99         31. 00       Adjustment for speech pathology costs in excess of limitation (chapter 14)       A-8-3       0 SPEECH PATHOLOGY       68. 00       31. 00         32. 00       CAH HIT Adjustment for Depreciation and Interest       0       0       0.00       0       32. 00         33. 00       REHAB RECYCLING REVENUE       B       -40 PHYSICAL THERAPY       66. 00       0       33. 00	28. 00			0	  *** Cost Center Deleted ***	19. 00		28. 00
therapy costs in excess of limitation (chapter 14)  30. 99 Hospice (non-distinct) (see instructions)  31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32. 00 CAH HIT Adjustment for Depreciation and Interest  33. 00 REHAB RECYCLING REVENUE  B OADULTS & PEDIATRICS  30. 00  30. 99  68. 00  31. 00  31. 00  32. 00  0 0 0 0 0 32. 00  0 33. 00		Physicians' assistant		0				
limitation (chapter 14)  30. 99 Hospice (non-distinct) (see instructions)  31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32. 00 CAH HIT Adjustment for Depreciation and Interest  33. 00 REHAB RECYCLING REVENUE  B OADULTS & PEDIATRICS  30. 00 30. 99  68. 00 31. 00  0 0. 00 0 32. 00 0 32. 00	30. 00		A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest 33. 00 REHAB RECYCLING REVENUE B OABULTS & PEDIATRICS 30. 00 30. 99  0 ADULTS & PEDIATRICS 30. 00 0 SPEECH PATHOLOGY 68. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32.00 CAH HIT Adjustment for Depreciation and Interest  33.00 REHAB RECYCLING REVENUE  A-8-3  O SPEECH PATHOLOGY  O O O O O O O O O O O O O O O O O O O	30. 99			0	ADULTS & PEDIATRICS	30. 00		30. 99
pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 REHAB RECYCLING REVENUE B -40 PHYSICAL THERAPY 66.00 0 33.00	31. 00		A-8-3	Λ	  SPEECH PATHOLOGY	68 NN		31. 00
32. 00 CAH HIT Adjustment for 0 0.00 0 32. 00 Depreciation and Interest 8 B -40 PHYSICAL THERAPY 66. 00 0 33. 00	55	pathology costs in excess of		0		22.00		
Depreciation and Interest 33.00 REHAB RECYCLING REVENUE B -40 PHYSICAL THERAPY 66.00 0 33.00	32 00			^		0.00		32 00
33.00 REHAB RECYCLING REVENUE B -40 PHYSICAL THERAPY 66.00 0 33.00	J∠. UU			Ü		0.00		3∠. 00
33. UT   MI SCELLANEOUS REVENUE   B   -1, 863 ADULTS & PEDIATRICS   30. 00  0  33. 01		REHAB RECYCLING REVENUE			l control of the cont			
	33. 01	MI SCELLANEOUS REVENUE	l R	-1, 863	ADULIS & PEDIATRICS	30.00	J 0	33. 01

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150010 Peri od: Worksheet A-8 From 07/01/2015 | To 06/30/2016 | Date/Time Prepared:

						11/22/2016 2:	42 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2. 00	3.00	4. 00	5, 00	
33. 02	MI SCELLANEOUS REVENUE	B		ADULTS & PEDIATRICS	30.00		33. 02
33. 02	MI SCELLANEOUS REVENUE	B		ONCOLOGY	76. 01		33. 02
33. 04	MI SCELLANEOUS REVENUE	B		PHYSI CAL THERAPY	66.00	-	33. 04
33. 05	MI SCELLANEOUS REVENUE	B	·	RADI OLOGY-DI AGNOSTI C	54.00		33. 05
33. 06	MI SCELLANEOUS REVENUE	B	·	LABORATORY	60.00		33. 06
33. 07	MI SCELLANEOUS REVENUE	B	·	ADMINISTRATIVE & GENERAL	5. 00		33. 07
33. 08	MI SCELLANEOUS REVENUE	B		EMPLOYEE BENEFITS DEPARTMENT	4. 00		33. 08
33. 09	MI SCELLANEOUS REVENUE	B	·	OPERATION OF PLANT	7. 00		33. 09
33. 10	MI SCELLANEOUS REVENUE	B		OPERATION OF PLANT	7.00	-	33. 10
33. 11	MI SCELLANEOUS REVENUE	B		ADMINISTRATIVE & GENERAL	5. 00	-	33. 11
33. 12		\ \ \		ADMINISTRATIVE & GENERAL	5. 00	-	33. 12
33. 12	TELEVISON OFFSET ELECTRICITY	\ \frac{1}{\lambda}		OPERATION OF PLANT	7. 00		33. 12
33. 14	TELEVISION OFFSET CABLE	\ \frac{1}{\lambda}	·	ADMINISTRATIVE & GENERAL	5. 00	-	33. 14
33. 15	CHARI TABLE CONTRIBUTIONS	\ \frac{1}{\lambda}		ADMINISTRATIVE & GENERAL	5.00	-	33. 15
33. 16	NON-ALLOWBLE MARKETING	Δ	·	ADMINISTRATIVE & GENERAL	5. 00	-	33. 16
33. 17	NON-ALLOWBLE MARKETING	Δ	·	DELIVERY ROOM & LABOR ROOM	52. 00		33. 17
33. 18	AHA DEPRECIATION	Δ		CAP REL COSTS-BLDG & FIXT	1.00		33. 18
33. 19	LOBBYING OFFSET	Ι Α	·	ADMINISTRATIVE & GENERAL	5. 00		33. 19
33. 20	RENTAL INCOME	B	·	OPERATION OF PLANT	7. 00		33. 20
33. 21	INCENTIVE PAY SALARIES	ΙΔ	·	ADMINISTRATIVE & GENERAL	5. 00		33. 21
33. 22	INCENTIVE PAY FICA	A	·	ADMINISTRATIVE & GENERAL	5. 00	-	33. 22
50. 00	TOTAL (sum of lines 1 thru 49)		800, 501		0.00	Ŭ	50. 00
50.00	(Transfer to Worksheet A,		555, 561				50.00
	column 6, line 200.)						
	•						

<sup>(1)</sup> 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.

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

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

Worksheet A-8-1

From 07/01/2015
To 06/30/2016 Date/Time Prepared: OFFICE COSTS

Line No.   Cost Center   Expense I tems   Anount of All lowable Cost   Anount   Included in   Included in   Included in   Included						10 06/30/2016	11/22/2016 2:	
1.00   2.00   3.00   4.00   5.00		Li ne No.	Cost Center		Expense Items	Amount of		
1.00					·		Included in	
1.00   2.00   3.00   4.00   5.00							Wks. A, column	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED  1. 00 1. 00 1. 00   58. 00   MAGNETIC RESONANCE I MAGING (							5	
HOME OFFICE COSTS:		1. 00	2.00		3. 00	4. 00	5. 00	
1.00			MENTS REQUIRED AS A RESULT OF	TRANSACT	TIONS WITH RELATED OF	GANIZATIONS OR	CLAIMED	
2.00			I					
3. 00		•	li .	1				
4. 00								
4. 01 4. 02 4. 03 4. 00 6MPLOYEE BENEFITS DEPARTMENT 4. 05 4. 05 4. 06 4. 07 4. 07 4. 08 4. 09 6MPLOYEE BENEFITS DEPARTMENT 5. 00 ADMIN ISTRATIVE & GENERAL 6. 06				1			· ·	
4. 02				1			- 1	
4. 03			l	ı				
4. 04				ı				
4.05								
4. 06 4. 07 4. 08 4. 09 4. 10 4. 10 4. 11 5. 00 PHARMACY 5. 00 DELIVERY ROOM & LABOR ROOM 4. 11 5. 00 DELIVERY ROOM & LABOR ROOM 5. 11 5. 00 DELIVERY ROOM & LABOR ROOM 6. 11 5. 00 DELIVERY ROOM & LABOR ROOM 6. 12 6. 00 DELIVERY ROOM & LABOR ROOM 6. 13 6. 00 DELIVERY ROOM & LABOR ROOM 6. 14 6. 00 CARDI AC CATHETERI ZATI ON 6. 01 ONCOLOGY 6. 10 6. 01 ONCOLOGY 6. 10 6. 01 ONCOLOGY 6. 10 6. 01 ONCOLOGY 6. 10 6. 01 ONCOLOGY 6. 10 6. 01 ONCOLOGY 6. 11 6. 00 PHARMACY 779, 612 779, 6			li .	ı		1, 431, 096	1, 431, 096	
4. 07 4. 08 4. 09 4. 09 4. 10 4. 10 52. 00 DELI VERY RODM & LABOR ROOM 4. 12 59. 00 CARDI AC CATHETERI ZATI ON 4. 13 54. 01 55. 00 DELECTROCARDI OLOGY 55. 00 DELI VERGE BACK 55.	4.05	5. 00	ADMINISTRATIVE & GENERAL	SVH CHAR	GE BACK	3, 713, 253	3, 713, 253	4.05
4. 08 4. 09 4. 10 4. 10 52. 00 DELIVERY ROOM & LABOR ROOM 54. 11 55. 00 DELIVERY ROOM & LABOR ROOM 64. 12 65. 00 DELIVERY ROOM & LABOR ROOM 65. 00 DELECTROCARDIOLOGY 67. 01 ONCOLOGY 68. 16 69. 00 ELECTROCARDIOLOGY 69. 00 PHYSICIANS' PRIVATE OFFICES 69. 194. 02 CLINIC OF HOPE 69. 194. 03 69. 00 ADMINISTRATIVE & GENERAL 69. 00 ADMINISTRATIVE & GENERA	4.06	15. 00	PHARMACY	SVH CHAR	GE BACK	-67, 255	-67, 255	4.06
4. 09 4. 10 4. 10 52. 00 DELI VERY ROOM & LABOR ROOM 4. 11 54. 00 RADI OLOGY - DI AGNOSTI C 59. 00 CARDI AC CATHETERI ZATI ON 59. 00 CARDIA CA	4.07	16. 00	MEDICAL RECORDS & LIBRARY	SVH CHAR	GE BACK	779, 612	779, 612	4. 07
4. 10	4.08	23. 00	SCHOOL OF RADIOLOGY-ALLIED H	SVH CHAR	GE BACK	13, 310	13, 310	4. 08
4. 11	4.09	30.00	ADULTS & PEDIATRICS	SVH CHAR	GE BACK	225	225	4. 09
4. 12	4. 10	52. 00	DELIVERY ROOM & LABOR ROOM	SVH CHAR	GE BACK	25	25	4. 10
4. 13 69. 00 ELECTROCARDI OLOGY SVH CHARGE BACK 51, 992 51, 992 4. 13 4. 14 76. 01 ONCOLOGY SVH CHARGE BACK 5, 436 5, 436 4. 14 4. 15 192. 00 PHYSI CI ANS' PRI VATE OFFI CES SVH CHARGE BACK 560, 904 560, 904 4. 15 4. 16 194. 02 CLI NI C OF HOPE SVH CHARGE BACK 5VH CHARGE BACK 50, 904 560, 904 4. 15 4. 17 5. 00 ADMI NI STRATI VE & GENERAL SVH HOME OFFI CE 5VH HOME OFFI CE 5VH HOME OFFI CE 5VH MARKETI NG 5. 00 TOTALS (sum of lines 1-4). Transfer col umn 6, line 5 to Worksheet A-8, col umn 2, 500 Worksheet A-8, co	4. 11	54. 00	RADI OLOGY-DI AGNOSTI C	SVH CHAR	GE BACK	62, 739	62, 739	4. 11
4. 14	4. 12	59. 00	CARDIAC CATHETERIZATION	SVH CHAR	GE BACK	5, 004	5, 004	4. 12
4. 15 4. 16 4. 17 4. 18 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	4. 13	69. 00	ELECTROCARDI OLOGY	SVH CHAR	GE BACK	51, 992	51, 992	4. 13
4. 16 4. 17 4. 18 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	4. 14	76. 01	ONCOLOGY	SVH CHAR	GE BACK	5, 436	5, 436	4. 14
4. 17 4. 18 5. 00 ADMINISTRATIVE & GENERAL 4. 18 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,  SVH HOME OFFICE SVH MARKETING SVH MARKETING SVH MARKETING 31, 272, 592 24, 068, 980 5. 00	4. 15	192. 00	PHYSICIANS' PRIVATE OFFICES	SVH CHAR	GE BACK	560, 904	560, 904	4. 15
4. 18	4. 16	194. 02	CLINIC OF HOPE	SVH CHAR	GE BACK	-69	-69	4. 16
5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	4. 17	5. 00	ADMINISTRATIVE & GENERAL	SVH HOME	OFFICE	14, 591, 077	8, 678, 685	4. 17
Transfer column 6, line 5 to Worksheet A-8, column 2,	4. 18	194. 03	MARKETI NG	SVH MARK	ETI NG	821, 324	O	4. 18
Worksheet A-8, column 2,	5.00	TOTALS (sum of lines 1-4).				31, 272, 592	24, 068, 980	5.00
		Transfer column 6, line 5 to						
line 12.		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 RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

Termbur Sement under titte XVIII.					
6.00	В	0. 00 ASCENSI ON HEALH 100. 00	6. 00		
7.00	В	0.00 STV HEALTH 100.00	7. 00		
8.00	A	0. 00 TRI MEDX 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.
- 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.

	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			_
1. 00	-229, 335			1. 00
2.00	-17			2. 00
3.00	-128			3. 00
4.00	-47			4. 00
4. 01	-36, 104			4. 01
4. 02	-654			4. 02
4. 03	736, 181	0		4. 03
4.04	0	0		4. 04
4. 05	0	0		4. 05
4. 06	0	0		4. 06
4. 07	0	0		4. 07
4. 08	0	0		4. 08
4. 09	0	0		4. 09
4. 10	0	0		4. 10
4. 11	0	0		4. 11
4. 12	0	0		4. 12
4. 13	0	0		4. 13
4. 14	0	0		4. 14
4. 15	0	0		4. 15
4. 16	0	0		4. 16
4. 17	5, 912, 392			4. 17
4. 18	821, 324			4. 18
5.00	7, 203, 612			5. 00

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

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

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

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

6.00	HOME OFFICE	6. 00
7.00	HOME OFFICE	7. 00
8.00	CLINICAL ENGINE	8. 00
9.00		9. 00
10.00	)	10.00
10. 00 100. 0	00	100.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150010 From 07/01/2015

Worksheet A-8-2

Date/Time Prepared:

06/30/2016

11/22/2016 2:42 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4.00 5. 00 6. 00 7. 00 5. 00 DR. A 1.00 1.00 462, 167 462, 167 2.00 30. 00 DR. B 65,000 65,000 181, 300 2,640 2.00 3.00 50.00 DR. C 8,000 8,000 3.00 28, 214 4.00 54.00 DR. D 28, 214 0 4.00 60. 00 DR. 5.00 Ε 157, 561 0 157, 561 260, 300 2,080 5.00 6.00 66.00 DR. F 7,000 7,000 211, 500 32 6.00 76.00 DR. G 161, 053 7.00 161, 053 0 0 7.00 76. 01 DR. H 8.00 19, 911 0 8.00 19, 911 0 C 9.00 0.00 0 0 0 9.00 10.00 0.00 10.00 908, 906 679, 345 229, 561 4, 752 200.00 200.00 Cost Center/Physician Unadjusted RCE 5 Percent of Physician Cost Wkst. A Line # Cost of Provi der I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Educati on 12 1. 00 2.00 8.00 9.00 12. 00 13.00 14.00 1. 00 1.00 5. 00 DR. A 0 0 2.00 30. 00 DR. B 230, 112 11, 506 0 0 0 2.00 3.00 50.00 DR. C 0 0 3.00 0 0 54.00 DR. D 0 0 0 0 0 0 4.00 4.00 0 60.00 DR. E 5.00 260, 300 13,015 0 0 5 00 6.00 66.00 DR. F 3, 254 163 6.00 7.00 76.00 DR. G 0 0 0 7.00 76. 01 DR. H 0 0 8.00 0 8.00 0 0 0 9.00 0.00 0 0 9.00 10.00 0.00 10.00 200.00 493, 666 24, 684 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCF Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 1. 00 2.00 15. 00 16. 00 17. 00 18. 00 1. 00 1.00 5. 00 DR. A 0 0 462, 167 2.00 30. 00 DR. B 0 230, 112 0 2.00 3.00 50.00 DR. C 0 8,000 3.00 54. 00 DR. D 60. 00 DR. E 4.00 0 0 4.00 28, 214 0 5.00 260, 300 O 5 00 6.00 66.00 DR. F 0 3, 254 3,746 3,746 6.00 7.00 76.00 DR. G 0 0 161,053 7.00 0 76. 01 DR. H 19, 911 8.00 8.00 0 0 0. 00 C 9.00 0 0 9.00 10.00 0.00 0 10.00

493, 666

3, 746

683, 091

200.00

200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

					Ţ	06/30/2016	Date/Time Pre	
		Cost Center Description	Net Expenses for Cost Allocation	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	42 pm
			(from Wkst A col. 7)					
			0	1.00	4.00	4A	5. 00	
4 00		AL SERVICE COST CENTERS	( 044 775	. 044 775			I	4 00
1. 00 4. 00	1	CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT	6, 344, 775 8, 657, 312					1. 00 4. 00
5. 00		ADMINISTRATIVE & GENERAL	27, 166, 912			29, 994, 520	29, 994, 520	5. 00
7.00		OPERATION OF PLANT	6, 025, 308			6, 968, 084		7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	544, 032			553, 948		8. 00 9. 00
10.00		DIETARY	1, 767, 248 676, 883			1, 805, 822 776, 525		10. 00
11. 00	01100	CAFETERI A	1, 211, 345	120, 796	0	1, 332, 141	411, 708	11. 00
13.00		NURSI NG ADMI NI STRATI ON	881, 876					13. 00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	17, 779, 663 1, 091, 299					15. 00 16. 00
23. 00		SCHOOL OF RADIOLOGY-ALLIED HEALTH	395, 779					23. 00
		I ENT ROUTINE SERVICE COST CENTERS	7 404 044	F. 6.4.0		0.540.040		
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	7, 496, 066 1, 557, 905			9, 543, 942 1, 983, 298		30. 00 31. 00
41. 00		SUBPROVI DER - I RF	1, 266, 981	259, 739		1, 783, 884		41. 00
43. 00		NURSERY	433, 994	30, 802	79, 231	544, 027	168, 135	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	6, 879, 288	619, 714	876, 317	8, 375, 319	2, 588, 451	50. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	1, 066, 076					52. 00
53.00	05300	ANESTHESI OLOGY	20, 572			25, 875		53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	2, 343, 772	494, 305		3, 114, 683		54. 00
54. 01 57. 00	1	ULTRA SOUND CT SCAN	366, 053 349, 448			439, 348 420, 501		54. 01 57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	321, 963			385, 647		58. 00
59. 00	1	CARDI AC CATHETERI ZATI ON	139, 515			162, 586		
60. 00 65. 00	1	LABORATORY RESPI RATORY THERAPY	5, 746, 945 1, 521, 861	151, 234 23, 681				60. 00 65. 00
66. 00	1	PHYSI CAL THERAPY	2, 503, 665			3, 126, 405		66. 00
67. 00		OCCUPATIONAL THERAPY	997, 346			1, 221, 360		67. 00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	232, 998 1, 056, 870			291, 727 1, 331, 043		68. 00 69. 00
70. 00		ELECTROENCEPHALOGRAPHY	454, 255			580, 825		70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 691, 331	82, 489		2, 835, 325		71. 00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	4, 119, 596 3, 606			4, 120, 024 4, 264		72. 00 73. 00
74.00		RENAL DIALYSIS	150, 123			150, 123		74. 00
76. 00	03950	BEHAVIORAL HEALTH SERVICES	1, 514, 245	87, 888		1, 913, 526	591, 389	76. 00
76. 01 76. 02		ONCOLOGY ENDOSCOPY	4, 955, 239 387, 279		, , , ,	5, 177, 167 432, 084		76. 01 76. 02
76. 02	1	WOUND CARE	924, 131					
		TIENT SERVICE COST CENTERS						
90. 00 91. 00		CLI NI C EMERGENCY	0 2, 314, 978	0 370, 236		0 3, 128, 545	966, 899	90. 00 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	2,314,770	370, 230	445, 551	0, 120, 343		92. 00
		REIMBURSABLE COST CENTERS						
95. 00 98. 00		AMBULANCE SERVICES OTHER REIMBURSABLE COST CENTERS	899, 877 0	75, 961 0	168, 944 0	1, 144, 782 0	353, 803 0	95. 00 98. 00
99. 00	09900		Ö	Ö	Ö	Ö	Ö	99. 00
99. 10	09910		0	0	0	0	0	99. 10
		I&R SERVICES-NOT APPRVD PRGM HOME HEALTH AGENCY	0	0		0		100. 00 101. 00
101.00		AL PURPOSE COST CENTERS						101.00
		INTEREST EXPENSE	405 050 440	5 000 500	0.050.700	404 705 400		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS	125, 258, 410	5, 930, 509	8, 853, 708	124, 795, 120	29, 298, 778	118.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19, 699	0	19, 699	6, 088	190. 00
		PHYSICIANS' PRIVATE OFFICES	642, 682			1, 033, 803		
		ASC-MOB EDUCATION CENTER	12, 799 12, 935			12, 799 12, 935		192. 01 192. 02
		NONPALD WORKERS	0	ő	1	0	0	193. 00
		FOUNDATION	0	3, 446	1	3, 446		194.00
		ASPR BIOTERRORISM GRANT CLINIC OF HOPE	14, 861 283, 283	0		14, 861 332, 307		194. 01 194. 02
		MARKETI NG	821, 324		0	821, 324		
200.00	1	Cross Foot Adjustments		_	_	0	_	200.00
201. 00 202. 00	1	Negative Cost Centers TOTAL (sum lines 118-201)	127, 046, 294	0 6, 344, 775	0 8, 902, 732	0 127, 046, 294		201. 00 202. 00
	1	1 (3	.27,070,274	3, 5, 7, 7, 7, 7, 7, 7, 7, 7, 7, 7, 7, 7, 7,	0, 702, 732			

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150010 Peri od:

Peri od: Worksheet B From 07/01/2015 Part I To 06/30/2016 Date/Time Prepared:

11/22/2016 2:42 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A **PLANT** LINEN SERVICE 9.00 10.00 11.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 9, 121, 619 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 21,509 746, 659 8.00 00900 HOUSEKEEPI NG 232, 078 2, 679, 672 9.00 83,670 9.00 10.00 01000 DI ETARY 216, 129 1, 232, 644 10.00 C 2, 005, 862 01100 CAFETERI A 11.00 262,013 C 0 11.00 13.00 01300 NURSING ADMINISTRATION 109,041 2,050 37, 722 13.00 15 00 01500 PHARMACY 132,833 Ω 31, 253 0 63, 567 15.00 01600 MEDICAL RECORDS & LIBRARY 16,00 101,608 0 84.138 16.00 C 683 23.00 02300 SCHOOL OF RADIOLOGY-ALLIED HEALTH 37, 205 9, 289 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 222, 616 845, 000 852, 841 426, 937 30.00 241, 262 87, 322 03100 INTENSIVE CARE UNIT 31.00 234, 026 58, 984 204.985 112, 665 31.00 41.00 04100 SUBPROVIDER - IRF 563, 390 23, 506 204, 985 171, 728 80, 173 41.00 04300 NURSERY 43 00 43.00 66, 811 9,872 101, 454 95, 410 18, 817 ANCILLARY SERVICE COST CENTERS 50 00 50 00 05000 OPERATING ROOM 1, 344, 199 513 453, 140 238, 254 05200 DELIVERY ROOM & LABOR ROOM 135, 532 163, 838 0 52.00 36, 363 69, 288 52.00 05300 ANESTHESI OLOGY 53.00 11, 502 C 0 0 53.00 Ω 05400 RADI OLOGY-DI AGNOSTI C 96, 681 54.00 1,072,177 16, 719 72.428 54.00 54.01 03630 ULTRA SOUND 0 2, 968 9, 539 14, 456 54.01 19, 159 57.00 05700 CT SCAN 0 6,023 C 57.00 0 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 1.453 17,052 58.00 05900 CARDIAC CATHETERIZATION 59 00 16,609 C 13,666 6, 771 59 00 60.00 06000 LABORATORY 328, 035 C 88, 130 Ω 60.00 06500 RESPIRATORY THERAPY 84, 587 65.00 51, 364 7, 243 0 0 0 65.00 06600 PHYSI CAL THERAPY 299.592 0 140, 215 66.00 13, 666 66.00 06700 OCCUPATIONAL THERAPY 128.557 67.00 C 1, 367 27,011 67.00 68.00 06800 SPEECH PATHOLOGY 43, 184 11, 780 5, 743 68.00 06900 ELECTROCARDI OLOGY 69.00 166, 218 0 5, 466 0 52, 455 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 113 276 37.745 22 153 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 178, 924 16, 206 80, 545 54, 330 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 C C 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 0 07400 RENAL DIALYSIS 74.00 C 13, 666 Λ 74.00 76.00 03950 BEHAVI ORAL HEALTH SERVICES 190,634 0 27, 331 0 79,678 76.00 0 76. 01 03480 ONCOLOGY 53, 321 76.01 76 02 03330 ENDOSCOPY O o 17, 053 76 02 03951 WOUND CARE 76.03 124, 570 43, 730 17, 972 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 C 0 245, 982 o 112, 096 09100 EMERGENCY 803, 063 90, 851 91 00 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 9, 861 69, 622 95.00 164, 765 0 0 o 0 09850 OTHER REIMBURSABLE COST CENTERS 98 00 98 00 0 C 0 99.00 09900 CMHC 0 0 0 0 0 99.00 99. 10 09910 CORF 0 0 99. 10 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 o 100.00 C 0 101.00 10100 HOME HEALTH AGENCY 0 0 101 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 2, 679, 672 8, 223, 052 746, 659 1, 232, 644 2, 005, 862 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 42,728 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 848, 365 0 0 192.00 0 0 192, 01 192. 01 19201 ASC-MOB 0 0 192. 02 19202 EDUCATION CENTER 0 0 0 C 0 192. 02 0 193. 00 19300 NONPALD WORKERS O 0 0 193.00 194. 00 07950 FOUNDATI ON 0 0 194.00 0 7,474 194. 01 07951 ASPR BI OTERRORI SM GRANT 0 0 0 C 0 194, 01 194. 02 07952 CLINIC OF HOPE 0 0 194. 02 0 o 194. 03 07953 MARKETI NG 0 0 0 194. 03 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 0 201.00 2, 679, 672 1, 232, 644 2, 005, 862 202. 00 202.00 TOTAL (sum lines 118-201) 9, 121, 619 746, 659

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150010

				''	0 00/30/2010	11/22/2016 2:	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL	SCHOOL OF	Subtotal	
		ADMI NI STRATI ON			RADI OLOGY-ALLI		
				LI BRARY	ED HEALTH		
		13. 00	15. 00	16. 00	23. 00	24. 00	
	NERAL SERVICE COST CENTERS						1 00
	0100 CAP REL COSTS-BLDG & FIXT 0400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
	D500 ADMINISTRATIVE & GENERAL						5.00
	0700 OPERATION OF PLANT						7.00
	0800 LAUNDRY & LINEN SERVICE						8.00
	0900 HOUSEKEEPING		•				9. 00
	1000 DI ETARY						10.00
	100 CAFETERI A						11.00
	300 NURSING ADMINISTRATION	1, 590, 979					13. 00
	500 PHARMACY	0	24, 016, 497				15. 00
16. 00 01	600 MEDICAL RECORDS & LIBRARY	0	О	1, 831, 271			16. 00
23. 00 02	2300 SCHOOL OF RADIOLOGY-ALLIED HEALTH	0	0	0	690, 736		23. 00
IN	IPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	602, 166	0	108, 812	0	16, 793, 198	
	3100 INTENSIVE CARE UNIT	123, 162	0	29, 461	0	3, 446, 855	
	1100 SUBPROVI DER - I RF	113, 079	0	19, 209	0	3, 511, 276	
	300 NURSERY	26, 540	0	11, 237	0	1, 042, 303	43. 00
	ICI LLARY SERVI CE COST CENTERS	201.040	ما	0.40 5.40	٥	40 504 407	
	OOOO OPERATING ROOM	336, 042	0	248, 568	l .	13, 584, 486	
	5200 DELIVERY ROOM & LABOR ROOM 5300 ANESTHESIOLOGY	97, 727	0	41, 300 30, 999	0	2, 302, 580 76, 373	52. 00 53. 00
	5400 RADI OLOGY-DI AGNOSTI C	0	0	85, 025	355, 725	5, 776, 053	1
	3630 ULTRA SOUND	0	0	28, 392		749, 280	1
	5700 CT SCAN	0	0	39, 658		781, 229	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	ő	12, 019		585, 647	58.00
	5900 CARDI AC CATHETERI ZATI ON	9, 550	o	6, 795	0	266, 225	1
	5000 LABORATORY	0	o	243, 703	o	8, 386, 767	
65. 00 06	5500 RESPI RATORY THERAPY	0	О	51, 986	0	2, 586, 529	
66. 00 06	6600 PHYSI CAL THERAPY	О	0	50, 715	0	4, 596, 830	66. 00
67. 00 06	5700 OCCUPATIONAL THERAPY	0	О	17, 212	0	1, 772, 977	67. 00
68. 00   06	SPEECH PATHOLOGY	0	0	3, 579	0	446, 173	68. 00
69.00 06	900 ELECTROCARDI OLOGY	0	0	51, 711	0	2, 018, 261	69. 00
	7000 ELECTROENCEPHALOGRAPHY	0	0	21, 348	0	954, 855	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	54, 957	0	4, 096, 564	
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	59, 616	0	5, 452, 962	72. 00
	7300 DRUGS CHARGED TO PATIENTS	0	23, 995, 675	189, 602	0	24, 190, 859	73. 00
	7400 RENAL DIALYSIS	0	0	670	0	210, 856	74.00
	8950 BEHAVI ORAL HEALTH SERVI CES	75 207	0	18, 605	0	2, 821, 163	
	3480 ONCOLOGY 3330 ENDOSCOPY	75, 207 24, 053	0	80, 526 20, 333	0 0	6, 986, 261 627, 062	
	8951 WOUND CARE	25, 348	0	59, 742	0	1, 622, 500	76. 02
	ITPATIENT SERVICE COST CENTERS	23, 340	O <sub>I</sub>	37, 142	O <sub>I</sub>	1, 022, 300	70.03
	2000 CLINIC	0	0	0	0	0	90.00
	P100 EMERGENCY	158, 105	0	214, 949	0	5, 720, 490	
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
ОТ	HER REIMBURSABLE COST CENTERS		·				
95. 00 09	9500 AMBULANCE SERVICES	0	0	30, 542	0	1, 773, 375	
	9850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	
	9900 CMHC	0	0	0	0	0	
99. 10 09		0	0	0	0	0	1
	0000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	
	0100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	PECIAL PURPOSE COST CENTERS	1					112 00
113.00 11	300 INTEREST EXPENSE	1 500 070	22 005 475	1 021 271	(00.72/	123, 179, 989	113.00
	SUBTOTALS (SUM OF LINES 1-117)  NREIMBURSABLE COST CENTERS	1, 590, 979	23, 995, 675	1, 831, 271	690, 736	123, 179, 989	1118.00
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	٥	0	0	69 515	190. 00
	2200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	2, 201, 672	
	2201 ASC-MOB	0	0	0	0		192. 00
	2202 EDUCATION CENTER	0	Ö	0	0		192. 02
	2300 NONPALD WORKERS	0	Ö	0	0		193. 00
	7950 FOUNDATION		ő	0	n		194. 00
	7951 ASPR BIOTERRORISM GRANT		ol	0	ol		194. 01
1	7952 CLINIC OF HOPE	0	20, 822	0	o	455, 831	
	7953 MARKETI NG	0	o	0	О	1, 075, 160	
200. 00	Cross Foot Adjustments		j		0	0	200. 00
201. 00	Negative Cost Centers	0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118-201)	1, 590, 979	24, 016, 497	1, 831, 271	690, 736	127, 046, 294	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150010

