KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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: 11/25/2015 Time: 15:14 2. [ ] Manually submitted cost report 3. [ ] 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 certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

ECR Encryption: 11/25/2015 15:14
UdocLImJgn8VL.gPBjiXFHVZaCjFU0
VdHKq0N26wHtAnAgFTcZdbHSjxTMwt
YdMC04W2ZS0ofOyk

PI Encryption: 11/25/2015 15:14
jDzgF2hi8qtS1MeksCl9.Fm0CdUVM0
oWrkY0nxPoTAutExMvzEFaLp6y3km3
j9eM0fh4VQ0k9Quo

(Signed) _____
Officer or Administrator of Provider(s)

CFO
Title

11/30/15
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		321,316	59,831	-44,538	3,512,136	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		321,316	59,831	-44,538	3,512,136	200

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	Provider 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 / 2014	To: 06 / 30 / 2015	20
21	Type of control (see instructions)	1		21

	Inpatient PPS Information	1	2	3	
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)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
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 column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	236	47			925	46	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							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 is in effect in the cost reporting period.			37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		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
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		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 payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. 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, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. 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 Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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 nonprovider 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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				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, indicate which program year began during this cost reporting period. (see instructions)				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, indicate which program year began during this cost reporting period. (see instructions)				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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

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
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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 applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
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	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. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			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
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	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	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	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, chapter 40, §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	4	
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. (see instructions)			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
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
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)	0.25			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 / 2014	06 / 30 / 2015	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			N	171

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 Accnountant? 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 in 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 Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	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	09/30/2015	Y	09/30/2015	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 Reoprt 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

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 Cost			
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 capitalization 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	Are 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 servcies 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 Report Preparer Contact 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

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips			
	Component	Wkst A 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			1,541	197	4,143
2	HMO and other (see instructions)						754	925	
3	HMO IPF Subprovider								
4	HMO IRF Subprovider								
5	Hospital Adults & Peds. Swing Bed SNF								
6	Hospital Adults & Peds. Swing Bed NF								
7	Total Adults & Peds. (exclude observation beds) (see instructions)		38	13,870			1,541	197	4,143
8	Intensive Care Unit	31	7	2,555			513	86	1,091
9	Coronary Care Unit	32							
10	Burn Intensive Care Unit	33							
11	Surgical Intensive Care Unit	34							
12	Other Special Care (specify)	35							
13	Nursery	43							633
14	Total (see instructions)		45	16,425			2,054	283	5,867
15	CAH Visits								
16	Subprovider - IPF	40							
17	Subprovider - IRF	41							
18	Subprovider I	42							
19	Skilled Nursing Facility	44							
20	Nursing Facility	45							
21	Other Long Term Care	46							
22	Home Health Agency	101							
23	ASC (Distinct Part)	115							
24	Hospice (Distinct Part)	116							
24.10	Hospice (non-distinct part)	30							
25	CMHC	99							
26	RHC	88							
27	Total (sum of lines 14-26)		45						
28	Observation Bed Days							122	1,001
29	Ambulance Trips								
30	Employee discount days (see instructions)								
31	Employee discount days-IRF								
32	Labor & delivery (see instructions)							46	71
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								
33	LTCH non-covered days								

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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)					924	327	1,834	1
2	HMO and other (see instructions)					822	326		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)		265.00	2.50		924	327	1,834	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)		265.00	2.50					27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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	14,943,633		14,943,633	545,734.00	27.38	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative		63,268		63,268	362.00	174.77	4
4.01	Physician-Part A - Teaching		8,171		8,171	63.00	129.70	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)		936,266		936,266	3,306.00	283.20	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		130,585		130,585	1,496.00	87.29	11
12	Contract management and administrative services		130,225		130,225	2,080.00	62.61	12
13	Contract labor: Physician-Part A - Administrative		222,515		222,515	1,753.00	126.93	13
14	Home office salaries & wage-related costs		4,084,106		4,084,106	75,515.00	54.08	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)		4,472,801		4,472,801			17
18	Wage-related costs (other)(see instructions)		14,900		14,900			18
19	Excluded areas		243,429		243,429			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative		79,718		79,718			22
22.01	Physician Part A - Teaching		572		572			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		83,320		83,320	7,289.00	11.43	26
27	Administrative & General		1,518,483		1,518,483	63,719.00	23.83	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		318,438		318,438	13,231.00	24.07	30
31	Laundry & Linen Service		24,517		24,517	1,621.00	15.12	31
32	Housekeeping		382,817		382,817	31,399.00	12.19	32
33	Housekeeping under contract (see instructions)		22,053		22,053	1,040.00	21.20	33
34	Dietary		212,107		212,107	16,181.00	13.11	34
35	Dietary under contract (see instructions)		87,841		87,841	3,328.00	26.39	35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		439,374		439,374	11,875.00	37.00	38
39	Central Services and Supply							39
40	Pharmacy		537,950		537,950	13,175.00	40.83	40
41	Medical Records & Medical Records Library		201,253		201,253	11,892.00	16.92	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		15,084,597		15,084,597	550,154.00	27.42	1
2	Excluded area salaries (see instructions)		936,266		936,266	3,306.00	283.20	2
3	Subtotal salarles (line 1 minus line 2)		14,148,331		14,148,331	546,848.00	25.87	3
4	Subtotal other wages & related costs (see instructions)		4,567,431		4,567,431	80,844.00	56.50	4
5	Subtotal wage-related costs (see instructions)		4,567,419		4,567,419		32.28%	5
6	Total (sum of lines 3 through 5)		23,283,181		23,283,181	627,692.00	37.09	6
7	Total overhead cost (see instructions)		3,867,394		3,867,394	174,865.00	22.12	7

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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	123,448	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)	1,443,324	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)	1,985,227	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	100,499	10
11	Life Insurance (If employee is owner or beneficiary)	48,938	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	16,919	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	67,263	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	-26,013	16
	TAXES		
17	FICA-Employers Portion Only	1,022,894	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	14,021	19
20	State or Federal Unemployment Taxes		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	14,900	23
24	Total Wage Related cost (Sum of lines 1-23)	4,811,420	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	615	25

