

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/30/2021 12:37 pm
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PART I - COST REPORT STATUS

Provider use only 1. Electronically prepared cost report Date: 11/30/2021 Time: 12:37 pm
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5. Cost Report Status 6. Date Received:
 (1) As Submitted 7. Contractor No. 10. NPR Date:
 (2) Settled without Audit 8. Initial Report for this Provider CCN 11. Contractor's Vendor Code: 4
 (3) Settled with Audit 9. Final Report for this Provider CCN 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.
 (4) Reopened
 (5) Amended

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. JOSEPHS REG MED CENTER PLYMOUTH (15-0076) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 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.

I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) ROBERT SINK
 Officer or Administrator of Provider(s)

CFO
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	254,709	-11,162	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0	0	0		0	6.00
200.00 Total	0	254,709	-11,162	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 12:37 pm
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1.00	2.00	3.00	4.00	1.00	2.00
Hospital and Hospital Health Care Complex Address:					
1.00	Street: 1915 LAKE AVENUE	PO Box: 670	Zip Code: 46563	County: MARSHALL	1.00
2.00	City: PLYMOUTH	State: IN			2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	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	Hospital	ST. JOSEPHS REG MED CENTER PLYMOUTH	150076	99915	1	07/01/1996	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:	
						1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2020	06/30/2021	20.00
21.00	Type of Control (see instructions)					1		21.00
						1.00	2.00	3.00

Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0076			Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 12:37 pm					
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If this provider is an IPPS hospital, enter the 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.	77	63	1	4	915	49		24.00			
25.00	If this provider is an IRF, enter the in-state 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.	0	0	0	0	0			25.00			
						Urban/Rural S		Date of Geogr				
						1.00		2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00				
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00				
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00				
						Beginning:		Ending:				
						1.00		2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00				
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00				
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01				
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00				
						Y/N		Y/N				
						1.00		2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y		Y		39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N		N		40.00		
						V		XVIII		XIX		
						1.00		2.00		3.00		
Prospective Payment System (PPS)-Capital												
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N		N		N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N		N		N		46.00
47.00	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N		N		N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N		N		N		48.00
Teaching Hospitals												
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N						56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.											57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N						58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N						59.00

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	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 instructions)						61.01
61.02	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 ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	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, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00		62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00		62.01
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N		63.00
		Unweighted FTEs Nonprovi- der Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	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 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00	
71.00	If line 70 is 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)					0 71.00	
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. 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)					0 76.00	

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			1.00			
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00		
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00		
			V 1.00	XIX 2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06	
Rural Providers						
105.00	Does this hospital qualify as a CAH?		N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00	
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
			1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 12:37 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H034	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 12:37 pm	
1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: SAINT JOSEPH REG MEDICAL CTR	Contractor's Name: WISCONSIN PHYSICIANS SERVICE INSURAN		Contractor's Number: 08001	
142.00	Street: 5215 HOLY CROSS PARKWAY	PO Box:			
143.00	City: MISHAWAKA	State: IN		Zip Code: 46545	
144.00 Are provider based physicians' costs included in Worksheet A?					
Y					
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					
146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					
N					
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					
N					
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					
N					
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					
N					
1.00					
155.00 Hospital					
N					
156.00 Subprovider - IPF					
N					
157.00 Subprovider - IRF					
N					
158.00 SUBPROVIDER					
N					
159.00 SNF					
N					
160.00 HOME HEALTH AGENCY					
N					
161.00 CMHC					
N					
1.00					
165.00 Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					
N					
1.00					
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					
0.00					
1.00					
167.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					
Y					
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					
168.01					
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					
9.99					
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					
170.00					
1.00					
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					
170.00					
1.00					
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					
N					
0					
171.00					

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0076		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 12:37 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				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 Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				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 the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
						Y/N	
						1.00	
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? 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)			Y	10/01/2021	Y	10/01/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
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.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 12:37 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TRACY		WORKMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	SAINT JOSEPH HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	574-335-4652		WORKMANT@SJRMC.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 12:37 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR REIMBURSEMENT ANALYST		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 12:37 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	38	13,870	0.00	0	1.00
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 beds) (see instructions)		38	13,870	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	7	2,555	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	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		45	16,425	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		45				27.00
28.00 Observation Bed Days					0	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)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 12:37 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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 Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,405	102	4,120			1.00
2.00 HMO and other (see instructions)	1,659	795				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,405	102	4,120			7.00
8.00 INTENSIVE CARE UNIT	447	0	1,220			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		163	432			13.00
14.00 Total (see instructions)	1,852	265	5,772	0.00	286.13	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	286.13	27.00
28.00 Observation Bed Days		252	1,225			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			50			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	49	82			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 12:37 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	496	359	1,724	1.00
2.00 HMO and other (see instructions)			400	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		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 beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	100.00	0	496	359	1,724	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	100.00					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 outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet S-3
Part II
Date/Time Prepared:
11/30/2021 12:37 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	19,143,371	0	19,143,371	595,145.27	32.17
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		37,300	0	37,300	266.00	140.23
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		344,989	0	344,989	6,214.00	55.52
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		695,924	0	695,924	26,551.66	26.21
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		354,780	0	354,780	5,490.00	64.62
12.00	Contract labor: Top level management and other management and administrative services		106,733	0	106,733	2,333.00	45.75
13.00	Contract Labor: Physician-Part A - Administrative		515,051	0	515,051	10,670.00	48.27
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		4,381,373	0	4,381,373	101,497.00	43.17
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,253,773	0	8,253,773		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		389,871	0	389,871		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		3,909	0	3,909		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		91,249	0	91,249		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,182,625	0	1,182,625		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet S-3
Part II
Date/Time Prepared:
11/30/2021 12:37 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	20,225	0	20,225	9.50	2,128.95	26.00
27.00	Administrative & General	2,068,896	0	2,068,896	65,723.38	31.48	27.00
28.00	Administrative & General under contract (see inst.)	236,673	0	236,673	1,729.00	136.88	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	329,812	0	329,812	12,021.17	27.44	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	413,498	0	413,498	28,401.03	14.56	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	333,466	0	333,466	19,765.15	16.87	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	477,867	0	477,867	10,191.40	46.89	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	719,295	0	719,295	14,130.26	50.90	40.00
41.00	Medical Records & Medical Records Library	249,961	0	249,961	9,593.75	26.05	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet S-3
Part III
Date/Time Prepared:
11/30/2021 12:37 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	19,035,055	0	19,035,055	590,660.27	32.23	1.00
2.00	Excluded area salaries (see instructions)	695,924	0	695,924	26,551.66	26.21	2.00
3.00	Subtotal salaries (line 1 minus line 2)	18,339,131	0	18,339,131	564,108.61	32.51	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,357,937	0	5,357,937	119,990.00	44.65	4.00
5.00	Subtotal wage-related costs (see inst.)	9,440,307	0	9,440,307	0.00	51.48	5.00
6.00	Total (sum of lines 3 thru 5)	33,137,375	0	33,137,375	684,098.61	48.44	6.00
7.00	Total overhead cost (see instructions)	4,849,693	0	4,849,693	161,564.64	30.02	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/30/2021 12:37 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			878,806 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)			325,708 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			227,314 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			4,057,065 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			782,596 9.00
10.00	Dental, Hearing and Vision Plan			150,209 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			25,846 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			766,153 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			104,855 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			39,883 16.00
TAXES				
17.00	FICA-Employers Portion Only			1,368,694 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			11,674 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			8,738,803 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part V Date/Time Prepared: 11/30/2021 12:37 pm
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	354,780	8,738,803	1.00
2.00	Hospital	354,780	8,738,803	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (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	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/30/2021 12:37 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.237328	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		9,216,805	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		35,829,074	6.00	
7.00	Medicaid cost (line 1 times line 6)		8,503,242	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (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 hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,800,737	351,314	3,152,051	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	664,693	351,314	1,016,007	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	664,693	351,314	1,016,007	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			5,683,466	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			150,667	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			231,796	27.01
28.00	Non-Medicare bad debt expense (see instructions)			5,451,670	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,374,963	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,390,970	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,390,970	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT		0	0	1,528,764	1,528,764	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	0	2,085,995	2,085,995	2.00
3.00 00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	20,225	-15,998	4,227	15,998	20,225	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	2,068,896	18,160,922	20,229,818	-1,351,043	18,878,775	5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	329,812	2,224,640	2,554,452	-435,458	2,118,994	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	177,528	177,528	-448	177,080	8.00
9.00 00900 HOUSEKEEPING	413,498	267,092	680,590	-1,161	679,429	9.00
10.00 01000 DIETARY	333,466	334,543	668,009	-21,388	646,621	10.00
11.00 01100 CAFETERIA	0	0	0	0	0	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300 NURSING ADMINISTRATION	477,867	227,952	705,819	-133,400	572,419	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 01500 PHARMACY	719,295	2,598,825	3,318,120	-2,422,033	896,087	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	249,961	89,919	339,880	0	339,880	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	2,730,597	1,050,562	3,781,159	-916,534	2,864,625	30.00
31.00 03100 INTENSIVE CARE UNIT	971,052	355,305	1,326,357	-13,978	1,312,379	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00 04300 NURSERY	0	0	0	402,745	402,745	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,950,675	3,565,154	5,515,829	-663,756	4,852,073	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	402,746	402,746	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,112,688	760,050	1,872,738	-335,293	1,537,445	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	397,241	725,148	1,122,389	-216,948	905,441	55.00
57.00 05700 CT SCAN	93,123	108,059	201,182	-43,639	157,543	57.00
59.00 05900 CARDIAC CATHETERIZATION	37,602	189,462	227,064	-132,239	94,825	59.00
60.00 06000 LABORATORY	1,619,478	3,604,337	5,223,815	-31,739	5,192,076	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	577,789	271,405	849,194	-29,190	820,004	65.00
65.01 06501 SLEEP LAB	0	48,294	48,294	-1,564	46,730	65.01
66.00 06600 PHYSICAL THERAPY	963,355	333,682	1,297,037	-12,698	1,284,339	66.00
66.01 06601 PHYSICAL THERAPY - LI FEPLEX	369,246	268,118	637,364	-6,752	630,612	66.01
66.02 06602 PHYSICAL THERAPY - CULVER MILITARY	14,094	7,129	21,223	0	21,223	66.02
67.00 06700 OCCUPATIONAL THERAPY	132,978	29,062	162,040	-3,882	158,158	67.00
68.00 06800 SPEECH PATHOLOGY	73,076	14,194	87,270	0	87,270	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	-63,766	-63,766	63,766	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	391,224	391,224	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	2,721,432	2,721,432	73.00
76.97 07697 CARDIAC REHABILITATION	134,708	142,970	277,678	-14,700	262,978	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	65,316	65,316	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	5,971	1,463	7,434	-16	7,418	90.01
90.02 09002 ATHLETIC TRAINERS	117,467	61,453	178,920	0	178,920	90.02
90.03 09003 SAINT JOSEPH HEALTH CENTER	713,349	316,166	1,029,515	-10,214	1,019,301	90.03
90.04 09004 WOUND CARE	164,142	720,688	884,830	-158,201	726,629	90.04
91.00 09100 EMERGENCY	1,655,796	2,254,676	3,910,472	-648,631	3,261,841	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	18,447,447	38,829,034	57,276,481	73,081	57,349,562	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,461	1,461	0	1,461	190.00
190.01 19001 LI FEPLEX FITNESS FORUM	283,304	619,107	902,411	-771	901,640	190.01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201 FOUNDATION ADMINISTRATION	0	0	0	0	0	192.01
192.02 19202 HOSPITALIST	0	0	0	0	0	192.02
192.03 19203 INTENSIVIST	0	0	0	0	0	192.03
192.04 19204 FOOT & ANKLE SPORTS MED PLY	363,376	104,728	468,104	0	468,104	192.04
194.00 07950 PLYMOUTH MOB-4	0	106,106	106,106	-72,310	33,796	194.00
194.01 07951 COMMUNITY OUTREACH & PARTNERSHIP	49,244	13,719	62,963	0	62,963	194.01
200.00 TOTAL (SUM OF LINES 118 through 199)	19,143,371	39,674,155	58,817,526	0	58,817,526	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet A
Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	593,781	2,122,545	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,085,995	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-48,264	-28,039	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,357,342	14,521,433	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2,118,994	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	177,080	8.00
9.00	00900	HOUSEKEEPING	-62,604	616,825	9.00
10.00	01000	DIETARY	-154,405	492,216	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	572,419	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-18,204	877,883	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	339,880	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,864,625	30.00
31.00	03100	INTENSIVE CARE UNIT	-25,168	1,287,211	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
43.00	04300	NURSERY	0	402,745	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,386,552	3,465,521	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	402,746	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,537,445	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-494,838	410,603	55.00
57.00	05700	CT SCAN	0	157,543	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	94,825	59.00
60.00	06000	LABORATORY	-365	5,191,711	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-22,010	797,994	65.00
65.01	06501	SLEEP LAB	0	46,730	65.01
66.00	06600	PHYSICAL THERAPY	-28,060	1,256,279	66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	0	630,612	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0	21,223	66.02
67.00	06700	OCCUPATIONAL THERAPY	0	158,158	67.00
68.00	06800	SPEECH PATHOLOGY	0	87,270	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	391,224	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,721,432	73.00
76.97	07697	CARDIAC REHABILITATION	-10	262,968	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	65,316	76.98
76.99	07699	LITHOTRIpsy	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0	7,418	90.01
90.02	09002	ATHLETIC TRAINERS	-152,738	26,182	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	-899	1,018,402	90.03
90.04	09004	WOUND CARE	0	726,629	90.04
91.00	09100	EMERGENCY	-41,554	3,220,287	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,199,232	51,150,330	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,461	190.00
190.01	19001	LIFEPLEX FITNESS FORUM	-535,765	365,875	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	FOUNDATION ADMINISTRATION	0	0	192.01
192.02	19202	HOSPITALIST	0	0	192.02
192.03	19203	INTENSIVIST	0	0	192.03
192.04	19204	FOOT & ANKLE SPORTS MED PLY	78	468,182	192.04
194.00	07950	PLYMOUTH MOB-4	0	33,796	194.00
194.01	07951	COMMUNITY OUTREACH & PARTNERSHIP	0	62,963	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,734,919	52,082,607	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - Negative Balances					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15,998	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	63,766	2.00
	TOTALS		0	79,764	
B - Implantable Devices					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	391,224	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		0	391,224	
C - Drugs Charged to Patients					
1.00	LABORATORY	60.00	0	2,874	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,721,432	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	TOTALS		0	2,724,306	
E - Building Depreciation					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,247,146	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	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
	TOTALS		0	1,247,146	
F - Equipment Depreciation					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00		2,085,995	1.00
2.00					2.00
3.00					3.00
4.00					4.00
5.00					5.00
6.00					6.00
7.00					7.00
8.00					8.00
9.00					9.00
10.00					10.00
11.00					11.00
12.00					12.00
13.00					13.00
14.00					14.00
15.00					15.00
16.00					16.00
17.00					17.00
18.00					18.00
19.00					19.00
20.00					20.00
21.00					21.00
22.00					22.00
23.00					23.00
24.00					24.00
25.00					25.00
			0	2,085,995	

