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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. [X] ELECTRONICALLY FILED COST REPORT DATE: 03/13/2015 TIME: 10:22 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [1] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [F] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED	6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. JOSEPH'S REG MED CENTER PLYMOUT (15-0076) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 07/01/2013 AND ENDING 06/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT 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.

ECR Encryption: 03/13/2015 10:22
qxs2diuj86RRH0E26LGy3am:q9coM0
WNsRs0PUgzKaGfSUTfTTiyYs0RzZZR
G1LV0XzDve0VXMeP

PI Encryption: 03/13/2015 10:22
KF9KMRnFaRVEJ3wotPgY3vg0Qy9R80
Wo1m50IxlrwOQilBFfWl9AkrolsZs6
wRa703pH6:04XA2s

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

CFO
TITLE

3/17/2015
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		1,185	3,373	608,626	188	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		1,185	3,373	608,626	188	200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 1915 LAKE AVENUE	P.O. Box: 670		1
2	City: PLYMOUTH	State: IN	ZIP Code: 46563	County: MARSHALL 2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Prov-ider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ST. JOSEPH'S REG MED CENTER PLYMOUT	15-0076	43780	1	07/01/1996	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2013	To: 06 / 30 / 2014	20
21	Type of control (see instructions)	1		21

		1	2	
Inpatient PPS Information				
22	Does this facility qualify for and receive disproportionate share hospital payments 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§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N	22
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)	N	Y	22.01
23	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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	214	34	3	6	853	46	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	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
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? 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)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	Y	Y	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional paymetn exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	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 Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	Y			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
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 baseline 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 osteopathci 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
	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 and enter in column 4 direct GME FTE unweighted count.				

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	
	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 and enter in column 4 direct GME FTE unweighted count.					
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)					62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)					62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N				63

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WORKSHEET S-2
PART I

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.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
	Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider 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)						66
	Enter in lines 67-67.49, column 1 the program name. 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)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67
Inpatient Psychiatric Faciltiy PPS				1	2	3	
70	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
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed 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 and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a 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 and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86

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WORKSHEET S-2
PART I

				V	XIX	
Title V and XIX Services				1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.			N	Y	90
91	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
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the appilcable column.				N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.					95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.					97
Rural Providers				1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elinination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	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 each therapy.					109
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If 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'		N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.			N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.			N		117
118	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
			Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:		1			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
120	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	Y	120
121	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
Transplant Center Information						
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.			N		125
126	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
127	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
128	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
129	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
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					130
131	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
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.					134

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WORKSHEET S-2
PART I

All Providers

		1	2	
140	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

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	Name: SAINT JOSEPH REG MEDICAL CTR	Contractor's Name: WISCONSIN PHYSICIANS SERVICE I Contractor's Number: 08102		141
142	Street: 5215 HOLY CROSS PARKWAY	P.O. Box:		142
143	City: MISHAWAKA	State: IN	ZIP Code: 46545	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	N		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
			1	2	3	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y		167
168	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
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.50		169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2013	06/30/2014	170

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	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
		Y/N	DATE	V/I	
		1	2	3	
2	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
3	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
		Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS		1	2	3	
4	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
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
			Y/N	Y/N	
APPROVED EDUCATIONAL ACTIVITIES			1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?		N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.		Y		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?		N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.		N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.		N		11
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	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
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	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	09/30/2014	Y	09/30/2014	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N		17
18	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 THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	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		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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 COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	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
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	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

		Y/N	DATE	
HOME OFFICE COSTS		1	2	
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?			36
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.			37
38	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
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.			39
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.			40

COST REORT PREPARER INFORMATION				
41	FIRST NAME: CRAIG	LAST NAME: NIETCH	TITLE: DIRECTOR OF REIMBURSEMENT	41
42	EMPLOYER: SAINT JOSEPH REGIONAL MEDICAL CENTER			42
43	PHONE NUMBER: 574-335-4653	E-MAIL ADDRESS: NIETCHC@SJRMC.COM		43

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	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	38	13,870			1,693	890	4,000	1
2	HMO AND OTHER (see instructions)						696			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		38	13,870			1,693	890	4,000	7
8	INTENSIVE CARE UNIT	31	7	2,555			487	108	1,074	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						158	606	13
14	TOTAL (see instructions)		45	16,425			2,180	1,156	5,680	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		45							27
28	OBSERVATION BED DAYS							110	907	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	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)					640	300	1,767	1
2	HMO AND OTHER (see instructions)					203			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		259.00	2.77		640	300	1,767	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)		259.00	2.77					27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	14,383,594		14,383,594	532,902.00	26.99	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE		208,330		208,330	1,001.00	208.12	4
4.01	PHYSICIAN-PART A - TEACHING		18,999		18,999	146.00	130.13	4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		342,659		342,659	1,766.00	194.03	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)							11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES		130,225		130,225	2,080.00	62.61	12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		117,695		117,695	1,256.00	93.71	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		4,579,332		4,579,332	90,399.00	50.66	14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)		4,833,458		4,833,458			17
18	WAGE-RELATED COSTS (other)(see instructions)		7,761		7,761			18
19	EXCLUDED AREAS		150,732		150,732			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE		50,012		50,012			22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		69,619		69,619	2,159.00	32.25	26
27	ADMINISTRATIVE & GENERAL		1,626,288		1,626,288	61,399.00	26.49	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		39,241		39,241	115.00	341.23	28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		357,877		357,877	14,435.00	24.79	30
31	LAUNDRY & LINEN SERVICE		29,935		29,935	2,104.00	14.23	31
32	HOUSEKEEPING		392,911		392,911	31,867.00	12.33	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		207,600		207,600	15,869.00	13.08	34
35	DIETARY UNDER CONTRACT (see instructions)		87,841		87,841	3,495.00	25.13	35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		439,250		439,250	11,666.00	37.65	38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY		483,800		483,800	12,316.00	39.28	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		216,412		216,412	12,592.00	17.19	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		14,491,677		14,491,677	536,366.00	27.02	1
2	EXCLUDED AREA SALARIES (see instructions)		342,659		342,659	1,766.00	194.03	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		14,149,018		14,149,018	534,600.00	26.47	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		4,827,252		4,827,252	93,735.00	51.50	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		4,891,231		4,891,231		34.57%	5
6	TOTAL (sum of lines 3 through 5)		23,867,501		23,867,501	628,335.00	37.99	6
7	TOTAL OVERHEAD COST (see instructions)		3,950,774		3,950,774	168,017.00	23.51	7

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	761,339	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	1,289,121	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	1,860,655	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	154,865	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	55,311	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	33,610	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE		15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	-155,086	16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	997,075	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	12,989	20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	24,323	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	5,034,202	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL	7,761	25

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE	06/30/2017		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)	07/01/2013	06/30/2014	2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH	1/01/2014		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)	7/01/2012		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)	7/01/2015		5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE	7/01/2012		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5	7/01/2015		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)	36		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2	12		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)	1,289,121		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)	1,289,121		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	1,289,121		19

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.266191	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	4,692,000	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	16,179,000	6
7	MEDICAID COST (line 1 times line 6)	4,306,704	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.		8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)		19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	4,034,749	131,345	4,166,094	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	1,074,014	34,963	1,108,977	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	41,204		41,204	22
23	COST OF CHARITY CARE (line 21 minus line 22)	1,032,810	34,963	1,067,773	23

24	DOES THE AMOUNT IN 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?		24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	4,514,000	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	102,819	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	4,411,181	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	1,174,217	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	2,241,990	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	2,241,990	31