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

	STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	Wage Index Fiscal Year Ending Date	06/30/2018		1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)	07/01/2014	06/30/2015	2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month	1/01/2015		3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)	7/01/2013		4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)	7/01/2016		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	7/01/2013		9
10	Ending Date of Averaging Period from Line 5	7/01/2016		10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
11.01		06/30/2013	1,289,121	11.01
11.02		06/30/2014	1,289,121	11.02
11.03		06/30/2015	1,751,747	11.03
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)	36		12
13	Total Contributions Made During Averaging Period	4,329,989		13
14	Average Monthly Contribution (Line 13 divided by Line 12)	120,277		14
15	Number of MOnths in Provider Cost Reporting Period on Line 2	12		15
16	Average Pension Contributions (Line 14 times Line 15)	1,443,324		16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	Annual Prefunding Installment (see instructions)			17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)			18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	1,443,324		19

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-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

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

		Outpatient		Training		Home		
	DESCRIPTION	Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable mrthod(s))

21	MCP	INITIAL METHOD	

	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

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)	0.259166	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	4,269,303	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	20,055,103	6
7	Medicaid cost (line 1 times line 6)	5,197,601	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.	928,298	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 care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig 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)	928,298	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	2,269,632	239,543	2,509,175	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	588,211	62,081	650,292	21
22	Partial payment by patients approved for charity care	15,787		15,787	22
23	Cost of charity care (line 21 minus line 22)	572,424	62,081	634,505	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)	6,046,213	26
27	Medicare bad debts for the entire hospital complex (see instructions)	153,116	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,893,097	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,527,290	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	2,161,795	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,090,093	31

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				1,300,831	1,300,831	697,060	1,997,891	1
2	00200	Cap Rel Costs-Mvble Equip				1,776,856	1,776,856		1,776,856	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	83,320	507,559	590,879	-723	590,156	-4,978	585,178	4
5	00500	Administrative & General	1,518,483	10,169,806	11,688,289	-906,964	10,781,325	122,662	10,903,987	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	318,438	1,822,572	2,141,010	-328,408	1,812,602	-10,886	1,801,716	7
8	00800	Laundry & Linen Service	24,517	164,353	188,870		188,870		188,870	8
9	00900	Housekeeping	382,817	259,245	642,062	-1,856	640,206	-62,500	577,706	9
10	01000	Dietary	212,107	464,099	676,206	-970	675,236	-199,249	475,987	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	439,374	115,687	555,061	-24,589	530,472		530,472	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	537,950	1,661,039	2,198,989	-1,551,281	647,708		647,708	15
16	01600	Medical Records & Library	201,253	252,862	454,115	-17	454,098		454,098	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)	10,303	1,137	11,440		11,440	-997	10,443	23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	2,023,771	974,414	2,998,185	-972,524	2,025,661		2,025,661	30
31	03100	Intensive Care Unit	834,153	385,421	1,219,574	-14,611	1,204,963	-57,975	1,146,988	31
43	04300	Nursery				404,010	404,010		404,010	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,848,237	3,679,118	5,527,355	-1,204,806	4,322,549	-1,155,164	3,167,385	50
52	05200	Delivery Room & Labor Room				404,010	404,010		404,010	52
54	05400	Radiology-Diagnostic	843,448	695,545	1,538,993	-338,483	1,200,510	-21,254	1,179,256	54
55	05500	Radiology-Therapeutic	273,294	287,611	560,905	-210,966	349,939	-99,450	250,489	55
57	05700	CT Scan	76,046	253,450	329,496		329,496		329,496	57
59	05900	Cardiac Catheterization	54,187	361,623	415,810	-355,190	60,620		60,620	59
60	06000	Laboratory	1,101,729	2,245,299	3,347,028	-93,826	3,253,202	-11,862	3,241,340	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	464,981	365,062	830,043	-39,794	790,249	-19,224	771,025	65
66	06600	Physical Therapy	925,482	350,334	1,275,816	-51,995	1,223,821	-27,088	1,196,733	66
71	07100	Medical Supplies Charged to Patients		-71,058	-71,058	71,058				71
72	07200	Impl. Dev. Charged to Patients				921,009	921,009		921,009	72
73	07300	Drugs Charged to Patients				1,543,551	1,543,551		1,543,551	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				540,073	540,073		540,073	76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	6,300	714	7,014	-7,014				90.01
90.02	09002	ATHLETIC TRAINERS	151,915	53,885	205,800		205,800	-32,850	172,950	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	212,154	247,832	459,986	-128,952	331,034	-5,455	325,579	90.03
90.04	09004	WOUND CARE	174,299	833,446	1,007,745	-685,457	322,288		322,288	90.04
91	09100	Emergency	1,299,112	867,331	2,166,443	-42,972	2,123,471	-23,832	2,099,639	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)	14,017,670	26,948,386	40,966,056		40,966,056	-913,042	40,053,014	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices								192
192.01	19201	FOUNDATION ADMINISTATION								192.01
192.02	19202	HOSPITALIST	925,963	288,967	1,214,930		1,214,930		1,214,930	192.02
192.03	19203	INTENSIVIST		1,234,597	1,234,597		1,234,597		1,234,597	192.03
194	07950	PLYMOUTH MOB-4								194
194.01	07951	COMMUNITY OUTREACH & PARTNERSHIP		166,707	166,707		166,707		166,707	194.01
200		TOTAL (sum of lines 118-199)	14,943,633	28,638,657	43,582,290		43,582,290	-913,042	42,669,248	200