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6
Date/Time Prepared:
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Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
I - Nursery and Labor/Delivery					
1.00	NURSERY	43.00	281,392	121,353	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	281,392	121,354	2.00
	TOTALS		562,784	242,707	
K - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		281,618	1.00
2.00			0	281,618	2.00
N - Hyperbaric Oxygen					
1.00	HYPERBARIC OXYGEN THERAPY	76.98	29,681	35,635	1.00
			29,681	35,635	
500.00	Grand Total: Increases		592,465	7,088,395	500.00

RECLASSIFICATIONS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6
Date/Time Prepared:
11/30/2021 12:37 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - Negative Balances							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	79,764	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	79,764			
B - Implantable Devices							
1.00	OPERATING ROOM	50.00	0	322,106	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	5	0		2.00
3.00	WOUND CARE	90.04	0	67,958	0		3.00
4.00	EMERGENCY	91.00	0	1,155	0		4.00
	TOTALS		0	391,224			
C - Drugs Charged to Patients							
1.00	PHARMACY	15.00	0	2,365,122	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	35,200	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	11,367	0		3.00
4.00	OPERATING ROOM	50.00	0	54,540	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	124,141	0		5.00
6.00	CT SCAN	57.00	0	36,219	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	3,592	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	1,389	0		8.00
9.00	OUTPATIENT TREATMENT & INFUSION CTR	90.01	0	16	0		9.00
10.00	SAINT JOSEPH HEALTH CENTER	90.03	0	7,798	0		10.00
11.00	WOUND CARE	90.04	0	13,008	0		11.00
12.00	EMERGENCY	91.00	0	71,914	0		12.00
	TOTALS		0	2,724,306			
E - Building Depreciation							
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	313,215	0		2.00
3.00	OPERATION OF PLANT	7.00	0	380,431	0		3.00
4.00	HOUSEKEEPING	9.00	0	1,161	0		4.00
5.00	DIETARY	10.00	0	3,454	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	55,235	0		6.00
7.00	PHARMACY	15.00	0	825	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	17,395	0		8.00
9.00	OPERATING ROOM	50.00	0	41,955	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,929	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	12,995	0		11.00
12.00	LABORATORY	60.00	0	1,122	0		12.00
13.00	SLEEP LAB	65.01	0	408	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	4,774	0		14.00
15.00	PHYSICAL THERAPY - LI FEPLEX	66.01	0	2,498	0		15.00
16.00	WOUND CARE	90.04	0	11,919	0		16.00
17.00	EMERGENCY	91.00	0	325,169	0		17.00
18.00	PLYMOUTH MOB-4	194.00	0	63,661	0		18.00
	TOTALS		0	1,247,146			
F - Equipment Depreciation							
1.00					9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		676,446			2.00
3.00	OPERATION OF PLANT	7.00		55,027			3.00
4.00	LAUNDRY & LINEN SERVICE	8.00		448			4.00
5.00	DIETARY	10.00		17,934			5.00
6.00	NURSING ADMINISTRATION	13.00		78,165			6.00
7.00	PHARMACY	15.00		56,086			7.00
8.00	ADULTS & PEDIATRICS	30.00		58,448			8.00
9.00	INTENSIVE CARE UNIT	31.00		2,611			9.00
10.00	OPERATING ROOM	50.00		245,155			10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00		200,223			11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00		203,953			12.00
13.00	CT SCAN	57.00		7,420			13.00
14.00	CARDIAC CATHETERIZATION	59.00		132,234			14.00
15.00	LABORATORY	60.00		33,491			15.00
16.00	RESPIRATORY THERAPY	65.00		25,598			16.00
17.00	SLEEP LAB	65.01		1,156			17.00
18.00	PHYSICAL THERAPY	66.00		6,535			18.00
19.00	PHYSICAL THERAPY - LI FEPLEX	66.01		4,254			19.00
20.00	OCCUPATIONAL THERAPY	67.00		3,882			20.00
21.00	CARDIAC REHABILITATION	76.97		14,700			21.00
22.00	SAINT JOSEPH HEALTH CENTER	90.03		2,416			22.00
23.00	EMERGENCY	91.00		250,393			23.00
24.00	LI FEPLEX FITNESS FORUM	190.01		771			24.00
25.00	PLYMOUTH MOB-4	194.00		8,649			25.00
	TOTALS		0	2,085,995			

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
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Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
I - Nursery and Labor/Delivery						
1.00	ADULTS & PEDIATRICS	30.00	562,784	242,707	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		562,784	242,707		
K - Interest Expense						
1.00					11	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	281,618		2.00
				281,618		
N - Hyperbaric Oxygen						
1.00	WOUND CARE	90.04	29,681	35,635		1.00
			29,681	35,635		
500.00	Grand Total: Decreases		592,465	7,088,395		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-7
Part I
Date/Time Prepared:
11/30/2021 12:37 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	477,930	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	45,077,670	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	28,025,403	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	73,581,003	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	73,581,003	0	0	0	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	477,930	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	45,077,670	17,230,315				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	28,025,403	14,979,983				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	73,581,003	32,210,298				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	73,581,003	32,210,298				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-7
Part II
Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-7
Part III
Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		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	2,122,545	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,085,995	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,208,540	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,122,545	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,085,995	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	4,208,540	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-281,618	CAP REL COSTS-BLDG & FIXT		1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 2.00
3.00 Investment income - other (chapter 2)		0			0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	0 7.00
8.00 Television and radio service (chapter 21)		0			0.00	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-1,893,923				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-60,735				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-154,386	DIETARY		10.00	0 14.00
15.00 Rental of quarters to employee and others		0			0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00 Sale of drugs to other than patients	B	-18,204	PHARMACY		15.00	0 17.00
18.00 Sale of medical records and abstracts		0			0.00	0 18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines	B	0	CAFETERIA		11.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	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-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 27.00
28.00 Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS		19.00	28.00
29.00 Physicians' assistant		0			0.00	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			0.00	0 32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 33.00
33.01 Other Operating Rev - Respiratory Care - Rent	B	-22,010	RESPIRATORY THERAPY	65.00	0 33.01
33.02 Other Operating Rev - Radiation Oncology - Rent	B	-113,346	RADIOLOGY-THERAPEUTIC	55.00	0 33.02
33.03 Other Operating Rev - Physical Therapy	B	-28,060	PHYSICAL THERAPY	66.00	0 33.03
33.04 Other Operating Rev - Athletic Trainers	B	-152,738	ATHLETIC TRAINERS	90.02	0 33.04
33.05 Other Operating Rev - Housekeeping	B	-62,604	HOUSEKEEPING	9.00	0 33.05
33.06 Other Operating Rev - Administration	B	-2,907	ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.07 Other Operating Rev - Vending	B	-19	DIETARY	10.00	0 33.07
33.08 OTHER REVENUE	B		LABORATORY	60.00	0 33.08
33.09 OTHER REVENUE	B		RESPIRATORY THERAPY	65.00	0 33.09
33.10 Other Operating Rev - Saint Joseph Health Center	B	-899	SAINT JOSEPH HEALTH CENTER	90.03	0 33.10
33.11 Other Operating Rev - Foot & Ankle Sports Med	B	78	FOOT & ANKLE SPORTS MED PLY	192.04	0 33.11
33.12 Other Operating Revenue - Cardiac Rehab Lifeplex	B	-10	CARDIAC REHABILITATION	76.97	0 33.12
33.13 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 33.13
33.14 Other Revenue - Lifeplex	B	-535,765	LIFEPLEX FITNESS FORUM	190.01	0 33.14
33.15 Other Revenue JESSE	B		PHYSICAL THERAPY	66.00	0 33.15
33.16 Gain Loss on Sale of Asset	B		CAP REL COSTS-MVBLE EQUIP	2.00	9 33.16
34.00 PROVIDER TAX	A		ADMINISTRATIVE & GENERAL	5.00	0 34.00
34.10 Provider Tax	A	-3,347,673	ADMINISTRATIVE & GENERAL	5.00	0 34.10
35.00 Donations	A	-56,500	ADMINISTRATIVE & GENERAL	5.00	0 35.00
35.10 Property Tax	A	-3,600	ADMINISTRATIVE & GENERAL	5.00	0 35.10
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,734,919			50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-1