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COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT				1,495,897	1,495,897	396,769	1,892,666	1
2	00200	CAP REL COSTS-MVBLE EQUIP				1,510,482	1,510,482		1,510,482	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	69,619	79,527	149,146	-1,182	147,964	-4,149	143,815	4
5	00500	ADMINISTRATIVE & GENERAL	1,626,288	11,847,075	13,473,363	-1,090,141	12,383,222	-2,464,692	9,918,530	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	357,877	1,508,053	1,865,930	-300,632	1,565,298	-5,369	1,559,929	7
8	00800	LAUNDRY & LINEN SERVICE	29,935	171,727	201,662		201,662		201,662	8
9	00900	HOUSEKEEPING	392,911	211,835	604,746	-1,445	603,301	-62,500	540,801	9
10	01000	DIETARY	207,600	480,463	688,063	-3,626	684,437	-164,314	520,123	10
11	01100	CAFETERIA								11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	439,250	114,548	553,798	-9,255	544,543		544,543	13
14	01400	CENTRAL SERVICES & SUPPLY								14
15	01500	PHARMACY	483,800	1,691,810	2,175,610	-1,547,604	628,006	234	628,240	15
16	01600	MEDICAL RECORDS & LIBRARY	216,412	278,979	495,391	-34	495,357		495,357	16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)	20,939	1,583	22,522		22,522	-8,997	13,525	23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	1,979,809	1,060,005	3,039,814	-1,057,656	1,982,158	-8,150	1,974,008	30
31	03100	INTENSIVE CARE UNIT	1,092,960	358,348	1,451,308	-15,151	1,436,157	-95,966	1,340,191	31
43	04300	NURSERY				436,135	436,135		436,135	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	1,713,149	3,069,469	4,782,618	-683,187	4,099,431	-1,032,589	3,066,842	50
52	05200	DELIVERY ROOM & LABOR ROOM				436,135	436,135		436,135	52
54	05400	RADIOLOGY-DIAGNOSTIC	818,023	596,050	1,414,073	-280,122	1,133,951	-175	1,133,776	54
55	05500	RADIOLOGY-THERAPEUTIC	289,996	343,625	633,621	-60,934	572,687	-96,786	475,901	55
57	05700	CT SCAN	73,420	159,673	233,093	-75,666	157,427		157,427	57
59	05900	CARDIAC CATHETERIZATION	74,672	530,112	604,784	-380,280	224,504		224,504	59
60	06000	LABORATORY	1,075,899	1,988,728	3,064,627	-94,139	2,970,488	-2,209	2,968,279	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	454,215	383,316	837,531	-56,387	781,144	-13,071	768,073	65
66	06600	PHYSICAL THERAPY	878,277	382,163	1,260,440	-51,609	1,208,831	-24,000	1,184,831	66
72	07200	IMPL. DEV. CHARGED TO PATIENTS				571,841	571,841		571,841	72
73	07300	DRUGS CHARGED TO PATIENTS				1,500,078	1,500,078		1,500,078	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				203,531	203,531		203,531	76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	5,545	1,197	6,742	-6,742				90.01
90.02	09002	ATHLETIC TRAINERS	144,843	67,975	212,818		212,818	-55,080	157,738	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	239,471	204,916	444,387	-64,943	379,444	-56,266	323,178	90.03
90.04	09004	WOUND CARE	148,546	762,548	911,094	-349,573	561,521		561,521	90.04
91	09100	EMERGENCY	1,228,418	658,022	1,886,440	-23,791	1,862,649	-21,480	1,841,169	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE								113
118		SUBTOTALS (sum of lines 1-117)	14,061,874	26,951,747	41,013,621		41,013,621	-3,718,790	37,294,831	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN								190
192	19200	PHYSICIANS' PRIVATE OFFICES								192
192.01	19201	FOUNDATION ADMINISTATION		1,157	1,157		1,157		1,157	192.01
192.02	19202	HOSPITALIST	321,720	1,533,566	1,855,286		1,855,286		1,855,286	192.02
194	07950	PLYMOUTH MOB-4		116,889	116,889		116,889		116,889	194
200		TOTAL (sum of lines 118-199)	14,383,594	28,603,359	42,986,953		42,986,953	-3,718,790	39,268,163	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DEPRECIATION RECLASSIFICATONS	A	CAP REL COSTS-MVBLE EQUIP	2		1,182	1
2			CAP REL COSTS-BLDG & FIXT	1		8,227	2
3			CAP REL COSTS-BLDG & FIXT	1		707,177	3
4			CAP REL COSTS-BLDG & FIXT	1		24,292	4
5			CAP REL COSTS-MVBLE EQUIP	2		366	5
6			CAP REL COSTS-MVBLE EQUIP	2		106,363	6
7			CAP REL COSTS-BLDG & FIXT	1		212,492	7
8			CAP REL COSTS-MVBLE EQUIP	2		88,140	8
9			CAP REL COSTS-MVBLE EQUIP	2		1,445	9
10			CAP REL COSTS-BLDG & FIXT	1		2,225	10
11			CAP REL COSTS-MVBLE EQUIP	2		1,266	11
12			CAP REL COSTS-MVBLE EQUIP	2		135	12
13			CAP REL COSTS-MVBLE EQUIP	2		9,255	13
14			CAP REL COSTS-BLDG & FIXT	1		58	14
15			CAP REL COSTS-MVBLE EQUIP	2		94	15
16			CAP REL COSTS-MVBLE EQUIP	2		47,374	16
17			CAP REL COSTS-MVBLE EQUIP	2		34	17
18			CAP REL COSTS-BLDG & FIXT	1		26,262	18
19			CAP REL COSTS-MVBLE EQUIP	2		10,804	19
20			CAP REL COSTS-MVBLE EQUIP	2		148,320	20
21			CAP REL COSTS-MVBLE EQUIP	2		4,088	21
22			CAP REL COSTS-MVBLE EQUIP	2		10,890	22
23			CAP REL COSTS-BLDG & FIXT	1		7,846	23
24			CAP REL COSTS-MVBLE EQUIP	2		18,000	24
25			CAP REL COSTS-MVBLE EQUIP	2		103,145	25
26			CAP REL COSTS-BLDG & FIXT	1		12,157	26
27			CAP REL COSTS-MVBLE EQUIP	2		997	27
28			CAP REL COSTS-MVBLE EQUIP	2		266,968	28
29			CAP REL COSTS-MVBLE EQUIP	2		1,052	29
30			CAP REL COSTS-MVBLE EQUIP	2		59,882	30
31			CAP REL COSTS-MVBLE EQUIP	2		27,928	31
32			CAP REL COSTS-MVBLE EQUIP	2		47,738	32
33			CAP REL COSTS-BLDG & FIXT	1		513	33
34			CAP REL COSTS-MVBLE EQUIP	2		369,037	34
35			CAP REL COSTS-BLDG & FIXT	1		707	35
36			CAP REL COSTS-MVBLE EQUIP	2		3,989	36
37			CAP REL COSTS-MVBLE EQUIP	2		89,443	37
38			CAP REL COSTS-BLDG & FIXT	1		442	38
39			CAP REL COSTS-MVBLE EQUIP	2		8,111	39
40			CAP REL COSTS-MVBLE EQUIP	2		47,834	40
41			CAP REL COSTS-BLDG & FIXT	1		46,712	41
42			CAP REL COSTS-BLDG & FIXT	1		4,774	42
43			CAP REL COSTS-MVBLE EQUIP	2		123	43
44			CAP REL COSTS-BLDG & FIXT	1		24,768	44
45			CAP REL COSTS-BLDG & FIXT	1		34,917	45
46			CAP REL COSTS-MVBLE EQUIP	2		5,258	46
47			CAP REL COSTS-BLDG & FIXT	1		117,435	47
48			CAP REL COSTS-BLDG & FIXT	1		21,177	48
49			CAP REL COSTS-MVBLE EQUIP	2		7,430	49
50			CAP REL COSTS-MVBLE EQUIP	2		23,791	50
500	TOTAL RECLASSIFICATIONS					2,762,663	500
	CODE LETTER - A						
1	DRUGS CHARGED TO PATIENTS	B	DRUGS CHARGED TO PATIENTS	73		1,500,078	1
500	TOTAL RECLASSIFICATIONS					1,500,078	500
	CODE LETTER - B						
1	INTEREST EXPENSE	C	INTEREST EXPENSE	113		243,716	1
2			CAP REL COSTS-BLDG & FIXT	1		243,716	2
500	TOTAL RECLASSIFICATIONS					487,432	500
	CODE LETTER - C						
1	NURSERY - LABOR/DELIVERY RECLASS	D	NURSERY	43	283,341	152,794	1
2			DELIVERY ROOM & LABOR ROOM	52	283,341	152,794	2
500	TOTAL RECLASSIFICATIONS				566,682	305,588	500
	CODE LETTER - D						
1	IMPLANTS RECLASS	E	IMPL. DEV. CHARGED TO PATIENT	72		173	1
2			IMPL. DEV. CHARGED TO PATIENT	72		560,938	2
3			IMPL. DEV. CHARGED TO PATIENT	72		10,730	3
500	TOTAL RECLASSIFICATIONS					571,841	500
	CODE LETTER - E						
1	RECLASS OUTPT TREATMENT EXPENSES	F	OPERATING ROOM	50	5,545	1,197	1
500	TOTAL RECLASSIFICATIONS				5,545	1,197	500
	CODE LETTER - F						