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		723	1
2			Cap Rel Costs-Bldg & Fixt	1		588,720	2
3			Cap Rel Costs-Mvble Equip	2		141,075	3
4			Cap Rel Costs-Bldg & Fixt	1		233,951	4
5			Cap Rel Costs-Mvble Equip	2		94,457	5
6			Cap Rel Costs-Mvble Equip	2		1,856	6
7			Cap Rel Costs-Mvble Equip	2		464	7
8			Cap Rel Costs-Bldg & Fixt	1		371	8
9			Cap Rel Costs-Mvble Equip	2		135	9
10			Cap Rel Costs-Mvble Equip	2		24,589	10
11			Cap Rel Costs-Bldg & Fixt	1		468	11
12			Cap Rel Costs-Mvble Equip	2		7,262	12
13			Cap Rel Costs-Mvble Equip	2		17	13
14			Cap Rel Costs-Mvble Equip	2		1,519	14
15			Cap Rel Costs-Bldg & Fixt	1		26,262	15
16			Cap Rel Costs-Mvble Equip	2		136,723	16
17			Cap Rel Costs-Mvble Equip	2		3,496	17
18			Cap Rel Costs-Mvble Equip	2		11,113	18
19			Cap Rel Costs-Mvble Equip	2		24,007	19
20			Cap Rel Costs-Bldg & Fixt	1		9,591	20
21			Cap Rel Costs-Mvble Equip	2		257,215	21
22			Cap Rel Costs-Bldg & Fixt	1		13,968	22
23			Cap Rel Costs-Mvble Equip	2		324,515	23
24			Cap Rel Costs-Mvble Equip	2		47,294	24
25			Cap Rel Costs-Mvble Equip	2		163,672	25
26			Cap Rel Costs-Bldg & Fixt	1		513	26
27			Cap Rel Costs-Mvble Equip	2		354,677	27
28			Cap Rel Costs-Bldg & Fixt	1		707	28
29			Cap Rel Costs-Mvble Equip	2		93,119	29
30			Cap Rel Costs-Mvble Equip	2		1,257	30
31			Cap Rel Costs-Bldg & Fixt	1		408	31
32			Cap Rel Costs-Mvble Equip	2		38,129	32
33			Cap Rel Costs-Bldg & Fixt	1		46,712	33
34			Cap Rel Costs-Mvble Equip	2		386	34
35			Cap Rel Costs-Bldg & Fixt	1		4,774	35
36			Cap Rel Costs-Mvble Equip	2		123	36
37			Cap Rel Costs-Bldg & Fixt	1		42,460	37
38			Cap Rel Costs-Bldg & Fixt	1		76,182	38
39			Cap Rel Costs-Mvble Equip	2		10,310	39
40			Cap Rel Costs-Bldg & Fixt	1		117,435	40
41			Cap Rel Costs-Bldg & Fixt	1		21,177	41
42			Cap Rel Costs-Mvble Equip	2		6,772	42
43			Cap Rel Costs-Bldg & Fixt	1		11,021	43
44			Cap Rel Costs-Mvble Equip	2		31,951	44
500	Total reclassifications					2,971,576	500
	Code Letter - A						
1	DRUGS CHARGED TO PATIENTS	B	Drugs Charged to Patients	73		1,543,551	1
500	Total reclassifications					1,543,551	500
	Code Letter - B						
1	INTEREST EXPENSE	C	Interest Expense	113		106,111	1
2			Cap Rel Costs-Bldg & Fixt	1		106,111	2
500	Total reclassifications					212,222	500
	Code Letter - C						
1	NURSERY - LABOR/DELIVERY RECLASS	D	Nursery	43	281,842	122,168	1
2			Delivery Room & Labor Room	52	281,842	122,168	2
500	Total reclassifications				563,684	244,336	500
	Code Letter - D						
1	IMPLANTS RECLASS	E	Impl. Dev. Charged to Patient	72		2	1
2			Impl. Dev. Charged to Patient	72		921,007	2
500	Total reclassifications					921,009	500
	Code Letter - E						
1	RECLASS OUTPT TREATMENT EXPENSES	F	Operating Room	50	6,300	714	1
500	Total reclassifications				6,300	714	500
	Code Letter - F						
1	RECLASS HBO COST FROM WOUND CARE	G	HYPERBARIC OXYGEN THERAPY	76.98	93,411	446,662	1
500	Total reclassifications				93,411	446,662	500
	Code Letter - G						
1	RECLASS NEGATIVE WKST A BALANCE	H	Medical Supplies Charged to P	71		71,058	1
500	Total reclassifications					71,058	500

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
	Code Letter - H						
	GRAND TOTAL (Increases)				663,395	6,411,128	

(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.

			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		723	9	1
2			Administrative & General	5		588,720	9	2
3			Administrative & General	5		141,075	9	3
4			Operation of Plant	7		233,951	9	4
5			Operation of Plant	7		94,457	9	5
6			Housekeeping	9		1,856	9	6
7			Dietary	10		464	10	7
8			Dietary	10		371	9	8
9			Dietary	10		135	9	9
10			Nursing Administration	13		24,589	9	10
11			Pharmacy	15		468	9	11
12			Pharmacy	15		7,262	9	12
13			Medical Records & Library	16		17	9	13
14			Adults & Pediatrics	30		1,519	10	14
15			Adults & Pediatrics	30		26,262	9	15
16			Adults & Pediatrics	30		136,723	9	16
17			Intensive Care Unit	31		3,496	10	17
18			Intensive Care Unit	31		11,113	9	18
19			Operating Room	50		24,007	10	19
20			Operating Room	50		9,591	9	20
21			Operating Room	50		257,215	9	21
22			Radiology-Diagnostic	54		13,968	9	22
23			Radiology-Diagnostic	54		324,515	9	23
24			Radiology-Therapeutic	55		47,294	9	24
25			Radiology-Therapeutic	55		163,672	9	25
26			Cardiac Catheterization	59		513	9	26
27			Cardiac Catheterization	59		354,677	9	27
28			Laboratory	60		707	9	28
29			Laboratory	60		93,119	9	29
30			Respiratory Therapy	65		1,257	10	30
31			Respiratory Therapy	65		408	9	31
32			Respiratory Therapy	65		38,129	9	32
33			Physical Therapy	66		46,712	10	33
34			Physical Therapy	66		386	10	34
35			Physical Therapy	66		4,774	9	35
36			Physical Therapy	66		123	9	36
37			SAINT JOSEPH HEALTH CENTER	90.03		42,460	10	37
38			SAINT JOSEPH HEALTH CENTER	90.03		76,182	9	38
39			SAINT JOSEPH HEALTH CENTER	90.03		10,310	9	39
40			WOUND CARE	90.04		117,435	10	40
41			WOUND CARE	90.04		21,177	9	41
42			WOUND CARE	90.04		6,772	9	42
43			Emergency	91		11,021	9	43
44			Emergency	91		31,951	9	44
500	Total reclassifications					2,971,576		500
	Code letter - A							
1	DRUGS CHARGED TO PATIENTS	B	Pharmacy	15		1,543,551		1
500	Total reclassifications					1,543,551		500
	Code letter - B							
1	INTEREST EXPENSE	C	Administrative & General	5		106,111	11	1
2			Interest Expense	113		106,111	11	2
500	Total reclassifications					212,222		500
	Code letter - C							
1	NURSERY - LABOR/DELIVERY RECLASS	D	Adults & Pediatrics	30	281,842	122,168		1
2			Adults & Pediatrics	30	281,842	122,168		2
500	Total reclassifications				563,684	244,336		500
	Code letter - D							
1	IMPLANTS RECLASS	E	Intensive Care Unit	31		2		1
2			Operating Room	50		921,007		2
500	Total reclassifications					921,009		500
	Code letter - E							
1	RECLASS OUTPT TREATMENT EXPENSES	F	OUTPATIENT TREATMENT & INFUSI	90.01	6,300	714		1
500	Total reclassifications				6,300	714		500
	Code letter - F							
1	RECLASS HBO COST FROM WOUND CARE	G	WOUND CARE	90.04	93,411	446,662		1
500	Total reclassifications				93,411	446,662		500
	Code letter - G							
1	RECLASS NEGATIVE WKST A BALANCE	H	Administrative & General	5		71,058		1