Date/Time Prepared:
11/30/2021 12:37 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HO NON CAPITAL COSTS	7,390,126	8,162,394 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	WORKERS COMP	93,553	77,981 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	INSURANCE	41,569	131,202 3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	PENSION	27,547	29,449 3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	RETIREE HEALTH COSTS	0	39,639 3.02
3.03	1.00	CAP REL COSTS-BLDG & FIXT	HO CAPITAL COSTS	875,399	0 3.03
3.04	4.00	EMPLOYEE BENEFITS DEPARTMENT		0	48,264 3.04
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,428,194	8,488,929 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.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	G		0.00	TRINITY HEALTH	0.00	6.00
7.00	G		0.00	SJPMC - INC	0.00	7.00
8.00	G	SJPMC - SB	0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet A-8-1 Date/Time Prepared: 11/30/2021 12:37 pm
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-772,268	0		1.00
2.00	15,572	0		2.00
3.00	-89,633	0		3.00
3.01	-1,902	0		3.01
3.02	-39,639	0		3.02
3.03	875,399	9		3.03
3.04	-48,264	0		3.04
4.00	0	0		4.00
5.00	-60,735			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 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
11/30/2021 12:37 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	31.00	INTENSIVE CARE UNIT	46,080	0	46,080	179,000	243	1.00
2.00	50.00	OPERATING ROOM	1,386,552	1,386,552	0	246,400	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	380,492	381,492	-1,000	179,000	10	4.00
5.00	60.00	LABORATORY	1,867	0	1,867	260,300	12	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	93,705	-3,308	97,013	179,000	606	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	66,193	54,650	11,543	179,000	86	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,974,889	1,819,386	155,503		957	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	31.00	INTENSIVE CARE UNIT	20,912	1,046	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	861	43	0	0	0	4.00
5.00	60.00	LABORATORY	1,502	75	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	52,151	2,608	0	0	0	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	7,401	370	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			82,827	4,142	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	31.00	INTENSIVE CARE UNIT	0	20,912	25,168	25,168	1.00
2.00	50.00	OPERATING ROOM	0	0	0	1,386,552	2.00
3.00	0.00		0	0	0	0	3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	0	861	0	381,492	4.00
5.00	60.00	LABORATORY	0	1,502	365	365	5.00
6.00	0.00		0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	52,151	44,862	41,554	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	0	7,401	4,142	58,792	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	82,827	74,537	1,893,923	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet B
Part I
Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,122,545	2,122,545			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,085,995		2,085,995		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	-28,039	0	0	-28,039	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	14,521,433	238,267	234,164	0	14,993,864
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	2,118,994	450,625	442,865	0	3,012,484
8.00 00800	LAUNDRY & LINEN SERVICE	177,080	8,068	7,929	0	193,077
9.00 00900	HOUSEKEEPING	616,825	3,994	3,925	0	624,744
10.00 01000	DIETARY	492,216	27,918	27,437	0	547,571
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	572,419	0	0	0	572,419
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	877,883	16,522	16,238	0	910,643
16.00 01600	MEDICAL RECORDS & LIBRARY	339,880	33,469	32,893	0	406,242
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,864,625	258,117	253,672	0	3,376,414
31.00 03100	INTENSIVE CARE UNIT	1,287,211	49,499	48,647	0	1,385,357
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
43.00 04300	NURSERY	402,745	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,465,521	256,280	251,867	0	3,973,668
52.00 05200	DELIVERY ROOM & LABOR ROOM	402,746	0	0	0	402,746
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,537,445	96,707	95,042	0	1,729,194
55.00 05500	RADIOLOGY-THERAPEUTIC	410,603	120,485	118,410	0	649,498
57.00 05700	CT SCAN	157,543	5,578	5,482	0	168,603
59.00 05900	CARDIAC CATHETERIZATION	94,825	28,264	27,778	0	150,867
60.00 06000	LABORATORY	5,191,711	57,860	56,863	0	5,306,434
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	797,994	44,160	43,399	0	885,553
65.01 06501	SLEEP LAB	46,730	0	0	0	46,730
66.00 06600	PHYSICAL THERAPY	1,256,279	77,842	76,502	0	1,410,623
66.01 06601	PHYSICAL THERAPY - LI FEPLEX	630,612	0	0	0	630,612
66.02 06602	PHYSICAL THERAPY - CULVER MILITARY	21,223	0	0	0	21,223
67.00 06700	OCCUPATIONAL THERAPY	158,158	0	0	0	158,158
68.00 06800	SPEECH PATHOLOGY	87,270	0	0	0	87,270
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	391,224	0	0	0	391,224
73.00 07300	DRUGS CHARGED TO PATIENTS	2,721,432	0	0	0	2,721,432
76.97 07697	CARDIAC REHABILITATION	262,968	0	0	0	262,968
76.98 07698	HYPERBARIC OXYGEN THERAPY	65,316	7,229	7,105	0	79,650
76.99 07699	LITHOTRIpsy	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 09001	OUTPATIENT TREATMENT & INFUSION CTR	7,418	0	0	0	7,418
90.02 09002	ATHLETIC TRAINERS	26,182	0	0	0	26,182
90.03 09003	SAINT JOSEPH HEALTH CENTER	1,018,402	0	0	0	1,018,402
90.04 09004	WOUND CARE	726,629	34,388	33,796	0	794,813
91.00 09100	EMERGENCY	3,220,287	109,264	107,382	0	3,436,933
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	51,150,330	1,924,536	1,891,396	0	50,785,761
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,461	2,530	2,486	0	6,477
190.01 19001	LI FEPLEX FITNESS FORUM	365,875	0	0	0	365,875
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	195,479	192,113	0	387,592
192.01 19201	FOUNDATION ADMINISTRATION	0	0	0	0	192.01
192.02 19202	HOSPITALIST	0	0	0	0	192.02
192.03 19203	INTENSIVIST	0	0	0	0	192.03
192.04 19204	FOOT & ANKLE SPORTS MED PLY	468,182	0	0	0	468,182
194.00 07950	PLYMOUTH MOB-4	33,796	0	0	0	33,796
194.01 07951	COMMUNITY OUTREACH & PARTNERSHIP	62,963	0	0	0	62,963
200.00	Cross Foot Adjustments					0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet B
Part I
Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
201.00 Negative Cost Centers		0	0	-28,039	-28,039	201.00
202.00 TOTAL (sum lines 118 through 201)	52,082,607	2,122,545	2,085,995	-28,039	52,082,607	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Prepared: 11/30/2021 12:37 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,993,864				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	1,216,938	0	4,229,422		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,996	0	23,802	294,875	8.00
9.00	00900	HOUSEKEEPING	252,375	0	11,783	0	888,902
10.00	01000	DIETARY	221,200	0	82,360	19	17,457
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	231,237	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	367,868	0	48,742	0	10,331
16.00	01600	MEDICAL RECORDS & LIBRARY	164,108	0	98,737	0	20,928
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,363,953	0	761,472	14,137	161,395
31.00	03100	INTENSIVE CARE UNIT	559,636	0	146,027	7,234	30,951
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
43.00	04300	NURSERY	162,695	0	0	976	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,605,223	0	756,053	39,636	160,249
52.00	05200	DELIVERY ROOM & LABOR ROOM	162,695	0	0	2,087	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	698,534	0	285,296	25,163	60,470
55.00	05500	RADIOLOGY-THERAPEUTIC	262,374	0	355,443	14,349	75,338
57.00	05700	CT SCAN	68,110	0	16,455	38,765	3,488
59.00	05900	CARDIAC CATHETERIZATION	60,945	0	83,382	932	17,673
60.00	06000	LABORATORY	2,143,596	0	170,692	62,978	36,179
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	357,732	0	130,276	14,597	27,613
65.01	06501	SLEEP LAB	18,877	0	0	622	0
66.00	06600	PHYSICAL THERAPY	569,842	0	229,643	6,047	48,674
66.01	06601	PHYSICAL THERAPY - LI FEPLEX	254,745	0	0	4,698	0
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	8,573	0	0	145	0
67.00	06700	OCCUPATIONAL THERAPY	63,890	0	0	1,098	0
68.00	06800	SPEECH PATHOLOGY	35,254	0	0	283	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	158,041	0	0	3,876	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,099,363	0	0	24,375	0
76.97	07697	CARDIAC REHABILITATION	106,230	0	0	1,050	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	32,176	0	21,327	1,153	4,520
76.99	07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	2,997	0	0	0	0
90.02	09002	ATHLETIC TRAINERS	10,577	0	0	0	0
90.03	09003	SAINT JOSEPH HEALTH CENTER	411,399	0	0	1,016	0
90.04	09004	WOUND CARE	321,077	0	101,449	3,497	21,503
91.00	09100	EMERGENCY	1,388,401	0	322,339	22,597	68,321
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,458,657	0	3,645,278	291,330	765,090
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,616	0	7,462	0	1,582
190.01	19001	LI FEPLEX FITNESS FORUM	147,801	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	156,574	0	576,682	0	122,230
192.01	19201	FOUNDATION ADMINISTRATION	0	0	0	0	0
192.02	19202	HOSPITALIST	0	0	0	2,027	0
192.03	19203	INTENSIVIST	0	0	0	616	0
192.04	19204	FOOT & ANKLE SPORTS MED PLY	189,129	0	0	902	0
194.00	07950	PLYMOUTH MOB-4	13,652	0	0	0	0
194.01	07951	COMMUNITY OUTREACH & PARTNERSHIP	25,435	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	14,993,864	0	4,229,422	294,875	888,902

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0076		Period: From 07/01/2020 To 06/30/2021		Worksheet B Part I Date/Time Prepared: 11/30/2021 12:37 pm	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	868,607					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	803,656		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	24,345	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	16,773	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	654,076	0	0	118,342	0	30.00
31.00	03100	INTENSIVE CARE UNIT	139,310	0	0	45,717	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	12,661	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	67,548	0	0	91,313	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,661	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	48,974	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	15,592	0	55.00
57.00	05700	CT SCAN	0	0	0	4,967	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,198	0	59.00
60.00	06000	LABORATORY	0	0	0	110,243	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,555	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	48,201	0	66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	0	0	0	17,139	0	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0	0	0	611	0	66.02
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,007	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,443	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	7,653	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,425	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	366	0	90.01
90.02	09002	ATHLETIC TRAINERS	0	0	0	9,241	0	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	0	0	0	37,779	0	90.03
90.04	09004	WOUND CARE	0	0	0	6,514	0	90.04
91.00	09100	EMERGENCY	7,673	0	0	83,659	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	868,607	0	0	753,379	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	LIFEPLEX FITNESS FORUM	0	0	0	35,214	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION ADMINISTRATION	0	0	0	0	0	192.01
192.02	19202	HOSPITALIST	0	0	0	0	0	192.02
192.03	19203	INTENSIVIST	0	0	0	0	0	192.03
192.04	19204	FOOT & ANKLE SPORTS MED PLY	0	0	0	11,440	0	192.04
194.00	07950	PLYMOUTH MOB-4	0	0	0	0	0	194.00
194.01	07951	COMMUNITY OUTREACH & PARTNERSHIP	0	0	0	3,623	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	868,607	0	0	803,656	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0076		Period: From 07/01/2020 To 06/30/2021		Worksheet B Part I Date/Time Prepared: 11/30/2021 12:37 pm	
Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,361,929					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	706,788				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	33,891	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	17,343	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	0	2,341	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	95,018	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,003	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	60,322	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	902	34,399	0	0	0	55.00
57.00	05700	CT SCAN	0	92,931	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	147	2,233	0	0	0	59.00
60.00	06000	LABORATORY	0	150,916	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	34,993	0	0	0	65.00
65.01	06501	SLEEP LAB	0	1,491	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	14,495	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	0	11,262	0	0	0	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0	349	0	0	0	66.02
67.00	06700	OCCUPATIONAL THERAPY	0	2,632	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	677	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,292	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,358,921	58,433	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	2,516	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,764	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	0	0	90.01
90.02	09002	ATHLETIC TRAINERS	0	0	0	0	0	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	0	2,436	0	0	0	90.03
90.04	09004	WOUND CARE	0	8,382	0	0	0	90.04
91.00	09100	EMERGENCY	0	54,171	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,359,970	698,290	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	LIFEPLEX FITNESS FORUM	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION ADMINISTRATION	0	0	0	0	0	192.01
192.02	19202	HOSPITALIST	0	4,859	0	0	0	192.02
192.03	19203	INTENSIVIST	0	1,477	0	0	0	192.03
192.04	19204	FOOT & ANKLE SPORTS MED PLY	1,959	2,162	0	0	0	192.04
194.00	07950	PLYMOUTH MOB-4	0	0	0	0	0	194.00
194.01	07951	COMMUNITY OUTREACH & PARTNERSHIP	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,361,929	706,788	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV					
	21.00	22.00					
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00		
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00		
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00		
5.00 00500 ADMINISTRATIVE & GENERAL					5.00		
6.00 00600 MAINTENANCE & REPAIRS					6.00		
7.00 00700 OPERATION OF PLANT					7.00		
8.00 00800 LAUNDRY & LINEN SERVICE					8.00		
9.00 00900 HOUSEKEEPING					9.00		
10.00 01000 DIETARY					10.00		
11.00 01100 CAFETERIA					11.00		
12.00 01200 MAINTENANCE OF PERSONNEL					12.00		
13.00 01300 NURSING ADMINISTRATION					13.00		
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00		
15.00 01500 PHARMACY					15.00		
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00		
17.00 01700 SOCIAL SERVICE					17.00		
19.00 01900 NONPHYSICIAN ANESTHETISTS					19.00		
20.00 02000 NURSING SCHOOL					20.00		
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0				21.00		
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV		0			22.00		
23.00 02300 PARAMED PRGM-(SPECIFY)			0		23.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	0	0	0	6,483,680	0 30.00		
31.00 03100 INTENSIVE CARE UNIT	0	0	0	2,331,575	0 31.00		
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 34.00		
43.00 04300 NURSERY	0	0	0	581,418	0 43.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	6,788,708	0 50.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	585,192	0 52.00		
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	2,907,953	0 54.00		
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	1,407,895	0 55.00		
57.00 05700 CT SCAN	0	0	0	393,319	0 57.00		
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	318,377	0 59.00		
60.00 06000 LABORATORY	0	0	0	7,981,038	0 60.00		
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30		
65.00 06500 RESPIRATORY THERAPY	0	0	0	1,480,319	0 65.00		
65.01 06501 SLEEP LAB	0	0	0	67,720	0 65.01		
66.00 06600 PHYSICAL THERAPY	0	0	0	2,327,525	0 66.00		
66.01 06601 PHYSICAL THERAPY - LIFFLEX	0	0	0	918,456	0 66.01		
66.02 06602 PHYSICAL THERAPY - CULVER MILITARY	0	0	0	30,901	0 66.02		
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	230,785	0 67.00		
68.00 06800 SPEECH PATHOLOGY	0	0	0	125,927	0 68.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	562,433	0 72.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	5,262,524	0 73.00		
76.97 07697 CARDIAC REHABILITATION	0	0	0	380,417	0 76.97		
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	143,015	0 76.98		
76.99 07699 LI THOTRIPSY	0	0	0	0	0 76.99		
OUTPATIENT SERVICE COST CENTERS							
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	10,781	0 90.01		
90.02 09002 ATHLETIC TRAINERS	0	0	0	46,000	0 90.02		
90.03 09003 SAINT JOSEPH HEALTH CENTER	0	0	0	1,471,032	0 90.03		
90.04 09004 WOUND CARE	0	0	0	1,257,235	0 90.04		
91.00 09100 EMERGENCY	0	0	0	5,384,094	0 91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00		
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)				0	49,478,319	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	18,137	0 190.00		
190.01 19001 LIFFLEX FITNESS FORUM	0	0	0	548,890	0 190.01		
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	1,243,078	0 192.00		
192.01 19201 FOUNDATION ADMINISTRATION	0	0	0	0	0 192.01		
192.02 19202 HOSPITALIST	0	0	0	6,886	0 192.02		
192.03 19203 INTENSIVIST	0	0	0	2,093	0 192.03		
192.04 19204 FOOT & ANKLE SPORTS MED PLY	0	0	0	673,774	0 192.04		
194.00 07950 PLYMOUTH MOB-4	0	0	0	47,448	0 194.00		
194.01 07951 COMMUNITY OUTREACH & PARTNERSHIP	0	0	0	92,021	0 194.01		
200.00	Cross Foot Adjustments				0	0 200.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0076

Period:
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To 06/30/2021

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Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	21.00	22.00			
201.00 Negative Cost Centers	0	0	0	-28,039	0
202.00 TOTAL (sum lines 118 through 201)	0	0	0	52,082,607	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0076