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS HBO COST FROM WOUND CARE	G	HYPERBARIC OXYGEN THERAPY	76.98	55,463	148,068	1
500	TOTAL RECLASSIFICATIONS				55,463	148,068	500
	CODE LETTER - G						
	GRAND TOTAL (INCREASES)				627,690	5,776,867	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	DEPRECIATION RECLASSIFICATONS	A	EMPLOYEE BENEFITS DEPARTMENT	4		1,182	9	1
2			ADMINISTRATIVE & GENERAL	5		8,227	10	2
3			ADMINISTRATIVE & GENERAL	5		707,177	9	3
4			ADMINISTRATIVE & GENERAL	5		24,292	9	4
5			ADMINISTRATIVE & GENERAL	5		366	10	5
6			ADMINISTRATIVE & GENERAL	5		106,363	9	6
7			OPERATION OF PLANT	7		212,492	9	7
8			OPERATION OF PLANT	7		88,140	9	8
9			HOUSEKEEPING	9		1,445	9	9
10			DIETARY	10		2,225	9	10
11			DIETARY	10		1,266	10	11
12			DIETARY	10		135	9	12
13			NURSING ADMINISTRATION	13		9,255	9	13
14			PHARMACY	15		58	9	14
15			PHARMACY	15		94	10	15
16			PHARMACY	15		47,374	9	16
17			MEDICAL RECORDS & LIBRARY	16		34	9	17
18			ADULTS & PEDIATRICS	30		26,262	9	18
19			ADULTS & PEDIATRICS	30		10,804	10	19
20			ADULTS & PEDIATRICS	30		148,320	9	20
21			INTENSIVE CARE UNIT	31		4,088	10	21
22			INTENSIVE CARE UNIT	31		10,890	9	22
23			OPERATING ROOM	50		7,846	9	23
24			OPERATING ROOM	50		18,000	10	24
25			OPERATING ROOM	50		103,145	9	25
26			RADIOLOGY-DIAGNOSTIC	54		12,157	9	26
27			RADIOLOGY-DIAGNOSTIC	54		997	10	27
28			RADIOLOGY-DIAGNOSTIC	54		266,968	9	28
29			RADIOLOGY-THERAPEUTIC	55		1,052	10	29
30			RADIOLOGY-THERAPEUTIC	55		59,882	9	30
31			CT SCAN	57		27,928	10	31
32			CT SCAN	57		47,738	9	32
33			CARDIAC CATHETERIZATION	59		513	9	33
34			CARDIAC CATHETERIZATION	59		369,037	9	34
35			LABORATORY	60		707	9	35
36			LABORATORY	60		3,989	9	36
37			LABORATORY	60		89,443	9	37
38			RESPIRATORY THERAPY	65		442	9	38
39			RESPIRATORY THERAPY	65		8,111	10	39
40			RESPIRATORY THERAPY	65		47,834	9	40
41			PHYSICAL THERAPY	66		46,712	10	41
42			PHYSICAL THERAPY	66		4,774	9	42
43			PHYSICAL THERAPY	66		123	9	43
44			SAINT JOSEPH HEALTH CENTER	90.03		24,768	10	44
45			SAINT JOSEPH HEALTH CENTER	90.03		34,917	9	45
46			SAINT JOSEPH HEALTH CENTER	90.03		5,258	9	46
47			WOUND CARE	90.04		117,435	10	47
48			WOUND CARE	90.04		21,177	9	48
49			WOUND CARE	90.04		7,430	9	49
50			EMERGENCY	91		23,791	9	50
500	TOTAL RECLASSIFICATIONS					2,762,663		500
	CODE LETTER - A							
1	DRUGS CHARGED TO PATIENTS	B	PHARMACY	15		1,500,078		1
500	TOTAL RECLASSIFICATIONS					1,500,078		500
	CODE LETTER - B							
1	INTEREST EXPENSE	C	ADMINISTRATIVE & GENERAL	5		243,716	11	1
2			INTEREST EXPENSE	113		243,716	11	2
500	TOTAL RECLASSIFICATIONS					487,432		500
	CODE LETTER - C							
1	NURSERY - LABOR/DELIVERY RECLASS	D	ADULTS & PEDIATRICS	30	283,341	152,794		1
2			ADULTS & PEDIATRICS	30	283,341	152,794		2
500	TOTAL RECLASSIFICATIONS				566,682	305,588		500
	CODE LETTER - D							
1	IMPLANTS RECLASS	E	INTENSIVE CARE UNIT	31		173		1
2			OPERATING ROOM	50		560,938		2
3			CARDIAC CATHETERIZATION	59		10,730		3
500	TOTAL RECLASSIFICATIONS					571,841		500
	CODE LETTER - E							
1	RECLASS OUTPT TREATMENT EXPENSES	F	OUTPATIENT TREATMENT & INFUSI	90.01	5,545	1,197		1
500	TOTAL RECLASSIFICATIONS				5,545	1,197		500

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
	CODE LETTER - F							
1	RECLASS HBO COST FROM WOUND CARE	G	WOUND CARE	90.04	55,463	148,068		1
500	TOTAL RECLASSIFICATIONS				55,463	148,068		500
	CODE LETTER - G							
	GRAND TOTAL (DECREASES)				627,690	5,776,867		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	477,930					477,930		1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES	33,182,461	2,056,452		2,056,452		35,238,913	11,631,559	3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	22,387,348	2,370,903		2,370,903	912,101	23,846,150	12,200,471	6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	56,047,739	4,427,355		4,427,355	912,101	59,562,993	23,832,030	8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	56,047,739	4,427,355		4,427,355	912,101	59,562,993	23,832,030	10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT								1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (sum of lines 1-2)								3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI				0.000000					1
2	CAP REL COSTS-MVBLE EQU				0.000000					2
3	TOTAL (sum of lines 1-2)				0.000000					3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	1,695,524	197,142	243,716		-243,716		1,892,666	1
2	CAP REL COSTS-MVBLE EQUIP	1,437,776	72,706					1,510,482	2
3	TOTAL (sum of lines 1-2)	3,133,300	269,848	243,716		-243,716		3,403,148	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)	B	-243,716	CAP REL COSTS-BLDG & FIXT	1	9	3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)						4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)						7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,201,920				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	1,256,658				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-164,314	DIETARY	10		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)	B	-243,716	CAP REL COSTS-BLDG & FIXT	1	13	21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	PROVIDER TAX EXPENSE	A	-2,712,894	ADMINISTRATIVE & GENERAL	5		33
34	HOSPITAL DONATION EXPENSE	A	-56,679	ADMINISTRATIVE & GENERAL	5		34
34.01	HOSPTIAL DONATION EXPENSE	A	-6,720	ATHLETIC TRAINERS	90.02		34.01
35	OFFSET OTHER REVENUE	B	-4,149	EMPLOYEE BENEFITS DEPARTMENT	4		35
35.01	OFFSET OTHER REVENUE	B	1,546	ADMINISTRATIVE & GENERAL	5		35.01
35.02	OFFSET OTHER REVENUE	B	-2,334	ADMINISTRATIVE & GENERAL	5		35.02
35.03	OFFSET OTHER REVENUE	B	-30,350	ADMINISTRATIVE & GENERAL	5		35.03
35.04	OFFSET OTHER REVENUE	B	-288	OPERATION OF PLANT	7		35.04
35.05	OFFSET OTHER REVENUE	B	-5,081	OPERATION OF PLANT	7		35.05
35.06	OFFSET OTHER REVENUE	B	-62,500	HOUSEKEEPING	9		35.06
35.07	OFFSET OTHER REVENUE	B	234	PHARMACY	15		35.07
35.08	OFFSET OTHER REVENUE	B	-500	ADULTS & PEDIATRICS	30		35.08
35.09	OFFSET OTHER REVENUE	B	-845	OPERATING ROOM	50		35.09
35.10	OFFSET OTHER REVENUE	B	-175	RADIOLOGY-DIAGNOSTIC	54		35.10
35.11	OFFSET OTHER REVENUE	B	-96,786	RADIOLOGY-THERAPEUTIC	55		35.11
35.12	OFFSET OTHER REVENUE	B	-2,209	LABORATORY	60		35.12
35.13	OFFSET OTHER REVENUE	B	-12,955	RESPIRATORY THERAPY	65		35.13
35.14	OFFSET OTHER REVENUE	B	-24,000	PHYSICAL THERAPY	66		35.14
35.15	OFFSET OTHER REVENUE	B	-8,252	SAINT JOSEPH HEALTH CENTER	90.03		35.15
35.16	OFFSET OTHER REVENUE	B	-3,360	ATHLETIC TRAINERS	90.02		35.16
35.17	OFFSET OTHER REVENUE	B	-45,000	ATHLETIC TRAINERS	90.02		35.17
35.18	OFFSET OTHER REVENUE	B	-32,181	SAINT JOSEPH HEALTH CENTER	90.03		35.18
35.19	OFFSET OTHER REVENUE	B	-15,833	SAINT JOSEPH HEALTH CENTER	90.03		35.19
35.20	OFFSET OTHER REVENUE	B	-355	EMERGENCY	91		35.20
36	PROPERTY TAX EXPENSE ADJ	A	-116	RESPIRATORY THERAPY	65		36
37							37
38							38
39							39
40							40
41							41
42							42

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,718,790				50

(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.

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	HO NON CAPITAL COSTS	6,681,600	6,961,033	-279,433		1
2	5	ADMINISTRATIVE & GENERAL	WORKER'S COMP	39,268	73,039	-33,771		2
3	5	ADMINISTRATIVE & GENERAL	INSURANCE	200,377	392,000	-191,623		3
3.01	5	ADMINISTRATIVE & GENERAL	PENSION	1,495,439	779,333	716,106		3.01
3.02	5	ADMINISTRATIVE & GENERAL	RETIREE HEALTH COSTS	6,092	-155,086	161,178		3.02
3.03	1	CAP REL COSTS-BLDG & FIXT	HO CAPITAL COSTS	884,201		884,201	9	3.03
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			9,306,977	8,050,319	1,256,658		5

* The amounts on lines 1 through 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 have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF 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.

				RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	G		100.00	CHE TRINITY HEALTH	100.00	HO OF PARENT COMPANY	6
7	G		100.00	SJRMC - INC	100.00	PARENT COMPANY	7
8	G	SJRMC - SOUTH BEND CAMPUS	100.00		100.00		8
9							9
10							10

(1) Use the following symbols to indicate the 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.
G. Other (financial Or non-financial) specify: FINANCIAL

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	31	INTENSIVE CARE UNIT A	80,580		80,580	142,500	334	22,882	1,144	1
2	5	ADMINISTRATIVE & GEN B	3,000		3,000	142,500	12	822	41	2
3	30	ADULTS & PEDIATRICS C	14,980		14,980	142,500	107	7,330	367	3
4	31	INTENSIVE CARE UNIT D	57,725		57,725	142,500	284	19,457	973	4
5	5	ADMINISTRATIVE & GEN E	52,047		52,047	142,500	264	18,087	904	5
6	23	PARAMED ED PRGM-(SPE F	18,999		18,999	142,500	146	10,002	500	6
7	50	OPERATING ROOM G	1,031,744	1,031,744						7
8	5	ADMINISTRATIVE & GEN H	300	300						8
9	60	LABORATORY I	54,170		54,170	142,500	832	57,000	2,850	9
10	91	EMERGENCY J	63,525		63,525	208,000	424	42,400	2,120	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,377,070	1,032,044	345,026		2,403	177,980	8,899	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	31	INTENSIVE CARE UNIT A					22,882	57,698	57,698	1
2	5	ADMINISTRATIVE & GEN B					822	2,178	2,178	2
3	30	ADULTS & PEDIATRICS C					7,330	7,650	7,650	3
4	31	INTENSIVE CARE UNIT D					19,457	38,268	38,268	4
5	5	ADMINISTRATIVE & GEN E					18,087	33,960	33,960	5
6	23	PARAMED ED PRGM-(SPE F					10,002	8,997	8,997	6
7	50	OPERATING ROOM G							1,031,744	7
8	5	ADMINISTRATIVE & GEN H							300	8
9	60	LABORATORY I					57,000			9
10	91	EMERGENCY J					42,400	21,125	21,125	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					177,980	169,876	1,201,920	200

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,892,666	1,892,666					1
2	CAP REL COSTS-MVBLE EQUIP	1,510,482		1,510,482				2
4	EMPLOYEE BENEFITS DEPARTMENT	143,815		1,213	145,028			4
5	ADMINISTRATIVE & GENERAL	9,918,530	213,625	109,186	16,478	10,257,819	10,257,819	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,559,929	404,023	90,479	3,626	2,058,057	727,712	7
8	LAUNDRY & LINEN SERVICE	201,662	7,233		303	209,198	73,971	8
9	HOUSEKEEPING	540,801	3,581	1,483	3,981	549,846	194,421	9
10	DIETARY	520,123	25,031	139	2,103	547,396	193,555	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	544,543		9,501	4,450	558,494	197,479	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	628,240	14,813	48,631	4,902	696,586	246,307	15
16	MEDICAL RECORDS & LIBRARY	495,357	30,008	35	2,193	527,593	186,553	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)	13,525			212	13,737	4,857	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,974,008	231,422	152,256	14,318	2,372,004	838,722	30
31	INTENSIVE CARE UNIT	1,340,191	44,379	11,179	11,074	1,406,823	497,441	31
43	NURSERY	436,135			2,871	439,006	155,229	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	3,066,842	229,775	105,882	17,412	3,419,911	1,209,246	50
52	DELIVERY ROOM & LABOR ROOM	436,135			2,871	439,006	155,229	52
54	RADIOLOGY-DIAGNOSTIC	1,133,776	86,706	274,053	8,288	1,502,823	531,386	54
55	RADIOLOGY-THERAPEUTIC	475,901	108,024	61,472	2,938	648,335	229,246	55
57	CT SCAN	157,427	5,001	49,005	744	212,177	75,024	57
59	CARDIAC CATHETERIZATION	224,504	25,341	378,832	757	629,434	222,563	59
60	LABORATORY	2,968,279	51,875	91,817	10,901	3,122,872	1,104,223	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	768,073	39,593	49,103	4,602	861,371	304,574	65
66	PHYSICAL THERAPY	1,184,831	69,792	126	8,899	1,263,648	446,816	66
72	IMPL. DEV. CHARGED TO PATIENTS	571,841				571,841	202,198	72
73	DRUGS CHARGED TO PATIENTS	1,500,078				1,500,078	530,416	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	203,531	6,481		562	210,574	74,457	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS	157,738			1,468	159,206	56,294	90.02
90.03	SAINT JOSEPH HEALTH CENTER	323,178		5,398	2,426	331,002	117,040	90.03
90.04	WOUND CARE	561,521	30,832	7,627	943	600,923	212,482	90.04
91	EMERGENCY	1,841,169	87,601	24,422	12,446	1,965,638	695,034	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	37,294,831	1,715,136	1,471,839	141,768	37,075,398	9,482,475	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,268			2,268	802	190
192	PHYSICIANS' PRIVATE OFFICES		175,262			175,262	61,971	192
192.01	FOUNDATION ADMINISTATION	1,157				1,157	409	192.01
192.02	HOSPITALIST	1,855,286			3,260	1,858,546	657,167	192.02
194	PLYMOUTH MOB-4	116,889		38,643		155,532	54,995	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	39,268,163	1,892,666	1,510,482	145,028	39,268,163	10,257,819	202

KPMG LLP

COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	PHARMACY	
		7	8	9	10	13	15	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	2,785,769						7
8	LAUNDRY & LINEN SERVICE	16,558	299,727					8
9	HOUSEKEEPING	8,197		752,464				9
10	DIETARY	57,296		14,898	813,145			10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION					755,973		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	33,908		8,817			985,618	15
16	MEDICAL RECORDS & LIBRARY	68,690		17,861				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	529,739	17,421	137,743	668,147	208,966	263	30
31	INTENSIVE CARE UNIT	101,587	6,896	26,415	126,003	68,575	187	31
43	NURSERY		1,485			79,379		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	398,342	54,540	136,764	11,310	158,758	579	50
52	DELIVERY ROOM & LABOR ROOM		2,777			79,379		52
54	RADIOLOGY-DIAGNOSTIC	198,474	27,158	51,608			38,687	54
55	RADIOLOGY-THERAPEUTIC	247,273	16,097	64,297				55
57	CT SCAN	11,448	31,665	2,977			19,964	57
59	CARDIAC CATHETERIZATION	58,007	2,371	15,083		6,417	546	59
60	LABORATORY	118,746	55,889	30,877				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	90,630	13,124	23,566			53	65
66	PHYSICAL THERAPY	159,757	9,386	41,541			450	66
72	IMPL. DEV. CHARGED TO PATIENTS		4,777					72
73	DRUGS CHARGED TO PATIENTS		21,793				891,177	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	14,836	2,301	3,858				76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER		375			24,415	21,731	90.03
90.04	WOUND CARE	70,575	3,358	18,351		16,929	11,842	90.04
91	EMERGENCY	200,523	28,314	52,141	7,685	113,155	139	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	2,384,586	299,727	646,797	813,145	755,973	985,618	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			1,350				190
192	PHYSICIANS' PRIVATE OFFICES	401,183		104,317				192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST							192.02
194	PLYMOUTH MOB-4							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,785,769	299,727	752,464	813,145	755,973	985,618	202

KPMG LLP

COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	23	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	800,697						16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)		18,594					23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	46,543		4,819,548		4,819,548		30
31	INTENSIVE CARE UNIT	18,423		2,252,350		2,252,350		31
43	NURSERY	3,968		679,067		679,067		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	145,709		5,535,159		5,535,159		50
52	DELIVERY ROOM & LABOR ROOM	7,419		683,810		683,810		52
54	RADIOLOGY-DIAGNOSTIC	72,556		2,422,692		2,422,692		54
55	RADIOLOGY-THERAPEUTIC	43,006		1,248,254		1,248,254		55
57	CT SCAN	84,596		437,851		437,851		57
59	CARDIAC CATHETERIZATION	6,335		940,756		940,756		59
60	LABORATORY	149,256		4,581,863		4,581,863		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	35,062		1,328,380		1,328,380		65
66	PHYSICAL THERAPY	25,076		1,946,674		1,946,674		66
72	IMPL. DEV. CHARGED TO PATIENTS	12,762		791,578		791,578		72
73	DRUGS CHARGED TO PATIENTS	58,223		3,001,687		3,001,687		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	6,147		312,173		312,173		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS			215,500		215,500		90.02
90.03	SAINT JOSEPH HEALTH CENTER	1,001		495,564		495,564		90.03
90.04	WOUND CARE	8,972		943,432		943,432		90.04
91	EMERGENCY	75,643	18,594	3,156,866		3,156,866		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	800,697	18,594	35,793,204		35,793,204		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			4,420		4,420		190
192	PHYSICIANS' PRIVATE OFFICES			742,733		742,733		192
192.01	FOUNDATION ADMINISTATION			1,566		1,566		192.01
192.02	HOSPITALIST			2,515,713		2,515,713		192.02
194	PLYMOUTH MOB-4			210,527		210,527		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	800,697	18,594	39,268,163		39,268,163		202