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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	
500	Total reclassifications					71,058		500
	Code letter - H							
	GRAND TOTAL (Decreases)				663,395	6,411,128		

(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.

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 Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	477,930					477,930		1
2	Land Improvements								2
3	Buildings and Fixtures	35,238,913	4,765,151		4,765,151	164,863	39,839,201	12,178,897	3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	23,846,150	4,282,089		4,282,089	6,254,722	21,873,517	7,496,465	6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	59,562,993	9,047,240		9,047,240	6,419,585	62,190,648	19,675,362	8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	59,562,993	9,047,240		9,047,240	6,419,585	62,190,648	19,675,362	10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	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	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
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	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,685,173	206,607	106,111				1,997,891	1
2	Cap Rel Costs-Mvble Equip	1,745,727	31,129					1,776,856	2
3	Total (sum of lines 1-2)	3,430,900	237,736	106,111				3,774,747	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.)

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	-106,111	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	-1,240,386				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	2,578,972				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-199,249	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)						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						32
33	PROVIDER TAX EXPENSE	A	-1,531,617	Administrative & General	5		33
34	HOSPITAL DONATION EXPENSE	A	-49,270	Administrative & General	5		34
34.01	HOSPTIAL DONATION EXPENSE	A	80	ATHLETIC TRAINERS	90.02		34.01
35	OFFSET OTHER REVENUE	B	-4,978	Employee Benefits Department	4		35
35.01	OFFSET OTHER REVENUE	B	-72,252	Administrative & General	5		35.01
35.02	OFFSET OTHER REVENUE	B	-997	PARAMED ED PRGM-(SPECIFY)	23		35.02
35.03	OFFSET OTHER REVENUE	B	-10,886	Operation of Plant	7		35.03
35.04	OFFSET OTHER REVENUE	B	-62,500	Housekeeping	9		35.04
35.05	OFFSET OTHER REVENUE	B	-10,000	Radiology-Diagnostic	54		35.05
35.06	OFFSET OTHER REVENUE	B	-99,450	Radiology-Therapeutic	55		35.06
35.07	OFFSET OTHER REVENUE	B	-11,862	Laboratory	60		35.07
35.08	OFFSET OTHER REVENUE	B	-19,224	Respiratory Therapy	65		35.08
35.09	OFFSET OTHER REVENUE	B	-27,088	Physical Therapy	66		35.09
35.10	OFFSET OTHER REVENUE	B	-7,499	Operating Room	50		35.10
35.11	OFFSET OTHER REVENUE	B	-32,930	ATHLETIC TRAINERS	90.02		35.11
35.12	OFFSET OTHER REVENUE	B	-5,455	SAINT JOSEPH HEALTH CENTER	90.03		35.12
35.13	OFFSET OTHER REVENUE	B	-340	Emergency	91		35.13
36							36
37							37
38							38
39							39
40							40
41							41
42							42
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)		-913,042				50

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **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 Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	HO NON CAPITAL COSTS	6,820,562	6,716,111	104,451		1
2	5	Administrative & General	WORKER'S COMP	41,356	71,587	-30,231		2
3	5	Administrative & General	INSURANCE	169,939	307,026	-137,087		3
3.01	5	Administrative & General	PENSION	1,938,484	132,136	1,806,348		3.01
3.02	5	Administrative & General	RETIREE HEALTH COSTS	6,307	-26,013	32,320		3.02
3.03	1	Cap Rel Costs-Bldg & Fixt	HO CAPITAL COSTS	803,171		803,171	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			9,779,819	7,200,847	2,578,972		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			CHE TRINITY HEALTH		HO OF PARENT COMPANY	6
7	G			SJRMC - INC		PARENT COMPANY	7
8	G	SJRMC - SOUTH BEND CAMPUS					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

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	31	Intensive Care Unit A	93,600		93,600	142,500	520	35,625	1,781	1
2	54	Radiology-Diagnostic B	16,324		16,324	142,500	74	5,070	254	2
3	60	Laboratory C	49,999		49,999	142,500	768	52,615	2,631	3
4	91	Emergency D	62,592		62,592	208,000	391	39,100	1,955	4
5	50	Operating Room E	1,147,665	1,147,665		142,500				5
6	23	PARAMED ED PRGM-(SPE F								6
7	50	Operating Room G								7
8	5	Administrative & Gen H								8
9	60	Laboratory I								9
10	91	Emergency J								10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,370,180	1,147,665	222,515		1,753	132,410	6,621	200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	31	Intensive Care Unit A					35,625	57,975	57,975	1
2	54	Radiology-Diagnostic B					5,070	11,254	11,254	2
3	60	Laboratory C					52,615			3
4	91	Emergency D					39,100	23,492	23,492	4
5	50	Operating Room E							1,147,665	5
6	23	PARAMED ED PRGM-(SPE F								6
7	50	Operating Room G								7
8	5	Administrative & Gen H								8
9	60	Laboratory I								9
10	91	Emergency J								10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					132,410	92,721	1,240,386	200