				To 06/30/2016 Date/Time Pre 11/22/2016 2:	
	Cost Center Description	Intern &	Total	1172272010 2.	TZ piii
		Residents Cost			
		& Post Stepdown			
		Adjustments			
	JOSEPH OF THE CONTROL	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS    OO100 CAP REL COSTS-BLDG & FIXT	T			1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL				5. 00
7.00	00700 OPERATION OF PLANT				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 10. 00	00900   HOUSEKEEPI NG   01000   DI ETARY				9. 00 10. 00
11. 00	01100 CAFETERI A				11. 00
13.00	01300 NURSING ADMINISTRATION				13. 00
	01500 PHARMACY				15. 00
	01600 MEDI CAL RECORDS & LI BRARY				16. 00
23. 00	02300   SCHOOL OF RADIOLOGY-ALLIED HEALTH   INPATIENT ROUTINE SERVICE COST CENTERS				23. 00
30. 00	03000 ADULTS & PEDI ATRI CS	0	16, 793, 198		30. 00
31.00	03100 INTENSIVE CARE UNIT	0	3, 446, 855		31. 00
	04100 SUBPROVI DER - I RF	0	3, 511, 276		41. 00
43. 00	04300 NURSERY	0	1, 042, 303		43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	13, 584, 486		50.00
	05200 DELIVERY ROOM & LABOR ROOM		2, 302, 580		52. 00
	05300 ANESTHESI OLOGY	0	76, 373		53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	5, 776, 053		54. 00
	03630 ULTRA SOUND	0	749, 280		54. 01
57. 00 58. 00	05700 CT SCAN   05800 MAGNETIC RESONANCE IMAGING (MRI)	0	781, 229 585, 647		57. 00 58. 00
	05900 CARDI AC CATHETERI ZATI ON		266, 225		59.00
	06000 LABORATORY	o	8, 386, 767		60.00
65.00	06500 RESPI RATORY THERAPY	0	2, 586, 529		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	4, 596, 830		66. 00
	06700 OCCUPATIONAL THERAPY	0	1, 772, 977		67.00
68. 00 69. 00	06800   SPEECH PATHOLOGY   06900   ELECTROCARDI OLOGY	0	446, 173 2, 018, 261		68. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY	o	954, 855		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 096, 564		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	5, 452, 962		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	24, 190, 859		73.00
	07400  RENAL DI ALYSI S   03950  BEHAVI ORAL HEALTH SERVI CES	0	210, 856 2, 821, 163		74. 00 76. 00
	03480 ONCOLOGY		6, 986, 261		76. 01
	03330 ENDOSCOPY	0	627, 062		76. 02
76. 03	03951 WOUND CARE	0	1, 622, 500		76. 03
00.00	OUTPATIENT SERVICE COST CENTERS		0		1 00 00
	09000   CLI NI C   09100   EMERGENCY	0	0 5, 720, 490		90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		5, 720, 470		92. 00
	OTHER REIMBURSABLE COST CENTERS				
	09500 AMBULANCE SERVICES	0	1, 773, 375		95. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00 99. 00
	09910 CORF		o		99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100 HOME HEALTH AGENCY	0	0		101. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE				1112 00
118.00		o	123, 179, 989		113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	<u> </u>	120, 177, 707		1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	68, 515		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	2, 201, 672		192. 00
	19201 ASC-MOB  19202 EDUCATION CENTER	0	16, 755 16, 933		192. 01 192. 02
	19300 NONPALD WORKERS		10, 933		193. 00
	07950 FOUNDATION		11, 985		194. 00
	07951 ASPR BIOTERRORISM GRANT	0	19, 454		194. 01
	07952 CLINIC OF HOPE	0	455, 831		194. 02
194. 03 200. 00	07953  MARKETING   Cross Foot Adjustments	0	1, 075, 160 0		194. 03 200. 00
200.00		0	0		200.00
202. 00		Ö	127, 046, 294		202. 00
		·			

| Peri od: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150010

					Ţ	06/30/2016	Date/Time Pre 11/22/2016 2:	
				CAPI TAL			11/22/2010 2.	42 piii
		0 1 0 1 5 11	D: 11	RELATED COSTS		EMBLOVEE	ADMINI CEDATINE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
			Capi tal			DEPARTMENT	& GENERAL	
			Related Costs					
	CENED	AL SERVICE COST CENTERS	0	1.00	2A	4. 00	5. 00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	245, 420	245, 420	245, 420		4. 00
5.00		ADMINISTRATIVE & GENERAL	2, 191, 932				3, 255, 538	5. 00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	880, 410 9, 916			233, 737 18, 582	7. 00 8. 00
9. 00	1	HOUSEKEEPI NG		38, 574			60, 574	9. 00
10. 00		DIETARY	0	99, 642			26, 048	
11. 00		CAFETERI A	0	120, 796			44, 685	11. 00
13. 00 15. 00		NURSI NG ADMI NI STRATI ON PHARMACY	0	50, 271 61, 240		4, 674 9, 142	1	13. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY		46, 844			1	16. 00
23. 00		SCHOOL OF RADIOLOGY-ALLIED HEALTH	0	17, 153				23. 00
		ENT ROUTINE SERVICE COST CENTERS	1			10.017	000 440	
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	563, 662 107, 893			320, 142 66, 528	30. 00 31. 00
41. 00		SUBPROVI DER - I RF	0	259, 739				41. 00
43.00	04300	NURSERY	0					43. 00
F0 00		LARY SERVICE COST CENTERS	1 0	(40.744	/40 744	04.450	000 040	F0 00
50. 00 52. 00		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0	619, 714 62, 484		24, 158 5, 922	280, 942 45, 062	50. 00 52. 00
53. 00		ANESTHESI OLOGY	0	5, 303			868	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	0	494, 305	494, 305		104, 479	54. 00
54. 01		ULTRA SOUND	0	0	· -	2, 021	14, 737	54. 01
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	0	· -	1, 959 1, 756	1	•
59. 00		CARDI AC CATHETERI ZATI ON	0	7, 657	-		5, 454	
60.00	06000	LABORATORY	0	151, 234	151, 234	123	l	60. 00
65. 00		RESPI RATORY THERAPY	0	23, 681		7, 753	61, 277	65. 00
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	138, 120 59, 268			104, 872 40, 969	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	0	19, 909				
69. 00	1	ELECTROCARDI OLOGY	0	76, 632				69. 00
70.00	1	ELECTROENCEPHALOGRAPHY	0	52, 224			1	1
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	82, 489 0			95, 108 138, 202	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	Ö				73. 00
74. 00		RENAL DIALYSIS	0	0	-	0	5, 036	
76. 00	1	BEHAVI ORAL HEALTH SERVI CES	0	87, 888	1		1	76. 00
76. 01 76. 02		ONCOLOGY ENDOSCOPY	0	0		6, 118 1, 235		76. 01 76. 02
76. 03	1	WOUND CARE	Ö	1		1, 395	34, 622	76. 03
		TIENT SERVICE COST CENTERS	_	_	_	-	_	
90. 00 91. 00		CLI NI C EMERGENCY	0	0 370, 236	370, 236	0 12, 222	0 104, 944	90. 00 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)		370, 230	370, 230	12, 222	104, 744	92.00
		REI MBURSABLE COST CENTERS				1		
95.00		AMBULANCE SERVICES	0	75, 961	75, 961	4, 657	38, 401	95.00
98. 00 99. 00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00 99. 00
	09910		0		0	0	0	
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	•	100. 00
101.00		HOME HEALTH AGENCY	0	0	0	0	0	101. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
118. 00	1	SUBTOTALS (SUM OF LINES 1-117)	2, 191, 932	5, 930, 509	8, 122, 441	244, 069	3, 180, 025	
		MBURSABLE COST CENTERS						
	1	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				l	190. 00
		PHYSICIANS' PRIVATE OFFICES ASC-MOB	0	391, 121 0		0	34, 678	192. 00 192. 01
		EDUCATION CENTER		0	_		l	192. 01
193.00	19300	NONPALD WORKERS	0	O	0	0	0	193. 00
		FOUNDATION	0	3, 446	3, 446	0		194.00
		ASPR BIOTERRORISM GRANT CLINIC OF HOPE	0	0		0 1, 351	498 11, 147	194. 01 194. 02
	1	MARKETI NG		0		0	27, 550	
200.00		Cross Foot Adjustments			0			200. 00
201.00	1	Negative Cost Centers	0.404.000	0	0 507 305	0		201. 00
202.00	'I	TOTAL (sum lines 118-201)	2, 191, 932	6, 344, 775	8, 536, 707	245, 420	3, 255, 538	1202. UU

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150010

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2015 | Part II |
| To 06/30/2016 | Date/Time Prepared: | 11/22/2016 2: 42 pm

					00/30/2016	11/22/2016 2:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	0.00	10.00	11 00	
	GENERAL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10.00	11. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT				T		1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	1, 115, 866					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	2, 631	31, 129	)			8. 00
9.00	00900 HOUSEKEEPI NG	10, 235	l	119, 059			9. 00
10. 00	01000 DI ETARY	26, 440	l e	0	152, 130		10.00
11. 00	01100 CAFETERI A	32, 053	l e	0	0	197, 534	
13. 00	01300 NURSI NG ADMI NI STRATI ON	13, 339	l .	91	0	3, 715	1
15. 00 16. 00	O1500   PHARMACY   O1600   MEDI CAL RECORDS & LI BRARY	16, 250	l	1, 389	U O	6, 260	1
23. 00	02300 SCHOOL OF RADIOLOGY-ALLIED HEALTH	12, 430 4, 551	0	1	0	8, 286 915	
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4, 331		,	<u> </u>	713	23.00
30. 00	03000 ADULTS & PEDIATRICS	149, 565	10, 057	37, 543	105, 256	42, 043	30.00
31.00	03100 INTENSIVE CARE UNIT	28, 629	l		13, 905	8, 599	1
41.00	04100 SUBPROVI DER - I RF	68, 921	980	9, 108	21, 194	7, 895	41.00
43.00	04300 NURSERY	8, 173	412	4, 508	11, 775	1, 853	43. 00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	164, 437	21		0	23, 463	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	16, 580	1		0	6, 823	1
53. 00 54. 00	05400 RADI OLOGY - O5400 RADI OLOGY	1, 407 131, 162	0 697	1	U O	0 9, 521	
54. 00	03400 KADI OLOGI - DI AGNOSTI C	131, 102	124		0	1, 424	1
57. 00	05700 CT SCAN	0	251		Ö	1, 887	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	61		o	1, 679	1
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 032	0		o	667	1
60.00	06000 LABORATORY	40, 129	0	3, 916	o	0	60.00
65. 00	06500 RESPI RATORY THERAPY	6, 284	0	322	0	8, 330	65. 00
66. 00	06600 PHYSI CAL THERAPY	36, 650	0		0	13, 808	1
67. 00	06700 OCCUPATI ONAL THERAPY	15, 727	0	61	0	2, 660	1
68. 00	06800 SPEECH PATHOLOGY	5, 283	0		0	566	1
69. 00 70. 00	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY	20, 334	0		U O	5, 166	1
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 857 21, 888	1	.,	0	2, 182 5, 350	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	21,000	0,0		o	0, 330	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		ol	0	1
74. 00	07400 RENAL DIALYSIS	0	Ö	607	ol	0	74. 00
76.00	03950 BEHAVI ORAL HEALTH SERVI CES	23, 321	o	1, 214	o	7, 847	1
76. 01	03480 ONCOLOGY	0	0	0	o	5, 251	76. 01
76. 02	03330 ENDOSCOPY	0	0	0	0	1, 679	1
76. 03	03951 WOUND CARE	15, 239	0	1, 943	0	1, 770	76. 03
00.00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC			J	ما	0	00 00
90. 00 91. 00	09100 EMERGENCY	98, 240		1	0	0 11, 039	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	90, 240	3, 700	10, 929	٩	11,039	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00		20, 156	411	0	0	6, 856	95. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	o	0	1
99. 00		0	0	0	o	0	99. 00
	09910 CORF	0	0	0	0	0	
	0 10000 I&R SERVICES-NOT APPRVD PRGM	0		0	0		100. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
112 0	SPECIAL PURPOSE COST CENTERS						1112 00
113.00	11300 INTEREST EXPENSE	1 005 042	31, 129	119, 059	152, 130	197, 534	113.00
110.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	1, 005, 943	31, 129	119,039	152, 130	197, 554	1116.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 227	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	103, 782			ol		192. 00
	1 19201 ASC-MOB	0		Ö	ō		192. 01
	2 19202 EDUCATION CENTER	0		ol o	o		192. 02
193.00	19300 NONPALD WORKERS	0	0	0	o		193. 00
	07950 FOUNDATI ON	914	0	0	O		194. 00
	1 07951 ASPR BIOTERRORISM GRANT	0	0		0		194. 01
	2 07952 CLINIC OF HOPE	0	0	0	0		194. 02
	3 O7953 MARKETI NG	0	0	ا ا	0	0	194. 03
200.00		_	_	,		_	200.00
201. 00 202. 00		1, 115, 866	0 31, 129	119, 059	0 152, 130	0 197, 534	201.00
∠∪∠. U(		1, 110, 000	J 31, 129	1 117,039	152, 130	177, 334	1202.00

| Peri od: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150010

			T	06/30/2016	Date/Time Pre 11/22/2016 2:	
Cost Center Description	NURSI NG	PHARMACY	MEDI CAL	SCHOOL OF	Subtotal	12 piii
	ADMI NI STRATI ON		RECORDS & LI BRARY	RADI OLOGY-ALLI ED HEALTH		
	13.00	15. 00	16. 00	23. 00	24. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00   OO400   EMPLOYEE BENEFITS DEPARTMENT 5.00   OO500   ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00   00700   OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMINI STRATI ON	109, 045					11. 00 13. 00
15. 00   01500   NORSTING ADMINISTRATION 15. 00   01500   PHARMACY	109, 045	703, 894				15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	o	0	113, 001			16. 00
23. 00 02300 SCHOOL OF RADIOLOGY-ALLIED HEALTH	0	0	0	41, 311		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	44 070	ما	. 700		1 017 100	
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	41, 273 8, 441	0	6, 722 1, 820		1, 317, 180 256, 135	30. 00 31. 00
41. 00   04100   SUBPROVI DER -   I RF	7, 750	0	1, 820		443, 703	41.00
43. 00   04300   NURSERY	1, 819	o	694		80, 469	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	23, 032	0	15, 224		1, 171, 124	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   53.00   05300   ANESTHESI OLOGY	6, 698	0	2, 551 1, 915		154, 915 9, 493	52. 00 53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0	5, 253		756, 260	54. 00
54. 01   03630   ULTRA SOUND	0	ő	1, 754		20, 484	54. 01
57.00 05700 CT SCAN	0	0	2, 450		20, 652	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	743		17, 175	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	655	0	420		17, 917	59. 00
60. 00   06000   LABORATORY 65. 00   06500   RESPI RATORY   THERAPY	0	0	15, 056 3, 212		408, 456 110, 859	60. 00 65. 00
66. 00   06600 PHYSI CAL THERAPY		0	3, 133		310, 550	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1, 063		124, 290	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	221		37, 358	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	3, 195		155, 665	69. 00
70.00 O7000 ELECTROENCEPHALOGRAPHY 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 319 3, 395		92, 792 214, 181	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0	3, 683		141, 897	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	703, 284	11, 713		715, 158	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0	41		5, 684	74. 00
76. 00 03950 BEHAVI ORAL HEALTH SERVI CES	0	0	1, 149		194, 191	76. 00
76. 01   03480   0NCOLOGY 76. 02   03330   ENDOSCOPY	5, 155 1, 649	0	4, 975 1, 256		195, 162 20, 313	76. 01 76. 02
76. 03   03951   WOUND CARE	1, 737	0	3, 691		117, 828	76. 02 76. 03
OUTPATIENT SERVICE COST CENTERS	.,	-,	2, 2		,	
90. 00 09000 CLI NI C	0	0	0		0	90. 00
91. 00 09100 EMERGENCY	10, 836	0	13, 279		635, 513	91.00
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVICES	0	0	1, 887		148, 329	95. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0		0	98. 00
99. 00 09900 CMHC	0	0	0		0	99. 00
99. 10   09910   CORF	0	0	0		0	99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0	0	0			100. 00 101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>				101.00
113. 00 11300   NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	109, 045	703, 284	113, 001	0	7, 893, 733	118. 00
NONREI MBURSABLE COST CENTERS		اه			05 507	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES		0	0		25, 587 529, 581	
192. 01 19201 ASC-MOB		0	0			192. 00
192. 02 19202 EDUCATION CENTER	o	o	0			192. 02
193. 00 19300 NONPALD WORKERS	0	O	0		0	193. 00
194. 00 07950 FOUNDATION	0	0	0			194. 00
194. 01 07951 ASPR BIOTERRORI SM GRANT	0	0	0		498 13, 108	194. 01
194. 02 07952 CLI NI C OF HOPE 194. 03 07953  MARKETI NG		610 0	0		13, 108 27, 550	
200.00 Cross Foot Adjustments	1		O	41, 311	41, 311	
201.00 Negative Cost Centers	0	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	109, 045	703, 894	113, 001	41, 311	8, 536, 707	202. 00

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ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150010

				To 06/30/2016 Date/Time Prep 11/22/2016 2:4	
	Cost Center Description	Intern &	Total	1172272010 2.	72 piii
		Residents Cost			
		& Post Stepdown			
		Adjustments			
		25. 00	26. 00		
1 00	GENERAL SERVICE COST CENTERS				1 00
1. 00 4. 00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT				1. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00	00700 OPERATION OF PLANT				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE				8. 00
9.00	00900 HOUSEKEEPI NG				9.00
	01000 DI ETARY 01100 CAFETERI A				10. 00 11. 00
	01300 NURSING ADMINISTRATION				13. 00
	01500 PHARMACY				15. 00
	01600 MEDICAL RECORDS & LIBRARY				16. 00
23. 00	02300 SCHOOL OF RADIOLOGY-ALLIED HEALTH				23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	O	1, 317, 180		30. 00
	03100 INTENSIVE CARE UNIT	o	256, 135		31. 00
	04100 SUBPROVI DER - I RF	O	443, 703		41. 00
43.00	04300 NURSERY	0	80, 469		43.00
FO 00	ANCILLARY SERVICE COST CENTERS		4 474 404		F0 00
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	1, 171, 124 154, 915		50. 00 52. 00
	05300 ANESTHESI OLOGY	0	9, 493		53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	756, 260		54.00
	03630 ULTRA SOUND	0	20, 484		54. 01
	05700 CT SCAN	0	20, 652		57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	17, 175 17, 917		58. 00 59. 00
	06000 LABORATORY	0	408, 456		60.00
	06500 RESPIRATORY THERAPY	0	110, 859		65. 00
	06600 PHYSI CAL THERAPY	0	310, 550		66. 00
	06700 OCCUPATI ONAL THERAPY	0	124, 290		67. 00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	37, 358 155, 665		68. 00 69. 00
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	0	92, 792		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	214, 181		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	141, 897		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	715, 158		73. 00
	07400 RENAL DI ALYSI S 03950 BEHAVI ORAL HEALTH SERVI CES	0	5, 684 194, 191		74. 00 76. 00
	03480 ONCOLOGY	0	195, 162		76. 00 76. 01
	03330 ENDOSCOPY	0	20, 313		76. 02
76. 03	03951 WOUND CARE	0	117, 828		76. 03
00.00	OUTPATIENT SERVICE COST CENTERS	0	0		00.00
	09000 CLI NI C 09100 EMERGENCY	0	0 635, 513		90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	000, 010		92. 00
	OTHER REIMBURSABLE COST CENTERS		<u> </u>		
	09500 AMBULANCE SERVICES	0	148, 329		95. 00
	09850 OTHER REIMBURSABLE COST CENTERS 09900 CMHC	0	0		98. 00 99. 00
	09910 CORF	0	0		99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0	ō		100.00
101. 00	10100 HOME HEALTH AGENCY	0	0		101. 00
112 00	SPECIAL PURPOSE COST CENTERS				112 00
118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	o	7, 893, 733		113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	<u> </u>	7,070,700		110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25, 587		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	529, 581		192.00
	19201 ASC-MOB 19202 EDUCATION CENTER	0	429 434		192. 01 192. 02
	19300 NONPALD WORKERS		0		192. 02
	07950 FOUNDATION	o o	4, 476		194. 00
194. 01	07951 ASPR BIOTERRORISM GRANT	0	498		194. 01
	07952 CLINIC OF HOPE	0	13, 108		194. 02
194. 03 200. 00	07953 MARKETING Cross Foot Adjustments	0	27, 550		194. 03 200. 00
200.00	, ,	0	41, 311		200.00
202. 00		O	8, 536, 707		202. 00
		•		·	

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150010 Peri od: Worksheet B-1 From 07/01/2015 06/30/2016 Date/Time Prepared: 11/22/2016 2:42 pm CAPI TAL RELATED COSTS Reconciliation ADMINISTRATIVE OPERATION OF Cost Center Description **EMPLOYEE** BLDG & FIXT (SOUARE FEET) BENEFITS & GENERAL PLANT DEPARTMENT (SQUARE FEET) (ACCUM. COST) (GROSS SALARIES) 1.00 5A 5. 00 7. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 331, 432 1 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 12,820 39, 978, 972 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 52, 948 8, 145, 951 -29, 994, 520 97, 051, 774 5.00 00700 OPERATION OF PLANT 45, 990 280, 066 6, 968, 084 7 00 219, 674 7 00 C00800 LAUNDRY & LINEN SERVICE 8.00 518 C 0 553, 948 518 8.00 9.00 00900 HOUSEKEEPI NG 2,015 1, 805, 822 2,015 9.00 01000 DI ETARY 5, 205 0 0 776, 525 5, 205 10.00 10.00 01100 CAFETERI A 0 1, 332, 141 11 00 6.310 6, 310 11 00 13.00 01300 NURSING ADMINISTRATION 2,626 761, 326 0 1, 101, 683 2,626 13.00 01500 PHARMACY 3, 199 1, 489, 154 0 18, 172, 515 3, 199 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 2, 447 531, 540 0 1, 256, 509 2, 447 16.00 16, 00 0 02300 SCHOOL OF RADIOLOGY-ALLIED HEALTH 355, 705 23.00 896 492, 142 896 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 29, 444 6, 665, 085 0 9, 543, 942 29, 444 30.00 03100 INTENSIVE CARE UNIT 1, 425, 779 0 31.00 5.636 1. 983. 298 5. 636 31.00 41.00 04100 SUBPROVIDER - IRF 13.568 1, 154, 831 0 1, 783, 884 13.568 41 00 04300 NURSERY 1,609 355, 797 544, 027 43.00 43.00 1, 609 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 32, 372 3, 935, 231 0 8, 375, 319 32, 372 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 3, 264 964, 582 1, 343, 358 3, 264 52.00 25, 875 05300 ANESTHESI OLOGY 0 53.00 277 277 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 25, 821 1, 242, 140 0 3, 114, 683 25, 821 54.00 54.01 03630 ULTRA SOUND 329, 144 0 439, 348 54.01 0 0 57.00 05700 CT SCAN 0 319, 074 0 420, 501 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 285, 984 385, 647 58.00 59.00 05900 CARDIAC CATHETERIZATION 400 69, 217 0 162, 586 400 59.00 0 60.00 06000 LABORATORY 7.900 20, 056 5, 902, 645 7.900 60.00 06500 RESPIRATORY THERAPY 1, 237 1, 262, 907 1, 826, 772 1, 237 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 7, 215 2, 176, 260 0 3, 126, 405 7, 215 66.00 06700 OCCUPATIONAL THERAPY 0 3, 096 3.096 739.815 1, 221, 360 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 1,040 174, 326 291, 727 1,040 68.00 06900 ELECTROCARDI OLOGY 887, 086 1, 331, 043 69.00 4,003 4,003 69.00 07000 ELECTROENCEPHALOGRAPHY 333, 862 580, 825 2,728 70.00 70.00 2.728 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 4, 309 4, 309 276, 197 71.00 2, 835, 325 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1, 924 4, 120, 024 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 2, 956 4, 264 73.00 0 07400 RENAL DIALYSIS 0 150 123 74 00 0 74 00 03950 BEHAVIORAL HEALTH SERVICES 0 76.00 4,591 1, 398, 356 1, 913, 526 4, 591 76.00 76.01 03480 ONCOLOGY 996, 601 0 5, 177, 167 0 76.01 0 76.02 03330 ENDOSCOPY 201, 202 432, 084 0 76.02 03951 WOUND CARE 3, 000 0 76.03 227, 155 1, 032, 146 3, 000 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 0 90.00 09000 CLI NI C 0 91.00 09100 EMERGENCY 19, 340 1, 990, 844 0 3, 128, 545 19, 340 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 95.00 09500 AMBULANCE SERVICES 3, 968 758, 670 1, 144, 782 3, 968 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 98.00 0 0 C 0 09900 CMHC 0 99.00 99 00 0 C 0 0 99. 10 09910 CORF 0 0 0 0 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 100 00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 309, 792 39, 758, 823 -29, 994, 520 94, 800, 600 198, 034 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,029 19, 699 1, 029 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 20, 431 192. 00 20, 431 1, 033, 803 12, 799 0 192. 01 192. 01 19201 ASC-MOB 0 0 0 192. 02 19202 EDUCATION CENTER 0 0 192. 02 0 Ω 12, 935 193. 00 19300 NONPALD WORKERS 0 0 193.00 194. 00 07950 FOUNDATI ON 0 180 Ω 3, 446 180 194. 00 194. 01 07951 ASPR BI OTERRORI SM GRANT 0 0 194, 01 0 14, 861 0 0 194. 02 194. 02 07952 CLINIC OF HOPE 0 220, 149 332, 307 194. 03 07953 MARKETI NG 821, 324 0 194. 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00

Heal th Financ	cial Systems S	ST. J	JOSEPH HOSPITAL	. & HEALTH CENT	ΓER	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS				Provi der	CCN: 150010	Peri od: From 07/01/2015	Worksheet B-1	
						To 06/30/2016		
			CAPITAL RELATED COSTS					
	Cost Center Description	-	BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliatio	on ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	
				DEPARTMENT (GROSS SALARI ES)		(ACCUM. COST)	(SQUARE FEET)	
		-	1.00	4. 00	5A	5. 00	7. 00	
	Cost to be allocated (per Wkst. B, Part I)		6, 344, 775	8, 902, 732		29, 994, 520	9, 121, 619	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part	1)	19. 143520	0. 222685		0. 309057	41. 523435	203. 00
	Cost to be allocated (per Wkst. B, Part II)			245, 420		3, 255, 538	1, 115, 866	204. 00
	Unit cost multiplier (Wkst. B, Part II)			0. 006139		0. 033544	5. 079645	205. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