KPMG LLP

COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT			1,213	1,213	1,213		4
5	ADMINISTRATIVE & GENERAL		213,625	109,186	322,811	138	322,949	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		404,023	90,479	494,502	30	22,910	7
8	LAUNDRY & LINEN SERVICE		7,233		7,233	3	2,329	8
9	HOUSEKEEPING		3,581	1,483	5,064	33	6,121	9
10	DIETARY		25,031	139	25,170	18	6,094	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION			9,501	9,501	37	6,217	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		14,813	48,631	63,444	41	7,754	15
16	MEDICAL RECORDS & LIBRARY		30,008	35	30,043	18	5,873	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)					2	153	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		231,422	152,256	383,678	120	26,405	30
31	INTENSIVE CARE UNIT		44,379	11,179	55,558	93	15,661	31
43	NURSERY					24	4,887	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		229,775	105,882	335,657	144	38,078	50
52	DELIVERY ROOM & LABOR ROOM					24	4,887	52
54	RADIOLOGY-DIAGNOSTIC		86,706	274,053	360,759	70	16,729	54
55	RADIOLOGY-THERAPEUTIC		108,024	61,472	169,496	25	7,217	55
57	CT SCAN		5,001	49,005	54,006	6	2,362	57
59	CARDIAC CATHETERIZATION		25,341	378,832	404,173	6	7,007	59
60	LABORATORY		51,875	91,817	143,692	91	34,764	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		39,593	49,103	88,696	39	9,589	65
66	PHYSICAL THERAPY		69,792	126	69,918	75	14,067	66
72	IMPL. DEV. CHARGED TO PATIENTS						6,366	72
73	DRUGS CHARGED TO PATIENTS						16,699	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY		6,481		6,481	5	2,344	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS					12	1,772	90.02
90.03	SAINT JOSEPH HEALTH CENTER			5,398	5,398	20	3,685	90.03
90.04	WOUND CARE		30,832	7,627	38,459	8	6,689	90.04
91	EMERGENCY		87,601	24,422	112,023	104	21,881	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		1,715,136	1,471,839	3,186,975	1,186	298,540	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,268		2,268		25	190
192	PHYSICIANS' PRIVATE OFFICES		175,262		175,262		1,951	192
192.01	FOUNDATION ADMINISTATION						13	192.01
192.02	HOSPITALIST					27	20,689	192.02
194	PLYMOUTH MOB-4			38,643	38,643		1,731	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		1,892,666	1,510,482	3,403,148	1,213	322,949	202

KPMG LLP

COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	PHARMACY	
		7	8	9	10	13	15	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	517,442						7
8	LAUNDRY & LINEN SERVICE	3,076	12,641					8
9	HOUSEKEEPING	1,523		12,741				9
10	DIETARY	10,642		252	42,176			10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION					15,755		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	6,298		149			77,686	15
16	MEDICAL RECORDS & LIBRARY	12,759		302				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	98,396	735	2,334	34,655	4,355	21	30
31	INTENSIVE CARE UNIT	18,869	291	447	6,535	1,429	15	31
43	NURSERY		63			1,654		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	73,990	2,300	2,316	587	3,309	46	50
52	DELIVERY ROOM & LABOR ROOM		117			1,654		52
54	RADIOLOGY-DIAGNOSTIC	36,866	1,145	874			3,049	54
55	RADIOLOGY-THERAPEUTIC	45,930	679	1,089				55
57	CT SCAN	2,126	1,335	50			1,574	57
59	CARDIAC CATHETERIZATION	10,774	100	255		134	43	59
60	LABORATORY	22,056	2,358	523				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	16,834	553	399			4	65
66	PHYSICAL THERAPY	29,674	396	703			35	66
72	IMPL. DEV. CHARGED TO PATIENTS		201					72
73	DRUGS CHARGED TO PATIENTS		919				70,242	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	2,756	97	65				76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER		16			509	1,713	90.03
90.04	WOUND CARE	13,109	142	311		353	933	90.04
91	EMERGENCY	37,246	1,194	883	399	2,358	11	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	442,924	12,641	10,952	42,176	15,755	77,686	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			23				190
192	PHYSICIANS' PRIVATE OFFICES	74,518		1,766				192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST							192.02
194	PLYMOUTH MOB-4							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	517,442	12,641	12,741	42,176	15,755	77,686	202

KPMG LLP

COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	23	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	48,995						16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)		155					23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,845		553,544		553,544		30
31	INTENSIVE CARE UNIT	1,126		100,024		100,024		31
43	NURSERY	243		6,871		6,871		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	8,906		465,333		465,333		50
52	DELIVERY ROOM & LABOR ROOM	453		7,135		7,135		52
54	RADIOLOGY-DIAGNOSTIC	4,435		423,927		423,927		54
55	RADIOLOGY-THERAPEUTIC	2,629		227,065		227,065		55
57	CT SCAN	5,171		66,630		66,630		57
59	CARDIAC CATHETERIZATION	387		422,879		422,879		59
60	LABORATORY	9,176		212,660		212,660		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,143		118,257		118,257		65
66	PHYSICAL THERAPY	1,533		116,401		116,401		66
72	IMPL. DEV. CHARGED TO PATIENTS	780		7,347		7,347		72
73	DRUGS CHARGED TO PATIENTS	3,559		91,419		91,419		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	376		12,124		12,124		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS			1,784		1,784		90.02
90.03	SAINT JOSEPH HEALTH CENTER	61		11,402		11,402		90.03
90.04	WOUND CARE	548		60,552		60,552		90.04
91	EMERGENCY	4,624		180,723		180,723		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	48,995		3,086,077		3,086,077		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			2,316		2,316		190
192	PHYSICIANS' PRIVATE OFFICES			253,497		253,497		192
192.01	FOUNDATION ADMINISTATION			13		13		192.01
192.02	HOSPITALIST			20,716		20,716		192.02
194	PLYMOUTH MOB-4			40,374		40,374		194
200	CROSS FOOT ADJUSTMENTS		155	155		155		200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	48,995	155	3,403,148		3,403,148		202

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	158,563						1
2	CAP REL COSTS-MVBLE EQUIP		1,471,432					2
4	EMPLOYEE BENEFITS DEPARTMENT		1,182	14,313,975				4
5	ADMINISTRATIVE & GENERAL	17,897	106,363	1,626,288	-10,257,819	29,010,344		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	33,848	88,140	357,877		2,058,057	101,957	7
8	LAUNDRY & LINEN SERVICE	606		29,935		209,198	606	8
9	HOUSEKEEPING	300	1,445	392,911		549,846	300	9
10	DIETARY	2,097	135	207,600		547,396	2,097	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		9,255	439,250		558,494		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	1,241	47,374	483,800		696,586	1,241	15
16	MEDICAL RECORDS & LIBRARY	2,514	34	216,412		527,593	2,514	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)			20,939		13,737		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	19,388	148,320	1,413,127		2,372,004	19,388	30
31	INTENSIVE CARE UNIT	3,718	10,890	1,092,960		1,406,823	3,718	31
43	NURSERY			283,341		439,006		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	19,250	103,145	1,718,694		3,419,911	14,579	50
52	DELIVERY ROOM & LABOR ROOM			283,341		439,006		52
54	RADIOLOGY-DIAGNOSTIC	7,264	266,968	818,023		1,502,823	7,264	54
55	RADIOLOGY-THERAPEUTIC	9,050	59,883	289,996		648,335	9,050	55
57	CT SCAN	419	47,738	73,420		212,177	419	57
59	CARDIAC CATHETERIZATION	2,123	369,037	74,672		629,434	2,123	59
60	LABORATORY	4,346	89,443	1,075,899		3,122,872	4,346	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,317	47,834	454,215		861,371	3,317	65
66	PHYSICAL THERAPY	5,847	123	878,277		1,263,648	5,847	66
72	IMPL. DEV. CHARGED TO PATIENTS					571,841		72
73	DRUGS CHARGED TO PATIENTS					1,500,078		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	543		55,463		210,574	543	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS			144,843		159,206		90.02
90.03	SAINT JOSEPH HEALTH CENTER		5,258	239,471		331,002		90.03
90.04	WOUND CARE	2,583	7,430	93,083		600,923	2,583	90.04
91	EMERGENCY	7,339	23,791	1,228,418		1,965,638	7,339	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	143,690	1,433,788	13,992,255	-10,257,819	26,817,579	87,274	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190				2,268		190
192	PHYSICIANS' PRIVATE OFFICES	14,683				175,262	14,683	192
192.01	FOUNDATION ADMINISTATION					1,157		192.01
192.02	HOSPITALIST			321,720		1,858,546		192.02
194	PLYMOUTH MOB-4		37,644			155,532		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,892,666	1,510,482	145,028		10,257,819	2,785,769	202
203	UNIT COST MULT-WS B PT I	11.936366	1.026539	0.010132		0.353592	27.322979	203
204	COST TO BE ALLOC PER B PT II			1,213		322,949	517,442	204
205	UNIT COST MULT-WS B PT II			0.000085		0.011132	5.075100	205