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From 07/01/2020
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING SCHOOL		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	6,483,680	30.00
31.00	03100 INTENSIVE CARE UNIT	2,331,575	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	34.00
43.00	04300 NURSERY	581,418	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	6,788,708	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	585,192	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,907,953	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,407,895	55.00
57.00	05700 CT SCAN	393,319	57.00
59.00	05900 CARDIAC CATHETERIZATION	318,377	59.00
60.00	06000 LABORATORY	7,981,038	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500 RESPIRATORY THERAPY	1,480,319	65.00
65.01	06501 SLEEP LAB	67,720	65.01
66.00	06600 PHYSICAL THERAPY	2,327,525	66.00
66.01	06601 PHYSICAL THERAPY - LIFEPLEX	918,456	66.01
66.02	06602 PHYSICAL THERAPY - CULVER MILITARY	30,901	66.02
67.00	06700 OCCUPATIONAL THERAPY	230,785	67.00
68.00	06800 SPEECH PATHOLOGY	125,927	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	562,433	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5,262,524	73.00
76.97	07697 CARDIAC REHABILITATION	380,417	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	143,015	76.98
76.99	07699 LI THOTRI PSY	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	10,781	90.01
90.02	09002 ATHLETIC TRAINERS	46,000	90.02
90.03	09003 SAINT JOSEPH HEALTH CENTER	1,471,032	90.03
90.04	09004 WOUND CARE	1,257,235	90.04
91.00	09100 EMERGENCY	5,384,094	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	49,478,319	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,137	190.00
190.01	19001 LIFEPLEX FITNESS FORUM	548,890	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,243,078	192.00
192.01	19201 FOUNDATION ADMINISTRATION	0	192.01
192.02	19202 HOSPITALIST	6,886	192.02
192.03	19203 INTENSIVIST	2,093	192.03
192.04	19204 FOOT & ANKLE SPORTS MED PLY	673,774	192.04
194.00	07950 PLYMOUTH MOB-4	47,448	194.00
194.01	07951 COMMUNITY OUTREACH & PARTNERSHIP	92,021	194.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	-28,039	201.00
202.00	TOTAL (sum lines 118 through 201)	52,082,607	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet B
Part II
Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT
		BLDG & FIXT	MVBLE EQUIP		
		0	2.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	238,267	234,164	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	450,625	442,865	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	8,068	7,929	8.00
9.00 00900	HOUSEKEEPING	0	3,994	3,925	9.00
10.00 01000	DIETARY	0	27,918	27,437	10.00
11.00 01100	CAFETERIA	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	14.00
15.00 01500	PHARMACY	0	16,522	16,238	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	33,469	32,893	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	258,117	253,672	30.00
31.00 03100	INTENSIVE CARE UNIT	0	49,499	48,647	31.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	34.00
43.00 04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	256,280	251,867	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	96,707	95,042	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	120,485	118,410	55.00
57.00 05700	CT SCAN	0	5,578	5,482	57.00
59.00 05900	CARDIAC CATHETERIZATION	0	28,264	27,778	59.00
60.00 06000	LABORATORY	0	57,860	56,863	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	44,160	43,399	65.00
65.01 06501	SLEEP LAB	0	0	0	65.01
66.00 06600	PHYSICAL THERAPY	0	77,842	76,502	66.00
66.01 06601	PHYSICAL THERAPY - LI FEPLEX	0	0	0	66.01
66.02 06602	PHYSICAL THERAPY - CULVER MILITARY	0	0	0	66.02
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	7,229	7,105	76.98
76.99 07699	LI THOTRI PSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01 09001	OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	90.01
90.02 09002	ATHLETIC TRAINERS	0	0	0	90.02
90.03 09003	SAINT JOSEPH HEALTH CENTER	0	0	0	90.03
90.04 09004	WOUND CARE	0	34,388	33,796	90.04
91.00 09100	EMERGENCY	0	109,264	107,382	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART			0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1,924,536	1,891,396	3,815,932
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,530	2,486	190.00
190.01 19001	LI FEPLEX FITNESS FORUM	0	0	0	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	195,479	192,113	192.00
192.01 19201	FOUNDATION ADMINISTRATION	0	0	0	192.01
192.02 19202	HOSPITALIST	0	0	0	192.02
192.03 19203	INTENSIVIST	0	0	0	192.03
192.04 19204	FOOT & ANKLE SPORTS MED PLY	0	0	0	192.04
194.00 07950	PLYMOUTH MOB-4	0	0	0	194.00
194.01 07951	COMMUNITY OUTREACH & PARTNERSHIP	0	0	0	194.01
200.00	Cross Foot Adjustments			0	200.00
201.00	Negative Cost Centers		0	0	201.00

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
202.00	TOTAL (sum lines 118 through 201)	0	1.00 2,122,545	2.00 2,085,995	2A 4,208,540	4.00	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Prepared: 11/30/2021 12:37 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	472,431			5.00		
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00		
7.00	00700	OPERATION OF PLANT	38,343	0	931,833	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	2,457	0	5,244	23,698	8.00	
9.00	00900	HOUSEKEEPING	7,952	0	2,596	0	18,467	9.00
10.00	01000	DIETARY	6,969	0	18,146	2	363	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	7,286	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	11,591	0	10,739	0	215	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,171	0	21,754	0	435	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,975	0	167,768	1,133	3,353	30.00
31.00	03100	INTENSIVE CARE UNIT	17,633	0	32,173	580	643	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	5,126	0	0	78	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	50,577	0	166,575	3,178	3,329	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,126	0	0	167	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,009	0	62,857	2,017	1,256	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	8,267	0	78,312	1,150	1,565	55.00
57.00	05700	CT SCAN	2,146	0	3,625	3,108	72	57.00
59.00	05900	CARDIAC CATHETERIZATION	1,920	0	18,371	75	367	59.00
60.00	06000	LABORATORY	67,553	0	37,607	5,108	752	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	11,271	0	28,703	1,170	574	65.00
65.01	06501	SLEEP LAB	595	0	0	50	0	65.01
66.00	06600	PHYSICAL THERAPY	17,954	0	50,595	485	1,011	66.00
66.01	06601	PHYSICAL THERAPY - LI FEPLEX	8,026	0	0	377	0	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	270	0	0	12	0	66.02
67.00	06700	OCCUPATIONAL THERAPY	2,013	0	0	88	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,111	0	0	23	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,979	0	0	311	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,638	0	0	1,954	0	73.00
76.97	07697	CARDIAC REHABILITATION	3,347	0	0	84	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,014	0	4,699	92	94	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	94	0	0	0	0	90.01
90.02	09002	ATHLETIC TRAINERS	333	0	0	0	0	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	12,962	0	0	81	0	90.03
90.04	09004	WOUND CARE	10,116	0	22,351	280	447	90.04
91.00	09100	EMERGENCY	43,745	0	71,018	1,812	1,419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	455,569	0	803,133	23,415	15,895	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	82	0	1,644	0	33	190.00
190.01	19001	LI FEPLEX FITNESS FORUM	4,657	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,933	0	127,056	0	2,539	192.00
192.01	19201	FOUNDATION ADMINISTRATION	0	0	0	0	0	192.01
192.02	19202	HOSPITALIST	0	0	0	162	0	192.02
192.03	19203	INTENSIVIST	0	0	0	49	0	192.03
192.04	19204	FOOT & ANKLE SPORTS MED PLY	5,959	0	0	72	0	192.04
194.00	07950	PLYMOUTH MOB-4	430	0	0	0	0	194.00
194.01	07951	COMMUNITY OUTREACH & PARTNERSHIP	801	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	472,431	0	931,833	23,698	18,467	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0076		Period: From 07/01/2020 To 06/30/2021		Worksheet B Part II Date/Time Prepared: 11/30/2021 12:37 pm	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	80,835					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	7,286		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	221	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	152	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	60,870	0	0	1,074	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,965	0	0	414	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	115	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,286	0	0	828	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	115	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	444	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	141	0	55.00
57.00	05700	CT SCAN	0	0	0	45	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	20	0	59.00
60.00	06000	LABORATORY	0	0	0	999	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	268	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	437	0	66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	0	0	0	155	0	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0	0	0	6	0	66.02
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	45	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	22	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	69	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	13	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	3	0	90.01
90.02	09002	ATHLETIC TRAINERS	0	0	0	84	0	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	0	0	0	343	0	90.03
90.04	09004	WOUND CARE	0	0	0	59	0	90.04
91.00	09100	EMERGENCY	714	0	0	758	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	80,835	0	0	6,830	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	LIFEPLEX FITNESS FORUM	0	0	0	319	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION ADMINISTRATION	0	0	0	0	0	192.01
192.02	19202	HOSPITALIST	0	0	0	0	0	192.02
192.03	19203	INTENSIVIST	0	0	0	0	0	192.03
192.04	19204	FOOT & ANKLE SPORTS MED PLY	0	0	0	104	0	192.04
194.00	07950	PLYMOUTH MOB-4	0	0	0	0	0	194.00
194.01	07951	COMMUNITY OUTREACH & PARTNERSHIP	0	0	0	33	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	80,835	0	0	7,286	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0076		Period: From 07/01/2020 To 06/30/2021		Worksheet B Part II Date/Time Prepared: 11/30/2021 12:37 pm	
Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	55,526					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	93,874				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	4,503	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,304	0			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0			34.00
43.00	04300	NURSERY	0	311	0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	12,626	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	665	0			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,015	0			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	37	4,571	0			55.00
57.00	05700	CT SCAN	0	12,348	0			57.00
59.00	05900	CARDIAC CATHETERIZATION	6	297	0			59.00
60.00	06000	LABORATORY	0	20,013	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	4,650	0			65.00
65.01	06501	SLEEP LAB	0	198	0			65.01
66.00	06600	PHYSICAL THERAPY	0	1,926	0			66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	0	1,496	0			66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0	46	0			66.02
67.00	06700	OCCUPATIONAL THERAPY	0	350	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	90	0			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,235	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,403	7,764	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	334	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	367	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0	0	0			90.01
90.02	09002	ATHLETIC TRAINERS	0	0	0			90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	0	324	0			90.03
90.04	09004	WOUND CARE	0	1,114	0			90.04
91.00	09100	EMERGENCY	0	7,198	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,446	92,745	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
190.01	19001	LIFEPLEX FITNESS FORUM	0	0	0			190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	FOUNDATION ADMINISTRATION	0	0	0			192.01
192.02	19202	HOSPITALIST	0	646	0			192.02
192.03	19203	INTENSIVIST	0	196	0			192.03
192.04	19204	FOOT & ANKLE SPORTS MED PLY	80	287	0			192.04
194.00	07950	PLYMOUTH MOB-4	0	0	0			194.00
194.01	07951	COMMUNITY OUTREACH & PARTNERSHIP	0	0	0			194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	55,526	93,874	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Prepared: 11/30/2021 12:37 pm
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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0			22.00
23.00 02300	PARAMED PRGM-(SPECIFY)			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS			793,465		0 30.00
31.00 03100	INTENSIVE CARE UNIT			164,858		0 31.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT			0		0 34.00
43.00 04300	NURSERY			5,630		0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM			751,546		0 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM			6,073		0 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC			288,347		0 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC			332,938		0 55.00
57.00 05700	CT SCAN			32,404		0 57.00
59.00 05900	CARDIAC CATHETERIZATION			77,098		0 59.00
60.00 06000	LABORATORY			246,755		0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS			0		0 62.30
65.00 06500	RESPIRATORY THERAPY			134,195		0 65.00
65.01 06501	SLEEP LAB			843		0 65.01
66.00 06600	PHYSICAL THERAPY			226,752		0 66.00
66.01 06601	PHYSICAL THERAPY - LI FEPLEX			10,054		0 66.01
66.02 06602	PHYSICAL THERAPY - CULVER MILITARY			334		0 66.02
67.00 06700	OCCUPATIONAL THERAPY			2,496		0 67.00
68.00 06800	SPEECH PATHOLOGY			1,246		0 68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT			0		0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS			6,525		0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS			99,759		0 73.00
76.97 07697	CARDIAC REHABILITATION			3,834		0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY			20,613		0 76.98
76.99 07699	LITHOTRIpsy			0		0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 09001	OUTPATIENT TREATMENT & INFUSION CTR			97		0 90.01
90.02 09002	ATHLETIC TRAINERS			417		0 90.02
90.03 09003	SAINT JOSEPH HEALTH CENTER			13,710		0 90.03
90.04 09004	WOUND CARE			102,551		0 90.04
91.00 09100	EMERGENCY			343,310		0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	3,665,850	0 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				6,775	0 190.00
190.01 19001	LI FEPLEX FITNESS FORUM				4,976	0 190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES				522,120	0 192.00
192.01 19201	FOUNDATION ADMINISTRATION				0	0 192.01
192.02 19202	HOSPITALIST				808	0 192.02
192.03 19203	INTENSIVIST				245	0 192.03
192.04 19204	FOOT & ANKLE SPORTS MED PLY				6,502	0 192.04
194.00 07950	PLYMOUTH MOB-4				430	0 194.00
194.01 07951	COMMUNITY OUTREACH & PARTNERSHIP				834	0 194.01
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0076		Period: From 07/01/2020 To 06/30/2021		Worksheet B Part II Date/Time Prepared: 11/30/2021 12:37 pm			
		INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments			
Cost Center Description		SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV					21.00	22.00
201.00	Negative Cost Centers	0	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	0	0	4,208,540	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Prepared: 11/30/2021 12:37 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING SCHOOL		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	793,465	30.00
31.00	03100 INTENSIVE CARE UNIT	164,858	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	34.00
43.00	04300 NURSERY	5,630	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	751,546	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,073	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	288,347	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	332,938	55.00
57.00	05700 CT SCAN	32,404	57.00
59.00	05900 CARDIAC CATHETERIZATION	77,098	59.00
60.00	06000 LABORATORY	246,755	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500 RESPIRATORY THERAPY	134,195	65.00
65.01	06501 SLEEP LAB	843	65.01
66.00	06600 PHYSICAL THERAPY	226,752	66.00
66.01	06601 PHYSICAL THERAPY - LIFEPLEX	10,054	66.01
66.02	06602 PHYSICAL THERAPY - CULVER MILITARY	334	66.02
67.00	06700 OCCUPATIONAL THERAPY	2,496	67.00
68.00	06800 SPEECH PATHOLOGY	1,246	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6,525	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	99,759	73.00
76.97	07697 CARDIAC REHABILITATION	3,834	76.97
76.98	07698 HYPERBARIIC OXYGEN THERAPY	20,613	76.98
76.99	07699 LI THOTRI PSY	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	97	90.01
90.02	09002 ATHLETIC TRAINERS	417	90.02
90.03	09003 SAINT JOSEPH HEALTH CENTER	13,710	90.03
90.04	09004 WOUND CARE	102,551	90.04
91.00	09100 EMERGENCY	343,310	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3,665,850	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,775	190.00
190.01	19001 LIFEPLEX FITNESS FORUM	4,976	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	522,120	192.00
192.01	19201 FOUNDATION ADMINISTRATION	0	192.01
192.02	19202 HOSPITALIST	808	192.02
192.03	19203 INTENSIVIST	245	192.03
192.04	19204 FOOT & ANKLE SPORTS MED PLY	6,502	192.04
194.00	07950 PLYMOUTH MOB-4	430	194.00
194.01	07951 COMMUNITY OUTREACH & PARTNERSHIP	834	194.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	4,208,540	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,008,830				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		2,008,830			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	19,123,146		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	225,502	225,502	2,068,896	-14,993,864	37,116,782
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	426,483	426,483	329,812	0	3,012,484
8.00 00800	LAUNDRY & LINEN SERVICE	7,636	7,636	0	0	193,077
9.00 00900	HOUSEKEEPING	3,780	3,780	413,498	0	624,744
10.00 01000	DIETARY	26,422	26,422	333,466	0	547,571
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	477,867	0	572,419
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	15,637	15,637	719,295	0	910,643
16.00 01600	MEDICAL RECORDS & LIBRARY	31,676	31,676	249,961	0	406,242
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	244,288	244,288	2,167,813	0	3,376,414
31.00 03100	INTENSIVE CARE UNIT	46,847	46,847	971,052	0	1,385,357
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
43.00 04300	NURSERY	0	0	281,392	0	402,745
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	242,550	242,550	1,950,675	0	3,973,668
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	281,392	0	402,746
54.00 05400	RADIOLOGY-DIAGNOSTIC	91,526	91,526	1,112,688	0	1,729,194
55.00 05500	RADIOLOGY-THERAPEUTIC	114,030	114,030	397,241	0	649,498
57.00 05700	CT SCAN	5,279	5,279	93,123	0	168,603
59.00 05900	CARDIAC CATHETERIZATION	26,750	26,750	37,602	0	150,867
60.00 06000	LABORATORY	54,760	54,760	1,619,478	0	5,306,434
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	41,794	41,794	577,789	0	885,553
65.01 06501	SLEEP LAB	0	0	0	0	46,730
66.00 06600	PHYSICAL THERAPY	73,672	73,672	963,355	0	1,410,623
66.01 06601	PHYSICAL THERAPY - LI FEPLEX	0	0	369,246	0	630,612
66.02 06602	PHYSICAL THERAPY - CULVER MILITARY	0	0	14,094	0	21,223
67.00 06700	OCCUPATIONAL THERAPY	0	0	132,978	0	158,158
68.00 06800	SPEECH PATHOLOGY	0	0	73,076	0	87,270
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	391,224
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,721,432
76.97 07697	CARDIAC REHABILITATION	0	0	134,708	0	262,968
76.98 07698	HYPERBARIC OXYGEN THERAPY	6,842	6,842	29,681	0	79,650
76.99 07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.01 09001	OUTPATIENT TREATMENT & INFUSION CTR	0	0	5,971	0	7,418
90.02 09002	ATHLETIC TRAINERS	0	0	117,467	0	26,182
90.03 09003	SAINT JOSEPH HEALTH CENTER	0	0	713,349	0	1,018,402
90.04 09004	WOUND CARE	32,546	32,546	134,461	0	794,813
91.00 09100	EMERGENCY	103,410	103,410	1,655,796	0	3,436,933
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,821,430	1,821,430	18,427,222	-14,993,864	35,791,897
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,394	2,394	0	0	6,477
190.01 19001	LI FEPLEX FITNESS FORUM	0	0	283,304	0	365,875
192.00 19200	PHYSICIANS' PRIVATE OFFICES	185,006	185,006	0	0	387,592
192.01 19201	FOUNDATION ADMINISTRATION	0	0	0	0	0
192.02 19202	HOSPITALIST	0	0	0	0	0
192.03 19203	INTENSIVIST	0	0	0	0	0
192.04 19204	FOOT & ANKLE SPORTS MED PLY	0	0	363,376	0	468,182
194.00 07950	PLYMOUTH MOB-4	0	0	0	0	33,796
194.01 07951	COMMUNITY OUTREACH & PARTNERSHIP	0	0	49,244	0	62,963
200.00	Cross Foot Adjustments					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)		-28,039		14,993,864	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		0.000000		0.403965	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		0		472,431	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.012728	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS REVENUE)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	1,356,845			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,636	211,031,509		8.00
9.00	00900	HOUSEKEEPING	0	3,780	0	1,345,429	9.00
10.00	01000	DIETARY	0	26,422	13,752	26,422	16,074
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	15,637	52	15,637	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,676	0	31,676	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	244,288	10,119,875	244,288	12,104
31.00	03100	INTENSIVE CARE UNIT	0	46,847	5,178,495	46,847	2,578
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
43.00	04300	NURSERY	0	0	698,924	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	242,550	28,372,143	242,550	1,250
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,493,755	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	91,526	18,012,010	91,526	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	114,030	10,271,538	114,030	0
57.00	05700	CT SCAN	0	5,279	27,748,785	5,279	0
59.00	05900	CARDIAC CATHETERIZATION	0	26,750	666,907	26,750	0
60.00	06000	LABORATORY	0	54,760	45,035,852	54,760	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	41,794	10,448,845	41,794	0
65.01	06501	SLEEP LAB	0	0	445,346	0	0
66.00	06600	PHYSICAL THERAPY	0	73,672	4,328,298	73,672	0
66.01	06601	PHYSICAL THERAPY - LIFFLEX	0	0	3,362,726	0	0
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0	0	104,064	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	785,823	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	202,230	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,774,533	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	17,447,818	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	751,388	0	0
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	6,842	825,268	6,842	0
76.99	07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	0	0
90.02	09002	ATHLETIC TRAINERS	0	0	0	0	0
90.03	09003	SAINT JOSEPH HEALTH CENTER	0	0	727,492	0	0
90.04	09004	WOUND CARE	0	32,546	2,502,964	32,546	0
91.00	09100	EMERGENCY	0	103,410	16,175,409	103,410	142
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,169,445	208,494,292	1,158,029	16,074
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,394	0	2,394	0
190.01	19001	LIFFLEX FITNESS FORUM	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	185,006	0	185,006	0
192.01	19201	FOUNDATION ADMINISTRATION	0	0	0	0	0
192.02	19202	HOSPITALIST	0	0	1,450,733	0	0
192.03	19203	INTENSIVIST	0	0	440,907	0	0
192.04	19204	FOOT & ANKLE SPORTS MED PLY	0	0	645,577	0	0
194.00	07950	PLYMOUTH MOB-4	0	0	0	0	0
194.01	07951	COMMUNITY OUTREACH & PARTNERSHIP	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	4,229,422	294,875	888,902	868,607