			To	06/30/2016	Date/Time Prep 11/22/2016 2:	
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	42 piii
	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(TOTAL PATIENT DAYS)	(HOURS OF SERVICE)	ADMI NI STRATI ON	
	LAUNDRY)	SERVI CE)	DA13)	SERVI CE)	(DIRECT NURS.	
	8. 00	9. 00	10.00	11. 00	HRS. ) 13. 00	
GENERAL SERVICE COST CENTERS	5. 55	7.00	10.00	00	10.00	
1.00   00100   CAP REL COSTS-BLDG & FIXT 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
5. 00   00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	773, 611	407.000				8. 00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY	240, 455	196, 088 0				9. 00 10. 00
11. 00  01100   CAFETERI A	0	0	25, 503	1, 129, 639		11. 00
13. 00 01300 NURSI NG ADMINI STRATI ON	0	150		21, 244	635, 256	13. 00
15. 00   01500   PHARMACY	0	2, 287		35, 799	0	15.00
16. 00   01600   MEDICAL RECORDS & LIBRARY 23. 00   02300   SCHOOL OF RADIOLOGY-ALLIED HEALTH	0	50 0		47, 384 5, 231	0	16. 00 23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	J	0		3, 231	0	23.00
30. 00 03000 ADULTS & PEDIATRICS	249, 973	61, 834		240, 437	240, 437	30. 00
31. 00   03100   NTENSI VE CARE UNI T	61, 113	15, 000		49, 177	49, 177	31.00
41. 00   04100   SUBPROVI DER - I RF 43. 00   04300   NURSERY	24, 355 10, 228	15, 000 7, 424		45, 151 10, 597	45, 151 10, 597	41. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	10,220	7, 121	1, 7, 1	10, 077	10, 077	10.00
50. 00 05000 OPERATING ROOM	531	33, 159		134, 177	134, 177	50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY	37, 676	11, 989		39, 021	39, 021	52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	17, 322	5, 300	0	54, 448	0	53. 00 54. 00
54. 01   03630   ULTRA SOUND	3, 075	698		8, 141	0	54. 01
57. 00   05700   CT   SCAN	6, 240	0	1	10, 790	0	57. 00
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI)	1, 505	1 000	0	9, 603	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON 60. 00   06000   LABORATORY	0	1, 000 6, 449	1	3, 813 0	3, 813 0	59. 00 60. 00
65. 00 06500 RESPIRATORY THERAPY	0	530	1	47, 637	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 000	1	78, 965	0	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0	100 862		15, 212	0	67.00
68. 00   06800  SPEECH PATHOLOGY 69. 00   06900  ELECTROCARDI OLOGY	0	400		3, 234 29, 541	0	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	2, 762	1	12, 476	Ö	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 791	5, 894	0	30, 597	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 74. 00   07400   RENAL DIALYSIS	0	1, 000	0	0	0	73. 00 74. 00
76. 00 03950 BEHAVI ORAL HEALTH SERVI CES	0	2, 000		44, 872	Ö	76. 00
76. 01 03480 ONCOLOGY	0	0	0	30, 029	30, 029	76. 01
76. 02   03330   ENDOSCOPY 76. 03   03951   WOUND CARE	0	3 200	0	9, 604		76. 02
76. 03   03951 WOUND_CARE   OUTPATIENT_SERVICE_COST_CENTERS	U	3, 200	<u> </u>	10, 121	10, 121	76. 03
90. 00 09000 CLI NI C	0			0		90. 00
91. 00   09100   EMERGENCY	94, 130	18, 000	0	63, 129	63, 129	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVICES	10, 217	0	0	39, 209	0	95. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00   09900   CMHC	0	0		0	0	99. 00
99. 10   09910   CORF 100. 00   10000   I&R   SERVI CES-NOT   APPRVD   PRGM	0	0	0	0	0	99. 10 100. 00
101. 00 10100 HOME HEALTH AGENCY	0	0		0		101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE 118.00  SUBTOTALS (SUM OF LINES 1-117)	773, 611	196, 088	25, 503	1 120 (20	/ DE DE/	113.00
NONREI MBURSABLE COST CENTERS	773,011	190, 000	25, 505	1, 129, 639	635, 256	116.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192. 00
192.01 19201 ASC-MOB 192.02 19202 EDUCATION CENTER	0	0	0	0		192. 01 192. 02
193. 00 19300 NONPALD WORKERS	0	0	0	0		192. 02
194. 00 07950 FOUNDATI ON	0	0	Ō	0		194. 00
194. 01 07951 ASPR BI OTERRORI SM GRANT	0	0	0	0		194. 01
194. 02 07952  CLINIC OF HOPE 194. 03 07953  MARKETING	0	0	0	0		194. 02 194. 03
200.00 Cross Foot Adjustments		0		0		194. 03 200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	746, 659	2, 679, 672	1, 232, 644	2, 005, 862	1, 590, 979	202. 00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	0. 965161	13. 665660	48. 333294	1. 775666	2. 504469	203 00
	3. 703 10 1	13. 003000	10. 000274	1. 773300	2. 304407	

Health Fina	ncial Systems	ST. JOSEPH HOSPITAI	_ & HEALTH CENT	ER	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provi der		eri od:	Worksheet B-1	
					rom 07/01/2015 o 06/30/2016	Date/Time Pre 11/22/2016 2:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	(HOURS OF	(TOTAL PATIENT	(HOURS OF	ADMI NI STRATI ON	
		(POUNDS OF	SERVI CE)	DAYS)	SERVICE)		
		LAUNDRY)				(DIRECT NURS.	
						HRS. )	
		8. 00	9. 00	10.00	11. 00	13.00	
204.00	Cost to be allocated (per Wkst. B,	31, 129	119, 059	152, 130	197, 534	109, 045	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 040239	0. 607171	5. 965181	0. 174865	0. 171655	205. 00
	11)						

Provi der CCN: 150010

			10	06/30/2016   Date/lime Pr   11/22/2016 2	
Cost Center Description	PHARMACY (COSTED	MEDICAL RECORDS &	SCHOOL OF RADI OLOGY-ALLI	·	
	REQUIS.)	LI BRARY (GROSS	ED HEALTH (ASSI GNED		
		CHARGES)	TIME)		
GENERAL SERVICE COST CENTERS	15. 00	16. 00	23. 00		_
1. 00 O0100 CAP REL COSTS-BLDG & FLXT					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL					5. 00
7.00   00700   0PERATION OF PLANT 8.00   00800   LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00   01100   CAFETERI A					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13. 00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	4, 276, 876 0	491, 901, 371			15. 00 16. 00
23. 00 02300 SCHOOL OF RADIOLOGY-ALLIED HEALTH		471, 701, 371	44, 344, 532		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	-1		,,		
30. 00 03000 ADULTS & PEDIATRICS	0	29, 226, 908			30. 00
31. 00   03100   INTENSI VE CARE UNI T	0	7, 913, 231	0		31.00
41. 00   04100   SUBPROVI DER - I RF 43. 00   04300   NURSERY	0	5, 159, 423 3, 018, 188	1		41. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	3,010,100	0		45.00
50. 00 05000 OPERATING ROOM	0	66, 786, 823	0		50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	11, 093, 247	0		52. 00
53. 00 05300 ANESTHESI OLOGY	0	8, 326, 308	1		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   03630   ULTRA SOUND	0	22, 837, 752 7, 626, 164	22, 837, 752 7, 626, 164		54. 00 54. 01
57. 00   05700   CT   SCAN		10, 652, 209			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	O	3, 228, 407			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1, 825, 067	0		59. 00
60. 00   06000   LABORATORY 65. 00   06500   RESPI RATORY   THERAPY	0	65, 458, 819 13, 963, 576	1		60. 00 65. 00
66. 00   06600   PHYSI CAL THERAPY	0	13, 622, 093	1		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	4, 623, 031	0		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	961, 369			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	13, 889, 570	0		69.00
70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	5, 734, 024 14, 761, 382	1		70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		16, 012, 785	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 273, 168	50, 927, 229	0		73. 00
74. 00 07400 RENAL DIALYSIS	0	180, 030	0		74.00
76. 00   03950   BEHAVI ORAL   HEALTH   SERVI CES 76. 01   03480   ONCOLOGY	0	4, 997, 201 21, 629, 292			76. 00 76. 01
76. 02   03330 ENDOSCOPY	0	5, 461, 446			76. 01
76. 03   03951   WOUND CARE	0	16, 046, 842	Ö		76. 03
OUTPATIENT SERVICE COST CENTERS					
90. 00   09000   CLI NI C	0	0	0		90.00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0	57, 735, 445	0		91.00
OTHER REIMBURSABLE COST CENTERS					72.00
95. 00 09500 AMBULANCE SERVICES	0	8, 203, 510	0		95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0		98. 00
99. 00   09900   CMHC 99. 10   09910   CORF	0	0	0		99. 00 99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM		0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0		101. 00
SPECIAL PURPOSE COST CENTERS	T				
113. 00 11300   INTEREST EXPENSE	4 272 140	401 001 271	44 244 522		113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	4, 273, 168	491, 901, 371	44, 344, 532		118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	O	0	0		192. 00
192. 01 19201 ASC-MOB	0	0	0		192. 01
192. 02 19202 EDUCATI ON CENTER 193. 00 19300 NONPAI D WORKERS	0	0	0		192. 02 193. 00
194. 00 07950  FOUNDATI ON		0	0		194. 00
194. 01 07951 ASPR BIOTERRORI SM GRANT	O	0	Ö		194. 01
194. 02 07952 CLINIC OF HOPE	3, 708	0	0		194. 02
194. 03 07953 MARKETI NG	0	0	0		194. 03
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers					200. 00 201. 00
202.00   Cost to be allocated (per Wkst. B,	24, 016, 497	1, 831, 271	690, 736		201.00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I)	5. 615430	0. 003723	0. 015577		203. 00

Heal th Financ	ial Systems	ST. J0	SEPH HOSPITAL	. & HEALTH CENT	ΓER		In Lie	u of Form CMS-	2552-10
COST ALLOCATI	ON - STATISTICAL BASIS			Provi der	CCN: 150010		iod: m 07/01/2015	Worksheet B-1	
						To	06/30/2016	Date/Time Pre 11/22/2016 2:	pared: 42 pm
(	Cost Center Description		PHARMACY	MEDI CAL	SCHOOL OF				
			(COSTED	RECORDS &	RADI OLOGY-ALI	_1			
			REQUIS.)	LI BRARY	ED HEALTH				
				(GROSS	(ASSI GNED				
				CHARGES)	TIME)				
			15. 00	16. 00	23.00				
204.00	Cost to be allocated (per Wkst. B,		703, 894	113, 001	41, 31	11			204. 00
F	Part II)								
205. 00 L	Unit cost multiplier (Wkst. B, Part		0. 164581	0. 000230	0. 00093	32			205. 00
	11)								

Health Financial Systems ST.	JOSEPH HOSPITA	L & HEALTH CENT	ΓER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150010	Peri od:	Worksheet C	
				From 07/01/2015		narad.
				To 06/30/2016	Date/Time Pre 11/22/2016 2:	pared: 42 pm
		Ti +I	e XVIII	Hospi tal	PPS	42 piii
		11.61	I I	Costs	110	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
0000 00mtor 2000mptrom	(from Wkst. B,	Adj.	10141 00010	Di sal I owance	10101 00010	
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	16, 793, 198		16, 793, 19	8 0	16, 793, 198	30.00
31.00 03100 INTENSIVE CARE UNIT	3, 446, 855		3, 446, 85		3, 446, 855	
41. 00   04100   SUBPROVI DER -   RF	3, 511, 276		3, 511, 27	6 0	3, 511, 276	41.00
43. 00   04300 NURSERY	1, 042, 303		1, 042, 30		1, 042, 303	
ANCILLARY SERVICE COST CENTERS					, ,	
50. 00 05000 OPERATING ROOM	13, 584, 486		13, 584, 48	6 0	13, 584, 486	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 302, 580		2, 302, 58		2, 302, 580	
53. 00   05300   ANESTHESI OLOGY	76, 373		76, 37		76, 373	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 776, 053		5, 776, 05		5, 776, 053	
54. 01   03630   ULTRA SOUND	749, 280		749, 28		749, 280	
57. 00   05700 CT SCAN	781, 229		781, 22		781, 229	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	585, 647		585, 64		585, 647	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	266, 225		266, 22		266, 225	
60. 00   06000   LABORATORY	8, 386, 767		8, 386, 76		8, 386, 767	60.00
65. 00 06500 RESPIRATORY THERAPY	2, 586, 529	0	2, 586, 52		2, 586, 529	
66. 00   06600 PHYSI CAL THERAPY	4, 596, 830		4, 596, 83		4, 600, 576	1
67. 00 06700 OCCUPATI ONAL THERAPY	1, 772, 977		1, 772, 97		1, 772, 977	1
68. 00   06800   SPEECH PATHOLOGY	446, 173		446, 17		446, 173	
69. 00   06900   ELECTROCARDI OLOGY	2, 018, 261	٥	2, 018, 26		2, 018, 261	
70. 00 07000 ELECTROENCEPHALOGRAPHY	954, 855		954, 85		954, 855	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 096, 564		4, 096, 56		4, 096, 564	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 452, 962		5, 452, 96		5, 452, 962	
73. 00 07300 DRUGS CHARGED TO PATTENTS	24, 190, 859		24, 190, 85		24, 190, 859	1
74. 00 07400 RENAL DIALYSIS	210, 856		210, 85		210, 856	1
76. 00 03950 BEHAVI ORAL HEALTH SERVI CES	2, 821, 163		2, 821, 16		2, 821, 163	
76. 01   03480   ONCOLOGY	6, 986, 261		6, 986, 26		6, 986, 261	1
76. 02 03330 ENDOSCOPY	627, 062		627, 06		627, 062	
76. 03   03951   WOUND CARE	1, 622, 500		1, 622, 50		1, 622, 500	
OUTPATIENT SERVICE COST CENTERS	1,022,300		1,022,30	0	1, 022, 300	70.03
90. 00   09000   CLINIC	0			0 0	0	90.00
91. 00   09100   EMERGENCY	5, 720, 490		5, 720, 49		5, 720, 490	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	671, 547		671, 54		671, 547	
OTHER REIMBURSABLE COST CENTERS	071, 347		071, 34	- 7	071, 347	72.00
95. 00 09500 AMBULANCE SERVICES	1, 773, 375		1, 773, 37	5 0	1, 773, 375	95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	1,773,373		1, 773, 37	0 0	1, 773, 373	98. 00
99. 00   09900   CMHC					0	99.00
99. 10   09910   CORF				0	0	99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM				0	0	
101. 00 10100 HOME HEALTH AGENCY				0	-	100.00
SPECIAL PURPOSE COST CENTERS				<u></u>		101.00
113 OO 11300 INTEREST EVRENSE						113 00

123, 851, 536

671, 547 123, 179, 989 123, 851, 536

671, 547 123, 179, 989 113. 00 123, 855, 282 200. 00 671, 547 201. 00 123, 183, 735 202. 00

3, 746

3, 746

113. 00 11300 INTEREST EXPENSE
200. 00 Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

201.00

202.00

In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 150010 Peri od: Worksheet C From 07/01/2015 Part I Date/Time Prepared: 06/30/2016 11/22/2016 2:42 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 26, 237, 632 26, 237, 632 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 913, 231 7, 913, 231 31.00 04100 SUBPROVI DER - I RF 41.00 5, 159, 423 5, 159, 423 41.00 3, 018, 188 43.00 04300 NURSERY 3, 018, 188 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 24, 315, 470 42, 471, 353 66, 786, 823 0. 203401 0.000000 50.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 10, 014, 353 1,078,894 11, 093, 247 0. 207566 0.000000 52.00 05300 ANESTHESI OLOGY 5, 102, 873 0.009172 3, 223, 435 8, 326, 308 0.000000 53.00 53.00 0. 252917 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 3, 228, 879 19, 608, 873 22, 837, 752 54 00 54.01 03630 ULTRA SOUND 1, 239, 238 6, 386, 926 7, 626, 164 0.098251 0.000000 54.01 57.00 05700 CT SCAN 2, 203, 533 8, 448, 676 10, 652, 209 0.073340 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 678, 018 3, 228, 407 0.181404 0.000000 58.00 550, 389 58.00 05900 CARDIAC CATHETERIZATION 59.00 444.914 1, 380, 153 1, 825, 067 0.145871 0.000000 59.00 06000 LABORATORY 25, 511, 033 39, 947, 786 65, 458, 819 0.128123 0.000000 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 10, 157, 983 3, 805, 593 13, 963, 576 0.185234 0.000000 65.00 06600 PHYSI CAL THERAPY 3.824.303 9, 797, 790 13, 622, 093 66.00 0.337454 0.000000 66,00 67.00 06700 OCCUPATIONAL THERAPY 3, 024, 248 1, 598, 783 4, 623, 031 0.383510 0.000000 67.00 06800 SPEECH PATHOLOGY 961, 369 0.464102 0.000000 68.00 564, 402 396, 967 68.00 06900 ELECTROCARDI OLOGY 2, 208, 236 11, 681, 334 13, 889, 570 0.145308 0.000000 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 170,668 5, 563, 356 5, 734, 024 0.166524 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 8, 281, 605 6, 479, 777 14, 761, 382 0.277519 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 12, 573, 418 3, 439, 367 16, 012, 785 0.340538 0.000000 72.00 42, 410, 918 73 00 07300 DRUGS CHARGED TO PATIENTS 8, 516, 311 50, 927, 229 0 475008 0.000000 73 00 74.00 07400 RENAL DIALYSIS 173, 460 6, 570 180, 030 1.171227 0.000000 74.00 76.00 03950 BEHAVIORAL HEALTH SERVICES 51, 999 4, 945, 202 4, 997, 201 0.564549 0.000000 76.00 76. 01 03480 ONCOLOGY 360, 635 21, 268, 657 21, 629, 292 0.323000 0.000000 76.01 03330 ENDOSCOPY 4, 969, 820 76.02 491,626 5, 461, 446 0.114816 0.000000 76.02 76.03 03951 WOUND CARE 220, 301 15, 826, 541 16, 046, 842 0.101110 0.000000 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 0.000000 90 00 09100 EMERGENCY 91.00 10, 371, 088 47, 364, 357 57, 735, 445 0.099081 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 989, 276 2, 989, 276 0. 224652 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVI CES 0 216173 0.000000 95 00 59,896 8.143.614 8, 203, 510 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 0.000000 0.000000 98.00 09900 CMHC 0 0 99.00 99.00 0 99. 10 09910 CORF 0 0 0 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100 00 Ω 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS

317, 791, 474

317, 791, 474

491, 901, 371

491, 901, 371

174, 109, 897

174, 109, 897

113.00

200 00

201.00

202.00

113. 00 11300 I NTEREST EXPENSE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201.00

202.00

Health Financial Systems	ST. JOSEPH HOSPITAL & H	EALTH CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 150010	Peri od: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/22/2016 2:42 pm

				11/22/2016 2:42 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Rati o			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
41. 00   04100   SUBPROVI DER -   RF				41. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 203401			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 207566			52. 00
53. 00   05300   ANESTHESI OLOGY	0. 009172			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 252917			54. 00
54. 01   03630   ULTRA SOUND	0. 098251			54. 01
57. 00   05700 CT SCAN	0. 073340			57. 00
58.00 05700 MAGNETIC RESONANCE IMAGING (MRI)	0. 073340			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 145871			59.00
60. 00 06000 LABORATORY	0. 128123			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 185234			65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 337729			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 383510			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 464102			68. 00
69. 00  06900  ELECTROCARDI OLOGY	0. 145308			69. 00
70. 00  07000   ELECTROENCEPHALOGRAPHY	0. 166524			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 277519			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 340538			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 475008			73.00
74. 00 07400 RENAL DIALYSIS	1. 171227			74.00
76. 00 03950 BEHAVI ORAL HEALTH SERVI CES	0. 564549			76. 00
76. 01 03480 ONCOLOGY	0. 323000			76. 01
76. 02   03330 ENDOSCOPY	0. 114816			76. 02
76. 03 03951 WOUND CARE	0. 101110			76. 03
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00   09100   EMERGENCY	0. 099081			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 224652			92. 00
OTHER REIMBURSABLE COST CENTERS	0. 22 1002			72. 00
95. 00 09500 AMBULANCE SERVICES	0. 216173			95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 210173			98.00
99. 00   09900   OHER RETMBURSABLE COST CENTERS	0.00000			98.00
99. 10   09910   CORF				99.00
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM				100.00
101. 00 10100 HOME HEALTH AGENCY				101. 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)				202. 00

		JUSEPH HUSPITAL				u or Form Cws	2332-10
COMPUT	FATION OF RATIO OF COSTS TO CHARGES		Provi der	F	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Pre	pared:
						11/22/2016 2:	42 pm
			Ti t	le XIX	Hospi tal	Cost	
			 	<del>-</del>	Costs	o .	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS	16, 793, 198		16, 793, 198	3 0	16, 793, 198	30.00
31. 00	03100 I NTENSI VE CARE UNI T	3, 446, 855		3, 446, 855		3, 446, 855	
41. 00	04100 SUBPROVI DER – I RF	3, 511, 276		3, 511, 276		3, 511, 276	
43. 00	04300 NURSERY	1, 042, 303		1, 042, 303		1, 042, 303	
43.00	ANCI LLARY SERVI CE COST CENTERS	1,042,303		1, 042, 300	9	1, 042, 303	45.00
50. 00	05000 OPERATING ROOM	13, 584, 486		13, 584, 486	0	13, 584, 486	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 302, 580		2, 302, 580		2, 302, 580	
53. 00	05300 ANESTHESI OLOGY	76, 373		76, 373		76, 373	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 776, 053		5, 776, 053		5, 776, 053	
54. 01	03630 ULTRA SOUND	749, 280		749, 280		749, 280	
57. 00	05700 CT SCAN	781, 229		781, 229		781, 229	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	585, 647		585, 647		585, 647	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	266, 225		266, 225		266, 225	59.00
60.00	06000 LABORATORY	8, 386, 767		8, 386, 767		8, 386, 767	60.00
65. 00	06500 RESPI RATORY THERAPY	2, 586, 529		2, 586, 529		2, 586, 529	
66. 00	06600 PHYSI CAL THERAPY	4, 596, 830				4, 600, 576	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 772, 977		1, 772, 977		1, 772, 977	67. 00
68. 00	06800 SPEECH PATHOLOGY	446, 173		446, 173		446, 173	
69. 00	06900 ELECTROCARDI OLOGY	2, 018, 261		2, 018, 261		2, 018, 261	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	954, 855		954, 855		954, 855	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 096, 564		4, 096, 564		4, 096, 564	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	5, 452, 962		5, 452, 962		5, 452, 962	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	24, 190, 859		24, 190, 859		24, 190, 859	
74. 00	07400 RENAL DIALYSIS	210, 856		210, 856		210, 856	
76. 00	03950 BEHAVI ORAL HEALTH SERVI CES	2, 821, 163		2, 821, 163		2, 821, 163	
76. 01	03480 ONCOLOGY	6, 986, 261		6, 986, 261		6, 986, 261	76. 01
76. 02	03330 ENDOSCOPY	627, 062		627, 062		627, 062	
76. 03	03951 WOUND CARE	1, 622, 500		1, 622, 500		1, 622, 500	1
	OUTPATIENT SERVICE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	l.	.,,	-1	.,,,	
90.00	09000 CLI NI C	0			0	0	90.00
91. 00	09100 EMERGENCY	5, 720, 490		5, 720, 490		5, 720, 490	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	671, 547		671, 547		671, 547	92. 00
	OTHER REIMBURSABLE COST CENTERS				1		
95.00	09500 AMBULANCE SERVI CES	1, 773, 375		1, 773, 375	5 0	1, 773, 375	95. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	l .			0	
99. 00	09900 CMHC	0				0	99. 00
99. 10	09910 CORF	0				0	99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0				0	1
	10100 HOME HEALTH AGENCY	0				0	101. 00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300   NTEREST EXPENSE						113. 00
200.00		123, 851, 536	0	123, 851, 536	3, 746	123, 855, 282	
201.00		671, 547		671, 547		671, 547	
202.00	Total (see instructions)	123, 179, 989		123, 179, 989	3, 746	123, 183, 735	202. 00
		•	•	•			•

Health Financial Systems	ST. JOSEPH HOSPITAL & H	EALTH CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 150010	Peri od: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/22/2016 2:42 pm

				11/22/2016 2:42 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
41. 00   04100   SUBPROVI DER -   RF				41.00
43. 00   04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
54. 01 03630 ULTRA SOUND	0. 000000			54. 01
57. 00   05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00   06000   LABORATORY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
74. 00 07400 RENAL DIALYSIS	0. 000000			74.00
76. 00 03950 BEHAVI ORAL HEALTH SERVI CES	0. 000000			74.00
76. 01   03480   ONCOLOGY	0. 000000			76. 00
76. 02   03330   ENDOSCOPY	0. 000000			76. 01
76. 03   03951   WOUND CARE	0. 000000			76. 02
OUTPATIENT SERVICE COST CENTERS	0.000000			70.03
90. 00   09000   CLINIC	0. 000000			90.00
91. 00   09100   EMERGENCY	0. 000000			91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	0.000000			92.00
	0.000000			0F 00
95. 00   09500   AMBULANCE SERVICES 98. 00   09850   OTHER REI MBURSABLE COST CENTERS	0.000000			95. 00 98. 00
	0. 000000			
99. 00   09900   CMHC				99. 00
99. 10   09910   CORF				99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM				100.00
101. 00 10100 HOME HEALTH AGENCY				101. 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)				202. 00

Heal th Financial Systems ST. JOSEPH HOSPI CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Provi der CCN: 150010

					00/30/2010	11/22/2016 2:	
			Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	·		(Wkst. B, Part	Net of Capital	Reducti on	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
		·		col . 2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	13, 584, 486	1, 171, 124	12, 413, 362	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 302, 580	154, 915	2, 147, 665	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	76, 373	9, 493	66, 880	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 776, 053	756, 260	5, 019, 793	0	0	54.00
54.01	03630 ULTRA SOUND	749, 280	20, 484	728, 796	0	0	54. 01
57.00	05700 CT SCAN	781, 229	20, 652	760, 577	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	585, 647	17, 175	568, 472	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	266, 225	17, 917	248, 308	0	0	59. 00
60.00	06000 LABORATORY	8, 386, 767	408, 456	7, 978, 311	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	2, 586, 529			0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 596, 830	310, 550	4, 286, 280	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 772, 977		1, 648, 687	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	446, 173			0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 018, 261	155, 665		0	0	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	954, 855		1	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 096, 564			0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	5, 452, 962			0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	24, 190, 859		1	0	Ö	1 /2.00
74. 00	07400 RENAL DIALYSIS	210, 856		1	0	0	1
76. 00	03950 BEHAVI ORAL HEALTH SERVI CES	2, 821, 163			0	0	76.00
76. 01	03480 ONCOLOGY	6, 986, 261	195, 162		0	0	1
76. 01	03330 ENDOSCOPY				0	0	1
76. 02	03951 WOUND CARE	627, 062 1, 622, 500		1	0	0	
70.03	OUTPATIENT SERVICE COST CENTERS	1, 622, 300	117,020	1, 304, 672		0	76.03
90. 00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	5, 720, 490			0		
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	671, 547			0		
92.00	OTHER REIMBURSABLE COST CENTERS	0/1, 34/	52, 673	010, 074	0	0	92.00
95. 00	09500 AMBULANCE SERVICES	1, 773, 375	148, 329	1, 625, 046	0	0	95. 00
	1	1, 773, 375			0	-	70.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	
99. 00	09900 CMHC	0		0	0	0	
99. 10	09910 CORF	0		0	0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0		0	0		100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
440.00	SPECIAL PURPOSE COST CENTERS					<u> </u>	140.00
	11300 I NTEREST EXPENSE	00 057 00.	F 040 040	00 000 005	-		113.00
200.00		99, 057, 904			0		200.00
201.00		671, 547			0		201. 00
202.00	Total (line 200 minus line 201)	98, 386, 357	5, 796, 246	92, 590, 111	0	1 0	202. 00

REDUCTIONS FOR MEDICALD ONLY

					11/22/2016 2:42 pm	1
			le XIX	Hospi tal	Cost	
Cost Center Description	Cost Net of	Total Charges				
	Capital and	(Worksheet C,	Cost to Charg	je		
		Part I, column		6		
	Reducti on	8)	/ col. 7)			
	6.00	7.00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	13, 584, 486	66, 786, 823	0. 20340	)1	50.0	00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 302, 580	11, 093, 247	0. 20756	6	52.0	00
53. 00 05300 ANESTHESI OLOGY	76, 373				53.0	00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 776, 053			7	54.0	00
54. 01   03630   ULTRA SOUND	749, 280		1		54.0	01
57. 00   05700   CT   SCAN	781, 229				57. 0	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	585, 647				58.0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	266, 225				59. 0	
60. 00   06000   LABORATORY	8, 386, 767				60.0	
65. 00 06500 RESPIRATORY THERAPY	2, 586, 529				65. 0	
66. 00   06600 PHYSI CAL THERAPY	4, 596, 830				66. 0	
l			1		67. 0	
l	1, 772, 977				68.0	
	446, 173				68.0	
69. 00 06900 ELECTROCARDI OLOGY	2, 018, 261		1			
70. 00 07000 ELECTROENCEPHALOGRAPHY	954, 855				70. 0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 096, 564		1		71. 0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	5, 452, 962				72. 0	
73.00 07300 DRUGS CHARGED TO PATIENTS	24, 190, 859				73. 0	
74. 00   07400   RENAL DI ALYSI S	210, 856				74.0	
76.00 03950 BEHAVI ORAL HEALTH SERVI CES	2, 821, 163				76. 0	
76. 01   03480   ONCOLOGY	6, 986, 261	21, 629, 292	0. 32300	00	76. 0	
76. 02   03330   ENDOSCOPY	627, 062	5, 461, 446	0. 11481	6	76. 0	02
76. 03 03951 WOUND CARE	1, 622, 500	16, 046, 842	0. 10111	0	76. 0	03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C	0.00000	00	90. 0	00
91. 00 09100 EMERGENCY	5, 720, 490	57, 735, 445	0. 09908	31	91.0	00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	671, 547	2, 989, 276	0. 22465	52	92. 0	00
OTHER REIMBURSABLE COST CENTERS	•					
95. 00 09500 AMBULANCE SERVI CES	1, 773, 375	8, 203, 510	0. 21617	'3	95. 0	00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0		0.00000	00	98. 0	00
99. 00 09900 CMHC	0	l c	0.00000		99. 0	
99. 10   09910   CORF		d	0.00000		99. 1	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM			0.00000		100. 0	
101. 00 10100 HOME HEALTH AGENCY			1		101. 0	
SPECIAL PURPOSE COST CENTERS			η 0.00000	,0	101.0	50
113. 00 11300   NTEREST EXPENSE					113. 0	വ
200.00 Subtotal (sum of lines 50 thru 199)	99, 057, 904	449, 572, 897	,		200. 0	
201.00 Less Observation Beds	671, 547				200. 0	
202.00 Total (line 200 minus line 201)	98, 386, 357		()		201. 0	
202.00   Total (Title 200 IIII hus Title 201)	70, 300, 337	1 447, 312, 091	I		J202. 0	50