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	1,997,891	1,997,891					1
2	Cap Rel Costs-Mvble Equip	1,776,856		1,776,856				2
4	Employee Benefits Department	585,178			585,178			4
5	Administrative & General	10,903,987	225,502	200,554	59,796	11,389,839	11,389,839	5
6	Maintenance & Repairs							6
7	Operation of Plant	1,801,716	426,483	379,301	12,540	2,620,040	954,040	7
8	Laundry & Linen Service	188,870	7,636	6,791	965	204,262	74,378	8
9	Housekeeping	577,706	3,780	3,362	15,075	599,923	218,451	9
10	Dietary	475,987	26,422	23,499	8,353	534,261	194,542	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	530,472			17,302	547,774	199,462	13
14	Central Services & Supply							14
15	Pharmacy	647,708	15,637	13,907	21,184	698,436	254,323	15
16	Medical Records & Library	454,098	31,676	28,172	7,925	521,871	190,030	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)	10,443			406	10,849	3,950	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,025,661	244,288	217,262	57,497	2,544,708	926,610	30
31	Intensive Care Unit	1,146,988	46,847	41,664	32,848	1,268,347	461,846	31
43	Nursery	404,010			11,099	415,109	151,154	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,167,385	242,550	215,715	73,024	3,698,674	1,346,814	50
52	Delivery Room & Labor Room	404,010			11,099	415,109	151,154	52
54	Radiology-Diagnostic	1,179,256	91,526	81,400	33,214	1,385,396	504,467	54
55	Radiology-Therapeutic	250,489	114,030	101,414	10,762	476,695	173,580	55
57	CT Scan	329,496	5,279	4,695	2,995	342,465	124,702	57
59	Cardiac Catheterization	60,620	26,750	23,790	2,134	113,294	41,254	59
60	Laboratory	3,241,340	54,760	48,701	43,385	3,388,186	1,233,747	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	771,025	41,794	37,170	18,310	868,299	316,175	65
66	Physical Therapy	1,196,733	73,672	65,521	36,445	1,372,371	499,724	66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	921,009				921,009	335,369	72
73	Drugs Charged to Patients	1,543,551				1,543,551	562,056	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	540,073	6,842	6,085	3,678	556,678	202,704	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS	172,950			5,982	178,932	65,155	90.02
90.03	SAINT JOSEPH HEALTH CENTER	325,579			8,354	333,933	121,596	90.03
90.04	WOUND CARE	322,288	32,546	28,945	3,185	386,964	140,906	90.04
91	Emergency	2,099,639	92,471	82,241	51,158	2,325,509	846,792	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)	40,053,014	1,810,491	1,610,189	548,715	39,662,484	10,294,981	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,394	2,129		4,523	1,647	190
192	Physicians' Private Offices		185,006	164,538		349,544	127,280	192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST	1,214,930			36,463	1,251,393	455,672	192.02
192.03	INTENSIVIST	1,234,597				1,234,597	449,556	192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP	166,707				166,707	60,703	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	42,669,248	1,997,891	1,776,856	585,178	42,669,248	11,389,839	202

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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	3,574,080						7
8	Laundry & Linen Service	20,276	298,916					8
9	Housekeeping	10,038		828,412				9
10	Dietary	70,165		16,402	815,370			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration					747,236		13
14	Central Services & Supply							14
15	Pharmacy	41,523		9,707			1,003,989	15
16	Medical Records & Library	84,117		19,664				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	648,713	17,991	151,649	675,357	197,288		30
31	Intensive Care Unit	124,403	6,542	29,081	123,541	78,792		31
43	Nursery		1,458			29,016		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	644,096	60,323	150,568	8,236	188,366	1,432	50
52	Delivery Room & Labor Room		2,337			29,016		52
54	Radiology-Diagnostic	243,050	27,016	56,817			38,445	54
55	Radiology-Therapeutic	302,809	7,622	70,786		25,646		55
57	CT Scan	14,020	32,367	3,277			19,397	57
59	Cardiac Catheterization	71,035	1,383	16,605		5,679	68	59
60	Laboratory	145,415	56,360	33,993				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	110,985	14,234	25,945				65
66	Physical Therapy	195,638	10,036	45,733			244	66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients		6,178					72
73	Drugs Charged to Patients		19,355				926,938	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	18,169	3,377	4,247				76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR					1,567		90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER		277			24,983	11,278	90.03
90.04	WOUND CARE	86,426	2,923	20,203		23,239	6,187	90.04
91	Emergency	245,559	29,137	57,403	8,236	143,644		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)	3,076,437	298,916	712,080	815,370	747,236	1,003,989	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	6,357		1,486				190
192	Physicians' Private Offices	491,286		114,846				192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST							192.02
192.03	INTENSIVIST							192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,574,080	298,916	828,412	815,370	747,236	1,003,989	202