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS REVENUE)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	3.117100	0.001397	0.660683	54.038012	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	931,833	23,698	18,467	80,835	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.686765	0.000112	0.013726	5.028929	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	20,185					11.00
12.00	01200	0	0				12.00
13.00	01300	444	0	19,741			13.00
14.00	01400	0	0	0	211,017,757		14.00
15.00	01500	598	0	598	52	2,499,965	15.00
16.00	01600	412	0	412	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,907	0	2,907	10,119,875	0	30.00
31.00	03100	1,123	0	1,123	5,178,495	0	31.00
34.00	03400	0	0	0	0	0	34.00
43.00	04300	311	0	311	698,924	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,243	0	2,243	28,372,143	0	50.00
52.00	05200	311	0	311	1,493,755	0	52.00
54.00	05400	1,203	0	1,203	18,012,010	0	54.00
55.00	05500	383	0	383	10,271,538	1,656	55.00
57.00	05700	122	0	122	27,748,785	0	57.00
59.00	05900	54	0	54	666,907	269	59.00
60.00	06000	2,708	0	2,708	45,035,852	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	726	0	726	10,448,845	0	65.00
65.01	06501	0	0	0	445,346	0	65.01
66.00	06600	1,184	0	1,184	4,328,298	0	66.00
66.01	06601	421	0	421	3,362,726	0	66.01
66.02	06602	15	0	15	104,064	0	66.02
67.00	06700	123	0	123	785,823	0	67.00
68.00	06800	60	0	60	202,230	0	68.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	2,774,533	0	72.00
73.00	07300	0	0	0	17,447,818	2,494,444	73.00
76.97	07697	188	0	188	751,388	0	76.97
76.98	07698	35	0	35	825,268	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	9	0	9	0	0	90.01
90.02	09002	227	0	227	0	0	90.02
90.03	09003	928	0	928	727,492	0	90.03
90.04	09004	160	0	160	2,502,964	0	90.04
91.00	09100	2,055	0	2,055	16,175,409	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		18,950	0	18,506	208,480,540	2,496,369	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	865	0	865	0	0	190.01
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	1,450,733	0	192.02
192.03	19203	0	0	0	440,907	0	192.03
192.04	19204	281	0	281	645,577	3,596	192.04
194.00	07950	0	0	0	0	0	194.00
194.01	07951	89	0	89	0	0	194.01
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	803,656	0	1,361,929	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	40.709994	0.000000	0.544779	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	7,286	0	55,526	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.369080	0.000000	0.022211	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
	16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	211,017,705					16.00
17.00 01700 SOCIAL SERVICE	0	0				17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00 02000 NURSING SCHOOL	0	0		0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	10,119,875	0	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	5,178,495	0	0	0	0	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00 04300 NURSERY	698,924	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	28,372,143	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,493,755	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	18,012,010	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	10,271,538	0	0	0	0	55.00
57.00 05700 CT SCAN	27,748,785	0	0	0	0	57.00
59.00 05900 CARDIAC CATHETERIZATION	666,907	0	0	0	0	59.00
60.00 06000 LABORATORY	45,035,852	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	10,448,845	0	0	0	0	65.00
65.01 06501 SLEEP LAB	445,346	0	0	0	0	65.01
66.00 06600 PHYSICAL THERAPY	4,328,298	0	0	0	0	66.00
66.01 06601 PHYSICAL THERAPY - LI FEPLEX	3,362,726	0	0	0	0	66.01
66.02 06602 PHYSICAL THERAPY - CULVER MILITARY	104,064	0	0	0	0	66.02
67.00 06700 OCCUPATIONAL THERAPY	785,823	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	202,230	0	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2,774,533	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	17,447,818	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	751,388	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	825,268	0	0	0	0	76.98
76.99 07699 LI THOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	0	0	90.01
90.02 09002 ATHLETIC TRAINERS	0	0	0	0	0	90.02
90.03 09003 SAINT JOSEPH HEALTH CENTER	727,492	0	0	0	0	90.03
90.04 09004 WOUND CARE	2,502,964	0	0	0	0	90.04
91.00 09100 EMERGENCY	16,175,409	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	208,480,488	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 19001 LI FEPLEX FITNESS FORUM	0	0	0	0	0	190.01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201 FOUNDATION ADMINISTRATION	0	0	0	0	0	192.01
192.02 19202 HOSPITALIST	1,450,733	0	0	0	0	192.02
192.03 19203 INTENSIVIST	440,907	0	0	0	0	192.03
192.04 19204 FOOT & ANKLE SPORTS MED PLY	645,577	0	0	0	0	192.04
194.00 07950 PLYMOUTH MOB-4	0	0	0	0	0	194.00
194.01 07951 COMMUNITY OUTREACH & PARTNERSHIP	0	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
		16.00	17.00	19.00	20.00	21.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	706,788	0	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.003349	0.000000	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	93,874	0	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000445	0.000000	0.000000	0.000000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1
Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description		INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)		
		SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
		22.00	23.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00
23.00	02300	PARAMED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	06501	SLEEP LAB	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
66.01	06601	PHYSICAL THERAPY - LI FEPLEX	0	0	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0	0	66.02
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0	0	90.01
90.02	09002	ATHLETIC TRAINERS	0	0	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	0	0	90.03
90.04	09004	WOUND CARE	0	0	90.04
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	LI FEPLEX FITNESS FORUM	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	FOUNDATION ADMINISTRATION	0	0	192.01
192.02	19202	HOSPITALIST	0	0	192.02
192.03	19203	INTENSIVIST	0	0	192.03
192.04	19204	FOOT & ANKLE SPORTS MED PLY	0	0	192.04
194.00	07950	PLYMOUTH MOB-4	0	0	194.00
194.01	07951	COMMUNITY OUTREACH & PARTNERSHIP	0	0	194.01
200.00		Cross Foot Adjustments			200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	
	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
	22.00	23.00	
201.00 Negative Cost Centers			201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	0	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 12:37 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	6,483,680		6,483,680	0	6,483,680	30.00
31.00 03100 INTENSIVE CARE UNIT	2,331,575		2,331,575	25,168	2,356,743	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
43.00 04300 NURSERY	581,418		581,418	0	581,418	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	6,788,708		6,788,708	0	6,788,708	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	585,192		585,192	0	585,192	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,907,953		2,907,953	0	2,907,953	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	1,407,895		1,407,895	0	1,407,895	55.00
57.00 05700 CT SCAN	393,319		393,319	0	393,319	57.00
59.00 05900 CARDIAC CATHETERIZATION	318,377		318,377	0	318,377	59.00
60.00 06000 LABORATORY	7,981,038		7,981,038	365	7,981,403	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	1,480,319	0	1,480,319	0	1,480,319	65.00
65.01 06501 SLEEP LAB	67,720	0	67,720	0	67,720	65.01
66.00 06600 PHYSICAL THERAPY	2,327,525	0	2,327,525	0	2,327,525	66.00
66.01 06601 PHYSICAL THERAPY - LI FEPLEX	918,456	0	918,456	0	918,456	66.01
66.02 06602 PHYSICAL THERAPY - CULVER MILITARY	30,901	0	30,901	0	30,901	66.02
67.00 06700 OCCUPATIONAL THERAPY	230,785	0	230,785	0	230,785	67.00
68.00 06800 SPEECH PATHOLOGY	125,927	0	125,927	0	125,927	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	562,433		562,433	0	562,433	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5,262,524		5,262,524	0	5,262,524	73.00
76.97 07697 CARDIAC REHABILITATION	380,417		380,417	0	380,417	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	143,015		143,015	0	143,015	76.98
76.99 07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	10,781		10,781	0	10,781	90.01
90.02 09002 ATHLETIC TRAINERS	46,000		46,000	0	46,000	90.02
90.03 09003 SAINT JOSEPH HEALTH CENTER	1,471,032		1,471,032	0	1,471,032	90.03
90.04 09004 WOUND CARE	1,257,235		1,257,235	0	1,257,235	90.04
91.00 09100 EMERGENCY	5,384,094		5,384,094	44,862	5,428,956	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,485,974		1,485,974		1,485,974	92.00
200.00 Subtotal (see instructions)	50,964,293	0	50,964,293	70,395	51,034,688	200.00
201.00 Less Observation Beds	1,485,974		1,485,974		1,485,974	201.00
202.00 Total (see instructions)	49,478,319	0	49,478,319	70,395	49,548,714	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 12:37 pm
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Cost Center Description		Charges			Hospital	PPS	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)				Cost or Other Ratio
		6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,306,915		8,306,915			30.00
31.00	03100	INTENSIVE CARE UNIT	5,178,495		5,178,495			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
43.00	04300	NURSERY	698,924		698,924			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,137,708	23,234,435	28,372,143	0.239274	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,434,785	58,970	1,493,755	0.391759	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,375,454	15,636,556	18,012,010	0.161445	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33,384	10,238,154	10,271,538	0.137068	0.000000	55.00
57.00	05700	CT SCAN	4,038,455	23,710,330	27,748,785	0.014174	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	56,847	610,060	666,907	0.477393	0.000000	59.00
60.00	06000	LABORATORY	8,442,435	36,593,417	45,035,852	0.177215	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	3,136,771	7,312,074	10,448,845	0.141673	0.000000	65.00
65.01	06501	SLEEP LAB	0	445,346	445,346	0.152062	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	472,029	3,856,269	4,328,298	0.537746	0.000000	66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	966	3,361,760	3,362,726	0.273128	0.000000	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0	104,064	104,064	0.296942	0.000000	66.02
67.00	06700	OCCUPATIONAL THERAPY	173,036	612,787	785,823	0.293686	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	55,634	146,596	202,230	0.622692	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	596,994	2,177,539	2,774,533	0.202713	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,590,825	10,856,993	17,447,818	0.301615	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	861	750,527	751,388	0.506286	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	825,268	825,268	0.173295	0.000000	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	0.000000	0.000000	90.01
90.02	09002	ATHLETIC TRAINERS	0	0	0	0.000000	0.000000	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	0	727,492	727,492	2.022059	0.000000	90.03
90.04	09004	WOUND CARE	18,175	2,484,789	2,502,964	0.502298	0.000000	90.04
91.00	09100	EMERGENCY	2,543,100	13,632,309	16,175,409	0.332857	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	300,200	1,512,760	1,812,960	0.819640	0.000000	92.00
200.00		Subtotal (see instructions)	49,591,993	158,888,495	208,480,488			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	49,591,993	158,888,495	208,480,488			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 12:37 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.239274		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.391759		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.161445		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.137068		55.00
57.00	05700 CT SCAN	0.014174		57.00
59.00	05900 CARDIAC CATHETERIZATION	0.477393		59.00
60.00	06000 LABORATORY	0.177223		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.141673		65.00
65.01	06501 SLEEP LAB	0.152062		65.01
66.00	06600 PHYSICAL THERAPY	0.537746		66.00
66.01	06601 PHYSICAL THERAPY - LIFEPLEX	0.273128		66.01
66.02	06602 PHYSICAL THERAPY - CULVER MILITARY	0.296942		66.02
67.00	06700 OCCUPATIONAL THERAPY	0.293686		67.00
68.00	06800 SPEECH PATHOLOGY	0.622692		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.202713		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.301615		73.00
76.97	07697 CARDIAC REHABILITATION	0.506286		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.173295		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	0.000000		90.01
90.02	09002 ATHLETIC TRAINERS	0.000000		90.02
90.03	09003 SAINT JOSEPH HEALTH CENTER	2.022059		90.03
90.04	09004 WOUND CARE	0.502298		90.04
91.00	09100 EMERGENCY	0.335630		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.819640		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 12:37 pm
		Title XIX	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	6,483,680		6,483,680	0	6,483,680	30.00
31.00 03100 INTENSIVE CARE UNIT	2,331,575		2,331,575	25,168	2,356,743	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
43.00 04300 NURSERY	581,418		581,418	0	581,418	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	6,788,708		6,788,708	0	6,788,708	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	585,192		585,192	0	585,192	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,907,953		2,907,953	0	2,907,953	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	1,407,895		1,407,895	0	1,407,895	55.00
57.00 05700 CT SCAN	393,319		393,319	0	393,319	57.00
59.00 05900 CARDIAC CATHETERIZATION	318,377		318,377	0	318,377	59.00
60.00 06000 LABORATORY	7,981,038		7,981,038	365	7,981,403	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	1,480,319	0	1,480,319	0	1,480,319	65.00
65.01 06501 SLEEP LAB	67,720	0	67,720	0	67,720	65.01
66.00 06600 PHYSICAL THERAPY	2,327,525	0	2,327,525	0	2,327,525	66.00
66.01 06601 PHYSICAL THERAPY - LI FEPLEX	918,456	0	918,456	0	918,456	66.01
66.02 06602 PHYSICAL THERAPY - CULVER MILITARY	30,901	0	30,901	0	30,901	66.02
67.00 06700 OCCUPATIONAL THERAPY	230,785	0	230,785	0	230,785	67.00
68.00 06800 SPEECH PATHOLOGY	125,927	0	125,927	0	125,927	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	562,433		562,433	0	562,433	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5,262,524		5,262,524	0	5,262,524	73.00
76.97 07697 CARDIAC REHABILITATION	380,417		380,417	0	380,417	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	143,015		143,015	0	143,015	76.98
76.99 07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	10,781		10,781	0	10,781	90.01
90.02 09002 ATHLETIC TRAINERS	46,000		46,000	0	46,000	90.02
90.03 09003 SAINT JOSEPH HEALTH CENTER	1,471,032		1,471,032	0	1,471,032	90.03
90.04 09004 WOUND CARE	1,257,235		1,257,235	0	1,257,235	90.04
91.00 09100 EMERGENCY	5,384,094		5,384,094	44,862	5,428,956	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,485,974		1,485,974		1,485,974	92.00
200.00 Subtotal (see instructions)	50,964,293	0	50,964,293	70,395	51,034,688	200.00
201.00 Less Observation Beds	1,485,974		1,485,974		1,485,974	201.00
202.00 Total (see instructions)	49,478,319	0	49,478,319	70,395	49,548,714	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 12:37 pm
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,306,915		8,306,915		30.00
31.00	03100	INTENSIVE CARE UNIT	5,178,495		5,178,495		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
43.00	04300	NURSERY	698,924		698,924		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,137,708	23,234,435	28,372,143	0.239274	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,434,785	58,970	1,493,755	0.391759	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,375,454	15,636,556	18,012,010	0.161445	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33,384	10,238,154	10,271,538	0.137068	55.00
57.00	05700	CT SCAN	4,038,455	23,710,330	27,748,785	0.141474	57.00
59.00	05900	CARDIAC CATHETERIZATION	56,847	610,060	666,907	0.477393	59.00
60.00	06000	LABORATORY	8,442,435	36,593,417	45,035,852	0.177215	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	3,136,771	7,312,074	10,448,845	0.141673	65.00
65.01	06501	SLEEP LAB	0	445,346	445,346	0.152062	65.01
66.00	06600	PHYSICAL THERAPY	472,029	3,856,269	4,328,298	0.537746	66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	966	3,361,760	3,362,726	0.273128	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0	104,064	104,064	0.296942	66.02
67.00	06700	OCCUPATIONAL THERAPY	173,036	612,787	785,823	0.293686	67.00
68.00	06800	SPEECH PATHOLOGY	55,634	146,596	202,230	0.622692	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	596,994	2,177,539	2,774,533	0.202713	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,590,825	10,856,993	17,447,818	0.301615	73.00
76.97	07697	CARDIAC REHABILITATION	861	750,527	751,388	0.506286	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	825,268	825,268	0.173295	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	0.000000	90.01
90.02	09002	ATHLETIC TRAINERS	0	0	0	0.000000	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	0	727,492	727,492	2.022059	90.03
90.04	09004	WOUND CARE	18,175	2,484,789	2,502,964	0.502298	90.04
91.00	09100	EMERGENCY	2,543,100	13,632,309	16,175,409	0.332857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	300,200	1,512,760	1,812,960	0.819640	92.00
200.00		Subtotal (see instructions)	49,591,993	158,888,495	208,480,488		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	49,591,993	158,888,495	208,480,488		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 12:37 pm
		Title XIX	Hospital	PPS