Health Financial Systems	ST. JOSEPH HOSPITAL	L & HEALTH CENT	TER	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	ITAL COSTS	Provi der		Period: From 07/01/2015 Fo 06/30/2016	Date/Time Pre 11/22/2016 2:	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 317, 180	0	1, 317, 180	18, 380	71. 66	30.00
31.00 INTENSIVE CARE UNIT	256, 135		256, 13	5 2, 331	109. 88	31.00
41. 00 SUBPROVI DER - I RF	443, 703	0	443, 70	3, 553	124. 88	41.00
43. 00 NURSERY	80, 469		80, 46	9 1, 974	40. 76	43.00
200.00 Total (lines 30-199)	2, 097, 487		2, 097, 48	7 26, 238		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8, 064	577, 866				30. 00
31.00 INTENSIVE CARE UNIT	1, 497	164, 490				31.00
41. 00 SUBPROVI DER - I RF	2, 780	347, 166				41. 00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	12, 341	1, 089, 522	2			200. 00

Health Financial Systems	ST. JOSEPH HOSPITAL & H	EALTH CENTER	In Lie	u of Form CMS-2552-10
ADDODTIONMENT OF INDATIENT A	NCLLLARY SERVICE CARLTAL COSTS	Provider CCN: 150010	Pari od:	Workshoot D

Health Financial Systems ST.	JOSEPH HOSPITA	L & HEALTH CENT	ΓER	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Pre 11/22/2016 2:	pared: 42 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	Inpati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	,					
50.00   05000   OPERATING ROOM	1, 171, 124				226, 728	
52.00   05200   DELIVERY ROOM & LABOR ROOM	154, 915				317	52. 00
53. 00   05300   ANESTHESI OLOGY	9, 493				1, 917	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	756, 260	22, 837, 752			63, 811	54.00
54. 01  03630  ULTRA SOUND	20, 484				1, 766	
57. 00  05700   CT   SCAN	20, 652				229	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	17, 175	3, 228, 407	0. 00532		1, 476	
59. 00   05900   CARDI AC   CATHETERI ZATI ON	17, 917	1, 825, 067	0. 00981	7 311, 273	3, 056	59. 00
60. 00   06000   LABORATORY	408, 456	65, 458, 819	0. 00624	0 12, 686, 111	79, 161	60.00
65. 00 06500 RESPIRATORY THERAPY	110, 859	13, 963, 576	0. 00793	9 5, 598, 000	44, 443	65.00
66. 00 06600 PHYSI CAL THERAPY	310, 550	13, 622, 093	0. 02279	8 1, 441, 673	32, 867	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	124, 290	4, 623, 031	0. 02688	5 1, 010, 129	27, 157	67. 00
68.00 06800 SPEECH PATHOLOGY	37, 358	961, 369	0. 03885	9 266, 635	10, 361	68. 00
69. 00 06900 ELECTROCARDI OLOGY	155, 665	13, 889, 570	0. 01120	7 1, 896, 436	21, 253	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	92, 792	5, 734, 024	0. 01618	3 95, 254	1, 541	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	214, 181	14, 761, 382	0. 01451	0 4, 626, 663	67, 133	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	141, 897	16, 012, 785	0. 00886	1 7, 990, 744	70, 806	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	715, 158	50, 927, 229	0. 01404	3 4, 599, 394	64, 589	73. 00
74. 00 07400 RENAL DIALYSIS	5, 684	180, 030	0. 03157	3 112, 891	3, 564	74. 00
76. 00 03950 BEHAVI ORAL HEALTH SERVI CES	194, 191	4, 997, 201	0. 03886	o o	0	76. 00
76. 01 03480 ONCOLOGY	195, 162	21, 629, 292	0.00902	3 219, 112	1, 977	76. 01
76. 02 03330 ENDOSCOPY	20, 313	5, 461, 446	0. 00371	9 433, 049	1, 611	76. 02
76. 03 03951 WOUND CARE	117, 828	16, 046, 842	0.00734	3 0	0	76. 03
OUTPATIENT SERVICE COST CENTERS	<u>'</u>					1
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
91. 00 09100 EMERGENCY	635, 513	57, 735, 445	0. 01100	7 5, 555, 661	61, 151	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	52, 673	2, 989, 276	0. 01762	1 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES						95.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.00000	ol ol	0	98.00
200.00 Total (lines 50-199)	5, 700, 590	441, 369, 387		64, 457, 876	786, 914	200. 00

Health Financial Systems ST.	JOSEPH HOSPITA	L & HEALTH CEN	ΓER	In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS   Provider CCN: 150010   Period:   Worksheet D					
				From 07/01/2015		
To 06/30/2016   Date/Time Prepare						
		Ti tl	e XVIII	Hospi tal	PPS	72 piii
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
	,	Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1. 00	2.00	3.00	4. 00	5. 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
41. 00   04100   SUBPROVI DER -   I RF	0	0	)	0	0	41.00
43. 00   04300   NURSERY	0	0	)	0	0	43.00
200.00 Total (lines 30-199)	0	0		0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	18, 380					30.00
31.00 03100 INTENSIVE CARE UNIT	2, 331					31. 00
41. 00   04100   SUBPROVI DER - I RF	3, 553			0		41. 00
43. 00   04300   NURSERY	1, 974	0.00	1	0 0		43.00
200.00   Total (lines 30-199)	26, 238		12, 34	1 0	l	200. 00

Health Financial Systems	ST. JOSEPH HOSPITAL & F	HEALTH CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENTHROUGH COSTS	T ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150010	Peri od: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared:

				1	o 06/30/2016	Date/lime Pre 11/22/2016 2:	pared:
			Ti tl	e XVIII	Hospi tal	PPS	72 piii
	Cost Center Description	Non Physician			All Other	Total Cost	
	<b>'</b>	Anesthetist	3		Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	05400  RADI OLOGY-DI AGNOSTI C	0	0	355, 725		355, 725	54.00
54. 01	03630 ULTRA SOUND	0	0	118, 793	0	118, 793	54. 01
57. 00	05700 CT SCAN	0	0	165, 929		165, 929	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	50, 289	0	50, 289	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76. 00	03950 BEHAVI ORAL HEALTH SERVI CES	0	0	0	0	0	76. 00
76. 01	03480 ONCOLOGY	0	0	0	0	0	76. 01
76. 02	03330 ENDOSCOPY	O	0	0	0	0	76. 02
76. 03	03951 WOUND CARE	0	0	0	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91. 00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	O	0	0	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
200.00	Total (lines 50-199)	0	0	690, 736	0	690, 736	200. 00
		•					

Health Financial Systems	al Systems ST. JOSEPH HOSPITAL & HEALTH CENTER In Lieu					
APPORTIONMENT OF INPATIENT/OUTPATIENT AND THROUGH COSTS	ILLARY SERVICE OTHER PASS	Provider CCN: 150010	Peri od: From 07/01/2015	Worksheet D		
HIROUGH COSTS				Date/Time Prep 11/22/2016 2:4		
		Title XVIII	Hospi tal	PPS		
Cost Center Description	Total To	otal Charges Ratio of Co	st Outpatient	Inpati ent		

Total Outpatient   Total Outpa								11/22/2016 2:	
Cost (sum of col 2, 3 and 4)					Ti tl	e XVIII	Hospi tal	PPS	
Cost (sum of col. 2, 3 and all and col. 1, col. (col. 5 * col. 7)   Col. 6 * col. 7)		Cost Center Description	Total	Total	Charges	Ratio of Cost	Outpati ent	I npati ent	
Col. 2, 3 and 4  8  77   (Col. 6 * Col. 7)				(from	Wkst. C,	to Charges	Ratio of Cost	Program	
ANCILLARY SERVICE COST CENTERS			Cost (sum of	Part	I, col.	(col. 5 ÷ col.	to Charges	Charges	
ANCILLARY SERVICE COST CENTERS			col . 2, 3 and		8)	7)	(col. 6 ÷ col.		
ANCILLARY SERVICE COST CENTERS   Service CO			4)				7)		
50.00   05000   05000   05000   0.000000   12, 930, 005   50.00   05200   0.000000   12, 930, 005   50.00   0.000000   0.000000   12, 930, 005   50.00   0.000000   0.000000   12, 930, 005   50.00   0.000000   0.000000   12, 930, 005   50.00   11, 093, 247   0.000000   0.000000   0.000000   12, 930, 005   52.00   0.000000   0.000000   12, 930, 005   52.00   0.000000   0.000000   12, 930, 005   52.00   0.000000   0.000000   12, 930, 005   52.00   0.000000   0.000000   12, 930, 005   52.00   0.000000   0.000000   12, 930, 005   52.00   0.000000			6.00	•	7. 00	8. 00	9. 00	10.00	
S2.00   05200   DELI VERY ROOM & LABOR ROOM   0   11, 093, 247   0.000000   0.000000   0.000000   1.681, 964   53.00   0.000000   0.000000   1.681, 964   53.00   0.000000   0.000000   1.681, 964   53.00   0.000000   0.000000   1.681, 964   53.00   0.000000   0.000000   1.681, 964   53.00   0.000000   0.000000   1.0000000   1.000000   1.000000   1.0000000   1.0000000   1.0000000   1.0000000   1.0000000   1.0000000   1.0000000   1.000000   1.00000									
53.00   05.0	50.00	05000 OPERATING ROOM	0	6	6, 786, 823	0.00000	0. 000000	12, 930, 005	50. 00
54.00   05400   RADIOLOGY_DIAGNOSTIC   355,725   22,837,752   0.015576   0.015576   1,927,010   54.01   03630   ULTRA SOUND   118,793   7,626,164   0.015577   0.015577   657,480   57,400   57,400   57,400   57,400   57,400   57,400   57,400   57,400   57,400   58,00   05700   CT SCAN   165,929   10,652,209   0.015577   0.015577   118,300   57,00   05900   CARDIA C CATHETERI ZATI ON   0 18,25,067   0.000000   0.000000   0.000000   311,273   59,00   0.00000   0.000000   12,686,111   60.00   65,458,819   0.000000   0.000000   1,441,673   65.00   66500   RESPI RATORY   THERAPY   0 13,963,576   0.000000   0.000000   0.000000   1,441,673   66.00   66.00   6600   PHYSI CAL THERAPY   0 13,963,576   0.000000   0.000000   1,441,673   66.00   66.00   6600   PHYSI CAL THERAPY   0 14,623,031   0.000000   0.000000   1,441,673   66.00   66.00   6600   PHYSI CAL THERAPY   0 14,623,031   0.000000   0.000000   1,441,673   66.00   66.00   6600   PHYSI CAL THERAPY   0 14,623,031   0.000000   0.000000   1,441,673   66.00   66.00   6600   PHYSI CAL THERAPY   0 14,623,031   0.000000   0.000000   1,441,673   66.00   66.00   6600   PHYSI CAL THERAPY   0 14,623,031   0.000000   0.000000   1,441,673   66.00   66.00   6600   PHYSI CAL THERAPY   0 14,623,031   0.000000   0.000000   1,441,673   66.00   66.00   6600   PHYSI CAL THERAPY   0 14,623,031   0.000000   0.000000   1,441,673   66.00   66.00   6600   PHYSI CAL THERAPY   0 14,623,031   0.000000   0.000000   1,441,673   66.00   66.00   6600   PHYSI CAL THERAPY   0 14,623,031   0.000000   0.000000   1,441,673   66.00   66.00   6600   PHYSI CAL THERAPY   0 14,623,031   0.000000   0.000000   1,441,673   66.00   66.00   66.00   6600   PHYSI CAL THERAPY   0 14,623,031   0.000000   0.000000   1,441,673   66.00   66.00   66.00   66.00   6600	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1	1, 093, 247	0.00000	0. 000000	22, 692	52. 00
54. 01 03630 ULTRA SOUND 118, 793 7, 626, 164 0.015577 0.015577 657, 480 54. 01 57. 00 05700 CT SCAN 165, 929 10, 6552, 209 0.015577 0.015577 17, 400 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI ) 50, 289 3, 228, 407 0.015577 0.015577 277, 400 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI ) 50, 289 3, 228, 407 0.015577 0.015577 277, 400 58. 00 05900 CARDI AC CATHETERI ZATI ON 0 1, 225, 067 0.000000 0.000000 311, 273 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 1, 255, 067 0.000000 0.000000 0.000000 12, 686, 111 60. 00 06500 RESPI RATORY THERAPY 0 13, 643, 576 0.000000 0.000000 0.000000 12, 686, 111 60. 00 06600 PHYSI CAL THERAPY 0 13, 643, 576 0.000000 0.000000 0.000000 1, 441, 673 66. 00 06600 PHYSI CAL THERAPY 0 4, 623, 031 0.000000 0.000000 1, 441, 673 66. 00 06800 SPEECH PATHOLOGY 0 961, 369 0.000000 0.000000 1, 441, 673 66. 00 06800 SPEECH PATHOLOGY 0 961, 369 0.000000 0.000000 0.000000 1, 441, 673 67. 00 07000 ELECTROCARDI OLOGY 0 13, 889, 570 0.000000 0.000000 0.000000 1, 896, 436 69. 00 07000 ELECTROCARDI OLOGY 0 13, 889, 570 0.000000 0.000000 0.000000 1, 896, 436 69. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 14, 761, 382 0.000000 0.000000 4, 626, 663 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 14, 761, 382 0.000000 0.000000 4, 626, 663 71. 00 07400 RENAL DI ALYSI S 0 180, 030 0.000000 0.000000 4, 599, 934 73. 00 07400 RENAL DI ALYSI S 0 180, 030 0.000000 0.000000 112, 891 74. 00 07400 RENAL DI ALYSI S 0 180, 030 0.000000 0.000000 0.000000 12, 112, 891 74. 00 07400 RENAL DI ALYSI S 0 180, 030 0.000000 0.000000 0.000000 0.000000 0.000000	53.00	05300 ANESTHESI OLOGY	0	) :	8, 326, 308	0.00000	0. 000000	1, 681, 964	53. 00
57. 00   05700   CT SCAN   165, 929   10, 652, 209   0. 015577   0. 015577   277, 400   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   50, 289   3, 228, 407   0. 015577   0. 015577   277, 400   58. 00   05900   CARDI AC CATHETERI ZATI ON   0   1, 825, 067   0. 000000   0. 000000   311, 273   59. 00   60. 00   06000   LABORATORY   0   65, 458, 819   0. 000000   0. 000000   12, 686, 111   60. 00   65. 00   06500   RESPI RATORY THERAPY   0   13, 963, 576   0. 000000   0. 000000   5, 598, 000   65. 00   66. 00   06600   PHSI CAL THERAPY   0   13, 622, 093   0. 000000   0. 000000   1, 411, 673   66. 00   66. 00   06600   PHSI CAL THERAPY   0   4, 623, 031   0. 000000   0. 000000   1, 411, 673   66. 00   66. 00   06900   ELECTROCARDI OLOGY   0   13, 899, 570   0. 000000   0. 000000   266, 635   68. 00   6800   SPEECH PATHOLOGY   0   13, 899, 570   0. 000000   0. 000000   1, 896, 436   69. 00   69	54.00	05400 RADI OLOGY-DI AGNOSTI C	355, 725	2:	2, 837, 752	0. 01557	0. 015576	1, 927, 010	54. 00
58. 00   05800   MAGNETIC RESONANCE I IMAGING (MRI)   50, 289   3, 228, 407   0. 015577   0. 015577   277, 400   58. 00   59. 00   05900   CARDI AC CATHETERIZATION   0   1, 825, 067   0. 000000   0. 000000   311, 273   59. 00   60. 00   0. 06000   LABORATORY   0   65, 458, 819   0. 000000   0. 000000   12, 686, 111   60. 00   66. 00   0. 06000   CARDI AC CATHETERIZATION   0   13, 963, 576   0. 000000   0. 000000   5, 598, 000   65. 00   66. 00   0. 06500   RESPI RATORY THERAPY   0   13, 622, 093   0. 000000   0. 000000   1, 441, 673   66. 00   67. 00   0. 06700   0. 000000   0. 000000   0. 000000   1, 441, 673   66. 00   67. 00   0. 06700   0. 000000   0. 000000   0. 000000   1, 441, 673   67. 00   0. 06800   SPEECH PATHOLOGY   0   961, 369   0. 000000   0. 000000   2.66, 635   68. 00   69. 00   0. 000000   0. 000000   2.66, 635   68. 00   0. 000000   0. 000000   0. 000000   2.66, 635   68. 00   0. 000000   0. 000000   0. 000000   2.66, 635   68. 00   0. 000000	54. 01		118, 793	·	7, 626, 164	0. 01557	0. 015577	657, 480	54. 01
59. 00   05900   CARDI AC CATHETERI ZATI ON   0   1, 825, 067   0.000000   0.000000   311, 273   59. 00   60. 00   06000   LABORATORY   0   65, 458, 819   0.000000   0.000000   12, 686, 111   60. 00   65. 00   06500   RESPI RATORY THERAPY   0   13, 623, 973   0.000000   0.000000   1, 441, 673   66. 00   66. 00   06600   PHYSI CAL THERAPY   0   13, 622, 093   0.000000   0.000000   1, 441, 673   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   0   4, 623, 031   0.000000   0.000000   1, 1010, 129   67. 00   68. 00   06800   SPECH PATHOLOGY   0   961, 369   0.000000   0.000000   1, 896, 436   69. 00   69. 00   06900   ELECTROCARDI OLOGY   0   13, 889, 570   0.000000   0.000000   1, 896, 436   69. 00   69. 00   07000   ELECTROCARDI OLOGY   0   5, 734, 024   0.000000   0.000000   95, 254   70. 00   67. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   14, 761, 382   0.000000   0.000000   4, 626, 663   71. 00   67. 00   07300   DRUGS CHARGED TO PATI ENTS   0   16, 012, 785   0.000000   0.000000   4, 599, 394   73. 00   67. 00   03950   BEHAVI ORAL HEALTH SERVI CES   0   4, 997, 201   0.000000   0.000000   112, 891   74. 00   67. 00   03950   BONDOSCOPY   0   21, 629, 292   0.000000   0.000000   0.000000   0.76. 00   67. 00   03950   ODDOSCOPY   0   5, 461, 446   0.000000	57.00	05700 CT SCAN	165, 929	10	0, 652, 209	0. 01557	0. 015577	118, 300	57.00
60. 00   06000   LABORATORY   0   65, 458, 819   0. 000000   0. 000000   12, 686, 111   60. 00   65. 00   06500   RESPIRATORY THERAPY   0   13, 622, 093   0. 000000   0. 000000   1, 416, 73   66. 00   06600   PHYSI CAL THERAPY   0   13, 622, 093   0. 000000   0. 000000   1, 417, 73   66. 00   06700   0CCUPATI ONAL THERAPY   0   4, 623, 031   0. 000000   0. 000000   1, 010, 129   67. 00   68. 00   06800   SPECH PATHOLOGY   0   961, 369   0. 000000   0. 000000   1, 610, 129   67. 00   69. 00   07000   ELECTROCARDI OLOGY   0   13, 889, 570   0. 000000   0. 000000   1, 896, 436   69. 00   07000   ELECTROENCEPHALOGRAPHY   0   5, 734, 024   0. 000000   0. 000000   95, 254   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   14, 761, 382   0. 000000   0. 000000   4, 626, 663   71. 00   72. 00   7200   IMPL. DEV. CHARGED TO PATI ENTS   0   16, 012, 785   0. 000000   0. 000000   4, 599, 394   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   180, 030   0. 000000   0. 000000   112, 891   74. 00   76. 00   07400   RENAL DI ALYSI S   0   180, 030   0. 000000   0. 000000   112, 891   74. 00   76. 00   03950   BEHAVI ORAL HEALTH SERVI CES   0   4, 997, 201   0. 000000   0. 000000   219, 112   76. 01   76. 01   03480   0NCOLOGY   0   21, 629, 292   0. 000000   0. 000000   219, 112   76. 01   76. 02   03330   RENDSCOPY   0   21, 629, 292   0. 000000   0. 000000   219, 112   76. 01   76. 02   03951   WOUND CARE   0   16, 046, 842   0. 000000	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	50, 289	) :	3, 228, 407	0. 01557	0. 015577	277, 400	58. 00
65. 00	59.00	05900 CARDI AC CATHETERI ZATI ON	0	)	1, 825, 067	0.00000	0.000000	311, 273	59. 00
66. 00 06600 PHYSICAL THERAPY 0 13, 622, 093 0.000000 0.000000 1, 441, 673 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 4, 623, 031 0.000000 0.000000 1, 010, 129 67. 00 68. 00 06800 SPECH PATHOLOGY 0 961, 369 0.000000 0.000000 1, 896, 436 69. 00 06900 ELECTROCARDI OLOGY 0 13, 889, 570 0.000000 0.000000 1, 896, 436 69. 00 070. 00 07000 ELECTROENCEPHALOGRAPHY 0 5, 734, 024 0.000000 0.000000 1, 896, 436 69. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 14, 761, 382 0.000000 0.000000 4, 626, 663 71. 00 072. 00 072. 00 072. 00 072. 00 072. 00 072. 00 072. 00 073	60.00	06000 LABORATORY	0	6!	5, 458, 819	0.00000	0.000000	12, 686, 111	60.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 4,623,031 0.000000 0.000000 1,010,129 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 961,369 0.000000 0.000000 266,635 68. 00 969. 00 06900 ELECTROCARDI OLOGY 0 13,889,570 0.000000 0.000000 1,896,436 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 5,734,024 0.000000 0.000000 95,254 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 14,761,382 0.000000 0.000000 4,626,663 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 16,012,785 0.000000 0.000000 7,990,744 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 50,927,229 0.000000 0.000000 4,599,394 73. 00 74. 00 07400 RENAL DI ALYSI S 0 180,030 0.000000 0.000000 0.000000 112,891 74. 00 07400 RENAL DI ALYSI S 0 4,997,201 0.000000 0.000000 0.000000 0.000000 0.000000	65.00	06500 RESPIRATORY THERAPY	0	1:	3, 963, 576	0.00000	0. 000000	5, 598, 000	65. 00
68. 00	66.00	06600 PHYSI CAL THERAPY	0	1:	3, 622, 093	0.00000	0.000000	1, 441, 673	66. 00
69. 00 06900 ELECTROCARDI OLOGY 0 13, 889, 570 0.000000 0.000000 1, 894, 436 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 5, 734, 024 0.000000 0.000000 95, 254 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 14, 761, 382 0.000000 0.000000 4, 626, 663 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 16, 012, 785 0.000000 0.000000 7, 990, 744 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 50, 927, 229 0.000000 0.000000 4, 599, 394 73. 00 73. 00 07400 RENAL DI ALYSI S 0 180, 033 0.000000 0.000000 12, 899, 394 73. 00 74. 00 07400 RENAL DI ALYSI S 0 180, 033 0.000000 0.000000 0.000000 0.000000 0.000000	67.00	06700 OCCUPATI ONAL THERAPY	0	) .	4, 623, 031	0.00000	0.000000	1, 010, 129	67.00
70. 00	68.00	06800 SPEECH PATHOLOGY	0		961, 369	0.00000	0.000000	266, 635	68. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	0	1:	3, 889, 570	0.00000	0.000000	1, 896, 436	69. 00
72. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	0	) !	5, 734, 024	0.00000	0. 000000	95, 254	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 50, 927, 229 0. 000000 0. 000000 4, 599, 394 73. 00 74. 00 07400 RENAL DI ALYSI S 0 180, 030 0. 000000 0. 000000 112, 891 74. 00 76. 00 03950 BEHAVI ORAL HEALTH SERVI CES 0 4, 997, 201 0. 000000 0. 000000 0. 000000 0. 76. 00 76. 01 03480 ONCOLOGY 0 21, 629, 292 0. 000000 0. 000000 219, 112 76. 01 76. 02 03330 ENDOSCOPY 0 5, 461, 446 0. 000000 0. 000000 433, 049 76. 02 76. 03 03951 WOUND CARE 0 16, 046, 842 0. 000000 0. 000000 0. 000000 0. 000000	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1.	4, 761, 382	0.00000	0. 000000	4, 626, 663	71. 00
74. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1	6, 012, 785	0.00000	0. 000000	7, 990, 744	72. 00
76. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	0	50	0, 927, 229	0.00000	0. 000000	4, 599, 394	73. 00
76. 01	74.00	07400 RENAL DIALYSIS	0	ol .	180, 030	0.00000	0. 000000	112, 891	74. 00
76. 02	76.00	03950 BEHAVI ORAL HEALTH SERVI CES	0	) .	4, 997, 201	0.00000	0. 000000	0	76. 00
76. 03   03951   WOUND CARE   0   16, 046, 842   0. 000000   0. 000000   0   76. 03	76. 01	03480 ONCOLOGY	0	2	1, 629, 292	0.00000	0. 000000	219, 112	76. 01
OUTPATIENT SERVICE COST CENTERS   OUTP	76. 02	03330 ENDOSCOPY	0	) !	5, 461, 446	0.00000	0. 000000	433, 049	76. 02
90. 00	76. 03	03951 WOUND CARE	0	1	6, 046, 842	0.00000	0. 000000	0	76. 03
91. 00   09100   EMERGENCY   0   57, 735, 445   0.000000   0.000000   5, 555, 661   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   2, 989, 276   0.000000   0.000000   0.000000   0.000000   0.000000   92. 00   0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000000		OUTPATIENT SERVICE COST CENTERS					<u>.                                      </u>		
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   2, 989, 276   0.000000   0.000000   0   92. 00	90.00	09000 CLI NI C	0		0	0.00000	0.000000	0	90.00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   2, 989, 276   0.000000   0.000000   0   92. 00	91.00	09100 EMERGENCY	0	5	7, 735, 445	0. 00000	0. 000000	5, 555, 661	91.00
95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0. 000000		92.00
98.00   09850   OTHER REI MBURSABLE COST CENTERS   0   0   0.000000   0.000000   0   98.00		OTHER REIMBURSABLE COST CENTERS							
98.00   09850   OTHER REI MBURSABLE COST CENTERS   0   0   0.000000   0.000000   0   98.00	95.00								95. 00
	98.00		0	ol	0	0. 00000	0. 000000	0	98. 00
			690, 736	44	1, 369, 387				200. 00

			'	0 00/30/2010	11/22/2016 2: 4	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Inpatient	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	19, 514, 885	C			50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	951	0			52.00
53. 00   05300   ANESTHESI OLOGY	0	1, 694, 036	C			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	30, 015	14, 263, 988	222, 176			54.00
54. 01   03630   ULTRA SOUND	10, 242	1, 936, 486	30, 165			54.01
57. 00   05700   CT   SCAN	1, 843	3, 368, 648	52, 473			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 321	1, 045, 010	16, 278			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	557, 657	· C			59.00
60. 00   06000   LABORATORY	o	7, 511, 020	o c			60.00
65. 00 06500 RESPIRATORY THERAPY	o	1, 942, 908	d			65.00
66. 00 06600 PHYSI CAL THERAPY	o	26, 117	d			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	o	18, 137	d			67.00
68. 00 06800 SPEECH PATHOLOGY	o	19, 669	d			68.00
69. 00 06900 ELECTROCARDI OLOGY	o	5, 476, 283	d			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	1, 675, 638				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	2, 150, 493				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	1, 440, 783	1			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	18, 402, 280	l c			73.00
74. 00 07400 RENAL DIALYSIS	o		l c			74.00
76. 00 03950 BEHAVI ORAL HEALTH SERVI CES	o	493, 706	l c			76.00
76. 01 03480 ONCOLOGY	o	3, 564, 255	l c			76. 01
76. 02 03330 ENDOSCOPY	o	2, 477, 935	l c			76. 02
76. 03 03951 WOUND CARE	ol	1, 444, 776				76. 03
OUTPATIENT SERVICE COST CENTERS				<u> </u>		
90. 00 09000 CLI NI C	0	O	C			90.00
91. 00 09100 EMERGENCY	ol	13, 885, 535	l c			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	309, 318	c c			92.00
OTHER REIMBURSABLE COST CENTERS	·			<u> </u>		
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	o	0	o c			98.00
200.00 Total (lines 50-199)	46, 421	103, 220, 514	321, 092		:	200. 00

Health Financial Systems	ST. JOSEPH HOSPITAL & HEALTH CENTER	In Lieu of Form CMS-2552-10
ilear til TTHanerai Systems		