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	815,682						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)		14,799					23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	49,098		5,211,414		5,211,414		30
31	Intensive Care Unit	17,855		2,110,407		2,110,407		31
43	Nursery	3,978		600,715		600,715		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	164,551		6,263,060		6,263,060		50
52	Delivery Room & Labor Room	6,377		603,993		603,993		52
54	Radiology-Diagnostic	73,727		2,328,918		2,328,918		54
55	Radiology-Therapeutic	20,801		1,077,939		1,077,939		55
57	CT Scan	88,330		624,558		624,558		57
59	Cardiac Catheterization	3,774		253,092		253,092		59
60	Laboratory	153,811		5,011,512		5,011,512		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	38,845		1,374,483		1,374,483		65
66	Physical Therapy	27,389		2,151,135		2,151,135		66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	16,861		1,279,417		1,279,417		72
73	Drugs Charged to Patients	52,821		3,104,721		3,104,721		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	9,215		794,390		794,390		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR			1,567		1,567		90.01
90.02	ATHLETIC TRAINERS			244,087		244,087		90.02
90.03	SAINT JOSEPH HEALTH CENTER	755		492,822		492,822		90.03
90.04	WOUND CARE	7,977		674,825		674,825		90.04
91	Emergency	79,517	14,799	3,750,596		3,750,596		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)	815,682	14,799	37,953,651		37,953,651		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			14,013		14,013		190
192	Physicians' Private Offices			1,082,956		1,082,956		192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST			1,707,065		1,707,065		192.02
192.03	INTENSIVIST			1,684,153		1,684,153		192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP			227,410		227,410		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	815,682	14,799	42,669,248		42,669,248		202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	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		225,502	200,554	426,056	426,056		5
6	Maintenance & Repairs							6
7	Operation of Plant		426,483	379,301	805,784	35,688	841,472	7
8	Laundry & Linen Service		7,636	6,791	14,427	2,782	4,774	8
9	Housekeeping		3,780	3,362	7,142	8,172	2,363	9
10	Dietary		26,422	23,499	49,921	7,277	16,519	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration					7,461		13
14	Central Services & Supply							14
15	Pharmacy		15,637	13,907	29,544	9,513	9,776	15
16	Medical Records & Library		31,676	28,172	59,848	7,108	19,804	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)					148		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		244,288	217,262	461,550	34,661	152,733	30
31	Intensive Care Unit		46,847	41,664	88,511	17,276	29,289	31
43	Nursery					5,654		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		242,550	215,715	458,265	50,380	151,644	50
52	Delivery Room & Labor Room					5,654		52
54	Radiology-Diagnostic		91,526	81,400	172,926	18,870	57,223	54
55	Radiology-Therapeutic		114,030	101,414	215,444	6,493	71,292	55
57	CT Scan		5,279	4,695	9,974	4,665	3,301	57
59	Cardiac Catheterization		26,750	23,790	50,540	1,543	16,724	59
60	Laboratory		54,760	48,701	103,461	46,150	34,236	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		41,794	37,170	78,964	11,827	26,130	65
66	Physical Therapy		73,672	65,521	139,193	18,693	46,060	66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients					12,545		72
73	Drugs Charged to Patients					21,025		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY		6,842	6,085	12,927	7,583	4,278	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS					2,437		90.02
90.03	SAINT JOSEPH HEALTH CENTER					4,549		90.03
90.04	WOUND CARE		32,546	28,945	61,491	5,271	20,348	90.04
91	Emergency		92,471	82,241	174,712	31,676	57,814	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)		1,810,491	1,610,189	3,420,680	385,101	724,308	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,394	2,129	4,523	62	1,497	190
192	Physicians' Private Offices		185,006	164,538	349,544	4,761	115,667	192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST					17,045		192.02
192.03	INTENSIVIST					16,816		192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP					2,271		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,997,891	1,776,856	3,774,747	426,056	841,472	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		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	21,983						8
9	Housekeeping		17,677					9
10	Dietary		350	74,067				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration				7,461			13
14	Central Services & Supply							14
15	Pharmacy		207			49,040		15
16	Medical Records & Library		420				87,180	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	1,322	3,235	61,349	1,969		5,245	30
31	Intensive Care Unit	481	621	11,222	787		1,907	31
43	Nursery	107			290		425	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,449	3,213	748	1,881	70	17,625	50
52	Delivery Room & Labor Room	172			290		681	52
54	Radiology-Diagnostic	1,985	1,212			1,878	7,876	54
55	Radiology-Therapeutic	560	1,510		256		2,222	55
57	CT Scan	2,379	70			947	9,436	57
59	Cardiac Catheterization	102	354		57	3	403	59
60	Laboratory	4,142	725				16,430	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,046	554				4,150	65
66	Physical Therapy	738	976			12	2,926	66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	454					1,801	72
73	Drugs Charged to Patients	1,422				45,277	5,642	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	248	91				984	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR				16			90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER	20			249	551	81	90.03
90.04	WOUND CARE	215	431		232	302	852	90.04
91	Emergency	2,141	1,225	748	1,434		8,494	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)	21,983	15,194	74,067	7,461	49,040	87,180	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		32					190
192	Physicians' Private Offices		2,451					192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST							192.02
192.03	INTENSIVIST							192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	21,983	17,677	74,067	7,461	49,040	87,180	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		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							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)	148						23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		722,064		722,064			30
31	Intensive Care Unit		150,094		150,094			31
43	Nursery		6,476		6,476			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		688,275		688,275			50
52	Delivery Room & Labor Room		6,797		6,797			52
54	Radiology-Diagnostic		261,970		261,970			54
55	Radiology-Therapeutic		297,777		297,777			55
57	CT Scan		30,772		30,772			57
59	Cardiac Catheterization		69,726		69,726			59
60	Laboratory		205,144		205,144			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		122,671		122,671			65
66	Physical Therapy		208,598		208,598			66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients		14,800		14,800			72
73	Drugs Charged to Patients		73,366		73,366			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY		26,111		26,111			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR		16		16			90.01
90.02	ATHLETIC TRAINERS		2,437		2,437			90.02
90.03	SAINT JOSEPH HEALTH CENTER		5,450		5,450			90.03
90.04	WOUND CARE		89,142		89,142			90.04
91	Emergency		278,244		278,244			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)		3,259,930		3,259,930			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		6,114		6,114			190
192	Physicians' Private Offices		472,423		472,423			192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST		17,045		17,045			192.02
192.03	INTENSIVIST		16,816		16,816			192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP		2,271		2,271			194.01
200	Cross Foot Adjustments	148	148		148			200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	148	3,774,747		3,774,747			202