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
34.00	03400 SURGICAL INTENSIVE CARE UNIT		34.00
43.00	04300 NURSERY		43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.239274	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.391759	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.161445	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.137068	55.00
57.00	05700 CT SCAN	0.014174	57.00
59.00	05900 CARDIAC CATHETERIZATION	0.477393	59.00
60.00	06000 LABORATORY	0.177223	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500 RESPIRATORY THERAPY	0.141673	65.00
65.01	06501 SLEEP LAB	0.152062	65.01
66.00	06600 PHYSICAL THERAPY	0.537746	66.00
66.01	06601 PHYSICAL THERAPY - LIFEPLEX	0.273128	66.01
66.02	06602 PHYSICAL THERAPY - CULVER MILITARY	0.296942	66.02
67.00	06700 OCCUPATIONAL THERAPY	0.293686	67.00
68.00	06800 SPEECH PATHOLOGY	0.622692	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.202713	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.301615	73.00
76.97	07697 CARDIAC REHABILITATION	0.506286	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.173295	76.98
76.99	07699 LI THOTRI PSY	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS			
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	0.000000	90.01
90.02	09002 ATHLETIC TRAINERS	0.000000	90.02
90.03	09003 SAINT JOSEPH HEALTH CENTER	2.022059	90.03
90.04	09004 WOUND CARE	0.502298	90.04
91.00	09100 EMERGENCY	0.335630	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.819640	92.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-0076