Heal th	Financial Systems ST.	JOSEPH HOSPITA	L & HEALTH CENT	ΓER	In Lie	u of Form CMS-	2552-10
APPORT	FIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
					From 07/01/2015	Part V	
					To 06/30/2016	Date/Time Pre	pared:
				20111		11/22/2016 2:	42 pm
			litl	e XVIII	Hospi tal	PPS	
				Charges	_	Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS				_		
50.00	05000 OPERATING ROOM	0. 203401	19, 514, 885		0	3, 969, 347	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 207566	951		0 0	197	52.00
53.00	05300 ANESTHESI OLOGY	0. 009172	1, 694, 036	,	0 0	15, 538	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 252917			0	3, 607, 605	54.00
54.01	03630 ULTRA SOUND	0. 098251	1, 936, 486		0	190, 262	54. 01
57.00	05700 CT SCAN	0. 073340			0 0	247, 057	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 181404			0	189, 569	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 145871		1	0	81, 346	1
60.00	06000 LABORATORY	0. 128123		1		962, 334	
65. 00	06500 RESPIRATORY THERAPY	0. 185234			0 0	359, 893	
66. 00	06600 PHYSI CAL THERAPY	0. 337454		1	o o	8, 813	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 383510			0	6, 956	
68. 00	06800 SPEECH PATHOLOGY	0. 464102		1	0 0	9, 128	1
69. 00	06900 ELECTROCARDI OLOGY	0. 145308		1	0 0	795, 748	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 166524		1	0 0	279, 034	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 100524			0 0	596, 803	1
				1	0 0		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 340538		1	-	490, 641	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 475008		1	0 16, 691	8, 741, 230	
74.00	07400 RENAL DIALYSIS	1. 171227	ł .		0	0	
76. 00	03950 BEHAVI ORAL HEALTH SERVI CES	0. 564549			0	278, 721	1
76. 01	03480 ONCOLOGY	0. 323000		1	0	1, 151, 254	
76. 02	03330 ENDOSCOPY	0. 114816			0	284, 507	1
76. 03	03951 WOUND CARE	0. 101110	1, 444, 776		0 0	146, 081	76. 03
	OUTPATIENT SERVICE COST CENTERS		1				
90.00	09000 CLI NI C	0. 000000	l .	1	0	0	70.00
91. 00	09100 EMERGENCY	0. 099081			0	1, 375, 793	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 224652	309, 318		0 0	69, 489	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0. 216173			0		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0	)	0	0	98. 00
200.00	Subtotal (see instructions)		103, 220, 514	85	0 16, 691	23, 857, 346	200.00
201.00					o o		201.00
	Only Charges						
202.00			103, 220, 514	85	0 16, 691	23, 857, 346	202. 00
					· ·		

				10 06/30/2016	11/22/2016 2:4	pared: 42 nm
		Ti tl	e XVIII	Hospi tal	PPS	12 piii
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
ANGLEL ADV. CEDVLCE, COCT. CENTEDO	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS  50. 00 05000 OPERATING ROOM	1	0	I			50. 00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00   05300   DELIVERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY	0	0				53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0	0				54.00
54. 00   03400   RADI 02001-DI AGNOSTI C	0	0				54. 00
57. 00   05700 CT SCAN	0	0				57. 00
58.00   05700   CT SCAN 58.00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0	0				58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00   06000   LABORATORY	109	0				60.00
65. 00 06500 RESPIRATORY THERAPY	107	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	7, 928				73. 00
74.00 07400 RENAL DIALYSIS	0	0				74. 00
76. 00   03950 BEHAVI ORAL HEALTH SERVI CES	0	0				76. 00
76. 01 03480 0NC0L0GY	0	0				76. 01
76. 02   03330   ENDOSCOPY	0	0				76. 02
76. 03   03951   WOUND CARE	0	0				76. 03
90. 00 O9000 CLINIC	0	0	I			90. 00
91. 00   09100   EMERGENCY	0	0				90.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0	0				91.00
OTHER REIMBURSABLE COST CENTERS	J O	0				92.00
95. 00 09500 AMBULANCE SERVI CES	0					95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
200.00 Subtotal (see instructions)	109	7, 928	ı			200.00
201.00 Less PBP Clinic Lab. Services-Program	0	., 720				201. 00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	109	7, 928				202. 00

	Financial Systems ST. FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	_JOSEPH_HOSPITA  AL_COSTS		CCN: 150010	Peri od:	u of Form CMS-2 Worksheet D	
					From 07/01/2015	Part II	
			Component	CCN: 15T010	To 06/30/2016	Date/Time Pre 11/22/2016 2:	pared: 42 pm
			Ti tl	e XVIII	Subprovi der  - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	<b>'</b>	Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 ÷ col	l. Charges	column 4)	
		Part II, col.	8)	2)	_		
		26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 171, 124			35 12, 350	217	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	154, 915				0	
53.00	05300 ANESTHESI OLOGY	9, 493				0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	756, 260				2, 856	
54. 01	03630 ULTRA SOUND	20, 484				67	
57.00	05700 CT SCAN	20, 652				58	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	17, 175				20	
59. 00	05900 CARDI AC CATHETERI ZATI ON	17, 917				0	1
60.00	06000 LABORATORY	408, 456				6, 620	
65.00	06500 RESPI RATORY THERAPY	110, 859				4, 841	1
66. 00	06600 PHYSI CAL THERAPY	310, 550				29, 584	
67. 00	06700 OCCUPATI ONAL THERAPY	124, 290				32, 891	
68. 00	06800 SPEECH PATHOLOGY	37, 358				5, 789	
69. 00	06900 ELECTROCARDI OLOGY	155, 665				173	
70. 00	07000 ELECTROENCEPHALOGRAPHY	92, 792				64	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	214, 181				4, 053	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	141, 897		0. 00886		47	
73.00	07300 DRUGS CHARGED TO PATIENTS	715, 158				7, 219	
74.00	07400 RENAL DIALYSIS	5, 684				976	
76.00	03950 BEHAVI ORAL HEALTH SERVI CES	194, 191				0	
76. 01	03480 ONCOLOGY	195, 162				0	1 , 0. 0 .
76. 02	03330 ENDOSCOPY	20, 313				0	
76. 03	03951 WOUND CARE	117, 828	16, 046, 842	0. 00734	43 0	0	76. 03
00.00	OUTPATIENT SERVICE COST CENTERS			0.0000	20		
90.00	09000 CLINIC	0 (05 540				0	
91.00	09100 EMERGENCY	635, 513				0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 989, 276	0.00000	00 0	0	92. 00
05 00	OTHER REIMBURSABLE COST CENTERS						1 05 00
95.00	09500 AMBULANCE SERVI CES 09850 OTHER REIMBURSABLE COST CENTERS		0	0.0000	20	0	95.00
98. 00 200. 00		E 447 017	ľ	0. 00000	5, 346, 545	-	98. 00 200. 00
ZUU. UU.	אן ן וטנמו (וווופט סט-199)	5, 647, 917	441,309,38/	I	0, 340, 545	90, 4/5	1200. UU

		JOSEPH HOSPITAL				eu of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi de	- CCN: 150010	Peri od: From 07/01/201	Worksheet D Part IV	
THRUUG	H COSTS		Componer	nt CCN: 15T010			
			Ti t	le XVIII	Subprovi der -	PPS	
	Cook Cooks Door isting	N== Db=! =! == !	N	1	I RF	Total Cost	
	Cost Center Description	Non Physician I Anesthetist	Nursing School	I Allied Heal	th All Other Medical	(sum of col 1	
		Cost			Education Cos	1 '	
		COST			Education Cos	4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	1 0.00		0.00	
	05000 OPERATING ROOM	0		0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		o	0	ol o	52. 00
53.00	05300 ANESTHESI OLOGY	0		o	0	ol o	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0 355,	725	355, 725	54.00
54. 01	03630 ULTRA SOUND	0		0 118,	793	118, 793	54. 01
57.00	05700 CT SCAN	0		0 165,	929	165, 929	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0 50, 3		50, 289	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	0	o	59.00
60.00	06000 LABORATORY	0		o	0	ol o	60.00
65.00	06500 RESPI RATORY THERAPY	0		o	0	o o	65. 00
66.00	06600 PHYSI CAL THERAPY	0		o	0	0	66. 00
67.00	06700 OCCUPATIONAL THERAPY	0		o	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0		o	0	0	68. 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 PATIENTS	0		0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	73. 00
	07400 RENAL DIALYSIS	0		0	0	0	74. 00
	03950 BEHAVIORAL HEALTH SERVICES	0		0	0	0	
	03480 ONCOLOGY	0		0	0	0	76. 01
	03330 ENDOSCOPY	0		0	0	0	76. 02
	03951 WOUND CARE	0		0	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS			_		_	
	09000 CLI NI C	0		0		0	
	09100 EMERGENCY	0		0	-	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS					1	05.00
	09500 AMBULANCE SERVICES						95. 00
	09850 OTHER REIMBURSABLE COST CENTERS Total (lines 50-199)	0		0 0 690, <sup>1</sup>		0 690, 736	
200.00							

Heal th	Financial Systems ST.	JOSEPH HOSPITA	L & HEAL	TH CENT	ER	In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		S Pr	ovi der	CCN: 150010	Peri od: From 07/01/2015	Worksheet D Part IV Date/Time Pre	
				mponent	CCN: 151010	To 06/30/2016	11/22/2016 2:	pareu: 42 pm
				Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total			Ratio of Cos		I npati ent	
		Outpati ent	(from W		to Charges	Ratio of Cost	Program	
		Cost (sum of			(col. 5 ÷ col		Charges	
		col . 2, 3 and	8	)	7)	(col. 6 ÷ col.		
		4)	_			7)		
		6. 00	7. (	00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS			701 000			10.050	
	05000 OPERATING ROOM	0		786, 823	0. 00000		12, 350	
	05200 DELIVERY ROOM & LABOR ROOM	0		093, 247	0. 00000		0	52. 00
	05300 ANESTHESI OLOGY	0		326, 308	0. 00000		0	
	05400 RADI OLOGY-DI AGNOSTI C	355, 725		837, 752	0. 0155		86, 258	
	03630 ULTRA SOUND	118, 793		626, 164	0. 0155		24, 800	1
	05700 CT SCAN	165, 929		652, 209	0. 0155		29, 750	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	50, 289		228, 407	0. 0155		3, 800	
	05900 CARDI AC CATHETERI ZATI ON	0		825, 067	0. 00000		0	
	06000 LABORATORY	0		458, 819	0.00000		1, 060, 904	
	06500 RESPI RATORY THERAPY	0		963, 576	0. 00000		609, 715	
	06600 PHYSI CAL THERAPY	0		622, 093	0. 00000		1, 297, 641	
	06700 OCCUPATI ONAL THERAPY	0		623, 031	0.00000		1, 223, 410	
	06800 SPEECH PATHOLOGY	0		961, 369	0.00000		148, 985	
	06900 ELECTROCARDI OLOGY	0	13,	889, 570	0.00000		15, 438	
	07000 ELECTROENCEPHALOGRAPHY	0	5,	734, 024	0.00000		3, 928	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		761, 382	0.00000		279, 298	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0		012, 785	0.00000		5, 297	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0		927, 229	0.00000		514, 073	
	07400 RENAL DI ALYSI S	0		180, 030	0.00000	0. 000000	30, 898	74. 00
	03950 BEHAVI ORAL HEALTH SERVI CES	0		997, 201	0.00000		0	76. 00
	03480 ONCOLOGY	0	21,	629, 292	0.00000		0	76. 01
	03330 ENDOSCOPY	0	5,	461, 446	0.00000		0	76. 02
76. 03	03951 WOUND CARE	0	16, (	046, 842	0.00000	0. 000000	0	76. 03
	OUTPATIENT SERVICE COST CENTERS							
	09000 CLI NI C	0		0	0.00000	0. 000000	0	90. 00
91.00	09100 EMERGENCY	0	57,	735, 445	0.00000	0. 000000	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,	989, 276	0.00000	0. 000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES							95. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0.00000	0. 000000	0	98. 00
200.00	Total (lines 50-199)	690, 736	441,	369, 387			5, 346, 545	200. 00

Health Financial Systems	ST. JOSEPH HOSPITAL & H	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150010 Component CCN: 15T010	From 07/01/2015	
		Title XVIII	Subprovi der - I RF	PPS

		Ti tl	e XVIII	Subprovi der -	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent	I RF		
cost center bescription	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8	charges	Costs (col. 9			
	x col . 10)		x col . 12)			
	11.00	12. 00	13.00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	C		0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	O	C		o		52. 00
53. 00   05300   ANESTHESI OLOGY	0	C		o		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 344	C		o		54. 00
54. 01   03630   ULTRA SOUND	386	C		o		54. 01
57. 00 05700 CT SCAN	463	C		o		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	59	C		o		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		o		59. 00
60. 00   06000   LABORATORY	0	C		o		60.00
65. 00 06500 RESPIRATORY THERAPY	0	C		o		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C		o		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C		o		67.00
68. 00 06800 SPEECH PATHOLOGY	0	C		o		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C		o		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73. 00
74.00 07400 RENAL DIALYSIS	0	C		0		74.00
76.00 03950 BEHAVIORAL HEALTH SERVICES	0	C		0		76. 00
76. 01   03480   ONCOLOGY	0	C		0		76. 01
76. 02   03330   ENDOSCOPY	0	C		0		76. 02
76. 03 03951 WOUND CARE	0	C		0		76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	0	C	)	0		90. 00
91. 00   09100   EMERGENCY	0	C	)	0		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0		92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	C		0		98. 00
200.00   Total (lines 50-199)	2, 252	C	)	0		200. 00

Health Financial Systems ST	JOSEPH HOSPITA	L & HEALTH CEN	TER	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS	Provi der		Period: From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 2:	
			le XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 317, 180	0	1, 317, 18	18, 380	71. 66	30. 00
31.00   INTENSIVE CARE UNIT	256, 135		256, 13	5 2, 331	109.88	31.00
41. 00   SUBPROVI DER - I RF	443, 703	0	443, 70	3, 553	124.88	41.00
43. 00 NURSERY	80, 469		80, 46	9 1, 974	40. 76	43.00
200.00 Total (lines 30-199)	2, 097, 487		2, 097, 48	7 26, 238		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	416					30. 00
31.00   INTENSIVE CARE UNIT	196	21, 536				31.00
41. 00   SUBPROVI DER - I RF	55	6, 868	3			41. 00
43. 00 NURSERY	280	11, 413	s			43.00
200.00 Total (lines 30-199)	947	69, 628	8			200. 00

Health Financial Systems	ST. JOSEPH HOSPITAL & HI	EALTH CENTER	In	In Lieu of Form CMS-2552-10		
ADDODEL ONMENT OF LANDATIENT ANOLL	LADY CEDULAE AARLEAL AACTO	D 1 1 00N 4F0040	D	Wassissian D		

Health Financial Systems ST.	JOSEPH HOSPI TAI	L & HEALTH CENT	TER	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Pre 11/22/2016 2:	pared: 42 pm
			le XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost			Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000 OPERATING ROOM	1, 171, 124				43, 499	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	154, 915				80, 955	
53. 00   05300   ANESTHESI OLOGY	9, 493				314	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	756, 260				7, 697	
54. 01  03630 ULTRA SOUND	20, 484				308	54. 01
57. 00  05700 CT SCAN	20, 652				387	
58.00   05800 MAGNETIC RESONANCE I MAGING (MRI)	17, 175	3, 228, 407	0. 00532	.0 60, 216	320	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	17, 917	1, 825, 067	0. 00981	7 13, 415	132	59. 00
60. 00   06000   LABORATORY	408, 456	65, 458, 819	0. 00624	3, 888, 879	24, 267	60.00
65. 00 06500 RESPIRATORY THERAPY	110, 859	13, 963, 576	0. 00793	772, 813	6, 135	65.00
66. 00 06600 PHYSI CAL THERAPY	310, 550	13, 622, 093	0. 02279	183, 866	4, 192	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	124, 290	4, 623, 031	0. 02688	88, 598	2, 382	67. 00
68.00 06800 SPEECH PATHOLOGY	37, 358	961, 369	0. 03885	14, 683	571	68. 00
69. 00 06900 ELECTROCARDI OLOGY	155, 665	13, 889, 570	0. 01120	150, 566	1, 687	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	92, 792	5, 734, 024	0. 01618	19, 640	318	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	214, 181	14, 761, 382	0. 01451	0 849, 381	12, 325	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	141, 897	16, 012, 785	0. 00886	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	715, 158	50, 927, 229	0. 01404	992, 055	13, 931	73. 00
74.00 07400 RENAL DIALYSIS	5, 684	180, 030	0. 03157	1, 215	38	74.00
76. 00 03950 BEHAVI ORAL HEALTH SERVI CES	194, 191	4, 997, 201	0. 03886	0 14, 647	569	76. 00
76. 01 03480 ONCOLOGY	195, 162	21, 629, 292	0. 00902	37, 733	340	76. 01
76. 02 03330 ENDOSCOPY	20, 313		•		144	76. 02
76. 03   03951   WOUND CARE	117, 828		•		214	76. 03
OUTPATIENT SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,		,		
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
91. 00 09100 EMERGENCY	635, 513	57, 735, 445			14, 854	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	52, 673				0	92.00
OTHER REIMBURSABLE COST CENTERS			2.21702			1
95. 00 09500 AMBULANCE SERVICES						95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	l o	0. 00000	0	0	
200. 00   Total (lines 50-199)	5, 700, 590			17, 604, 730	_	

Health Financial Systems ST.	JOSEPH HOSPITA	L & HEALTH CEN	TER	In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der	CCN: 150010	Peri od:	Worksheet D	
				From 07/01/2015 To 06/30/2016		narodi
				10 00/30/2010	11/22/2016 2:	
		Ti t	tle XIX	Hospi tal	Cost	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)	minus col. 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS	0	C		0 0	0	30.00
31.00   03100   INTENSIVE CARE UNIT	0	C		0	0	31.00
41. 00   04100   SUBPROVI DER -   I RF	0	C		0 0	0	41.00
43. 00   04300 NURSERY	0	C		0	0	43.00
200.00 Total (lines 30-199)	0	C		0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7.00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS	18, 380	0.00	4	16 0	,	30.00
31.00   03100   I NTENSI VE CARE UNIT	2, 331	0.00	19	96 0	,	31.00
41. 00   04100   SUBPROVI DER -   RF	3, 553	0.00		55 0		41. 00
43. 00   04300   NURSERY	1, 974	0.00	28	30 0	,	43.00
200.00   Total (lines 30-199)	26, 238		94	17 O		200. 00

Health Financial Systems	ST. JOSEPH HOSPITAL & F	IEALTH CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150010		Worksheet D
THROUGH COSTS			From 07/01/2015	Part IV

THROUGH COSTS					To	06/30/2016	Date/Time Pre 11/22/2016 2:	
			Т	itle XIX		Hospi tal	Cost	
Cos	t Center Description	Non Physician	Nursing Scho	ol Allied H	leal th	All Other	Total Cost	
	·	Anesthetist	,			Medi cal	(sum of col 1	
		Cost				Education Cost	through col.	
							4)	
		1.00	2. 00	3. 0	0	4. 00	5. 00	
	SERVICE COST CENTERS							
	RATING ROOM	0		0	0	0	0	50.00
	IVERY ROOM & LABOR ROOM	0		0	0	0	0	52. 00
53. 00   05300 ANE	STHESI OLOGY	0		0	0	0	0	53.00
54. 00   05400 RAD	I OLOGY-DI AGNOSTI C	0		0 3	55, 725	0	355, 725	54. 00
54. 01   03630 ULT	RA SOUND	0		0 1	18, 793	0	118, 793	54. 01
57. 00   05700 CT		0		0 1	65, 929	0	165, 929	57. 00
58. 00   05800 MAG	NETIC RESONANCE IMAGING (MRI)	0		0	50, 289	0	50, 289	58. 00
59. 00 05900 CAR	DIAC CATHETERIZATION	0		0	0	0	0	59. 00
60. 00 06000 LAB	ORATORY	0		0	0	0	0	60.00
65. 00 06500 RES	PI RATORY THERAPY	0		0	0	0	0	65.00
66. 00 06600 PHY	SI CAL THERAPY	o		o	0	0	0	66. 00
	UPATI ONAL THERAPY	o		o	0	0	0	67. 00
68. 00 06800 SPE	ECH PATHOLOGY	O		o	0	0	0	68. 00
69. 00 06900 ELE	CTROCARDI OLOGY	0		o	0	0	0	69. 00
70. 00 07000 ELE	CTROENCEPHALOGRAPHY	0		o	0	0	0	70. 00
71. 00 07100 MED	ICAL SUPPLIES CHARGED TO PATIENTS	0		o	0	0	0	71. 00
72. 00 07200 I MP	L. DEV. CHARGED TO PATIENTS	0		0	0	0	0	72. 00
73. 00 07300 DRU	GS CHARGED TO PATIENTS	0		0	0	0	0	73. 00
74. 00 07400 REN	AL DIALYSIS	0		0	0	0	0	74. 00
76. 00 03950 BEH	AVIORAL HEALTH SERVICES	0		0	0	0	0	76. 00
76. 01 03480 ONC	OLOGY	o		o	0	0	0	76. 01
76. 02 03330 END		o		o	0	0	0	76. 02
76. 03 03951 WOU	ND CARE	o		o	0	0	0	76. 03
OUTPATI EN	T SERVICE COST CENTERS	<u>'</u>		<u>'</u>				
90. 00 09000 CLI	NI C	0		0	0	0	0	90.00
91. 00 09100 EME	RGENCY	o		o	0	0	0	91.00
92. 00 09200 OBS	ERVATION BEDS (NON-DISTINCT PART)	o		o	0	0	0	92.00
	MBURSABLE COST CENTERS				<u> </u>			
95. 00 09500 AMB	ULANCE SERVICES							95. 00
98. 00 09850 OTH	ER REIMBURSABLE COST CENTERS	0		o	0	0	0	98. 00
200. 00 Tota	al (lines 50-199)	o		0 6	90, 736	o	690, 736	200. 00

Health Financial Systems	ST. JOSEPH HOSPITAL & H	EALTH CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150010	Peri od: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/22/2016 2:42 pm
		Title XIX	Hospi tal	Cost

				1	0 06/30/2016	Date/lime Prep   11/22/2016 2:4	
			Ti +l	le XIX	Hospi tal	Cost	+2 piii
Cost Center Description	Total	Total Ch		Ratio of Cost	Outpati ent	Inpatient	
oost conten boscii pti on	Outpati ent	(from Wks		to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I,		(col . 5 ÷ col .	to Charges	Charges	
	col. 2, 3 and	8)	00	7)	(col . 6 ÷ col .	onal goo	
	4)			.,	7)		
	6.00	7. 00	0	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS	•						
50.00 05000 OPERATING ROOM	0	66, 78	86, 823	0. 000000	0.000000	2, 480, 670	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	11, 09	93, 247	0.000000	0.000000	5, 796, 968	52.00
53. 00   05300   ANESTHESI OLOGY	0	8, 32	26, 308	0.000000	0.000000	275, 452	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	355, 725	22, 83	37, 752	0. 015576	0. 015576	232, 428	54.00
54.01 03630 ULTRA SOUND	118, 793	7, 62	26, 164	0. 015577	0. 015577	114, 642	54. 01
57. 00   05700   CT   SCAN	165, 929	10, 6	52, 209	0. 015577	0. 015577	199, 616	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	50, 289	3, 22	28, 407	0. 015577	0. 015577	60, 216	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	1, 82	25, 067	0.000000	0.000000	13, 415	59.00
60. 00   06000   LABORATORY	0	65, 45	58, 819	0.000000	0.000000	3, 888, 879	60.00
65. 00 06500 RESPIRATORY THERAPY	0	13, 90	63, 576	0.000000	0.000000	772, 813	65.00
66. 00 06600 PHYSI CAL THERAPY	0	13, 62	22, 093	0.000000	0.000000	183, 866	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	4, 62	23, 031	0.000000	0.000000	88, 598	67.00
68. 00 06800 SPEECH PATHOLOGY	0	90	61, 369	0.000000	0.000000	14, 683	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	13, 88	89, 570	0.000000	0.000000	150, 566	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	5, 73	34, 024	0.000000	0.000000	19, 640	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14, 76	61, 382	0.000000	0.000000	849, 381	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	16, 0°	12, 785	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	50, 92	27, 229	0.000000	0.000000	992, 055	73.00
74.00 07400 RENAL DIALYSIS	0	18	80, 030	0.000000	0.000000	1, 215	74.00
76. 00 03950 BEHAVI ORAL HEALTH SERVI CES	0	4, 99	97, 201	0.000000	0.000000	14, 647	76.00
76. 01 03480 ONCOLOGY	0	21, 62	29, 292	0.000000	0.000000	37, 733	76. 01
76. 02   03330   ENDOSCOPY	0	5, 40	61, 446	0.000000	0.000000	38, 684	76. 02
76. 03   03951   WOUND CARE	0	16, 04	46, 842	0.000000	0.000000	29, 090	76. 03
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0		0	0. 000000	0.000000	0	90.00
91. 00   09100   EMERGENCY	0	57, 73	35, 445	0.000000	0.000000	1, 349, 473	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 98	89, 276	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVICES							95. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	1	0	0.000000	0.000000	0	98. 00
200.00 Total (lines 50-199)	690, 736	441, 36	69, 387			17, 604, 730	200. 00

Health Financial Systems	ST. JOSEPH HOSPITAL & H	IEALTH CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150010	From 07/01/2015	Worksheet D Part IV Date/Time Prepared:

					lo	06/30/2016	Date/lime Pr   11/22/2016 2	
-			Ti	tle XIX	Но	ospi tal	Cost	<u></u>
	Cost Center Description	I npati ent	Outpati ent	Outpati ent				
		Program	Program	Program				
		Pass-Through	Charges	Pass-Through				
		Costs (col. 8		Costs (col.	9			
		x col. 10)		x col. 12)				
		11. 00	12. 00	13. 00				
	ICI LLARY SERVI CE COST CENTERS							
	OPERATING ROOM	0		0	0			50.00
	5200 DELIVERY ROOM & LABOR ROOM	0		0	0			52. 00
	3300 ANESTHESI OLOGY	0		0	0			53. 00
	7400 RADI OLOGY-DI AGNOSTI C	3, 620		0	0			54. 00
	3630 ULTRA SOUND	1, 786		0	0			54. 01
	5700 CT SCAN	3, 109		0	0			57. 00
1	5800 MAGNETIC RESONANCE IMAGING (MRI)	938		0	0			58. 00
	5900 CARDI AC CATHETERI ZATI ON	0		0	0			59. 00
	6000 LABORATORY	0		0	0			60.00
	5500 RESPIRATORY THERAPY	0		0	0			65. 00
	6600 PHYSI CAL THERAPY	0		0	0			66. 00
	5700 OCCUPATI ONAL THERAPY	0		0	0			67. 00
	S800 SPEECH PATHOLOGY	0		0	0			68. 00
	5900 ELECTROCARDI OLOGY	0		0	0			69. 00
	7000 ELECTROENCEPHALOGRAPHY	0		0	0			70. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0			71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0			72. 00
	7300 DRUGS CHARGED TO PATIENTS	0		0	0			73. 00
	7400 RENAL DIALYSIS	0		0	0			74. 00
	3950 BEHAVIORAL HEALTH SERVICES	0		0	0			76. 00
	3480 ONCOLOGY	0		0	0			76. 01
76. 02   03	3330 ENDOSCOPY	0		0	0			76. 02
	3951 WOUND CARE	0		0	0			76. 03
	JTPATIENT SERVICE COST CENTERS							
	9000 CLI NI C	0		0	0			90. 00
91.00 09	9100 EMERGENCY	0		0	0			91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0			92. 00
	THER REIMBURSABLE COST CENTERS							
	9500 AMBULANCE SERVICES							95. 00
1	9850 OTHER REIMBURSABLE COST CENTERS	0		0	0			98. 00
200.00	Total (lines 50-199)	9, 453		o	0			200. 00

Health Financial Systems	ST. JOSEPH HOSPITAL & HEALTH CENTER	In Lieu of Form CMS-2552-10

Health Financial Systems ST.	JOSEPH HOSPITAL	L & HEALTH CENT	ΓER	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 07/01/2015		
				To 06/30/2016		pared:
<del></del>					11/22/2016 2:	42 pm_
		li t	le XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS		T -	T	.1	_	
50.00 05000 OPERATING ROOM	0. 203401	0	2, 091, 00		0	50.00
52.00  05200   DELIVERY ROOM & LABOR ROOM	0. 207566		1,		_	52. 00
53. 00   05300   ANESTHESI OLOGY	0. 009172	0	279, 88	6 0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 252917	0	1, 434, 51	7 0	0	54.00
54. 01   03630   ULTRA SOUND	0. 098251	0	459, 21	8 0	0	54. 01
57. 00  05700 CT SCAN	0. 073340	0	882, 93	6 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 181404			0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 145871		61, 23	8 0	0	59.00
60. 00   06000   LABORATORY	0. 128123		5, 172, 81		0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 185234		1		0	65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 337454		373, 05		Ö	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 383510		141, 18		0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 464102		23, 90		ő	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 145308		475, 65		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 166524		424, 16		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 277519		616, 43		0	71.00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATTENTS	0. 340538		1	0 0	0	71.00
			1	0	0	
	0. 475008		371, 50		_	73.00
74. 00   07400   RENAL DI ALYSI S	1. 171227	0	1	0	0	74.00
76. 00 03950 BEHAVI ORAL HEALTH SERVI CES	0. 564549		1, 587, 26		0	76.00
76. 01   03480   0NCOLOGY	0. 323000		2, 896, 05		0	76. 01
76. 02   03330   ENDOSCOPY	0. 114816	l e	165, 84		0	76. 02
76. 03 03951 WOUND CARE	0. 101110	0	875, 33	0 0	0	76. 03
OUTPATIENT SERVICE COST CENTERS		1				
90. 00  09000   CLI NI C	0. 000000	l e	1	0	_	90. 00
91. 00   09100   EMERGENCY	0. 099081	0				91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 224652	0	1, 516, 58	7 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0. 216173	0		0	I	95. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98. 00
200.00 Subtotal (see instructions)		0	27, 954, 21	5 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0	I	201.00
Only Charges					I	
202.00 Net Charges (line 200 +/- line 201)		0	27, 954, 21	5 0	0	202. 00
	•		•			•

Health Financial Systems	ST. JOSEPH HOSPITAL & H	EALTH CENTER		In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL.	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150010	Peri od:	Worksheet D