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	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		158,563					2
4	Employee Benefits Department			14,860,313				4
5	Administrative & General	17,897	17,897	1,518,483	-11,389,839	31,279,409		5
6	Maintenance & Repairs							6
7	Operation of Plant	33,848	33,848	318,438		2,620,040	106,818	7
8	Laundry & Linen Service	606	606	24,517		204,262	606	8
9	Housekeeping	300	300	382,817		599,923	300	9
10	Dietary	2,097	2,097	212,107		534,261	2,097	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration			439,374		547,774		13
14	Central Services & Supply							14
15	Pharmacy	1,241	1,241	537,950		698,436	1,241	15
16	Medical Records & Library	2,514	2,514	201,253		521,871	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)			10,303		10,849		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	19,388	19,388	1,460,087		2,544,708	19,388	30
31	Intensive Care Unit	3,718	3,718	834,153		1,268,347	3,718	31
43	Nursery			281,842		415,109		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	19,250	19,250	1,854,537		3,698,674	19,250	50
52	Delivery Room & Labor Room			281,842		415,109		52
54	Radiology-Diagnostic	7,264	7,264	843,448		1,385,396	7,264	54
55	Radiology-Therapeutic	9,050	9,050	273,294		476,695	9,050	55
57	CT Scan	419	419	76,046		342,465	419	57
59	Cardiac Catheterization	2,123	2,123	54,187		113,294	2,123	59
60	Laboratory	4,346	4,346	1,101,729		3,388,186	4,346	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,317	3,317	464,981		868,299	3,317	65
66	Physical Therapy	5,847	5,847	925,482		1,372,371	5,847	66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients					921,009		72
73	Drugs Charged to Patients					1,543,551		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	543	543	93,411		556,678	543	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS			151,915		178,932		90.02
90.03	SAINT JOSEPH HEALTH CENTER			212,154		333,933		90.03
90.04	WOUND CARE	2,583	2,583	80,888		386,964	2,583	90.04
91	Emergency	7,339	7,339	1,299,112		2,325,509	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	143,690	13,934,350	-11,389,839	28,272,645	91,945	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	190	190			4,523	190	190
192	Physicians' Private Offices	14,683	14,683			349,544	14,683	192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST			925,963		1,251,393		192.02
192.03	INTENSIVIST					1,234,597		192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP					166,707		194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,997,891	1,776,856	585,178		11,389,839	3,574,080	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.599982	11.205994	0.039379		0.364132	33.459529	203
204	Cost to be allocated (Per Wkst. B, Part II)					426,056	841,472	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.013621	7.877624	205

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	146,445,357						8
9	Housekeeping		105,912					9
10	Dietary		2,097	99				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration				236,561			13
14	Central Services & Supply							14
15	Pharmacy		1,241			1,671,859		15
16	Medical Records & Library		2,514				146,445,357	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	8,814,674	19,388	82	62,458		8,814,674	30
31	Intensive Care Unit	3,205,481	3,718	15	24,944		3,205,481	31
43	Nursery	714,247			9,186		714,247	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	29,545,628	19,250	1	59,633	2,385	29,545,628	50
52	Delivery Room & Labor Room	1,144,884			9,186		1,144,884	52
54	Radiology-Diagnostic	13,236,479	7,264			64,019	13,236,479	54
55	Radiology-Therapeutic	3,734,558	9,050		8,119		3,734,558	55
57	CT Scan	15,858,181	419			32,301	15,858,181	57
59	Cardiac Catheterization	677,554	2,123		1,798	114	677,554	59
60	Laboratory	27,614,101	4,346				27,614,101	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	6,974,003	3,317				6,974,003	65
66	Physical Therapy	4,917,196	5,847			407	4,917,196	66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	3,027,150					3,027,150	72
73	Drugs Charged to Patients	9,483,097				1,543,551	9,483,097	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,654,461	543				1,654,461	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR				496			90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER	135,523			7,909	18,780	135,523	90.03
90.04	WOUND CARE	1,432,129	2,583		7,357	10,302	1,432,129	90.04
91	Emergency	14,276,011	7,339	1	45,475		14,276,011	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	146,445,357	91,039	99	236,561	1,671,859	146,445,357	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
192.03	INTENSIVIST							192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	298,916	828,412	815,370	747,236	1,003,989	815,682	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.002041	7.821701	8,236.060606	3.158746	0.600523	0.005570	203
204	Cost to be allocated (Per Wkst. B, Part II)	21,983	17,677	74,067	7,461	49,040	87,180	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000150	0.166903	748.151515	0.031539	0.029333	0.000595	205

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
71	Medical Supplies Charged to Patients							71
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
192.03	INTENSIVIST							192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	14,799						202
203	Unit Cost Multiplier (Wkst. B, Part I)	147.990000						203
204	Cost to be allocated (Per Wkst. B, Part II)	148						204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.480000						205

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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 Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	5,211,414		5,211,414		5,211,414	30
31	Intensive Care Unit	2,110,407		2,110,407	57,975	2,168,382	31
43	Nursery	600,715		600,715		600,715	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,263,060		6,263,060		6,263,060	50
52	Delivery Room & Labor Room	603,993		603,993		603,993	52
54	Radiology-Diagnostic	2,328,918		2,328,918	11,254	2,340,172	54
55	Radiology-Therapeutic	1,077,939		1,077,939		1,077,939	55
57	CT Scan	624,558		624,558		624,558	57
59	Cardiac Catheterization	253,092		253,092		253,092	59
60	Laboratory	5,011,512		5,011,512		5,011,512	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,374,483		1,374,483		1,374,483	65
66	Physical Therapy	2,151,135		2,151,135		2,151,135	66
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients	1,279,417		1,279,417		1,279,417	72
73	Drugs Charged to Patients	3,104,721		3,104,721		3,104,721	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	794,390		794,390		794,390	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION CTR	1,567		1,567		1,567	90.01
90.02	ATHLETIC TRAINERS	244,087		244,087		244,087	90.02
90.03	SAINT JOSEPH HEALTH CENTER	492,822		492,822		492,822	90.03
90.04	WOUND CARE	674,825		674,825		674,825	90.04
91	Emergency	3,750,596		3,750,596	23,492	3,774,088	91
92	Observation Beds (Non-Distinct Part)	1,014,123		1,014,123		1,014,123	92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	38,967,774		38,967,774	92,721	39,060,495	200
201	Less Observation Beds	1,014,123		1,014,123		1,014,123	201
202	Total (line 200 minus line 201)	37,953,651		37,953,651		38,046,372	202