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE GROSS REVENUE	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		8	9	10	13	15	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	134,464,506						8
9	HOUSEKEEPING		105,912					9
10	DIETARY		2,097	5,608				10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION				282,974			13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		1,241			1,659,050		15
16	MEDICAL RECORDS & LIBRARY		2,514				134,464,506	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	7,815,764	19,388	4,608	78,219	443	7,815,764	30
31	INTENSIVE CARE UNIT	3,093,629	3,718	869	25,669	315	3,093,629	31
43	NURSERY	666,275			29,713		666,275	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	24,468,293	19,250	78	59,426	975	24,468,293	50
52	DELIVERY ROOM & LABOR ROOM	1,245,851			29,713		1,245,851	52
54	RADIOLOGY-DIAGNOSTIC	12,183,994	7,264			65,121	12,183,994	54
55	RADIOLOGY-THERAPEUTIC	7,221,754	9,050				7,221,754	55
57	CT SCAN	14,205,829	419			33,605	14,205,829	57
59	CARDIAC CATHETERIZATION	1,063,833	2,123		2,402	919	1,063,833	59
60	LABORATORY	25,070,658	4,346				25,070,658	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	5,887,907	3,317			90	5,887,907	65
66	PHYSICAL THERAPY	4,210,941	5,847			758	4,210,941	66
72	IMPL. DEV. CHARGED TO PATIENTS	2,143,127					2,143,127	72
73	DRUGS CHARGED TO PATIENTS	9,777,134				1,500,078	9,777,134	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,032,270	543				1,032,270	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER	168,169			9,139	36,579	168,169	90.03
90.04	WOUND CARE	1,506,616	2,583		6,337	19,933	1,506,616	90.04
91	EMERGENCY	12,702,462	7,339	53	42,356	234	12,702,462	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	134,464,506	91,039	5,608	282,974	1,659,050	134,464,506	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		190					190
192	PHYSICIANS' PRIVATE OFFICES		14,683					192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST							192.02
194	PLYMOUTH MOB-4							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	299,727	752,464	813,145	755,973	985,618	800,697	202
203	UNIT COST MULT-WS B PT I	0.002229	7.104615	144.997325	2.671528	0.594086	0.005955	203
204	COST TO BE ALLOC PER B PT II	12,641	12,741	42,176	15,755	77,686	48,995	204
205	UNIT COST MULT-WS B PT II	0.000094	0.120298	7.520685	0.055676	0.046826	0.000364	205

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PARAMED EDUCATION ASSIGNED TIME						
		23						
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)	100						23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	EMERGENCY	100						91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100						118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST							192.02
194	PLYMOUTH MOB-4							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	18,594						202
203	UNIT COST MULT-WS B PT I	185.940000						203
204	COST TO BE ALLOC PER B PT II	155						204
205	UNIT COST MULT-WS B PT II	1.550000						205

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	4,819,548		4,819,548	7,650	4,827,198	30
31	INTENSIVE CARE UNIT	2,252,350		2,252,350	95,966	2,348,316	31
43	NURSERY	679,067		679,067		679,067	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,535,159		5,535,159		5,535,159	50
52	DELIVERY ROOM & LABOR ROOM	683,810		683,810		683,810	52
54	RADIOLOGY-DIAGNOSTIC	2,422,692		2,422,692		2,422,692	54
55	RADIOLOGY-THERAPEUTIC	1,248,254		1,248,254		1,248,254	55
57	CT SCAN	437,851		437,851		437,851	57
59	CARDIAC CATHETERIZATION	940,756		940,756		940,756	59
60	LABORATORY	4,581,863		4,581,863		4,581,863	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,328,380		1,328,380		1,328,380	65
66	PHYSICAL THERAPY	1,946,674		1,946,674		1,946,674	66
72	IMPL. DEV. CHARGED TO PATIENTS	791,578		791,578		791,578	72
73	DRUGS CHARGED TO PATIENTS	3,001,687		3,001,687		3,001,687	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	312,173		312,173		312,173	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION CTR						90.01
90.02	ATHLETIC TRAINERS	215,500		215,500		215,500	90.02
90.03	SAINT JOSEPH HEALTH CENTER	495,564		495,564		495,564	90.03
90.04	WOUND CARE	943,432		943,432		943,432	90.04
91	EMERGENCY	3,156,866		3,156,866	21,125	3,177,991	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	892,252		892,252		892,252	92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	36,685,456		36,685,456	124,741	36,810,197	200
201	LESS OBSERVATION BEDS	892,252		892,252		892,252	201
202	TOTAL (SEE INSTRUCTIONS)	35,793,204		35,793,204		35,917,945	202

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,627,203		5,627,203				30
31	INTENSIVE CARE UNIT	3,093,629		3,093,629				31
43	NURSERY	666,275		666,275				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	6,642,956	17,825,337	24,468,293	0.226218	0.226218	0.226218	50
52	DELIVERY ROOM & LABOR ROOM	1,175,591	70,260	1,245,851	0.548870	0.548870	0.548870	52
54	RADIOLOGY-DIAGNOSTIC	1,270,855	10,913,139	12,183,994	0.198842	0.198842	0.198842	54
55	RADIOLOGY-THERAPEUTIC	10,154	7,211,600	7,221,754	0.172846	0.172846	0.172846	55
57	CT SCAN	2,009,164	12,196,665	14,205,829	0.030822	0.030822	0.030822	57
59	CARDIAC CATHETERIZATION	223,133	840,700	1,063,833	0.884308	0.884308	0.884308	59
60	LABORATORY	4,046,345	21,024,313	25,070,658	0.182758	0.182758	0.182758	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,684,131	4,203,776	5,887,907	0.225612	0.225612	0.225612	65
66	PHYSICAL THERAPY	497,802	3,713,139	4,210,941	0.462290	0.462290	0.462290	66
72	IMPL. DEV. CHARGED TO PATIENTS	1,705,394	437,733	2,143,127	0.369357	0.369357	0.369357	72
73	DRUGS CHARGED TO PATIENTS	3,820,524	5,956,610	9,777,134	0.307011	0.307011	0.307011	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY		1,032,270	1,032,270	0.302414	0.302414	0.302414	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER		168,169	168,169	2.946821	2.946821	2.946821	90.03
90.04	WOUND CARE	3,688	1,502,928	1,506,616	0.626193	0.626193	0.626193	90.04
91	EMERGENCY	1,933,617	10,768,845	12,702,462	0.248524	0.248524	0.250187	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	188,940	1,999,621	2,188,561	0.407689	0.407689	0.407689	92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	34,599,401	99,865,105	134,464,506				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	34,599,401	99,865,105	134,464,506				202

KPMG LLP

COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] PPS** **[XX] TITLE XVIII, PART A** **[ ] TEFRA** **[ ] TITLE XIX**

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	553,544		553,544	4,907	112.81	1,693	190,987	30
31	INTENSIVE CARE UNIT	100,024		100,024	1,074	93.13	487	45,354	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	6,871		6,871	606	11.34			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	660,439		660,439	6,587		2,180	236,341	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-0076** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

		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 (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	465,333	24,468,293	0.019018	2,061,792	39,211	50
52	DELIVERY ROOM & LABOR ROOM	7,135	1,245,851	0.005727			52
54	RADIOLOGY-DIAGNOSTIC	423,927	12,183,994	0.034794	67,146	2,336	54
55	RADIOLOGY-THERAPEUTIC	227,065	7,221,754	0.031442	10,154	319	55
57	CT SCAN	66,630	14,205,829	0.004690	930,995	4,366	57
59	CARDIAC CATHETERIZATION	422,879	1,063,833	0.397505	63,134	25,096	59
60	LABORATORY	212,660	25,070,658	0.008482	1,956,859	16,598	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	118,257	5,887,907	0.020085	859,719	17,267	65
66	PHYSICAL THERAPY	116,401	4,210,941	0.027643	299,454	8,278	66
72	IMPL. DEV. CHARGED TO PATIENTS	7,347	2,143,127	0.003428	718,713	2,464	72
73	DRUGS CHARGED TO PATIENTS	91,419	9,777,134	0.009350	1,907,002	17,830	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	12,124	1,032,270	0.011745			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION CTR						90.01
90.02	ATHLETIC TRAINERS	1,784					90.02
90.03	SAINT JOSEPH HEALTH CENTER	11,402	168,169	0.067801			90.03
90.04	WOUND CARE	60,552	1,506,616	0.040191			90.04
91	EMERGENCY	180,723	12,702,462	0.014227	826,400	11,757	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	102,316	2,188,561	0.046750	157,322	7,355	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	2,527,954	125,077,399		9,858,690	152,877	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] PPS**
[XX] TITLE XVIII, PART A **[ ] TEFRA**
[ ] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [XX] TITLE XVIII, PART A [ ] TEFRA [ ] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	4,907		1,693		30
31	INTENSIVE CARE UNIT	1,074		487		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	606				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	6,587		2,180		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0076** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	EMERGENCY			18,594		18,594	18,594	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			18,594		18,594	18,594	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0076** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	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)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	24,468,293			2,061,792		4,189,929		50
52	DELIVERY ROOM & LABOR ROOM	1,245,851							52
54	RADIOLOGY-DIAGNOSTIC	12,183,994			67,146		2,324,152		54
55	RADIOLOGY-THERAPEUTIC	7,221,754			10,154		2,651,744		55
57	CT SCAN	14,205,829			930,995		3,371,098		57
59	CARDIAC CATHETERIZATION	1,063,833			63,134		394,065		59
60	LABORATORY	25,070,658			1,956,859		1,204,004		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	5,887,907			859,719		1,304,369		65
66	PHYSICAL THERAPY	4,210,941			299,454				66
72	IMPL. DEV. CHARGED TO PATIENTS	2,143,127			718,713		116,108		72
73	DRUGS CHARGED TO PATIENTS	9,777,134			1,907,002		2,121,988		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,032,270					802,368		76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION CTR								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	168,169							90.03
90.04	WOUND CARE	1,506,616					455,685		90.04
91	EMERGENCY	12,702,462	0.001464	0.001464	826,400	1,210	2,320,028	3,397	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,188,561			157,322		334,065		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	125,077,399			9,858,690	1,210	21,589,603	3,397	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-0076** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9) 1	PPS REIM-BURSED SERVICES (see inst.) 2	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.) 3	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.) 4	PPS SERVICES (see inst.) 5	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.) 6	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.) 7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.226218	4,189,929			947,837			50
52	DELIVERY ROOM & LABOR ROOM	0.548870							52
54	RADIOLOGY-DIAGNOSTIC	0.198842	2,324,152			462,139			54
55	RADIOLOGY-THERAPEUTIC	0.172846	2,651,744			458,343			55
57	CT SCAN	0.030822	3,371,098			103,904			57
59	CARDIAC CATHETERIZATION	0.884308	394,065			348,475			59
60	LABORATORY	0.182758	1,204,004			220,041			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.225612	1,304,369			294,281			65
66	PHYSICAL THERAPY	0.462290							66
72	IMPL. DEV. CHARGED TO PATIENTS	0.369357	116,108			42,885			72
73	DRUGS CHARGED TO PATIENTS	0.307011	2,121,988		40,504	651,474		12,435	73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.302414	802,368			242,647			76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION CTR								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	2.946821							90.03
90.04	WOUND CARE	0.626193	455,685			285,347			90.04
91	EMERGENCY	0.248524	2,320,028			576,583			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.407689	334,065			136,195			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		21,589,603		40,504	4,770,151		12,435	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		21,589,603		40,504	4,770,151		12,435	202