From 07/01/2015 | Part V | To 06/30/2016 | Date/Time Prepared: 11/22/2016 2:42 pm Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 425, 313 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 19,072 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 2 567 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 362, 814 54.00 54.01 03630 ULTRA SOUND 45, 119 54.01 64, 755 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 8, 933 0 59.00 06000 LABORATORY 662, 756 0 60.00 60.00 06500 RESPIRATORY THERAPY 0 77, 652 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 125, 890 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 54, 145 0 67.00 06800 SPEECH PATHOLOGY 68.00 11,096 68.00 Ol 06900 ELECTROCARDI OLOGY 69 00 69, 117 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70,633 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 171, 074 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 176, 467 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 03950 BEHAVIORAL HEALTH SERVICES 896, 089 0 76.00 76.00 03480 ONCOLOGY 0 76. 01 935.427 76.01 03330 ENDOSCOPY 0 76.02 19,041 76.02 76.03 03951 WOUND CARE 88, 505 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 752, 472 09100 EMERGENCY 91.00 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 340, 704 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 200.00 5, 379, 641 0 200. 00 Subtotal (see instructions) Less PBP Clinic Lab. Services-Program 201.00 201.00

5, 379, 641

0

202.00

Only Charges

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems	ST. J(	OSEPH HOSPITAL & F	HEALTH CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND \	VACCINE COST	Provider CCN: 150010	Peri od: From 07/01/2015	Worksheet D Part V
			Component CCN: 15T010	To 06/30/2016	Date/Time Prepared: 11/22/2016 2:42 pm
			Title XIX	Subprovi der -	Cost
				IRF	

					11/22/2016 2:	42 pm
		Ti t	Ie XIX	Subprovi der -	Cost	
			01	I RF		
		550 5 1 1	Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
ANOLILABLY OFFICE OFFICE	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.000404			ما م		
50. 00   05000   OPERATING ROOM	0. 203401	0		0	-	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 207566	0		0		52.00
53. 00 05300 ANESTHESI OLOGY	0. 009172	0		0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 252917	0		0	0	54. 00
54. 01   03630   ULTRA SOUND	0. 098251	0		0	0	54. 01
57. 00  05700   CT SCAN	0. 073340	0		0	0	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 181404	0		0 0	0	58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0. 145871	0		0 0	0	59. 00
60. 00   06000   LABORATORY	0. 128123	0		0 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 185234	0		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 337454	0		o o	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 383510	0		o o	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 464102	0		o o	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 145308	l o		ol o	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 166524	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 277519	0		0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 340538	l .		0 0	l ő	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 475008			0	l ő	73. 00
74. 00 07400 RENAL DI ALYSI S	1. 171227	0			0	74.00
76. 00 03950 BEHAVI ORAL HEALTH SERVICES	0. 564549			0	0	76.00
76. 01   03480   ONCOLOGY	0. 323000				0	76. 01
76. 02   03330   ENDOSCOPY	0. 323000				1	76. 01
76. 03   03330   ENDOSCOFT 76. 03   03951   WOUND CARE	0. 114810				-	76. 02
OUTPATIENT SERVICE COST CENTERS	0. 101110			0  0		76.03
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00   09100   EMERGENCY	0. 099081					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 224652	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	0.04/470	Γ	1		Г	05.00
95. 00 09500 AMBULANCE SERVICES	0. 216173		1	0		95.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	_	
200.00 Subtotal (see instructions)		0		0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				U  0		201. 00
Only Charges		_		_	_	
202.00   Net Charges (line 200 +/- line 201)	1	0	1	0 0	1 0	202. 00

Health Financial Systems ST.	JOSEPH HOSPITA	L & HEALTH C	ENTER	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi d	er CCN: 150010 ent CCN: 15T010	Peri od: From 07/01/2015	Worksheet D Part V	epared:
		-	itle XIX	Subprovi der - I RF	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed	!			
	Servi ces	Services No				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coin				
	(see inst.)	(see inst.	)			
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0		0			50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0		0			52.00
53. 00   05300   ANESTHESI OLOGY	0		0			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0		0			54.00
54. 01   03630   ULTRA SOUND	0		0			54. 01
57.00  05700 CT SCAN	0		0			57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0		0			58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0		0			59. 00
60. 00   06000   LABORATORY	0		0			60.00
65. 00 06500 RESPIRATORY THERAPY	0		0			65.00
66. 00   06600 PHYSI CAL THERAPY	0		0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0			67. 00
68. 00 06800 SPEECH PATHOLOGY	0		0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		o			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		o			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0			73. 00
74.00 07400 RENAL DIALYSIS	0		0			74. 00
76. 00 03950 BEHAVI ORAL HEALTH SERVI CES	0		o			76. 00
76. 01 03480 ONCOLOGY	0		o			76. 01
76. 02 03330 ENDOSCOPY	0		О			76. 02
76. 03 03951 WOUND CARE	0		О			76. 03
OUTDATIENT CEDVICE COST CENTEDS						

0

0 0 0 0

0

0

0

0

90.00

91.00

92.00

95.00

98.00

200.00

201. 00

202. 00

OUTPATIENT SERVICE COST CENTERS

90. 00 09000 CLINIC

09500 AMBULANCE SERVICES

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 +/- line 201)

91. 00 09100 EMERGENCY

92.00

95.00

200.00

201.00

202.00

Heal th	Financial Systems	ST. JOSEPH HOSPITAL 8	k HEALTH CENTER	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 150010	Peri od: From 07/01/2015	Worksheet D-1	
				To 06/30/2016	Date/Time Prep 11/22/2016 2:	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room	n days and swing-bed day	s, excluding newborn)		18, 380	1. 00
2.00	Inpatient days (including private room	n days, excluding swing-	bed and newborn days)		18, 380	2. 00
3. 00	Private room days (excluding swing-bed do not complete this line.	d and observation bed da	ys). If you have only pr	ivate room days,	0	3. 00

	Cost Center Description		
	DADT I ALL DOOM DED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	18, 380	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18, 380	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation bed days)	17, 645	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	17, 043	5.00
	reporting period	-	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	o <sub>l</sub>	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8, 064	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)	-	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	o	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
44.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		44.00
14. 00 15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT	-	
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
10.00	reporting period	0.00	10 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0. 00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)	16, 793, 198	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6   x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26. 00	x line 20)   Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16, 793, 198	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
28. 00		0	28. 00
29. 00		0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	30. 00 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	33. 00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 16, 793, 198	36. 00 37. 00
57.00	27 minus line 36)	.5, 7,5, 1,6	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.20	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	040 17	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)	913. 67 7, 367, 835	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	7, 307, 635	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	7, 367, 835	

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	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	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	16, 793, 198	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	913. 67	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	7, 367, 835	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	7, 367, 835	41.00

	Financial Systems ST.  ATION OF INPATIENT OPERATING COST	JUSEPH HUSPITAL	A HEALTH CENT	TER CCN: 150010	In Lie Period:	u of Form CMS-2 Worksheet D-1	
01111 0 1	ATTON OF THE ATTENT OF ENVITTING GOOT		l l ovi dei	100010	From 07/01/2015 To 06/30/2016		
						11/22/2016 2:	42 pm
	Cost Center Description	Total	Ti tl Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	oost contor bescription	Inpatient Cost				(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
2. 00	NURSERY (title V & XIX only)	1.00	2.00				42. 0
	Intensive Care Type Inpatient Hospital Units						
3. 00 4. 00	INTENSIVE CARE UNIT	3, 446, 855	2, 331	1, 478. 7	1, 497	2, 213, 614	43.0
4. 00 5. 00	BURN INTENSIVE CARE UNIT						45.0
6. 00	SURGICAL INTENSIVE CARE UNIT						46.0
7. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.0
	cost center bescription					1. 00	
8. 00	Program inpatient ancillary service cost (Wk			,		14, 251, 339	•
9.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructio	ins)		23, 832, 788	49. C
0. 00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	742, 356	50. C
1 00	Describerant costs applicable to Dragger in	ationt anaillan	v comileos (fr	om Wko+ D s	um of Dorsto II	022 225	E1 (
1. 00	Pass through costs applicable to Program inp and IV)	atrent anciliar	y services (Tr	OH WKSL. D, S	um UI PALES II	833, 335	51.0
2. 00	Total Program excludable cost (sum of lines					1, 575, 691	
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-phy	sician anesth	etist, and	22, 257, 097	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	<u></u>					1
	Program di scharges					0	
o. 00 o. 00	Target amount per discharge Target amount (line 54 x line 55)						55. ( 56. (
. 00	, ,	ing cost and ta	rget amount (I	ine 56 minus	line 53)	Ö	1
3. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	enaing 1996, u	ipdated and co	mpounded by the	0. 00	59.
0. 00	Lesser of lines 53/54 or 55 from prior year					0.00	1
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.
	amount (line 56), otherwise enter zero (see		S (TITIES 54 X	60), OI 1% OI	the target		
	Relief payment (see instructions)					0	
3. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.0
1. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. (
5. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Necemb	er 31 of the c	ost reporting	neriod (See	0	65. (
5. 00	instructions) (title XVIII only)	ts arter beceilib	el 31 ol the c	ost reporting	perrou (See		05.
5. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. (
7. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost re	portina period	0	67. (
	(line 12 x line 19)	· ·					
3. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	0	68. (
9. 00	Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	68)		0	69. (
	PART III - SKILLED NURSING FACILITY, OTHER N						70.
. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	,		` ,			70. (
2. 00	Program routine service cost (line 9 x line	71)					72.
. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73.
i. 00	Capital -related cost allocated to inpatient	•			art II, column		74. (
	26, line 45)		•		,		
6. 00 7. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. (
3. 00	, ,	•					78.
. 00	Aggregate charges to beneficiaries for exces				0)		79.
. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitation	ı (Iıne 78 mir	us line 79)		80.
. 00	Inpatient routine service cost jer dreim frim		)				82.
. 00	Reasonable inpatient routine service costs (	see instruction	* .				83.
. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84.
. 00							86.
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
7. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			735 913. 67	1
3. 00							

Health Financial Systems ST.	JOSEPH HOSPITA	L & HEALTH CENT	ER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 07/01/2015	Worksheet D-1	
				To 06/30/2016	Date/Time Pre 11/22/2016 2:	pared: 42 pm_
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 317, 180	16, 793, 198	0. 07843	5 671, 547	52, 673	90.00
91.00 Nursing School cost	0	16, 793, 198	0.00000	0 671, 547	0	91.00
92.00 Allied health cost	0	16, 793, 198	0.00000	0 671, 547	0	92.00
93.00 All other Medical Education	0	16, 793, 198	0. 00000	0 671, 547	0	93. 00

Health Financial Systems	ST. JOSEPH HOSPITAL & F	IEALTH CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150010		Worksheet D-1
		Component CCN: 15T010	From 07/01/2015 To 06/30/2016	
		Title XVIII	Subprovi der -	PPS
			LDE	

		II the Aviii	I RF	FF3	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	avaludi na nawbara)		2 552	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-bed			3, 553 3, 553	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed days)		vate room days,	0	3. 00
4 00	do not complete this line.			0.550	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		31 of the cost	3, 553 0	4. 00 5. 00
0.00	reporting period	adjo) ili odgi bocombol	0. 0. 1.10 0001	· ·	0.00
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room of	days) through December	31 of the cost	0	7. 00
	reporting period	3 ,			
8. 00	Total swing-bed NF type inpatient days (including private room of	days) after December 3°	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 780	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, ento				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year				
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed of	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 of	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services a	after December 31 of th	ne cost	0.00	20. 00
21 00	reporting period			2 E11 27/	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	na period (line	3, 511, 276 0	21. 00 22. 00
	5 x line 17)	•		-	
23. 00	Swing-bed cost applicable to SNF type services after December 3'x line 18)	l of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 3	31 of the cost reportin	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 31 $\times$ line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (li	ne 21 minus line 26)		3, 511, 276	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed a	and observation hed cha	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and object vation bed che	11 gc3)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ l	i ne 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34.00	Average per diem private room charge differential (line 32 minus		tions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line	31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and	d private room cost dit	ferential (line	0 3, 511, 276	36. 00 37. 00
200	27 minus line 36)	,		2, 0,270	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	MENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST Adjusted general inpatient routine service cost per diem (see in			988. 26	38, 00
39. 00	Program general inpatient routine service cost (line 9 x line 38			2, 747, 363	
40.00	Medically necessary private room cost applicable to the Program			0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 +	iine 40)	l	2, 747, 363	41.00

44.00   COROMANY CARE UNIT		<u> </u>	JOSEPH HOSPITAL				eu of Form CMS-2	
Cost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150010			
Cost Center Description				Componen	t CCN: 15T010	To 06/30/2016		
Initial   Initial   Initial   Initial   Initial   Inpatient Cost   Impatient   Initial   Inpatient Cost   Impatient   Initial   Initia				Ti tl	e XVIII			
Col. 20   NAPSERY (Little V & XIX cmt)   1.00   2.00   3.00   4.00   5.00   42.00		Cost Center Description	Total	Total	Average Per		Program Cost	
1.00		·	Inpatient Cost	Inpatient Days	Diem (col. 1		(col. 3 x col.	
A stressive Care Type Impatient lise place   Institute   Institu			1.00	2. 00		4. 00		
	42. 00		0	C	0.	00 0	0	42. 00
44.00 COROMARY CARE UNIT 45.00 BUBNI NTERGINE CARE UNIT 45.00 BUBNI NTERGINE CARE UNIT 45.00 BUBNI NTERGINE CARE UNIT 47.00 COTTER SPECIAL CARE (SPECIAL) 48.00 Program Inpatient costs (sum of lines 41 through 48) (see instructions) 49.00 Program Inpatient costs (sum of lines 41 through 48) (see instructions) 49.00 Program Inpatient costs (sum of lines 41 through 48) (see instructions) 49.00 Program Inpatient costs (sum of lines 41 through 48) (see instructions) 49.00 Program Inpatient costs (sum of lines 41 through 48) (see instructions) 49.00 Program Inpatient costs (sum of lines 41 through 48) (see instructions) 49.01 Dray See Instructions (see instructions) 49.02 Program excludable cost (sum of lines 50 and 51) 49.03 Program excludable cost (sum of lines 50 and 51) 49.04 Program excludable cost (sum of lines 50 and 51) 49.05 Program excludable cost (sum of lines 50 and 51) 49.06 Program excludable cost (sum of lines 50 and 51) 49.07 Program Inpatient operating cost excluding capital related, non-physician anesthetist, and inedical education costs (line 20 and sum lines 50) 49.07 Program discreption (line 50 and sum lines 50) 49.07 Program discreption (line 54 x line 55) 59.00 Infarence between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Discreption of lines 53/54 or 55 From prior year cost reporting period ending 1996, updated and compounded by the 10 or 50 on 50 or 10 or 11 cms 53/54 or 55 From prior year cost reporting period ending 1996, updated and compounded by the 10 or 50 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 18, of the target amount (line 56, otherwise enter zero (see instructions)  40.00 (line 12 x line 30) 40.00 (line 50) otherwise enter zero (see instructions) 40.00 (line 12 x line 30) 40.00 (line 50) otherwise enter zero (see instructions) 40.00 (line 12 x line 30) 40.00 (line 50) otherwise enter zero (see instructions) 40.00 (line 50) otherwise enter zero (see instructio	43. 00		0	C	0.	00 0	0	43.00
40.00   SINGICAL INTENSIVE CARE UNIT   44.00   OTHER PECILAL CARE (PECILATY)   Cost Center Description   1.04.70   OTHER PECILAL CARE (PECILATY)   Cost Center Description   1.04.70   Cost Center Description		CORONARY CARE UNIT						44.00
47.00								45.00
1.00		OTHER SPECIAL CARE (SPECIFY)						47. 00
		Cost Center Description					1.00	
ASS THROUGH COST ADJUSTMENTS  50.00 Plass through costs applicable to Program inpatient routine services (from West. D., sum of Parts I and 347, 166 50.00 Plass through costs applicable to Program inpatient ancillary services (from West. D., sum of Parts II 97, 727 51.01 Plass through costs applicable to Program inpatient ancillary services (from West. D., sum of Parts II 97, 727 51.01 Plass through costs applicable to Program inpatient ancillary services (from West. D., sum of Parts II 97, 727 51.01 Plass through costs applicable to Program inpatient operating ocst excluding applicable to Program inpatient operating ocst excluding applicable to Program inpatient operating ocst excluding applicable to Program inpatient operating ocst and target amount (line 54 mount per discharges 0.00 55.00 Plass amount per discharges 0.00 55.00 Plass amount per discharges 0.00 55.00 Plass amount (line 54 x line 55) 0.50 Plass amount (line 55 and parts amount (line 54 x line 55) 0.50 Plass amount (line 55 and parts amount (line 55 and parts amount per discharges 0.00 Plass amount (line 55 and parts amount (line 5	48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)				48. 00
50.00 Peass through costs applicable to Program Inpatient routine services (from Wkst. D. sum of Parts I and I 347.166 50.00 III) 51.00 Pass through costs applicable to Program Inpatient ancillary services (from Wkst. D. sum of Parts II 97, 727 51.00 and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 3.920.147 52.00 parts of the St. 100 Program inpatient operating cost excluding capital related, non-physician anesthetist, and 3.920.147 52.00 parts of the St. 100 Program inscharges 0.00 55.00 parts of the St. 100 Program inscharges 0.00 55.00 parts of the St. 100 Program inscharges 0.00 55.00 parts of the St. 100 Program inscharges 0.00 55.00 parts of the St. 100 Program inscharges 0.00 parts of the small parts of the St. 100 Program inscharges 0.00 parts of the small parts of the small parts of the St. 100 Program inscharges 0.00 parts of the small parts of the small parts of the small parts of the parts of the small parts of the parts of the total Redictions 0.00 parts of the parts of th	49. 00		41 through 48)(	see instruction	ons)		4, 365, 040	49. 00
51.00 Pass through costs applicable to Program Inpatient ancillary services (from Wkst. D. sum of Parts II and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and group and inpatient operating cost excluding capital related, non-physician anesthetist, and group and inpatient operating cost excluding capital related, non-physician anesthetist, and group and inpatient operating cost excluding capital related, non-physician anesthetist, and group an	50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, su	m of Parts I and	347, 166	50.00
and IV)   10   10   10   10   10   10   10   1	51 00	1 (	atient ancillar	v services (fr	om Wkst D	sum of Parts II	97 727	51 00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		and IV)		, 30, v. 003 (11	om mot. D,	Su 01 1 a1 t3 11		
medical education costs (line 49 minus line 52)				lated non-nhy	veician anest	hatist and		1
54.00 Program discharges 55.00 Target amount per discharge 55.00 Target amount (line 54 x line 55) 55.00 Target amount (line 54 x line 55) 55.00 Target amount (line 54 x line 55) 55.00 Target amount (line 54 x line 55) 55.00 Target amount (line 54 x line 55) 55.00 Target amount (line 54 x line 55) 55.00 Target amount (line 54 x line 55) 55.00 Target amount (line 54 x line 55) 55.00 Target amount (line 54 x line 55) 55.00 Target amount (line 54 x line 55) 55.00 Target amount (line 53 x line 54 x line 55) 55.00 Target amount (see instructions) 65.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.01 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Reliafe payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only). For CM (see instructions) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only). For CM (see instructions) (title XVIII only). For CM (see instructions) (title XVIII only). For CM (see instructions) (title XVIII only). For CM (see instructions) (title XVIII only). For CM (see instructions) (title XVIII only). For CM (see instructions) (title XVIII only). For CM (see instructions) (title XVIII only). For CM (see instructions) (title XVIII only). For CM (see instructions) (title XVIII only). For CM (see instructions) (title XVIII only). For CM (see instructions) (title XVIII only). For CM (see instructions) (title XVIII only). For CM (see instructions) (title XVIII only	55.00	medical education costs (line 49 minus line !		πατεά, ποπ-ρης	Joi Ci aii aiieSt	notist, and	5, 720, 147	] 33.00
55.00   Target amount per discharge   0.00   55.00   50.00   Target amount (ine 54 x line 55)   0.50.00   Target amount (ine 54 x line 55)   0.50.00   57.00	54 00						1 0	54.00
1.5.00   Dirference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0.57.00		, 3					-	
58.00 Bonus payment (see instructions)  9.00 Lesser of lines \$3/54 or 55 from the cost report, updated by the market basket  60.00 Lesser of lines \$3/54 or 55 from the cost report, updated by the market basket  60.01 Lesser of lines \$3/54 is less than the lower of lines \$5, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line \$3) are less than expected costs (lines \$4 x 60), or 1% of the target amount (line \$6), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See instructions)  68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 PART III - SKILLED NURSING FACILITY, Offler NURSING FACILITY, and IC/XIII only.  70.00 Skilled nursing facility/other nursing facility/IC/F/IID routine service cost (line 37)  71.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  72.00 Program routine service cost (line 9 x line 71)  73.00 Program capital-related costs (line 9 x line 76)  74.00 Program capital-related costs (line 9 x line 76)  75.00 Program capital-related costs (line 9 x line 76)  77.00 Program capital-related costs (line 74 minus line 77)  78.00 Program capital-related costs (line 9 x line 76)  79.00 Program capital-related costs (line 74 minus line 77)  79.00 Program capital related costs (line 74 minus line 77)  79.00 Program capital related costs			ng cost and to	react amount (	ino E/ minuo	Line E2)		
market basket 6.00 Lesser of Ilnes 53/54 or 55 from prior year cost report, updated by the market basket 6.00 Loser of Ilnes 53/54 is less than the lower of Ilnes 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 6.20 Relice payment (see instructions) 6.30 Allowable Inpatient cost plus incentive payment (see instructions) 6.30 Allowable Inpatient cost plus incentive payment (see instructions) 6.30 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile VVII in VII) 6.50 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (tile VVII in VII) 6.50 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 6.70 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 6.70 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 0 fline 12 x line 19) 6.70 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 0 fline 13 x line 20) 6.70 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 part III - SKILLED NURSING FACILITY, Offer RURSING FACILITY, and INCE/IID NUTY 7.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 7.01 Medicard general inpatient routine service costs (line 72 + line 73) 7.02 Medicard general inpatient routine service costs (line 72 + line 73) 7.03 Medicard general inpatient routine service costs (line 72 + line 73) 7.04 Offer a line 40 plus for the cost period military of the cost reporting period 0 fline 1 x line 1 year and year and year and year and year and year and year and year and year and year and year and year and year and year and yea		, , , , , , , , , , , , , , , , , , , ,	ng cost and ta	irget allibuitt (1	THE 50 IIITIUS	111le 53)	-	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 folion 51.00 line 53/54 is less than the lower of lines 55,59 or 60 enter the lesser of 50% of the amount by which operating costs (Ilne 53) are less than expected costs (Ilnes 54 x 60), or 1% of the target amount (Ilne 56), otherwise enter zero (see instructions) 0.62.00 Relief payment (see instructions) 0.62.00 Relief payment (see instructions) 0.63.00 Allowable Inpatient cost plus Incentive payment (see instructions) 0.63.00 Allowable Inpatient cost plus Incentive payment (see instructions) 0.63.00 Redicare sing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (Itile XVIII only) 1.00 Instructions) (Itile XVIII only) 1.00 Redicare sing-bed SNF inpatient routine costs (Ilne 44 plus Ilne 65) (Itile XVIII only). For 0.00 CAH (see instructions) (Itile XVIII only) 1.00 CAH (see instructions) (Ille 2 x Ilne 19) 0.00 Redicare sing-bed NF inpatient routine costs through December 31 of the cost reporting period (Ilne 12 x Ilne 19) 0.00 Redicare sing-bed NF inpatient routine costs after December 31 of the cost reporting period (Ilne 12 x Ilne 19) 0.00 Redicare sing-bed NF inpatient routine costs after December 31 of the cost reporting period (Ilne 13 x Ilne 20) 0.00 Redicare sing-bed NF inpatient routine costs (Ilne 67 + Ilne 68) 0.00 Redicare single	59. 00		porting period	endi ng 1996, เ	updated and c	ompounded by the	0.00	59. 00
1.00   If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)   0 62.00	60. 00		cost report, up	dated by the m	narket basket		0.00	60.00
amount (Line 56), otherwise enter zero (see instructions) 63.00 A llowable Inpatient cost plus incentive payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.01 Total Wedicare swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Skilled nursing facility/Other nursing facility/CF/IID routine service cost (line 37) 60 Adjusted general inpatient routine service cost (line 70 + line 2) 61.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 62.00 Porgram routine service cost (line 9 x line 71) 63.00 Program general inpatient routine service costs (from Worksheet B, Part II, column 26. line 45) 64.00 Program capital-related costs (line 9 x line 76) 65.00 Program capital-related cost (line 9 x line 76) 67.00 Program inpatient routine service costs (from provider records) 67.00 Program inpatient routine service costs (from provider records) 68.00 Utilization review - physician compensation (see instructions) 68.00 Utilization review - physician compensation (see instructions) 68.00 Utilization review - physician compensation (see instructions) 69.00 Utilization review - p	61. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60	enter the less	ser of 50% of	the amount by	0	61.00
Relief payment (see instructions)   0 62.00				S (IInes 54 X	60), or 1% o	r the target		
PROGRAM INPATIENT ROUTINE SWING BED COST  44.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only)  45.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)  46.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  47.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  48.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  49.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  40.01 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  40.02 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  40.03 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  40.04 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  40.05 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  40.06 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID DONLY  40.07 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 2)  41.00 Program routine service cost (line 9 x line 71)  42.01 Total Program general inpatient routine service costs (line 72 + line 73)  43.02 Total Program apital related costs (line 9 x line 76)  44.02 Program capital -related costs (line 74 minus line 77)  45.00 Program capital -related costs (line 74 minus line 77)  47.00 Program capital related costs (line 74 minus line 77)  48.00 Program inpatient routine service costs (see instructions)  48.00 Reasonable inpatient routine service costs (see instructions)  48.00 Reasonable inpatient routine service costs (see instructions)  48.00 Total Program inpatient ancillary services (see instructions)  48.00 Valueted	62.00	Relief payment (see instructions)						1
Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)	63.00		ent (see instru	ICTI ONS)			] 0	63.00
Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	64. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of the	e cost report	ing period (See	0	64. 00
instructions) (title XVIII only)  6.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  7.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  8.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  9.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9.01 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9.02 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9.03 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9.04 Adjusted general inpatient routine service cost (line 37)  9.05 XiIIed nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  9.06 Adjusted general inpatient routine service cost (line 70 ÷ line 2)  9.07 On Total Program routine service cost (line 9 x line 71)  9.08 Medically necessary private room cost applicable to Program (line 14 x line 35)  9.09 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  9.00 Program capital-related costs (line 75 + line 2)  9.01 Program capital-related costs (line 9 x line 76)  9.02 Program capital-related costs (line 74 minus line 77)  9.03 Aggregate charges to beneficiaries for excess costs (from provider records)  9.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  9.01 Inpatient routine service costs (see instructions)  9.02 Aggregate charges to beneficiaries for excess costs (from provider records)  9.03 Aggregate charges to beneficiaries for excess costs (from provider records)  9.04 Reasonable inpatient routine service costs (see instructions)  9.05 Aggregate charges to beneficiaries for excess costs (see instructions)  9.06 Aggregate charges to beneficiaries for excess costs (see instructions)  9.07 Aggre	65. 00		ts after Decemb	er 31 of the d	cost reportin	g period (See	0	65. 00
CAH (see instructions)  71 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  88.00  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00  Skilled nursing facility/ICF/IID routine service cost (line 37)  71.00  Adjusted general inpatient routine service cost per diem (line 70 + line 2)  Program routine service cost (line 9 x line 71)  72.00  Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00  Per diem capital-related costs (line 75 + line 2)  Program capital-related costs (line 75 + line 2)  77.00  78.00  Rogram capital-related costs (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provider records)  Routon Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  Inpatient routine service cost (see instructions)  Routon Program inpatient ancillary services (see instructions)  Routon Program inpatient ancillary services (see instructions)  Total Program inpatient operating costs (sum of lines 83 through 85)  PART III - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total lobservation bed days (see instructions)  Oditive Comparison to the cost per diem (line 27 + line 2)  Oditive Comparison to cost per diem (line 27 + line 2)	// 00	instructions)(title XVIII only)			•			// 00
(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY TO. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) To. 00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) To. 00 Program routine service cost (line 9 x line 71) To. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) To. 01 Total Program general inpatient routine service costs (line 72 + line 73) To. 02 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) To. 00 Per diem capital-related costs (line 7 x line 2) To. 00 Inpatient routine service cost (line 7 x minus line 77) To. 00 Inpatient routine service costs (from provider records) Total Program routine service costs for excess costs (from provider records) Total Program routine service cost per diem limitation Total Program routine service cost (line 7 x minus line 79) Total Program routine service costs (see instructions) Reasonable inpatient routine service (see instructions) Reasonable inpatient routine service (see instructions) Reasonable inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total Observation bed days (see instructions) Reasonable deneral inpatient routine cost per diem (line 27 + line 2) Total observation bed days (see instructions) Reasonable deneral inpatient routine cost per diem (line 27 + line 2) Total observation bed days (see instructions) Reasonable deneral inpatient routine cost per diem (line 27 + line 2) Total observation bed days (see instructions) Reasonable deneral inpatient routine cost per diem (line 27 + line 2) Reasonable deneral inpatient routine cost per diem (line 27 + line 2) Reasonable deneral inpatient routine cost per diem (line 27 + line 2) Reasonable deneral inpatient routine cost per diem	66.00		ie costs (Trie	o4 prus rine d	os)(title xvi	ii oniy). For	0	00.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Inpatient routine service cost simitation (line 9 x line 81) 82.00 Inpatient routine service cost simitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Ultization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	67. 00		e costs through	December 31 o	of the cost r	eporting period	0	67. 00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  71.00 Program routine service cost (line 9 x line 71)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Program capital -related costs (line 75 ÷ line 2)  77.00 Program capital -related costs (line 9 x line 76)  10 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  70 Total observation bed days (see instructions)  87 Adjusted general inpatient routine cost per diem (line 27 + line 2)  88 Adjusted general inpatient routine cost per diem (line 27 + line 2)	68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  71.00 Program routine service cost (line 9 x line 71)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital -related costs (line 75 ÷ line 2)  77.00 Program capital -related costs (line 9 x line 76)  80.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service see instructions)  83.00 Reasonable inpatient routine service see instructions)  84.00 Program inpatient ancillary services (see instructions)  84.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	69 00	,	coutine costs (	line 67 + line	- 68)		0	69 00
71. 00 72. 00 72. 00 73. 00 74. 00 75. 00 75. 00 76. 00 77. 00 78. 00 79. 00 79. 00 70		PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY			1
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.01 Total Program routine service cost per diem limitation 81.02 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions)			,		•	)		70.00
74. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 76. 00 76. 00 76. 00 77. 00 78. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 70	72. 00	Program routine service cost (line 9 x line 7	71)		ŕ			72. 00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Octoor Servation bed days (see instructions)			9	•	,			73.00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 77.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	75. 00	Capital-related cost allocated to inpatient i	•			Part II, column		75. 00
77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 RAT IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Oscillation (line 78 minus line 79) 89.00 Security (line 78 minus line 79) 80.00 Security (line 78 minus line 79)	76 00		ne 2)					76 00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Robbits of the cost limitation (line 78 minus line 79)  80.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  80.00 Robbits imitation (line 78 minus line 79)  81.00 Robbits imitation (line 78 minus line 79)  81.00 Robbits imitation (line 78 minus line 79)  82.00 Robbits imitation (line 78 minus line 79)  82.00 Robbits imitation (line 78 minus line 79)  83.00 Robbits imitation (line 78 minus line 79)  84.00 Robbits imitation (line 78 minus line 79)  85.00 Robbits imitation (line 78 minus line 79)  86.00 Robbits imitation (line 78 minus line 79)  87.00 Robbits imitation (line 78 minus line 79)  88.00 Robbits imitation (line 78 minus line 79)  89.00 Robbits imitation (line 78	77. 00							77. 00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Reasonable inpatient routine routine cost per diem (line 27 ÷ line 2) 89.00 Reasonable inpatient routine routine cost per diem (line 27 ÷ line 2) 80.00 Reasonable inpatient routine routine cost per diem (line 27 ÷ line 2) 80.00 Reasonable inpatient routine r		l ·		rovi der record	16)			78.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	80.00	1 33 3				nus line 79)		80.00
83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Reasonable inpatient routine service costs (see instructions)  87.00 Section 1. See instructions (see instructions)  88.00 Reasonable inpatient routine service costs (see instructions)  87.00 Reasonable inpatient routine service costs (see instructions)  88.00 Reasonable inpatient routine service costs (see instructions)  87.00 Reasonable inpatient routine service costs (see instructions)  88.00 Reasonable inpatient routine service costs (see instructions)  87.00 Reasonable inpatient routine service costs (see instructions)  88.00 Reasonable inpatient routine services (see instructions)  88.00 Reasonable in	81.00	1 .		)				81.00
85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Review - physician compensation (see instructions)  88.00 Review - physician compensation (see	82.00	1 .		* .				82.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Reservation bed days (see instructions)	84.00							84.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  98.00 Reservation bed days (see instructions)	85. 00 86. 00							85.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00		PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST				I	1
	87. 00 88. 00	,		· line 2)				1
·		, , , , , , , , , , , , , , , , , , , ,	•					1