Period: From 07/01/2020 To 06/30/2021

Worksheet C Part II Date/Time Prepared: 11/30/2021 12:37 pm

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,788,708	751,546	6,037,162	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	585,192	6,073	579,119	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,907,953	288,347	2,619,606	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,407,895	332,938	1,074,957	0	0	55.00
57.00	05700	CT SCAN	393,319	32,404	360,915	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	318,377	77,098	241,279	0	0	59.00
60.00	06000	LABORATORY	7,981,038	246,755	7,734,283	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,480,319	134,195	1,346,124	0	0	65.00
65.01	06501	SLEEP LAB	67,720	843	66,877	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,327,525	226,752	2,100,773	0	0	66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	918,456	10,054	908,402	0	0	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	30,901	334	30,567	0	0	66.02
67.00	06700	OCCUPATIONAL THERAPY	230,785	2,496	228,289	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	125,927	1,246	124,681	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	562,433	6,525	555,908	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,262,524	99,759	5,162,765	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	380,417	3,834	376,583	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	143,015	20,613	122,402	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	10,781	97	10,684	0	0	90.01
90.02	09002	ATHLETIC TRAINERS	46,000	417	45,583	0	0	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	1,471,032	13,710	1,457,322	0	0	90.03
90.04	09004	WOUND CARE	1,257,235	102,551	1,154,684	0	0	90.04
91.00	09100	EMERGENCY	5,384,094	343,310	5,040,784	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,485,974	181,852	1,304,122	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	41,567,620	2,883,749	38,683,871	0	0	200.00
201.00		Less Observation Beds	1,485,974	181,852	1,304,122	0	0	201.00
202.00		Total (Line 200 minus Line 201)	40,081,646	2,701,897	37,379,749	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet C
Part II
Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	6,788,708	28,372,143	0.239274		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	585,192	1,493,755	0.391759		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,907,953	18,012,010	0.161445		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,407,895	10,271,538	0.137068		55.00
57.00	05700 CT SCAN	393,319	27,748,785	0.014174		57.00
59.00	05900 CARDIAC CATHETERIZATION	318,377	666,907	0.477393		59.00
60.00	06000 LABORATORY	7,981,038	45,035,852	0.177215		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	1,480,319	10,448,845	0.141673		65.00
65.01	06501 SLEEP LAB	67,720	445,346	0.152062		65.01
66.00	06600 PHYSICAL THERAPY	2,327,525	4,328,298	0.537746		66.00
66.01	06601 PHYSICAL THERAPY - LIFEPLEX	918,456	3,362,726	0.273128		66.01
66.02	06602 PHYSICAL THERAPY - CULVER MILITARY	30,901	104,064	0.296942		66.02
67.00	06700 OCCUPATIONAL THERAPY	230,785	785,823	0.293686		67.00
68.00	06800 SPEECH PATHOLOGY	125,927	202,230	0.622692		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	562,433	2,774,533	0.202713		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5,262,524	17,447,818	0.301615		73.00
76.97	07697 CARDIAC REHABILITATION	380,417	751,388	0.506286		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	143,015	825,268	0.173295		76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	10,781	0	0.000000		90.01
90.02	09002 ATHLETIC TRAINERS	46,000	0	0.000000		90.02
90.03	09003 SAINT JOSEPH HEALTH CENTER	1,471,032	727,492	2.022059		90.03
90.04	09004 WOUND CARE	1,257,235	2,502,964	0.502298		90.04
91.00	09100 EMERGENCY	5,384,094	16,175,409	0.332857		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,485,974	1,812,960	0.819640		92.00
200.00	Subtotal (sum of lines 50 thru 199)	41,567,620	194,296,154			200.00
201.00	Less Observation Beds	1,485,974	0			201.00
202.00	Total (Line 200 minus Line 201)	40,081,646	194,296,154			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part I Date/Time Prepared: 11/30/2021 12:37 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	793,465	0	793,465	5,345	148.45	30.00	
31.00	INTENSIVE CARE UNIT	164,858		164,858	1,220	135.13	31.00	
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00	
43.00	NURSERY	5,630		5,630	432	13.03	43.00	
200.00	Total (lines 30 through 199)	963,953		963,953	6,997		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,405	208,572					30.00
31.00	INTENSIVE CARE UNIT	447	60,403					31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0					34.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	1,852	268,975					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/30/2021 12:37 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	751,546	28,372,143	0.026489	1,397,766	37,025	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,073	1,493,755	0.004066	12,244	50	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	288,347	18,012,010	0.016009	934,778	14,965	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	332,938	10,271,538	0.032414	17,873	579	55.00
57.00	05700 CT SCAN	32,404	27,748,785	0.001168	1,531,708	1,789	57.00
59.00	05900 CARDIAC CATHETERIZATION	77,098	666,907	0.115605	23,790	2,750	59.00
60.00	06000 LABORATORY	246,755	45,035,852	0.005479	3,033,135	16,619	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	134,195	10,448,845	0.012843	683,501	8,778	65.00
65.01	06501 SLEEP LAB	843	445,346	0.001893	0	0	65.01
66.00	06600 PHYSICAL THERAPY	226,752	4,328,298	0.052388	210,817	11,044	66.00
66.01	06601 PHYSICAL THERAPY - LIFEPLEX	10,054	3,362,726	0.002990	640	2	66.01
66.02	06602 PHYSICAL THERAPY - CULVER MILITARY	334	104,064	0.003210	0	0	66.02
67.00	06700 OCCUPATIONAL THERAPY	2,496	785,823	0.003176	82,740	263	67.00
68.00	06800 SPEECH PATHOLOGY	1,246	202,230	0.006161	27,963	172	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6,525	2,774,533	0.002352	200,132	471	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	99,759	17,447,818	0.005718	2,172,628	12,423	73.00
76.97	07697 CARDIAC REHABILITATION	3,834	751,388	0.005103	861	4	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	20,613	825,268	0.024977	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	97	0	0.000000	0	0	90.01
90.02	09002 ATHLETIC TRAINERS	417	0	0.000000	0	0	90.02
90.03	09003 SAINT JOSEPH HEALTH CENTER	13,710	727,492	0.018846	0	0	90.03
90.04	09004 WOUND CARE	102,551	2,502,964	0.040972	4,223	173	90.04
91.00	09100 EMERGENCY	343,310	16,175,409	0.021224	859,445	18,241	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	181,852	1,812,960	0.100307	151,620	15,209	92.00
200.00	Total (lines 50 through 199)	2,883,749	194,296,154		11,345,864	140,557	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part III Date/Time Prepared: 11/30/2021 12:37 pm
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	5,345	0.00	1,405	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	1,220	0.00	447	31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	0	0.00	0	34.00	
43.00	04300	NURSERY		0	432	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	6,997		1,852	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0						34.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	0	0	0	0	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0	0	0	0	66.02
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	0	90.01
90.02	09002	ATHLETIC TRAINERS	0	0	0	0	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	0	0	0	0	90.03
90.04	09004	WOUND CARE	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/30/2021 12:37 pm
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	28,372,143	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	1,493,755	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	18,012,010	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	10,271,538	0.000000	55.00
57.00 05700 CT SCAN	0	0	0	27,748,785	0.000000	57.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	666,907	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	45,035,852	0.000000	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00 06500 RESPIRATORY THERAPY	0	0	0	10,448,845	0.000000	65.00
65.01 06501 SLEEP LAB	0	0	0	445,346	0.000000	65.01
66.00 06600 PHYSICAL THERAPY	0	0	0	4,328,298	0.000000	66.00
66.01 06601 PHYSICAL THERAPY - LI FEPLEX	0	0	0	3,362,726	0.000000	66.01
66.02 06602 PHYSICAL THERAPY - CULVER MILITARY	0	0	0	104,064	0.000000	66.02
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	785,823	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	202,230	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,774,533	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	17,447,818	0.000000	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	751,388	0.000000	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	825,268	0.000000	76.98
76.99 07699 LI THOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	0	0.000000	90.01
90.02 09002 ATHLETIC TRAINERS	0	0	0	0	0.000000	90.02
90.03 09003 SAINT JOSEPH HEALTH CENTER	0	0	0	727,492	0.000000	90.03
90.04 09004 WOUND CARE	0	0	0	2,502,964	0.000000	90.04
91.00 09100 EMERGENCY	0	0	0	16,175,409	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,812,960	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	194,296,154		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/30/2021 12:37 pm
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Cost Center Description		Title XVIII				Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000000	1,397,766	0	5,157,483	0	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	12,244	0	0	0	52.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	934,778	0	2,926,313	0	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	17,873	0	2,902,794	0	55.00	
57.00	05700 CT SCAN	0.000000	1,531,708	0	5,965,594	0	57.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	23,790	0	199,741	0	59.00	
60.00	06000 LABORATORY	0.000000	3,033,135	0	3,041,870	0	60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500 RESPIRATORY THERAPY	0.000000	683,501	0	2,011,095	0	65.00	
65.01	06501 SLEEP LAB	0.000000	0	0	101,281	0	65.01	
66.00	06600 PHYSICAL THERAPY	0.000000	210,817	0	2,731	0	66.00	
66.01	06601 PHYSICAL THERAPY - LIFEPLEX	0.000000	640	0	3,665	0	66.01	
66.02	06602 PHYSICAL THERAPY - CULVER MILITARY	0.000000	0	0	0	0	66.02	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	82,740	0	1,490	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	27,963	0	2,289	0	68.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	200,132	0	461,571	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	2,172,628	0	3,396,421	0	73.00	
76.97	07697 CARDIAC REHABILITATION	0.000000	861	0	0	0	76.97	
76.98	07698 HYPERBARIAC OXYGEN THERAPY	0.000000	0	0	226,968	0	76.98	
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS								
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	0.000000	0	0	0	0	90.01	
90.02	09002 ATHLETIC TRAINERS	0.000000	0	0	0	0	90.02	
90.03	09003 SAINT JOSEPH HEALTH CENTER	0.000000	0	0	0	0	90.03	
90.04	09004 WOUND CARE	0.000000	4,223	0	832,470	0	90.04	
91.00	09100 EMERGENCY	0.000000	859,445	0	2,233,029	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	151,620	0	400,829	0	92.00	
200.00	Total (lines 50 through 199)		11,345,864	0	29,867,634	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/30/2021 12:37 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.239274	5,157,483	0	0	1,234,052	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.391759	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161445	2,926,313	0	0	472,439	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.137068	2,902,794	0	0	397,880	55.00
57.00	05700	CT SCAN	0.014174	5,965,594	2	0	84,556	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.477393	199,741	0	0	95,355	59.00
60.00	06000	LABORATORY	0.177215	3,041,870	3,663	0	539,065	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.141673	2,011,095	0	0	284,918	65.00
65.01	06501	SLEEP LAB	0.152062	101,281	0	0	15,401	65.01
66.00	06600	PHYSICAL THERAPY	0.537746	2,731	0	0	1,469	66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	0.273128	3,665	0	0	1,001	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0.296942	0	0	0	0	66.02
67.00	06700	OCCUPATIONAL THERAPY	0.293686	1,490	0	0	438	67.00
68.00	06800	SPEECH PATHOLOGY	0.622692	2,289	0	0	1,425	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202713	461,571	0	0	93,566	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301615	3,396,421	0	7,023	1,024,412	73.00
76.97	07697	CARDIAC REHABILITATION	0.506286	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.173295	226,968	0	0	39,332	76.98
76.99	07699	LITHOTRIpsy	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0.000000	0	0	0	0	90.01
90.02	09002	ATHLETIC TRAINERS	0.000000	0	0	0	0	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	2.022059	0	0	0	0	90.03
90.04	09004	WOUND CARE	0.502298	832,470	0	0	418,148	90.04
91.00	09100	EMERGENCY	0.332857	2,233,029	1	0	743,279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.819640	400,829	0	0	328,535	92.00
200.00		Subtotal (see instructions)		29,867,634	3,666	7,023	5,775,271	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		29,867,634	3,666	7,023	5,775,271	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/30/2021 12:37 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (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
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00 05700 CT SCAN	0	0		57.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	649	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
65.01 06501 SLEEP LAB	0	0		65.01
66.00 06600 PHYSICAL THERAPY	0	0		66.00
66.01 06601 PHYSICAL THERAPY - LIFEPLEX	0	0		66.01
66.02 06602 PHYSICAL THERAPY - CULVER MILITARY	0	0		66.02
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,118		73.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS				
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0		90.01
90.02 09002 ATHLETIC TRAINERS	0	0		90.02
90.03 09003 SAINT JOSEPH HEALTH CENTER	0	0		90.03
90.04 09004 WOUND CARE	0	0		90.04
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	649	2,118		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	649	2,118		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part I Date/Time Prepared: 11/30/2021 12:37 pm
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Cost Center Description		Title XIX			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	793,465	0	793,465	5,345	148.45	30.00
31.00	INTENSIVE CARE UNIT	164,858		164,858	1,220	135.13	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
43.00	NURSERY	5,630		5,630	432	13.03	43.00
200.00	Total (lines 30 through 199)	963,953		963,953	6,997		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	102	15,142				
31.00	INTENSIVE CARE UNIT	0	0				
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				
43.00	NURSERY	163	2,124				
200.00	Total (lines 30 through 199)	265	17,266				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet D
Part II
Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	751,546	28,372,143	0.026489	959,555	25,418	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,073	1,493,755	0.004066	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	288,347	18,012,010	0.016009	242,975	3,890	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	332,938	10,271,538	0.032414	1,362	44	55.00
57.00	05700	CT SCAN	32,404	27,748,785	0.001168	477,563	558	57.00
59.00	05900	CARDIAC CATHETERIZATION	77,098	666,907	0.115605	3,440	398	59.00
60.00	06000	LABORATORY	246,755	45,035,852	0.005479	889,921	4,876	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	134,195	10,448,845	0.012843	275,536	3,539	65.00
65.01	06501	SLEEP LAB	843	445,346	0.001893	0	0	65.01
66.00	06600	PHYSICAL THERAPY	226,752	4,328,298	0.052388	20,142	1,055	66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	10,054	3,362,726	0.002990	0	0	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	334	104,064	0.003210	0	0	66.02
67.00	06700	OCCUPATIONAL THERAPY	2,496	785,823	0.003176	4,945	16	67.00
68.00	06800	SPEECH PATHOLOGY	1,246	202,230	0.006161	2,400	15	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,525	2,774,533	0.002352	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,759	17,447,818	0.005718	503,982	2,882	73.00
76.97	07697	CARDIAC REHABILITATION	3,834	751,388	0.005103	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	20,613	825,268	0.024977	0	0	76.98
76.99	07699	LI THOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	97	0	0.000000	0	0	90.01
90.02	09002	ATHLETIC TRAINERS	417	0	0.000000	0	0	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	13,710	727,492	0.018846	0	0	90.03
90.04	09004	WOUND CARE	102,551	2,502,964	0.040972	11,774	482	90.04
91.00	09100	EMERGENCY	343,310	16,175,409	0.021224	419,404	8,901	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	181,852	1,812,960	0.100307	0	0	92.00
200.00		Total (lines 50 through 199)	2,883,749	194,296,154		3,812,999	52,074	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part III Date/Time Prepared: 11/30/2021 12:37 pm
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS
			1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	5,345	0.00	102	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,220	0.00	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	0	0.00	0	34.00
43.00	04300	NURSERY		0	432	0.00	163	43.00
200.00		Total (lines 30 through 199)		0	6,997		265	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
			9.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0					34.00
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description		Title XIX			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY - LI FEPLEX	0	0	0	0	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0	0	0	0	66.02
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	0	90.01
90.02	09002	ATHLETIC TRAINERS	0	0	0	0	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	0	0	0	0	90.03
90.04	09004	WOUND CARE	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/30/2021 12:37 pm
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Cost Center Description	Title XIX				Hospital	PPS		
	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)			
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	28,372,143	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,493,755	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,012,010	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	10,271,538	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	27,748,785	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	666,907	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	45,035,852	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,448,845	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	445,346	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	4,328,298	0.000000	66.00
66.01	06601	PHYSICAL THERAPY - LI FEPLEX	0	0	0	3,362,726	0.000000	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0	0	0	104,064	0.000000	66.02
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	785,823	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	202,230	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,774,533	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,447,818	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	751,388	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	825,268	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	0	0.000000	90.01
90.02	09002	ATHLETIC TRAINERS	0	0	0	0	0.000000	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	0	0	0	727,492	0.000000	90.03
90.04	09004	WOUND CARE	0	0	0	2,502,964	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	16,175,409	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,812,960	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	194,296,154		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/30/2021 12:37 pm
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Cost Center Description			Title XIX			Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	959,555	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	242,975	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	1,362	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	477,563	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	3,440	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	889,921	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	275,536	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	20,142	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	0.000000	0	0	0	0	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0.000000	0	0	0	0	66.02
67.00	06700	OCCUPATIONAL THERAPY	0.000000	4,945	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,400	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	503,982	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIAC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0.000000	0	0	0	0	90.01
90.02	09002	ATHLETIC TRAINERS	0.000000	0	0	0	0	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	0.000000	0	0	0	0	90.03
90.04	09004	WOUND CARE	0.000000	11,774	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	419,404	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,812,999	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 12:37 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,345	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,345	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,120	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,405	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
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)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
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	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
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)		6,483,680	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
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 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		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 (line 21 minus line 26)		6,483,680	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	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 27 minus line 36)		6,483,680	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)		1,213.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,704,321	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)		1,704,321	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 12:37 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,356,743	1,220	1,931.76	447	863,497	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,426,459	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,994,277	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					268,975	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					140,557	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					409,532	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,584,745	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	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	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
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)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
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
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,225	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,213.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,485,974	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0076		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/30/2021 12:37 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	793,465	6,483,680	0.122379	1,485,974	181,852	90.00
91.00	Nursing School cost	0	6,483,680	0.000000	1,485,974	0	91.00
92.00	Allied health cost	0	6,483,680	0.000000	1,485,974	0	92.00
93.00	All other Medical Education	0	6,483,680	0.000000	1,485,974	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 12:37 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,345	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,345	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,120	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		102	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
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)		432	15.00
16.00	Nursery days (title V or XIX only)		163	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
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	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
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)		6,483,680	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
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 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		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 (line 21 minus line 26)		6,483,680	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	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 27 minus line 36)		6,483,680	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)		1,213.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		123,730	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)		123,730	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 12:37 pm		
Cost Center Description			Title XIX	Hospital	PPS		
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	581,418	432	1,345.88	163	219,378	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,356,743	1,220	1,931.76	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					786,637	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,129,745	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					17,266	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					52,074	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					69,340	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,060,405	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	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	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
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)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
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
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,225	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,213.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,485,974	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0076		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/30/2021 12:37 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	793,465	6,483,680	0.122379	1,485,974	181,852	90.00
91.00	Nursing School cost	0	6,483,680	0.000000	1,485,974	0	91.00
92.00	Allied health cost	0	6,483,680	0.000000	1,485,974	0	92.00
93.00	All other Medical Education	0	6,483,680	0.000000	1,485,974	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/30/2021 12:37 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,681,099	30.00
31.00	03100	INTENSIVE CARE UNIT		1,865,725	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.239274	1,397,766	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.391759	12,244	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161445	934,778	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.137068	17,873	55.00
57.00	05700	CT SCAN	0.014174	1,531,708	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.477393	23,790	59.00
60.00	06000	LABORATORY	0.177223	3,033,135	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.141673	683,501	65.00
65.01	06501	SLEEP LAB	0.152062	0	65.01
66.00	06600	PHYSICAL THERAPY	0.537746	210,817	66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	0.273128	640	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0.296942	0	66.02
67.00	06700	OCCUPATIONAL THERAPY	0.293686	82,740	67.00
68.00	06800	SPEECH PATHOLOGY	0.622692	27,963	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202713	200,132	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301615	2,172,628	73.00
76.97	07697	CARDIAC REHABILITATION	0.506286	861	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.173295	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0.000000	0	90.01
90.02	09002	ATHLETIC TRAINERS	0.000000	0	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	2.022059	0	90.03
90.04	09004	WOUND CARE	0.502298	4,223	90.04
91.00	09100	EMERGENCY	0.335630	859,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.819640	151,620	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,345,864	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		11,345,864	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/30/2021 12:37 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,425,930	30.00
31.00	03100	INTENSIVE CARE UNIT		519,761	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.239274	959,555	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.391759	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161445	242,975	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.137068	1,362	55.00
57.00	05700	CT SCAN	0.014174	477,563	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.477393	3,440	59.00
60.00	06000	LABORATORY	0.177223	889,921	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.141673	275,536	65.00
65.01	06501	SLEEP LAB	0.152062	0	65.01
66.00	06600	PHYSICAL THERAPY	0.537746	20,142	66.00
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	0.273128	0	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY	0.296942	0	66.02
67.00	06700	OCCUPATIONAL THERAPY	0.293686	4,945	67.00
68.00	06800	SPEECH PATHOLOGY	0.622692	2,400	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202713	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301615	503,982	73.00
76.97	07697	CARDIAC REHABILITATION	0.506286	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.173295	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	0.000000	0	90.01
90.02	09002	ATHLETIC TRAINERS	0.000000	0	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	2.022059	0	90.03
90.04	09004	WOUND CARE	0.502298	11,774	90.04
91.00	09100	EMERGENCY	0.335630	419,404	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.819640	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,812,999	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		3,812,999	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 12:37 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		4,227,827	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		8,765	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		3,593,167	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		41.64	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		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 § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) 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 for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 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 § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		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	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		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 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.85	30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.78	31.00
32.00	Sum of lines 30 and 31		22.63	32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.88	33.00
34.00	Disproportionate share adjustment (see instructions)		83,288	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 12:37 pm	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		831,827	510,674	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		209,093	381,956	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		591,049		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
		Before 1/1	On/After 1/1		
		1.00	1.01		
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		4,910,929		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			4,910,929	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			318,122	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			106,537	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			5,335,588	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			5,335,588	61.00
62.00	Deductibles billed to program beneficiaries			549,216	62.00
63.00	Coinurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			78,511	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			51,032	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			8,448	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			4,837,404	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-24,528	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 12:37 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2020	681,867	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2021	51,940	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,546,683	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		5,291,974	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		254,709	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		368,912	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0 90.00
91.00	Capital outlier from Wkst. L, Pt. 1, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0 95.00
96.00	Time value of money for capital related expenses (see instructions)			0 96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	0 100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000 101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0 102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000 103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0 104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/30/2021 12:37 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,227,827	0	4,227,827		4,227,827	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	8,765	0	8,765		8,765	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	3,593,167	0	3,593,167	0	3,593,167	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0788	0.0788	0.0788	0.0788		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	83,288	0	83,288	0	83,288	11.00
11.01	Uncompensated care payments	36.00	591,049	0	209,093	381,956	591,049	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,910,929	0	4,528,973	381,956	4,910,929	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,910,929	0	4,528,973	381,956	4,910,929	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	318,122	0	318,122	0	318,122	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/30/2021 12:37 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	106,537	0	106,537	0	106,537	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	4,953,632	381,956	5,335,588	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	316,088	0	316,088	0	316,088	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,034	0	2,034	0	2,034	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	318,122	0	318,122	0	318,122	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.137650	0.135985		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			681,867		681,867	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				51,940	51,940	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/30/2021 12:37 pm