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES: **[ ] TITLE V [XX] PPS**
[ ] TITLE XVIII, PART A [ ] TEFRA
[XX] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	553,544		553,544	4,907	112.81	890	100,401	30
31	INTENSIVE CARE UNIT	100,024		100,024	1,074	93.13	108	10,058	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	6,871		6,871	606	11.34	158	1,792	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	660,439		660,439	6,587		1,156	112,251	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-0076** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

		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 (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	465,333	24,468,293	0.019018	937,588	17,831	50
52	DELIVERY ROOM & LABOR ROOM	7,135	1,245,851	0.005727	654,943	3,751	52
54	RADIOLOGY-DIAGNOSTIC	423,927	12,183,994	0.034794	83,719	2,913	54
55	RADIOLOGY-THERAPEUTIC	227,065	7,221,754	0.031442			55
57	CT SCAN	66,630	14,205,829	0.004690	160,665	754	57
59	CARDIAC CATHETERIZATION	422,879	1,063,833	0.397505	16,586	6,593	59
60	LABORATORY	212,660	25,070,658	0.008482	369,702	3,136	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	118,257	5,887,907	0.020085	111,420	2,238	65
66	PHYSICAL THERAPY	116,401	4,210,941	0.027643	21,509	595	66
72	IMPL. DEV. CHARGED TO PATIENTS	7,347	2,143,127	0.003428	50,512	173	72
73	DRUGS CHARGED TO PATIENTS	91,419	9,777,134	0.009350	445,084	4,162	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	12,124	1,032,270	0.011745			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION CTR						90.01
90.02	ATHLETIC TRAINERS	1,784					90.02
90.03	SAINT JOSEPH HEALTH CENTER	11,402	168,169	0.067801			90.03
90.04	WOUND CARE	60,552	1,506,616	0.040191			90.04
91	EMERGENCY	180,723	12,702,462	0.014227	128,282	1,825	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	102,316	2,188,561	0.046750			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	2,527,954	125,077,399		2,980,010	43,971	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [ ] TITLE XVIII, PART A [ ] TEFRA [XX] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [ ] TITLE XVIII, PART A [ ] TEFRA [XX] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	4,907		890		30
31	INTENSIVE CARE UNIT	1,074		108		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	606		158		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	6,587		1,156		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0076** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	EMERGENCY			18,594		18,594	18,594	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			18,594		18,594	18,594	200

(A) Worksheet A line numbers

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0076** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	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)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	24,468,293			937,588				50
52	DELIVERY ROOM & LABOR ROOM	1,245,851			654,943				52
54	RADIOLOGY-DIAGNOSTIC	12,183,994			83,719				54
55	RADIOLOGY-THERAPEUTIC	7,221,754							55
57	CT SCAN	14,205,829			160,665				57
59	CARDIAC CATHETERIZATION	1,063,833			16,586				59
60	LABORATORY	25,070,658			369,702				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	5,887,907			111,420				65
66	PHYSICAL THERAPY	4,210,941			21,509				66
72	IMPL. DEV. CHARGED TO PATIENTS	2,143,127			50,512				72
73	DRUGS CHARGED TO PATIENTS	9,777,134			445,084				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,032,270							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION CTR								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	168,169							90.03
90.04	WOUND CARE	1,506,616							90.04
91	EMERGENCY	12,702,462	0.001464	0.001464	128,282	188			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,188,561							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	125,077,399			2,980,010	188			200

(A) Worksheet A line numbers

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-0076** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF
[ ] TITLE XVIII, PART B [ ] IPF [ ] SNF [ ] SWING BED NF
[XX] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.226218							50
52	DELIVERY ROOM & LABOR ROOM	0.548870							52
54	RADIOLOGY-DIAGNOSTIC	0.198842							54
55	RADIOLOGY-THERAPEUTIC	0.172846							55
57	CT SCAN	0.030822							57
59	CARDIAC CATHETERIZATION	0.884308							59
60	LABORATORY	0.182758							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.225612							65
66	PHYSICAL THERAPY	0.462290							66
72	IMPL. DEV. CHARGED TO PATIENTS	0.369357							72
73	DRUGS CHARGED TO PATIENTS	0.307011							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.302414							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION CTR								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	2.946821							90.03
90.04	WOUND CARE	0.626193							90.04
91	EMERGENCY	0.248524							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.407689							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0076** **WORKSHEET D-1 PART I**

CHECK	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[XX] PPS**
APPLICABLE	**[XX] TITLE XVIII, PART A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
BOXES:	**[ ] TITLE XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[ ] OTHER**

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	4,907	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	4,907	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,000	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	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)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,693	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,827,198	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,827,198	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	4,827,198	37

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0076** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	983.74	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	1,665,472	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	1,665,472	41

		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	2,348,316	1,074	2,186.51	487	1,064,830	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

		1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	2,377,901	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	5,108,203	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	236,341	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	154,087	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	390,428	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	4,717,775	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	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 (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0076** **WORKSHEET D-1**
PARTS III & IV

CHECK APPLICABLE BOXES:
[ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS
[XX] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA
[ ] TITLE XIX - I/P [ ] IRF [ ] NF [ ] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					907	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					983.74	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					892,252	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	553,544	4,827,198	0.114672	892,252	102,316	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0076** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[XX] PPS**	
	[ ] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[XX] TITLE XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] OTHER**	

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	4,907	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	4,907	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,000	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	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)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	890	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)	606	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	158	16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,827,198	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,827,198	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	4,827,198	37

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0076** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	983.74	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	875,529	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	875,529	41

		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)	679,067	606	1,120.57	158	177,050	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	2,348,316	1,074	2,186.51	108	236,143	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

		1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	897,888	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	2,186,610	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	112,251	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	44,159	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	156,410	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	2,030,200	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	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 (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0076** **WORKSHEET D-1**
PARTS III & IV

CHECK APPLICABLE BOXES:
[ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P
[XX] HOSPITAL [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF [ ] NF
[ ] ICF/MR
[XX] PPS [ ] TEFRA [ ] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					907	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 15-0076** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		2,092,672		30
31	INTENSIVE CARE UNIT		1,325,245		31
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.226218	2,061,792	466,414	50
52	DELIVERY ROOM & LABOR ROOM	0.548870			52
54	RADIOLOGY-DIAGNOSTIC	0.198842	67,146	13,351	54
55	RADIOLOGY-THERAPEUTIC	0.172846	10,154	1,755	55
57	CT SCAN	0.030822	930,995	28,695	57
59	CARDIAC CATHETERIZATION	0.884308	63,134	55,830	59
60	LABORATORY	0.182758	1,956,859	357,632	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.225612	859,719	193,963	65
66	PHYSICAL THERAPY	0.462290	299,454	138,435	66
72	IMPL. DEV. CHARGED TO PATIENTS	0.369357	718,713	265,462	72
73	DRUGS CHARGED TO PATIENTS	0.307011	1,907,002	585,471	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.302414			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT & INFUSION CTR				90.01
90.02	ATHLETIC TRAINERS				90.02
90.03	SAINT JOSEPH HEALTH CENTER	2.946821			90.03
90.04	WOUND CARE	0.626193			90.04
91	EMERGENCY	0.250187	826,400	206,755	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.407689	157,322	64,138	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		9,858,690	2,377,901	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		9,858,690		202