Health Financial Systems ST.	JOSEPH HOSPITA	L & HEALTH CENT	TER	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 07/01/2015 To 06/30/2016		
		Ti tl	e XVIII	Subprovi der -	PPS	
				<u>I RF</u>		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	443, 703	3, 511, 276	0. 12636	5 0	0	90. 00
91.00 Nursing School cost	0	3, 511, 276	0.00000	0	0	91.00
92.00 Allied health cost	0	3, 511, 276	0.00000	0	0	92.00
93.00 All other Medical Education	0	3, 511, 276	0.00000	0 0	0	93. 00

Health Fina	ncial Systems	ST. JOSEPH HOSPITAL & H	HEALTH CENTER	In Lie	u of Form CMS-2	2552-10
COMPUTATI ON	N OF INPATIENT OPERATING COST		Provi der CCN: 150010	Peri od: From 07/01/2015	Worksheet D-1	
				To 06/30/2016	Date/Time Prep 11/22/2016 2:	pared: 42 pm
			Title XIX	Hospi tal	Cost	
	Cost Center Description					
					1. 00	
PART	I - ALL PROVIDER COMPONENTS					
I NPA	TIENT DAYS					
1.00 I npa	Inpatient days (including private room days and swing-bed days, excluding newborn) 18,380 1				1.00	
2.00 Inpa	tient days (including private room	days, excluding swing-be	ed and newborn days)		18, 380	2.00
3.00 Pri v	rate room days (excluding swing-bed	and observation bed days	s). If you have only pr	ivate room days,	0	3. 00

	Cost Center Description		
		1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	18, 380	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18, 380	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	17, 645	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	416	9. 00
	newborn days)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	1, 974	15.00
16.00	Nursery days (title V or XIX only)	280	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18.00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	16, 793, 198	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)	_	
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16, 793, 198	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line)	16, 793, 198	37. 00
37.00	27 minus line 36)	10, 173, 170	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)	913. 67	38. 00
	Program general inpatient routine service cost (line 9 x line 38)		
39.00	, , , , , , , , , , , , , , , , , , , ,	380, 087	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0 380, 087	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	38U, U8/	4 I. UU

8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and	416	9. 00
7.00	newborn days)	410	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
40.00	through December 31 of the cost reporting period		40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	1, 974	
16. 00	Nursery days (title V or XIX only)		16. 00
	SWING BED ADJUSTMENT	200	. 0. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18.00
	reporting period		
19. 00	Medical drate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20. 00	reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	16, 793, 198	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)	_	
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25 00	7 x line 19)	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	U	25. 00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16, 793, 198	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	10/11/0/11/0	
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 16, 793, 198	
37.00	27 minus line 36)	10, 793, 198	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)	913, 67	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	380, 087	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	380, 087	41.00

	Financial Systems ST.  ATION OF INPATIENT OPERATING COST	JOSEPH HOSPITAL			In Lie Period:	wof Form CMS-2 Worksheet D-1	
01	5. 2.0 5. 2.0 5. 5.0.			1	From 07/01/2015 Fo 06/30/2016	Date/Time Pre	pared:
			T: 4			11/22/2016 2:	42 pm
	Cost Center Description	Total	Total	le XIX Average Per	Hospital Program Days	Cost Program Cost	
	·	Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
2. 00	NURSERY (title V & XIX only)	1, 042, 303					42. 0
	Intensive Care Type Inpatient Hospital Units						l
3. 00 4. 00	INTENSIVE CARE UNIT	3, 446, 855	2, 331	1, 478. 70	196	289, 825	43. 0 44. 0
5. 00	BURN INTENSIVE CARE UNIT						45. 0
6. 00	1						46. 0
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1. 00	
8. 00	Program inpatient ancillary service cost (Wk					3, 447, 235	
9. 00	Total Program inpatient costs (sum of lines	41 through 48)(	(see instructio	ns)		4, 264, 993	49.0
0. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	patient routine	services (from	Wkst. D. sum	of Parts I and	0	50.0
	111)		•				
1. 00	Pass through costs applicable to Program inpland IV)	oatient ancillar	ry services (fr	om Wkst. D, si	um of Parts II	0	51. C
2. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.0
3. 00	Total Program inpatient operating cost exclu	ıding capital re	elated, non-phy	sician anesth	etist, and	0	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
4. 00	Program discharges					0	54.0
	Target amount per discharge					l	55.0
6. 00	, ,			!	! F2)	l e	56.0
7. 00 8. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amount (i	ine 56 minus i	ine 53)	0	
9. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	ending 1996, u	pdated and cor	mpounded by the		59.0
0 00	market basket						,,,
0. 00 1. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60. C
1. 00	which operating costs (line 53) are less that						01.0
0 00	amount (line 56), otherwise enter zero (see	instructions)					
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	nent (see instru	ıctions)			0	
0. 00	PROGRAM INPATIENT ROUTINE SWING BED COST	10111 (300 1113111	10 (1 0113)				] 00.0
4. 00		sts through Dece	ember 31 of the	cost reporti	ng period (See	0	64.0
5. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	sts after Decemb	er 31 of the c	ost reportina	period (See	0	65.0
	instructions) (title XVIII only)						
6. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.0
7. 00	Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 o	f the cost rep	orting period	0	67.0
0 00	(line 12 x line 19)						,,,,
8.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ie costs after L	ecember 31 or	tne cost repoi	rting perioa	0	68. 0
9. 00	Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	68)		0	69. 0
0 00	PART III - SKILLED NURSING FACILITY, OTHER N					T	70.6
0. 00 1. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	,		,			70.0
2. 00				_,			72.0
3. 00	Medically necessary private room cost applic						73.0
i. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			art II column		74.0
, 00	26, line 45)	Toutine Service	, costs (IIOII W	orkaneet b, Po	art II, COLUMII		'5. (
5. 00	Per diem capital-related costs (line 75 ÷ li						76.0
7. 00 8. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.0
9. 00	Aggregate charges to beneficiaries for exces	•	rovi der record	s)			79.0
0. 00	Total Program routine service costs for comp	parison to the o			us line 79)		80.0
1.00	Inpatient routine service cost per diem limi						81.0
2. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (		* .				82.0
4. 00	Program inpatient ancillary services (see in	•	,				84. 0
5. 00	Utilization review - physician compensation	(see instruction					85.0
6. 00			rough 85)				86.0
7. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					735	87. 0
8. 00	Adjusted general inpatient routine cost per	•	line 2)			913. 67	1
0. 00		e instructions)				671, 547	

Health Financial Systems	ST. JOS	EPH HOSPITAL	_ & HEALTH CENT	ER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Period: From 07/01/2015	Worksheet D-1	
					To 06/30/2016	Date/Time Prep 11/22/2016 2:	pared: 42 pm_
			Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Cost	Routine Cost	column 1 ÷	Total	Observati on	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	Τ					
90.00 Capi tal -related cost		1, 317, 180	16, 793, 198	0. 07843	5 671, 547	52, 673	90.00
91.00 Nursing School cost		0	16, 793, 198	0.00000	671, 547	0	91.00
92.00 Allied health cost		0	16, 793, 198	0.00000	671, 547	0	92.00
93.00 All other Medical Education	1	0	16, 793, 198	0. 000000	671, 547	0	93. 00

Health Financial Systems	ST. JOSEPH HOSPITAL & F	HEALTH CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010	Peri od: From 07/01/2015	Worksheet D-1
		Component CCN: 15T010		
		Title XIX	Subprovi der -	Cost

		TI LIE XIX	I RF	Cost	
	Cost Center Description			4 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			3, 553	
2.00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days)			3, 553	2. 00
3. 00	do not complete this line.	). IT you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		3, 553	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	3, 553	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December 1	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	uays) arter becember s	or or the cost	U	6.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7.00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	55	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		nom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enti-	er 0 on this line)	Join days) ares.		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	room dove)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar yea			U	13.00
14.00	Medically necessary private room days applicable to the Program			0	14.00
15. 00	Total nursery days (title V or XIX only)			1, 974	
16. 00	Nursery days (title V or XIX only)			280	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services	through December 31 of	the cost	0.00	17. 00
17.00	reporting period	tin odgir becember of or	1110 0031	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of 1	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	0.00	19. 00
19.00	reporting period	till ought beceiliber 31 of	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20.00
21 00	reporting period			2 511 27/	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	3, 511, 276 0	21.00
22.00	5 x line 17)	or or the cost reporti	ng perrou (rrne	o l	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18)   Swing-bed cost applicable to NF type services through December:	21 of the cost reportin	na poriod (Line	0	24. 00
24.00	7 x line 19)	or the cost reporting	ig perrou (Trie	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25.00
07.00	x line 20)				04.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ne 21 minus line 26)		0 3, 511, 276	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	The 21 millius Title 20)	ļ	3, 311, 270	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	ino 20)		0. 000000	30. 00 31. 00
31. 00 32. 00	Average private room per diem charge (line 29 ÷ line 3)	THE 20)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34.00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruct	tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line	31)		0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	d	S6	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and 27 minus line 36)	a private room cost dii	rerential (line	3, 511, 276	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST				
38. 00	Adjusted general inpatient routine service cost per diem (see in			988. 26	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program			54, 354 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 +	,		54, 354	
	, J. J. J		ļ	, 1	

Heal th	Financial Systems ST.	JOSEPH HOSPITAL	& HEALTH CENTE	R	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	Fr	eriod: com 07/01/2015	Worksheet D-1	
			·	CCN: 15T010 To		11/22/2016 2:	
			litl	e XIX	Subprovider - IRF	Cost	
	Cost Center Description	Total Inpatient Cost	Total npatient Days D	Average Per iem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (4: 41 - V 0 VIV1.)	1.00	2.00	3.00	4. 00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. 00	0	0	42. 00
43. 00 44. 00	INTENSIVE CARE UNIT	0	0	0. 00	0	0	43. 00 44. 00
45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00 47. 00
47.00	OST Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	line 200)			1. 00 67, 115	48. 00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			s)		121, 469	•
50.00	Pass through costs applicable to Program inp	atient routine :	services (from	Wkst. D, sum c	f Parts I and	0	50. 00
51. 00		atient ancillar	y services (fro	m Wkst. D, sum	of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)	,			0	52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital re	ated, non-phys	ician anesthet	ist, and	ő	•
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	1
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	•
57. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (li	ne 56 minus li	ne 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period (	endi ng 1996, up	dated and comp	ounded by the	0.00	58. 00 59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. upo	dated by the ma	rket basket		0.00	60. 00
	If line 53/54 is less than the lower of line	s 55, 59 or 60 (	enter the lesse	r of 50% of th		0	61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (TITIES 54 X 6	U), OF 1% OF L	ne target		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos			cost reporting	nariod (See	0	64. 00
	instructions) (title XVIII only)	3				0	
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)				•		
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line o	64 plus line 65	)(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 of	the cost repo	rting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after De	ecember 31 of t	he cost report	ing period	О	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70. 00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line	,	ne 70 ÷ line 2	)			71. 00 72. 00
73. 00	Medically necessary private room cost applic	abĺe to Program		e 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	,	rksheet B, Par	t II, column		74. 00 75. 00
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der records	)			79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitation	(line 78 minus	line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		5)				83. 00 84. 00
85. 00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		rough 85)				86. 00
87. 00	Total observation bed days (see instructions	)	1: 22			0	•
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		iine 2)			l e	88. 00 89. 00

Health Financial Systems	ST. JOSEPH HOSPITA	L & HEALTH CENT	ER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 2:	
		Tit	le XIX	Subprovi der -	Cost	
				<u>I RF</u>		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THRO	DUGH COST					
90.00 Capital-related cost	443, 703	3, 511, 276	0. 12636	5 0	0	90. 00
91.00 Nursing School cost	0	3, 511, 276	0. 000000	0	0	91. 00
92.00 Allied health cost	0	3, 511, 276	0. 000000	0	0	92. 00
93.00 All other Medical Education	0	3, 511, 276	0. 000000	0 0	0	93. 00

Health Financial Systems ST. JOSEPH HOSPITA	AL & HEALTH CENT	TER	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150010	Peri od:	Worksheet D-3	
			From 07/01/2015		
			To 06/30/2016	Date/Time Pre	
	Ti +I	e XVIII	Hospi tal	11/22/2016 2: PPS	42 piii
Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
		10 charges	Charges	(col. 1 x col.	
			onar ges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			12, 039, 909		30. 00
31.00 03100 INTENSIVE CARE UNIT			5, 095, 254		31. 00
41. 00   04100   SUBPROVI DER - I RF			0		41.00
43. 00   04300   NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 20340	12, 930, 005	2, 629, 976	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 20756	6 22, 692	4, 710	52.00
53. 00   05300   ANESTHESI OLOGY		0. 00917	1, 681, 964	15, 427	53.00
54. OO O5400 RADI OLOGY-DI AGNOSTI C		0. 25291	7 1, 927, 010	487, 374	54.00
54. 01   03630   ULTRA SOUND		0. 09825	1 657, 480	64, 598	54. 01
57. 00  05700  CT   SCAN		0. 07334	0 118, 300	8, 676	57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0. 18140	277, 400	50, 321	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 14587			59.00
60. 00   06000   LABORATORY		0. 12812		1, 625, 383	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 18523			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 33772		486, 895	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY		0. 38351		387, 395	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 46410			68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 14530			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 16652			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 27751			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 34053		2, 721, 152	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 47500		2, 184, 749	73. 00
74. 00   07400   RENAL DI ALYSI S		1. 17122		132, 221	74. 00
76. 00 03950 BEHAVI ORAL HEALTH SERVI CES		0. 56454		0	76. 00
76. 01   03480   ONCOLOGY		0. 32300		70, 773	76. 01
76. 02   03330   ENDOSCOPY		0. 11481		49, 721	76. 02
76. 03 03951 WOUND CARE		0. 10111	0 0	0	76. 03

0. 099081

0. 224652

0.000000

5, 555, 661

64, 457, 876

64, 457, 876

0 90.00

91.00

92.00

95. 00 98. 00

201. 00 202. 00

550, 460

0

ol

14, 251, 339 200. 00

OUTPATIENT SERVICE COST CENTERS

95. 00 09500 AMBULANCE SERVICES 98. 00 09850 OTHER REIMBURSABLE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

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

Net Charges (line 200 minus line 201)

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

09000 CLI NI C

09100 EMERGENCY

90.00

91.00

92.00

200.00

201.00

202.00

NPATI EN	NT ANCILLARY SERVICE COST APPORTIONMENT	rovi der	CCN: 150010	Period: From 07/01/2015	Worksheet D-3	
	C	Component	CCN: 15T010		Date/Time Pre 11/22/2016 2:	
		Ti tl	e XVIII	Subprovi der - I RF	PPS	12
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3. 00	
I	NPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
	3000 ADULTS & PEDI ATRI CS			0		30. (
1.00 0	3100 INTENSIVE CARE UNIT			0		31. (
	4100 SUBPROVI DER - I RF			4, 060, 340		41. (
	4300 NURSERY					43. (
	NCI LLARY SERVI CE COST CENTERS					
	5000 OPERATI NG ROOM		0. 2034	1	2, 512	1
	DELIVERY ROOM & LABOR ROOM		0. 2075		0	
	15300 ANESTHESI OLOGY		0.0091		0	53. (
	15400 RADI OLOGY-DI AGNOSTI C 13630 ULTRA SOUND		0. 2529			
	15700 CT SCAN		0. 0982 0. 0733	· ·	2, 437 2, 182	1
	5500 MAGNETIC RESONANCE IMAGING (MRI)		0.0733		689	
9.00 0	15900 CARDI AC CATHETERI ZATI ON		0. 1458		007	
	16000 LABORATORY		0. 1281		135, 926	1
	16500 RESPI RATORY THERAPY		0. 1852		112, 940	
	16600 PHYSI CAL THERAPY		0. 3377		438, 251	1
	06700 OCCUPATI ONAL THERAPY		0. 3835		469, 190	
8.00 0	6800 SPEECH PATHOLOGY		0. 4641	02 148, 985	69, 144	68.
9.00 0	6900 ELECTROCARDI OLOGY		0. 1453	08 15, 438	2, 243	69.
	17000 ELECTROENCEPHALOGRAPHY		0. 1665		654	
	17100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2775			
	17200 I MPL. DEV. CHARGED TO PATIENTS		0. 3405		1, 804	1
3.00 0	07300 DRUGS CHARGED TO PATIENTS		0. 4750			
	17400 RENAL DIALYSIS		1. 1712		36, 189	
	13950 BEHAVI ORAL HEALTH SERVI CES 13480 ONCOLOGY		0. 5645		0	
	13480 ONCOLOGY 13330 ENDOSCOPY		0. 3230 0. 1148		0 0	
	13951 WOUND CARE		0. 1148		0	
	UTPATI ENT SERVI CE COST CENTERS		0. 1011	10  0	0	70.
	9000 CLI NI C		0.0000	00 0	0	90. (
	9100 EMERGENCY		0. 0990		Ö	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2246		0	92.
0	THER REIMBURSABLE COST CENTERS					
	9500 AMBULANCE SERVICES					95.
8. 00 0	9850 OTHER REIMBURSABLE COST CENTERS		0.0000	00 0	0	98. (
00.00	Total (sum of lines 50-94 and 96-98)			5, 346, 545	1, 617, 677	
201.00	Less PBP Clinic Laboratory Services-Program only charges (li	ne 61)		0		201. (
202.00	Net Charges (line 200 minus line 201)			5, 346, 545		202.

	SPITAL & HEALTH CEN			eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
			From 07/01/2015 To 06/30/2016	Date/Time Pre	pared:
-				11/22/2016 2:	42 pm
	Ti 1	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			3, 393, 643		30.00
31.00 03100 INTENSIVE CARE UNIT			732, 666		31.00
41. 00   04100   SUBPROVI DER -   RF			0		41.00
43. 00 04300 NURSERY			1, 544, 706		43.00
ANCILLARY SERVICE COST CENTERS					1
50.00 05000 OPERATING ROOM		0. 20340	2, 480, 670	504, 571	50.00
52.00   O5200   DELIVERY ROOM & LABOR ROOM		0. 20756	5, 796, 968	1, 203, 253	52.00
53. 00   05300   ANESTHESI OLOGY		0.00917	275, 452	2, 526	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 25291			
54. 01   03630   ULTRA SOUND		0. 09825			
57.00  05700   CT   SCAN		0. 07334			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 18140			
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 14587			
60. 00   06000   LABORATORY		0. 12812			
65. 00 06500 RESPI RATORY THERAPY		0. 18523			
66. 00   06600   PHYSI CAL THERAPY		0. 33745			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 38351			
68. 00   06800   SPEECH PATHOLOGY		0. 46410			
69. 00   06900   ELECTROCARDI OLOGY		0. 14530			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 16652			
71. 00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 27751		235, 719	1
72. 00 O7200 I MPL. DEV. CHARGED TO PATIENTS		0. 34053			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0.47500			1
74. 00   07400   RENAL DI ALYSI S		1. 17122			
76. 00 03950 BEHAVI ORAL HEALTH SERVI CES		0. 56454			
76. 01   03480   ONCOLOGY		0. 32300			
76. 02   03330   ENDOSCOPY		0. 11481			
76. 03 O3951 WOUND CARE OUTPATIENT SERVICE COST CENTERS		0. 10111	0 29, 090	2, 941	1 /6.03
90. 00 09000 CLINIC		0.00000	0	0	90.00
91. 00   09100   EMERGENCY		0.00000		_	
92 OO O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0.07700			

0. 224652

0.000000

17, 604, 730

17, 604, 730

92.00

201. 00

202. 00

0

95. 00 98. 00 3, 447, 235 200. 00

92.00

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

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

Net Charges (line 200 minus line 201)

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

95. 00 09500 AMBULANCE SERVICES 98. 00 09850 OTHER REIMBURSABLE COST CENTERS

	ncial Systems ST. JOSEPH HOSPITAL & HEA NCILLARY SERVICE COST APPORTIONMENT F		CCN: 150010	Peri od:	worksheet D-3	
		omponent	CCN: 15T010	From 07/01/2015 To 06/30/2016	Date/Time Pre	nared.
					11/22/2016 2:	
		Ti t	le XIX	Subprovi der – I RF	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
I NDA	TENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	ADULTS & PEDIATRICS			0		30.00
	INTENSIVE CARE UNIT			0		31.00
	SUBPROVI DER - I RF			183, 491		41.00
43.00 0430				0		43.00
ANCI I	LARY SERVICE COST CENTERS			<u>'</u>	•	1
50.00 0500	OPERATING ROOM		0. 2034	01 0	0	50.00
	DELIVERY ROOM & LABOR ROOM		0. 2075	66 0	0	52.00
	ANESTHESI OLOGY		0. 0091	72 0	0	53.00
	RADI OLOGY-DI AGNOSTI C		0. 2529	17 4, 270	1, 080	54.00
	ULTRA SOUND		0. 0982		0	
	CT SCAN		0. 0733		0	
	MAGNETIC RESONANCE IMAGING (MRI)		0. 1814		0	
	CARDI AC CATHETERI ZATI ON		0. 1458		0	
	LABORATORY		0. 1281	· ·	5, 736	
	RESPIRATORY THERAPY		0. 1852			
	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY		0. 3374 0. 3835			1
	SPEECH PATHOLOGY		0. 3633		2, 447	
	ELECTROCARDI OLOGY		0. 1453		2, 447	1
	ELECTROENCEPHALOGRAPHY		0. 1665		164	
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2775		0	
	IMPL. DEV. CHARGED TO PATIENTS		0. 3405		0	
	DRUGS CHARGED TO PATIENTS		0. 4750		9, 831	
74. 00 0740	RENAL DIALYSIS		1. 1712	27 0	0	74.00
76. 00   03950	BEHAVIORAL HEALTH SERVICES		0. 5645	49 660	373	76.00
	ONCOLOGY		0. 3230		0	
	ENDOSCOPY		0. 1148		0	
	WOUND CARE		0. 1011	10 0	0	76. 03
	ATLENT SERVICE COST CENTERS				_	
	CLINIC		0.0000			
	EMERGENCY		0.0990			
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 2246	52 0	0	92.00
	R REIMBURSABLE COST CENTERS  AMBULANCE SERVICES					95.00
	OTHER REIMBURSABLE COST CENTERS		0. 0000	00 0	_	98.00
200.00	Total (sum of lines 50-94 and 96-98)		0.0000	220, 494	l e	
201.00	Less PBP Clinic Laboratory Services-Program only charges (li	ne 61)		220, 494	07, 115	201. 00
-01.00	12000 . D. Olithio Euboratory oct vices irrogram only charges (1)	01)	I	1	I	1-01.00

Health Financial Systems	ST. JOSEPH HOSPITAL & H	EALTH CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150010	From 07/01/2015	Worksheet E Part A Date/Time Prepared: 11/22/2016 2:42 pm

	Ti +Lo VVIII	ospi tal	11/22/2016 2: 4 PPS	42 pm
	Title XVIII H	ospi tal	PPS	
	1		1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments		0	1. 00
1. 00 1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see		4, 024, 163	1. 00
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	:	12, 898, 292	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior	to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or	after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)		565, 522	2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2. 01 2. 02
3.00	Managed Care Simulated Payments		2, 528, 612	3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions Indirect Medical Education Adjustment	.)	104. 99	4. 00
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period or before 12/31/1996. (see instructions)	endi ng on	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to for new programs in accordance with 42 CFR 413.79(e)	the cap	0. 00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv	(B) (1)	0.00	7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(i If the cost report straddles July 1, 2011 then see instructions.		0. 00	7. 01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 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 under section 5503 of the the cost report straddles July 1, 2011, see instructions.	ACA. If	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hos under section 5506 of ACA. (see instructions)	pi tal	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0. 00	9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10. 00 11. 00
12. 00			0.00	
13.00			0.00	
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September otherwise enter zero.	30, 1997,	0. 00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.		0.00	15. 00
16. 00			0. 00	
17. 00				17. 00
18. 00 19. 00			0. 00 0. 000000	
20.00	, ,		0. 000000	
21. 00			0.000000	
22. 00	·		0	
22. 01	IME payment adjustment - Managed Care (see instructions)		0	22. 01
22.00	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	2 105	0.00	22.00
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 41 $(f)(1)(iv)(C)$ .	2. 105	0.00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (s	.ee	0. 00	25. 00
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)		0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)		0. 000000	
28. 00			0.000000	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)		0	28. 01
29. 00			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29. 01
20.00	Disproportionate Share Adjustment  Descentage of SSL registers not entirest days to Medicare Port A nations days (see instructions)		2 05	20.00
30. 00 31. 00			3. 85 23. 86	
31.00			23. 86 27. 71	
33. 00			12. 08	
	Disproportionate share adjustment (see instructions)		511, 059	
		'		

ALCUL	Financial Systems ST. JOSEPH HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150010	Peri od:	u of Form CMS-2 Worksheet E	
			From 07/01/2015 To 06/30/2016	Part A Date/Time Pre	
		Title XVIII	Hospi tal	11/22/2016 2: PPS	42 p
		I tre will	Prior to 10/1		
			1.00	2. 00	
	Uncompensated Care Adjustment				
5. 00	Total uncompensated care amount (see instructions)		0	0	
5. 01	Factor 3 (see instructions)	nton zono on this line)	0. 000000000	0.000000000	
5. 02	Hospital uncompensated care payment (If line 34 is zero, e (see instructions)	inter zero on this rine)	1, 250, 131	1, 026, 564	35.
5. 03	Pro rata share of the hospital uncompensated care payment a	mount (see instructions)	315, 102	768, 521	35.
. 00	Total uncompensated care (sum of columns 1 and 2 on line 35 Additional payment for high percentage of ESRD beneficiary		1, 083, 623		36.
. 00	Total Medicare discharges on Worksheet S-3, Part I excludin		2, 063		40.
	652, 682, 683, 684 and 685 (see instructions)				١
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		41.
. 01	Total ESRD Medicare covered and paid discharges excluding M	S-DRGs 652, 682, 683, 684	0		41
2. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qua	lify for adjustment)	0.00		42
. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,				43
00	instructions)	•			١
. 00	Ratio of average length of stay to one week (line 43 divide days)	d by line 41 divided by 7	0. 000000		44
. 00	Average weekly cost for dialysis treatments (see instruction		0.00		45
. 00	Total additional payment (line 45 times line 44 times line	41. 01)	10,000,750		46
. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	small rural hosnitals	19, 082, 659		47
. 00	only. (see instructions)	silari rurar 1103pi tars			40
				Amount	
. 00	Total payment for inpatient operating costs (see instructio	ne)		1. 00 19, 082, 659	49
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I			1, 461, 167	
. 00	Exception payment for inpatient program capital (Wkst. L, P			0	1
. 00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		0	
. 00	Nursing and Allied Health Managed Care payment			13, 500	
. 00	Special add-on payments for new technologies Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	(0)		0	
. 00	Cost of physicians' services in a teaching hospital (see in	•		0	
. 00	Routine service other pass through costs (from Wkst. D, Pt.	*	hrough 35).	0	
. 00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, col. 11 line 200)		46, 421	58
. 00	Total (sum of amounts on lines 49 through 58)			20, 603, 747	
. 00	Primary payer payments	us line (O)		5, 145	
. 00	Total amount payable for program beneficiaries (line 59 min Deductibles billed to program beneficiaries	us iille ou)		20, 598, 602 1, 934, 856	
. 00	Coinsurance billed to program beneficiaries			61, 103	
. 00	Allowable bad debts (see instructions)			178, 738	
. 00	Adjusted reimbursable bad debts (see instructions)			116, 180	
	Allowable bad debts for dual eligible beneficiaries (see in	structions)		49, 618	
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			18, 718, 823	67
00	Credits received from manufacturers for replaced devices fo			0	
00	Outlier payments reconciliation (sum of lines 93, 95 and 96	). (FOR SCH SEE INSTRUCTION	S)	0	1
. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT			0	
. 88	SCH or MDH volume decrease adjustment			0	1
	Pioneer ACO demonstration payment adjustment amount (see in	structions)		0	1
. 89	HSP bonus payment HVBP adjustment amount (see instructions)	•		0	1
	HSP bonus payment HRR adjustment amount (see instructions)			0	70
). 90 ). 91					
). 90 ). 91 ). 92	Bundled Model 1 discount amount (see instructions)			0	
0. 89 0. 90 0. 91 0. 92 0. 93 0. 94	Bundled Model 1 discount amount (see instructions)			0 43, 973 0	70