		Title XVIII			Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)			
	0	1.00	2.00	3.00	4.00			
1.00	DRG amounts other than outlier payments	1.00					1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,227,827	4,227,827		4,227,827	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0	0	0	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00					2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01	
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	8,765	8,765		8,765	2.02	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0	0	0	2.03	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	3,593,167	3,593,167	0	3,593,167	4.00	
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01	
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0788	0.0788	0.0788		10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	83,288	83,288	0	83,288	11.00	
11.01	Uncompensated care payments	36.00	591,049	209,093	381,956	591,049	11.01	
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	4,910,929	4,528,973	381,956	4,910,929	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,910,929	4,528,973	381,956	4,910,929	15.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	318,122	318,122	0	318,122	16.00	
17.00	Special add-on payments for new technologies	54.00	106,537	106,537	0	106,537	17.00	
17.01	Net organ acquisition cost						17.01	
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00	
19.00	SUBTOTAL			4,953,632	381,956	5,335,588	19.00	

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/30/2021 12:37 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	316,088	316,088	0	316,088	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,034	2,034	0	2,034	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	318,122	318,122	0	318,122	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	681,867	681,867		681,867	28.00
29.00	Low volume adjustment on or after October 1	70.97	51,940		51,940	51,940	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-24,528	-24,528	0	-24,528	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 12:37 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,767	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,775,271	2.00
3.00	OPPS payments		4,945,505	3.00
4.00	Outlier payment (see instructions)		8,307	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
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		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,767	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		10,689	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		10,689	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
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)		10,689	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		7,922	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		2,767	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		4,953,812	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		890,236	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		4,066,343	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,066,343	30.00
31.00	Primary payer payments		3,244	31.00
32.00	Subtotal (line 30 minus line 31)		4,063,099	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		153,285	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		99,635	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		85,217	36.00
37.00	Subtotal (see instructions)		4,162,734	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,162,734	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		4,173,896	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-11,162	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	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	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet E-1
Part I
Date/Time Prepared:
11/30/2021 12:37 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part 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		5,291,974		4,173,896	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
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			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,291,974		4,173,896	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	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 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		254,709		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		11,162	6.02	
7.00	Total Medicare program liability (see instructions)		5,546,683		4,162,734	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet E-1
Part II
Date/Time Prepared:
11/30/2021 12:37 pm

Title XVIII		Hospital	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-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

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

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet G

Date/Time Prepared:
11/30/2021 12:37 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	467,698	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	81,494,233	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,335,585	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	45,766	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	83,343,282	0	0	0	11.00
FIXED ASSETS						
12.00	Land	477,930	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	44,673,700	0	0	0	15.00
16.00	Accumulated depreciation	-32,768,343	0	0	0	16.00
17.00	Leasehold improvements	403,970	0	0	0	17.00
18.00	Accumulated depreciation	-403,970	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	146,274	0	0	0	21.00
22.00	Accumulated depreciation	-120,888	0	0	0	22.00
23.00	Major movable equipment	27,869,160	0	0	0	23.00
24.00	Accumulated depreciation	-24,399,034	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,878,799	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	56,220,624	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	56,220,624	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	155,442,705	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	59,581,919	0	0	0	37.00
38.00	Salaries, wages, and fees payable	22,228,297	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	763,459	0	0	0	40.00
41.00	Deferred income	96,900	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	147,731	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	82,818,306	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	8,158,236	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,158,236	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	90,976,542	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	64,466,163	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	64,466,163	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	155,442,705	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-1

Date/Time Prepared:
11/30/2021 12:37 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		53,893,409		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		10,530,839			2.00
3.00	Total (sum of line 1 and line 2)		64,424,248		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	Unrest NA rel from rest for cap	41,914		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		41,914		0	10.00
11.00	Subtotal (line 3 plus line 10)		64,466,162		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		64,466,162		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	Unrest NA rel from rest for cap		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/30/2021 12:37 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	9,005,839		9,005,839	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,005,839		9,005,839	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,178,495		5,178,495	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,178,495		5,178,495	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,184,334		14,184,334	17.00
18.00	Ancillary services	32,546,184	140,531,144	173,077,328	18.00
19.00	Outpatient services	2,861,475	18,357,350	21,218,825	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	ADMIN & OTHER	-59,554	60,354	800	27.00
27.02	HOSPITALIST	982,597	468,136	1,450,733	27.02
27.03	INTENSIVISTS	415,965	24,942	440,907	27.03
27.04	FOOT & ANKLE SPORTS MED PLY	21,391	624,186	645,577	27.04
27.99	REVENUE ADJUSTMENTS	557,651	3,145,910	3,703,561	27.99
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	51,510,043	163,212,022	214,722,065	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		58,817,526		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		58,817,526		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0076

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-3

Date/Time Prepared:
11/30/2021 12:37 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	214,722,065	1.00
2.00	Less contractual allowances and discounts on patients' accounts	153,598,527	2.00
3.00	Net patient revenues (line 1 minus line 2)	61,123,538	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	58,817,526	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,306,012	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	620,927	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	764	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	Other specify	10,896,292	24.00
24.50	COVID-19 PHE Funding	-3,293,156	24.50
25.00	Total other income (sum of lines 6-24)	8,224,827	25.00
26.00	Total (line 5 plus line 25)	10,530,839	26.00
27.00	Other expenses specify	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	10,530,839	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/30/2021 12:37 pm
		Title XVII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		316,088	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		2,034	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		14.99	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		318,122	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00