(A) Worksheet A line numbers

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 15-0076** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		732,899		30
31	INTENSIVE CARE UNIT		173,092		31
43	NURSERY		399,151		43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.226218	937,588	212,099	50
52	DELIVERY ROOM & LABOR ROOM	0.548870	654,943	359,479	52
54	RADIOLOGY-DIAGNOSTIC	0.198842	83,719	16,647	54
55	RADIOLOGY-THERAPEUTIC	0.172846			55
57	CT SCAN	0.030822	160,665	4,952	57
59	CARDIAC CATHETERIZATION	0.884308	16,586	14,667	59
60	LABORATORY	0.182758	369,702	67,566	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.225612	111,420	25,138	65
66	PHYSICAL THERAPY	0.462290	21,509	9,943	66
72	IMPL. DEV. CHARGED TO PATIENTS	0.369357	50,512	18,657	72
73	DRUGS CHARGED TO PATIENTS	0.307011	445,084	136,646	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.302414			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT & INFUSION CTR				90.01
90.02	ATHLETIC TRAINERS				90.02
90.03	SAINT JOSEPH HEALTH CENTER	2.946821			90.03
90.04	WOUND CARE	0.626193			90.04
91	EMERGENCY	0.250187	128,282	32,094	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.407689			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		2,980,010	897,888	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		2,980,010		202

(A) Worksheet A line numbers

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	1,102,722			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	3,114,622			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	8,440			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	1,382,029			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	42.52			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA SECTION 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				7.01
8	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) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	2.4900			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.2035			31
32	SUM OF LINES 30 AND 31	2.6935			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0806			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	151,639			34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		467,097		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		349,363		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	349,363			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
41.01	TOTAL ESRD MEDICARE COVERED AND PAID DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41.01
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41.01 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41.01)				46
47	SUBTOTAL (see instructions)	4,726,786			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	4,726,786			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	335,297			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)	1,210			58
59	TOTAL (sum of amounts on lines 49 through 58)	5,063,293			59
60	PRIMARY PAYER PAYMENTS	19,741			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	5,043,552			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	590,112			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	3,344			63
64	ALLOWABLE BAD DEBTS (see instructions)	49,576			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	32,224			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	4,482,320			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.96	LOW VOLUME ADJUSTMENT FOR FEDERAL FISCAL YEAR (2013)	93,856			70.96
70.97	LOW VOLUME ADJUSTMENT FOR FEDERAL FISCAL YEAR (2014)	316,849			70.97
71	AMOUNT DUE PROVIDER (see instructions)	4,893,025			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	97,861			71.01
72	INTERIM PAYMENTS	4,793,979			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	1,185			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	360,609			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2				91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)				94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (see instructions)				95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)				96

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97) **EXHIBIT 4**

		AMOUNTS FROM E PART A	PRIOR TO 10/1/2010 OR AFTER 3/31/2015 PRE/POST ENTITLE-MENT	10/01/2012 through 09/30/2013		10/01/2013 through 09/30/2014		(COLUMNS 2 THROUGH 4) TOTAL	
		1	2	3	3.01	4	4.01	5	
1	DRG Amounts Other Than Outlier Payments								1
1.01	DRG Amounts Other Than Outlier Payments for Discharges prior to 10/1/2013	1,102,722		1,102,722				1,102,722	1.01
1.02	DRG Amounts Other Than Outlier Payments for Discharges on/after 10/1/2013	3,114,622				3,114,622		3,114,622	1.02
1.03	DRG for Federal Specific Operating Payment for Model 4 BPCI								1.03
2	Outlier Payments for Discharges	8,440				8,440		8,440	2
2.01	Outlier Payment for Discharges for Model 4 BPCI								2.01
3	Operating Outlier Reconciliation								3
4	Managed Care Simulated Payments	1,382,029		395,337		986,692		1,382,029	4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT								
5	Amount from Worksheet E Part A, Line 21								5
6	IME Payment Adjustment								6
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422								
7	Amount from Worksheet E Part A, Line 27								7
8	IME Add-on Adjustment								8
9	Total IME Payment								9
	DISPROPORTIONATE SHARE ADJUSTMENT								
10	Allowable Disproportionate Share Percentage	0.0806	0.0806	0.0806	0.0806	0.0806	0.0806		10
11	Disproportionate Share Adjustment	151,639		88,879		62,760		151,639	11
11.01	Uncompensated Care Payments	349,363				349,363		349,363	11.01
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES								
12	Total ESRD Additional Payment								12
13	Subtotal	4,726,786		1,191,601		3,535,185		4,726,786	13
14	Hospital Specific Payments								14
15	Total Payment for Inpatient Operating Costs - E Part A Line 49	4,726,786		1,191,601		3,535,185		4,726,786	15
16	Payment for Inpatient Program Capital	335,297		87,216		248,081		335,297	16
17	Special Add-on Payments for New Technologies								17
18	Capital Outlier Reconciliatino Adjustment Amount								18
19	Subtotal			1,278,817		3,783,266		5,062,083	19
	CAPITAL PAYMENTS								
20	Capital DRG Other Than Outlier	334,342		87,216		247,126		334,342	20
20.01	Model 4 BPCI Capital DRG Other Than Outlier								20.01
21	Capital DRG Outlier Payments	955				955		955	21
21.01	Model 4 BPCI Capital DRG Outlier Payments								21.01
22	Indirect Medical Education Percentage								22
23	Indirect Medical Education Adjustment								23
24	Allowable Disproportionate Share Percentage								24
25	Disproportionate Share Adjustment								25
26	Total Prospective Capital Payments	335,297		87,216		248,081		335,297	26
	LOW VOLUME ADJUSTMENT								
27	Low Volume Adjustment Factor			0.073393		0.083750			27
28	Low Volume Adjustment			93,856				93,856	28
29	Low Volume Adjustment					316,849		316,849	29

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-0076** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	12,435			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	4,766,754			2
3	PPS PAYMENTS	4,214,622			3
4	OUTLIER PAYMENT (see instructions)	27,599			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)	0.906			5
6	LINE 2 TIMES LINE 5	4,318,679			6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6	0.9823			7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200	3,397			9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	12,435			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	40,504			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	40,504			14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	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)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)	40,504			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	28,069			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	12,435			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	4,245,618			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	36,170			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	931,365			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	3,290,518			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	3,290,518			30
31	PRIMARY PAYER PAYMENTS	1,066			31
32	SUBTOTAL (line 30 minus line 31)	3,289,452			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	108,608			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	70,595			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)	3,360,047			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	-26			38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	3,360,073			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	67,201			40.01
41	INTERIM PAYMENTS	3,289,499			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	3,373			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 15-0076** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				4,660,194		3,236,874	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	01/20/2015	133,785	01/20/2015	11,825	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08			01/02/2014	40,800	3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		133,785		52,625	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				4,793,979		3,289,499	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01					6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK APPLICABLE BOX: **[XX] HOSPITAL [ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,767	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,180	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	696	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	5,074	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	134,464,506	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	4,166,094	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	621,047	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	12,421	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	608,626	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	608,626	32

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-0076** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] OTHER

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES	2,980,010		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)	2,980,010		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	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)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	2,980,010		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	2,980,010		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	188		26
27	SUBTOTAL (sum of lines 22 through 26)	188		27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21	188		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)	188		31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	188		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)	188		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)	188		40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)	188		42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	43,819,000				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	8,709,000				4
5	OTHER RECEIVABLES	1,390,000				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-1,435,000				6
7	INVENTORY	912,000				7
8	PREPAID EXPENSES	285,000				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	53,680,000				11
	FIXED ASSETS					
12	LAND					12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	18,709,000				15
16	ACCUMULATED DEPRECIATION					16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT					23
24	ACCUMULATED DEPRECIATION					24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	18,709,000				30
	OTHER ASSETS					
31	INVESTMENTS	193,000				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	27,000				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	220,000				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	72,609,000				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,833,000				37
38	SALARIES, WAGES & FEES PAYABLE	1,504,000				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	123,000				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	612,000				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	4,072,000				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	6,265,000				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	217,000				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	6,482,000				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	10,554,000				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	62,055,000				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	62,055,000				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	72,609,000				60

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		59,347,954			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		2,707,047			2
3	TOTAL (sun of line 1 and line 2)		62,055,001			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		62,055,001			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		62,055,001			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	34,770,000		34,770,000	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	34,770,000		34,770,000	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	34,770,000		34,770,000	17
18	ANCILLARY SERVICES		99,840,000	99,840,000	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER PATIENT REVENUES		154,000	154,000	27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	34,770,000	99,994,000	134,764,000	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		42,986,953	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		42,986,953	43

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	134,764,000	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	90,336,000	2
3	NET PATIENT REVENUES (line 1 minus line 2)	44,428,000	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	42,986,953	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	1,441,047	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER REVENUE)	1,222,000	24
24.01	OTHER (RESTRICTED ASSETS RELEASED)	44,000	24.01
25	TOTAL OTHER INCOME (sum of lines 6-24)	1,266,000	25
26	TOTAL (line 5 plus line 25)	2,707,047	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	2,707,047	29

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CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 15-0076** **WORKSHEET L**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	334,342	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	955	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	13.90	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	335,297	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	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)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 15-0076** **WORKSHEET L**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	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)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST							192.02
194	PLYMOUTH MOB-4							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202