	Financial Systems ST. JOSEPH HOSPITAL & F				u of Form CMS-2	2002 10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150010	Period: From 07/01/2015	Worksheet E Part A	
				To 06/30/2016		nared:
				10 00/00/2010	11/22/2016 2:	
		Ti tl	e XVIII	Hospi tal	PPS	
	· · · · · · · · · · · · · · · · · · ·		FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
	the corresponding federal year for the period ending on or afte	r 10/1)				
70. 98	Low Volume Payment-3				0	, 0. , 0
70. 99	HAC adjustment amount (see instructions)				0	1 . 0 . , ,
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	& 70)			18, 762, 796	
71. 01	Sequestration adjustment (see instructions)				375, 256	
	Interim payments				18, 299, 487	
73. 00	Tentative settlement (for contractor use only)				0	
74. 00			•	74. 00		
75. 00	Protested amounts (nonallowable cost report items) in accordance	e with			158, 323	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instr	uctions)			0	
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	7
92. 00	Operating outlier reconciliation adjustment amount (see instruc				0	1 /2.00
93. 00	Capital outlier reconciliation adjustment amount (see instructi				0	70.00
	The rate used to calculate the time value of money (see instruc	tions)			0.00	
	Time value of money for operating expenses (see instructions)	,			0	
96.00	Time value of money for capital related expenses (see instructi	ons)		D : 1 40/4	0 (4.6) 10 (1	96. 00
				Prior to 10/1 1.00		
	LICD Danua Daymant Amount			1.00	2. 00	
100 00	HSP Bonus Payment Amount HSP bonus amount (see instructions)			O	0	100.00
100.00	HVBP Adjustment for HSP Bonus Payment			U U	U	100.00
101 00	HVBP adjustment factor (see instructions)			0.0000000000	0. 0000000000	101 00
	HVBP adjustment factor (see firstructions)			0.000000000		101.00
102.00	HRR Adjustment for HSP Bonus Payment (see Instructions)			U U	0	102.00
102 00	HRR adjustment factor (see instructions)			0.0000	0.0000	102 00
	HINN AUTUSTIICHT TACTOL (SEE HISTIACHOUS)			0. 0000	0.0000	1103.00

Health Financial Systems	ST. JOSEPH HOSPITAL & H	EALTH CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150010	From 07/01/2015	Worksheet E Part B Date/Time Prepared: 11/22/2016 2:42 pm

			To 06/30/2016	Date/Time Prep 11/22/2016 2:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			8, 037	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		23, 536, 254	2. 00
3.00	PPS payments			19, 057, 403	3.00
4. 00 5. 00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instruct	i one)		87, 676 0. 250	4. 00 5. 00
6. 00	Line 2 times line 5	1 0113)		5, 884, 064	
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		321, 092	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			8, 037	11. 00
	Reasonable charges				
12.00	Ancillary service charges			17, 541	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)			17, 541	14. 00
15 00	Customary charges			0	15 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pa Amounts that would have been realized from patients liable for			0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	payment for services t	on a chargebasi's	O	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00
18. 00	Total customary charges (see instructions)			17, 541	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	9, 504	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only</pre>	if line 11 eveneds li	no 18) (soo	0	20. 00
20.00	instructions)	TT TITLE TT CACCCUS TT	110 10) (300	O	20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		8, 037	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00					23. 00
24. 00	.00 Total prospective payment (sum of lines 3, 4, 8 and 9)  COMPUTATION OF REIMBURSEMENT SETTLEMENT				24. 00
25. 00					25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)	)	3, 865, 575	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	2 and 23] (see	15, 607, 797	27. 00
20.00	instructions)	o FO)		0	20.00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, lin ESRD direct medical education costs (from Wkst. E-4, line 36)	e 30)		0	28. 00 29. 00
30.00	Subtotal (sum of lines 27 through 29)			15, 607, 797	
31.00	Primary payer payments			5, 296	
32. 00	Subtotal (line 30 minus line 31)			15, 602, 501	32. 00
00.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)	T	-	00.00
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 337, 918	
35. 00	Adjusted reimbursable bad debts (see instructions)			219, 647	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		167, 343	
37. 00	Subtotal (see instructions)			15, 822, 148	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R				38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50 39. 98	Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replace	d dovi cos (sos i netru	ations)	0	39. 50 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	d devices (see ilistid	Li uis)	0	39. 99
40. 00	Subtotal (see instructions)			15, 822, 148	40. 00
40. 01	Sequestration adjustment (see instructions)			316, 443	40. 01
41.00				15, 389, 791	
42.00	· · · · · · · · · · · · · · · · · · ·			0	42.00
43.00	, , ,			115, 914 0	43. 00 44. 00
44. 00	§115. 2	e with two Pub. 15-2,	спартег Т,	U	44.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			0	
55			'	٥١	

Heal th FinancialSystemsST. JOSEPANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICESRENDERED Provider CCN: 150010 | Period: | Worksheet E-1 | Part I | Date/Time Prepared: | 11/22/2016 2: 42 pm

					11/22/2016 2: 4	42 pm_
			e XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4.00	
1.00	Total interim payments paid to provider		18, 256, 587		15, 298, 391	1. 00
2.00	Interim payments payable on individual bills, either		(	)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	01/20/2016	42, 900	01/20/2016	91, 400	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER	0172072010	72, 700		0	3. 02
3. 03					0	3. 03
3. 04			(		0	3. 04
3. 05			(		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		(	)	0	3.50
3.51			(	)	0	3. 51
3.52			(	)	0	3. 52
3.53			(	)	0	3. 53
3.54			(	)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		42, 900	)	91, 400	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		18, 299, 487		15, 389, 791	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			•	'	
5. 01	TENTATI VE TO PROVI DER		(	)	0	5. 01
5.02			(	)	0	5. 02
5.03			(	)	0	5.03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(		0	5. 50
5. 51			(		0	5. 51
5. 52			(		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(	)	0	5. 99
/ 00	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		88, 053		115, 914	6. 01
6. 02	SETTLEMENT TO PROGRAM		88, 03.		113, 714	6. 02
7. 00	Total Medicare program liability (see instructions)		18, 387, 540		15, 505, 705	7. 00
7.00	1.0 ca., moar our o program Trability (300 Histractions)		10, 307, 340	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8.00	Name of Contractor					8. 00
	·					

		Ti tl	e XVIII	Subprovider -	PPS	12 piii
		Inpatier	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4, 070, 25(	0	0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03			•	0	0	3. 03
3.04				0	0	3. 04
3. 05	Dravi dan ta Dragnam			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		Ι ,	0	0	3. 50
3. 51	ADJUSTINIENTS TO FROUNAIN			0		3. 51
3. 52				0		3. 52
3. 53				o o	l ol	3. 53
3.54				Ö	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4, 070, 250	0	0	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5.03	Dani dan ta Danaman			0	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			0	0	5. 50
5. 50	ILINIATIVE TO FROGRAM		•	0		5. 50
5. 52				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		12, 51:		0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 082, 76		0	7. 00
			2	Contractor Number	NPR Date (Mo/Day/Yr)	
8. 00	Name of Contractor		0	1. 00	2. 00	8. 00
0.00	INAME OF COTTE ACTO			I	1	0.00

Hool +h	Financial Systems ST IOSEDH HOSDITAL & I	JEALTH CENTED	In Lio	u of Form CMS-2	DEED 10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 150010 Period: From 07/01/2015 To 06/30/2016				Worksheet E-1 Part II	pared:	
		Title XVIII	Hospi tal	PPS		
				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	S-3, Pt. I col. 15 line	14	6, 006	1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-1	2		9, 561	2. 00	
3.00	00   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	2		19, 976	4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			491, 901, 371	5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lir			10, 787, 942	6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of cer line 168	tified HIT technology	Wkst. S-2, Pt. I	0	7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)			848, 038	8. 00	
9.00	Sequestration adjustment amount (see instructions)			16, 961	9. 00	
10.00	Calculation of the HIT incentive payment after sequestration (s		831, 077	10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			805, 428	30.00	
31.00	Other Adjustment (specify)			0	31.00	
22 00	20 Release due provider (line 0 (or line 10) minus line 20 and line 21) (occ instructions)					

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

805, 428 30. 00 0 31. 00 25, 649 32. 00

Health Financial Systems	ST. JOSEPH HOSPITAL & H	EALTH CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150010	Peri od: From 07/01/2015	Worksheet E-3
		Component CCN: 15T010		
		Title XVIII	Subprovi der -	PPS

			I RF		
	DART III. MEDICARE DART A CERVICEC. LRE DRO			1. 00	
1. 00	PART III - MEDICARE PART A SERVICES - IRF PPS  Net Federal PPS Payment (see instructions)			4, 084, 803	1 00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0263	1. 00 2. 00
3. 00	Inpatient Rehabilitation LIP Payments (see instructions)			108, 656	3. 00
4. 00	Outlier Payments			60, 247	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost	roporting poriod andi	ng on or prior	0.00	5. 00
5.00	to November 15, 2004 (see instructions)	reporting period endi	ing on or prior	0.00	3.00
5. 01	Cap increases for the unweighted intern and resident FTE count for	or residents that were	displaced by	0. 00	5. 01
3.01	program or hospital closure, that would not be counted without a			0.00	3.01
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	tompor ary out aug ao timo			
6.00	New Teaching program adjustment. (see instructions)			0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the	new program growth per	iod of a "new	0.00	7. 00
	teaching program" (see instructions)	7 3 3 3 1 7			
8.00	Current year's unweighted I&R FTE count for residents within the	new program growth per	iod of a "new	0.00	8. 00
	teaching program" (see instructions)				
9.00	Intern and resident count for IRF PPS medical education adjustmen	nt (see instructions)		0.00	9. 00
10.00	Average Daily Census (see instructions)			9. 707650	10.00
11. 00	Teaching Adjustment Factor (see instructions)			0.000000	
12.00	Teaching Adjustment (see instructions)			0	12. 00
13.00	Total PPS Payment (see instructions)			4, 253, 706	
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	)		0	14. 00
15. 00	Organ acquisition (DO NOT USE THIS LINE)				15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instruc-	tions)		0	16. 00
17. 00	Subtotal (see instructions)			4, 253, 706	
18. 00	Primary payer payments			0	18. 00
19. 00	Subtotal (line 17 less line 18).			4, 253, 706	
20.00	Deducti bl es			80, 276	
21. 00	Subtotal (line 19 minus line 20)			4, 173, 430	
22. 00	Coinsurance			16, 289	
23. 00	Subtotal (line 21 minus line 22)			4, 157, 141	
24. 00	Allowable bad debts (exclude bad debts for professional services)	(see instructions)		10, 294	
25. 00	Adjusted reimbursable bad debts (see instructions)	h!>		6, 691	
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	tions)		7, 672	26. 00
27. 00 28. 00	Subtotal (sum of lines 23 and 25)	40)		4, 163, 832	27. 00 28. 00
29. 00	Direct graduate medical education payments (from Wkst. E-4, line Other pass through costs (see instructions)	49)		0 2, 252	
30.00	Outlier payments reconciliation			2, 252	30.00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	31.50
31. 99	Recovery of Accelerated Depreciation			0	31. 99
32. 00	Total amount payable to the provider (see instructions)			4, 166, 084	
32. 01	Sequestration adjustment (see instructions)			83, 322	32. 01
33. 00	Interim payments			4, 070, 250	
34. 00	Tentative settlement (for contractor use only)			0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 33, and	34)		12, 512	35. 00
36, 00	Protested amounts (nonallowable cost report items) in accordance		apter 1.	36, 763	
	§115. 2		,		
	TO BE COMPLETED BY CONTRACTOR		'		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			60, 247	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52.00	The rate used to calculate the Time Value of Money			0.00	52. 00
53.00	Time Value of Money (see instructions)			0	53.00
			,	,	

Health Financial Systems	ST. JOSEPH HOSPITAL & HEAL	In Lieu	ı of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pro	ovider CCN: 150010	From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Prepared:

			To 06/30/2016	Date/Time Pre 11/22/2016 2:	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		4, 264, 993		1. 00
2.00	Medical and other services			5, 379, 641	2. 00
3.00	Organ acquisition (certified transplant centers only)		5, 671, 015		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		9, 936, 008	5, 379, 641	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		9, 936, 008	5, 379, 641	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges		1		
8. 00	Routi ne servi ce charges		5, 671, 015		8. 00
9. 00	Ancillary service charges		17, 604, 730	27, 954, 215	9. 00
10.00	Organ acquisition charges, net of revenue		5, 671, 015		10.00
11.00	Incentive from target amount computation		00.044.740	07.054.045	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		28, 946, 760	27, 954, 215	12. 00
12 00	CUSTOMARY CHARGES				12 00
13. 00	Amount actually collected from patients liable for payment for basis	services on a charge	0	0	13. 00
14. 00	Amounts that would have been realized from patients liable for	normant for convices on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42		U	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CIR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		28, 946, 760	27, 954, 215	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	19, 010, 752	22, 574, 574	
17.00	line 4) (see instructions)	TT TIME TO EXCEEDES	17,010,702	22,071,071	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)			_	
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16	)	9, 936, 008	5, 379, 641	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provid	ers.		
22.00	Other than outlier payments	·	0	0	22. 00
23.00	Outlier payments		0	0	23. 00
	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	26. 00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		9, 936, 008	5, 379, 641	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1		
30. 00	Excess of reasonable cost (from line 18)		0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		9, 936, 008	5, 379, 641	
32. 00	Deducti bl es		0	0	32. 00
	Coinsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review		0	E 070 / / /	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	9, 936, 008	5, 379, 641	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0 007 000	U F 270 (41	37. 00
	Subtotal (line 36 ± line 37)		9, 936, 008	5, 379, 641	38. 00 39. 00
	Direct graduate medical education payments (from Wkst. E-4)		9, 936, 008	E 270 //1	40. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)			5, 379, 641	
41. 00 42. 00	Interim payments		9, 936, 008	5, 379, 641 0	41. 00 42. 00
42.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance	o with CMS Dub 15 2	0	0	42.00
43.00	chapter 1, §115.2	e with two Pub 15-2,		U	43.00
	onaptor 1, 3110.2		1		ı

Health Financial Systems	ST. JOSEPH HOSPITAL & F	HEALTH CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150010		Worksheet E-3
			From 07/01/2015	
		Component CCN: 15T010	To 06/30/2016	
				11/22/2016 2:42 pm
		Title XIX	Subprovi der -	Cost

		II tie xix	I RF	COST	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	FS FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	ES TOR TITLES VOR ALL	OLIVI OLO		1
1.00	Inpatient hospital/SNF/NF services		121, 469		1.00
2. 00	Medical and other services		121, 107	0	
3. 00	Organ acquisition (certified transplant centers only)		0	Ü	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		121, 469	0	
5. 00	Inpatient primary payer payments		0	ŭ	5. 00
6.00	Outpatient primary payer payments		Ĭ	0	1
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		121, 469	0	
	COMPUTATION OF LESSER OF COST OR CHARGES		12.7.10.1		
	Reasonable Charges				1
8.00	Routine service charges		0		8.00
9. 00	Ancillary service charges		220, 494	0	
10.00	Organ acquisition charges, net of revenue		0	ŭ	10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		220, 494	0	1
	CUSTOMARY CHARGES				1
13.00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13.00
	basis	3.			
14.00	Amounts that would have been realized from patients liable for pa	yment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 C	FR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		220, 494	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only i	fline 16 exceeds	99, 025	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only i	fline 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instruct	ions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		121, 469	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provide			
	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	
	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		١	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		121, 469	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
30.00	Excess of reasonable cost (from line 18)		١	-	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		121, 469	0	
32. 00	Deductibles		0		
33. 00	Coinsurance		0	0	
35. 00	Allowable bad debts (see instructions) Utilization review		0	U	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	`	121, 469	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		121, 409	0	
	Subtotal (line 36 ± line 37)		121, 469	0	
	Direct graduate medical education payments (from Wkst. E-4)		121, 407	O	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		121, 469	0	
41. 00	Interim payments		121, 469	0	
42. 00	Balance due provider/program (line 40 minus line 41)		121, 407	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2	0	0	
10.00	chapter 1, §115. 2	5110 1 45 10 2,		O	10.00
	1		1		

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

Provi der CCN: 150010

| Period: | Worksheet G | From 07/01/2015 | To 06/30/2016 | Date/Time Prepared: | 11/22/2016 2: 42 pm |

					11/22/2016 2:	42 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
	AUDDENT ACCETO	1.00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	1 520	ı		0	1 00
1.00	Cash on hand in banks	1, 520	l .		0	1.00
2.00	Temporary investments	0	C		0	2.00
3.00	Notes recei vable	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	C	<u> </u>	0	3.00
4.00	Accounts receivable	46, 130, 173	1		0	4.00
5.00	Other receivable	999, 404	l .		0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-26, 822, 788	l .		0	6.00
7. 00 8. 00	Inventory  Proposid expenses	1, 858, 816	1		0	7.00
9. 00	Prepaid expenses Other current assets	130, 047	l .		0	8. 00 9. 00
10. 00	Due from other funds	1, 004, 437		<u> </u>	0	10.00
11. 00	Total current assets (sum of lines 1-10)	23, 301, 609			0	11.00
11.00	FIXED ASSETS	23, 301, 009	1	) U	U	] 11.00
12. 00	Land	722, 779	· C	0	0	12. 00
13. 00	Land improvements	1, 764, 978			0	13.00
14. 00	Accumulated depreciation	-1, 373, 654	1	_	0	14. 00
15. 00	Buildings	87, 352, 168	1		0	15. 00
16. 00	Accumulated depreciation	-49, 282, 721	1		0	16.00
17. 00	Leasehold improvements	47, 202, 721		_	0	17. 00
18. 00	Accumulated depreciation	0		o o	0	18. 00
19. 00	Fixed equipment	0		0	0	19. 00
20. 00	Accumulated depreciation	0		0	0	20.00
21. 00	Automobiles and trucks	0	l č	o o	0	21.00
22. 00	Accumulated depreciation	0		_	0	22. 00
23. 00	Major movable equipment	37, 992, 015	1		0	23. 00
24. 00	Accumulated depreciation	-52, 594, 989	l .	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	d	0	0	25. 00
26. 00	Accumulated depreciation	l o	d	0	0	26. 00
27. 00	HIT designated Assets	0		0	0	27. 00
28. 00	Accumul ated depreciation	0		0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	590, 153		0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	25, 170, 729	d c	0	0	30.00
	OTHER ASSETS					ĺ
31.00	Investments	144, 512, 883	C	0	0	31.00
32.00	Deposits on Leases	0	C	0	0	32. 00
33.00	Due from owners/officers	0	) c	0	0	33. 00
34.00	Other assets	83, 561		0	0	34.00
35.00	Total other assets (sum of lines 31-34)	144, 596, 444	-  c	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	193, 068, 782	C	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	4, 960, 743	1	0	0	37. 00
38. 00	Salaries, wages, and fees payable	3, 943, 548	1	0	0	38. 00
39. 00	Payroll taxes payable	318, 759		0	0	39. 00
40. 00	Notes and Loans payable (short term)	2, 279, 393	C	0	0	40. 00
41. 00	Deferred income	0	) C	0	0	41. 00
42. 00	Accel erated payments	0				42. 00
43. 00	Due to other funds	0		0	0	43. 00
44. 00	Other current liabilities	4, 880, 625		1	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	16, 383, 068	<u> </u> C	0	0	45. 00
47.00	LONG TERM LIABILITIES	0410:-			=	4/ 65
46. 00	Mortgage payable	211, 310	1	_	0	46. 00
47. 00	Notes payable	15, 907, 534	i		0	47. 00
48. 00	Unsecured Loans	1 007 007	C		0	48. 00
49. 00	Other long term liabilities	1, 937, 907	ı		0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18, 056, 751			0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	34, 439, 819	<u> </u> C	0	0	51.00
E2 00	CAPITAL ACCOUNTS	150 (20 0(2	1			F2 00
52. 00	General fund balance	158, 628, 963	il c			52.00
53.00	Specific purpose fund Donor created - endowment fund balance - restricted			,		53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted  Donor created - endowment fund balance - unrestricted					54. 00 55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
50.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	158, 628, 963		) 0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	193, 068, 782	l .	n n	0	60.00
	59)					
	•	1	•			

17.00

18.00

19.00

0

0

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 150010 Peri od: Worksheet G-1 From 07/01/2015 06/30/2016 Date/Time Prepared: 11/22/2016 2:42 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 168, 332, 651 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 25, 355, 717 2.00 Total (sum of line 1 and line 2) 3.00 193, 688, 368 0 3.00 4.00 RELEASE OF RESTRICED ASSETS 160, 968 0 0 4.00 5.00 0 5.00 6.00 0 6.00 0 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 0 9.00 10.00 Total additions (sum of line 4-9) 160, 968 10.00 Subtotal (line 3 plus line 10) 193, 849, 336 11 00 0 11.00 12.00 RECONCILING ITEM 395, 437 0 12.00 13.00 TRANSFER TO AFFILIATES 34, 702, 616 13.00 UNRESTRICTED CONTROLLING INTEREST 122, 320 0 14.00 14.00 0 0 15.00 15.00 0 0 16.00 0 0 16.00 17.00 0 17.00 18.00 Total deductions (sum of lines 12-17) 35, 220, 373 18.00 Fund balance at end of period per balance 19.00 158, 628, 963 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 RELEASE OF RESTRICED ASSETS 4.00 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 0 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 RECONCILING ITEM 12.00 TRANSFER TO AFFILIATES 13.00 13.00 14.00 UNRESTRICTED CONTROLLING INTEREST 0 14.00 15.00 0 15.00

0

16.00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Health Financial Systems ST. JC STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150010

			Т	o 06/30/2016	Date/Time Pre 11/22/2016 2:	
	Cost Center Description		Inpati ent	Outpati ent	Total	12 piii
			1. 00	2.00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		29, 508, 625		29, 508, 625	1. 00
2. 00	SUBPROVIDER - IPF		27,000,020		27,000,020	2. 00
3.00	SUBPROVIDER - IRF		5, 191, 409		5, 191, 409	3. 00
4. 00	SUBPROVI DER		0, 171, 107		0, 1, 1, 10,	4. 00
5. 00	Swing bed - SNF		(		0	5. 00
6.00	Swing bed - NF		C		0	6.00
7. 00	SKILLED NURSING FACILITY			<b>'</b>	U	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)		34, 700, 034		34, 700, 034	10.00
10.00	Intensive Care Type Inpatient Hospital Services		34, 700, 034		34, 700, 034	10.00
11. 00	INTENSIVE CARE UNIT	T	8, 032, 420	1	8, 032, 420	11. 00
12. 00	CORONARY CARE UNIT		0, 032, 420	<b>'</b>	0, 032, 420	12.00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	inos	8, 032, 420		8, 032, 420	16. 00
10.00	111-15)	illes	0, 032, 420	'	0, 032, 420	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		42, 732, 454		42, 732, 454	17. 00
18. 00	Ancillary services		131, 375, 668		438, 434, 966	
19. 00	Outpatient services		131, 373, 000		10, 732, 177	19.00
20. 00	RURAL HEALTH CLINIC		C		10, 732, 177	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		C	-	0	21. 00
22. 00	HOME HEALTH AGENCY		C	,	0	22.00
23. 00	AMBULANCE SERVICES	1	C		0	23. 00
24. 00	CMHC	+	C	,	0	24. 00
24. 00	CORF	1	_		0	24. 00
25. 00		1	C	, 	U	25. 00
26. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE					26. 00
27. 00	PHYSI CI AN		_	00 054	00.054	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	a Wkat	174, 108, 122	88, 854 317, 880, 329	88, 854 491, 988, 451	28.00
26.00	G-3, line 1)	U WKSL.	174, 100, 122	317,000,329	491, 900, 401	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			126, 245, 793		29. 00
30.00	ADD (SPECIFY)		C			30.00
31. 00	ADD (SPECITI)		C			31. 00
32. 00			C			32.00
33. 00		ł	(			33. 00
34. 00		+	C			34. 00
35. 00		1	C	1		35. 00
36. 00	Total additions (sum of lines 20 25)		C	0		36.00
36.00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)		C	-		36.00
38.00	DEDUCT (SPECIFY)		C	1		
			C			38. 00
39. 00			_			39.00
40.00			C	(		40.00
41. 00	Total deductions (sum of lines 27 41)		C	<u>'</u>		41.00
42. 00	Total deductions (sum of lines 37-41)	(+manafa:-		124 245 702		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		126, 245, 793		43. 00
	to Wkst. G-3, line 4)	1				I

	51	UEAL THE OFFITED		6.5. 040.4	
	Financial Systems ST. JOSEPH HOSPITAL & I			u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 150010	Peri od:	Worksheet G-3	
			From 07/01/2015 To 06/30/2016	Date/Time Pre	nared:
			10 00/30/2010	11/22/2016 2:	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		491, 988, 451	1. 00
2.00	Less contractual allowances and discounts on patients' accounts	3		338, 559, 203	2.00
3.00	Net patient revenues (line 1 minus line 2)			153, 429, 248	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		126, 245, 793	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			27, 183, 455	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			22, 351	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		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			642, 802	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other that	nn patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			21, 765	17. 00
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			457, 092	22. 00
23.00	Governmental appropriations			957, 007	23. 00
24. 00	OTHER MI SCELLANEOUS REVENUE			291, 793	24. 00

2, 392, 810 29, 576, 265

4, 220, 548 27. 00 4, 220, 548 28. 00 25, 355, 717 29. 00

25. 00 26. 00

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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)

27. 00 LOSS ON INVESTMENTS

ALCUI	Financial Systems ST. JOSEPH HOSPITAL ATION OF CAPITAL PAYMENT	Provi der CCN: 150010	Peri od:	u of Form CMS-2 Worksheet L	
			From 07/01/2015 To 06/30/2016	Parts I-III Date/Time Pre	
		Title XVIII	Hospi tal	11/22/2016 2: PPS	42 p
		TI LIE XVIII	1103pi tai	113	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			1, 345, 563	l l 1.
01	Model 4 BPCI Capital DRG other than outlier			1, 345, 565	
00	Capital DRG outlier payments			37, 965	2.
01	Model 4 BPCI Capital DRG outlier payments			07,700	
00				55. 80	
00	Number of interns & residents (see instructions)			0.00	4
00				0.00	5.
00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	, columns 1 and	0	6
00	1.01) (see instructions)	+:+ (W		2.05	_
00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)	patrent days (worksheet E	, part a line	3. 85	7
00	Percentage of Medicaid patient days to total days (see instru	uctions)		23. 86	8
00	Sum of lines 7 and 8	401.03)		27. 71	
0. 00	Allowable disproportionate share percentage (see instructions	s)		5. 77	
. 00	Disproportionate share adjustment (see instructions)			77, 639	11
2. 00	Total prospective capital payments (see instructions)			1, 461, 167	12
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
00	Program inpatient routine capital cost (see instructions)			0	1
00	Program inpatient ancillary capital cost (see instructions)			0	2
00	Total inpatient program capital cost (line 1 plus line 2)			0	_
00	Capital cost payment factor (see instructions)			0	
00	Total inpatient program capital cost (line 3 x line 4)			0	5
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00 00	Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circumstance	nos (soo instructions)		0	
	Net program inpatient capital costs for extraordinary circumstant (line 1 minus line 2)	ces (see instructions)		0	
	Applicable exception percentage (see instructions)			0.00	
	Capital cost for comparison to payments (line 3 x line 4)			0.00	
00		nstructions)		0.00	
00 00	Percentage adjustment for extraordinary circumstances (see in			_	7
00 00 00	Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary		line 6)	0	
00 00 00 00	, ,		line 6)	0	8
00 00 00 00 00 00	Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli	y circumstances (line 2 x icable)	,	0	9
00 00 00 00 00 00 00	Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to comparison.	y circumstances (line 2 x icable) capital payments (line 8	less line 9)	0 0	9 10
00 00 00 00 00 00 00	Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over 6	y circumstances (line 2 x icable) capital payments (line 8	less line 9)	0	9 10
00 00 00 00 00 00 00 . 00	Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over (Worksheet L, Part III, line 14)	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri	less line 9) or year	0 0	9 10 11
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