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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 SERVICE COST CENTERS							
30	Adults & Pediatrics	6,260,498		6,260,498				30
31	Intensive Care Unit	3,205,481		3,205,481				31
43	Nursery	714,247		714,247				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,269,742	22,275,886	29,545,628	0.211979	0.211979	0.211979	50
52	Delivery Room & Labor Room	1,113,460	31,424	1,144,884	0.527558	0.527558	0.527558	52
54	Radiology-Diagnostic	1,246,235	11,990,244	13,236,479	0.175947	0.175947	0.176797	54
55	Radiology-Therapeutic	20,579	3,713,979	3,734,558	0.288639	0.288639	0.288639	55
57	CT Scan	1,877,012	13,981,169	15,858,181	0.039384	0.039384	0.039384	57
59	Cardiac Catheterization	50,124	627,430	677,554	0.373538	0.373538	0.373538	59
60	Laboratory	3,790,805	23,823,296	27,614,101	0.181484	0.181484	0.181484	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,730,378	5,243,625	6,974,003	0.197087	0.197087	0.197087	65
66	Physical Therapy	604,313	4,312,883	4,917,196	0.437472	0.437472	0.437472	66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	2,326,705	700,445	3,027,150	0.422647	0.422647	0.422647	72
73	Drugs Charged to Patients	3,945,753	5,537,344	9,483,097	0.327395	0.327395	0.327395	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	5,735	1,648,726	1,654,461	0.480150	0.480150	0.480150	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		135,523	135,523	3.636445	3.636445	3.636445	90.03
90.04	WOUND CARE	2,829	1,429,300	1,432,129	0.471204	0.471204	0.471204	90.04
91	Emergency	2,018,710	12,257,301	14,276,011	0.262720	0.262720	0.264366	91
92	Observation Beds (Non-Distinct Part)	262,584	2,291,592	2,554,176	0.397045	0.397045	0.397045	92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	36,445,190	110,000,167	146,445,357				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	36,445,190	110,000,167	146,445,357				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[XX] PPS** **[ ] TEFRA**

		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 SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	722,064		722,064	5,144	140.37	1,541	216,310	30
31	Intensive Care Unit	150,094		150,094	1,091	137.57	513	70,573	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	6,476		6,476	633	10.23			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	878,634		878,634	6,868		2,054	286,883	200

(A) Worksheet A line numbers

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	688,275	29,545,628	0.023295	1,958,993	45,635	50
52	Delivery Room & Labor Room	6,797	1,144,884	0.005937			52
54	Radiology-Diagnostic	261,970	13,236,479	0.019792	637,504	12,617	54
55	Radiology-Therapeutic	297,777	3,734,558	0.079736	2,746	219	55
57	CT Scan	30,772	15,858,181	0.001940	830,420	1,611	57
59	Cardiac Catheterization	69,726	677,554	0.102908			59
60	Laboratory	205,144	27,614,101	0.007429	1,789,335	13,293	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	122,671	6,974,003	0.017590	887,573	15,612	65
66	Physical Therapy	208,598	4,917,196	0.042422	368,304	15,624	66
71	Medical Supplies Charged to Pat						71
72	Impl. Dev. Charged to Patients	14,800	3,027,150	0.004889	1,009,801	4,937	72
73	Drugs Charged to Patients	73,366	9,483,097	0.007737	1,692,814	13,097	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	26,111	1,654,461	0.015782	5,735	91	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION	16					90.01
90.02	ATHLETIC TRAINERS	2,437					90.02
90.03	SAINT JOSEPH HEALTH CENTER	5,450	135,523	0.040215			90.03
90.04	WOUND CARE	89,142	1,432,129	0.062244			90.04
91	Emergency	278,244	14,276,011	0.019490	661,661	12,896	91
92	Observation Beds (Non-Distinct	140,511	2,554,176	0.055012	160,797	8,846	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,521,807	136,265,131		10,005,683	144,478	200

(A) Worksheet A line numbers

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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 [ ] Other

		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 SERVICE 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

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 [ ] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	5,144		1,541		30
31	Intensive Care Unit	1,091		513		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	633				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	6,868		2,054		200

(A) Worksheet A line numbers

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/IID | [XX] PPS [ ] TEFRA [ ] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient 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
71	Medical Supplies Charged to Pat							71
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							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	Emergency			14,799		14,799	14,799	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			14,799		14,799	14,799	200

(A) Worksheet A line numbers

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/IID | [XX] PPS [ ] TEFRA [ ] Other

		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	29,545,628			1,958,993		4,995,045		50
52	Delivery Room & Labor Room	1,144,884							52
54	Radiology-Diagnostic	13,236,479			637,504		2,800,047		54
55	Radiology-Therapeutic	3,734,558			2,746		1,038,806		55
57	CT Scan	15,858,181			830,420		3,948,521		57
59	Cardiac Catheterization	677,554							59
60	Laboratory	27,614,101			1,789,335		2,090,608		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	6,974,003			887,573		1,527,233		65
66	Physical Therapy	4,917,196			368,304				66
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	3,027,150			1,009,801		267,174		72
73	Drugs Charged to Patients	9,483,097			1,692,814		2,475,587		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,654,461			5,735		869,922		76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	135,523							90.03
90.04	WOUND CARE	1,432,129					820		90.04
91	Emergency	14,276,011	0.001037	0.001037	661,661	686	1,897,467	1,968	91
92	Observation Beds (Non-Distinct	2,554,176			160,797		948,843		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	136,265,131			10,005,683	686	22,860,073	1,968	200

(A) Worksheet A line numbers

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/IID**

			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	0.211979	4,995,045			1,058,845			50
52	Delivery Room & Labor Room	0.527558							52
54	Radiology-Diagnostic	0.175947	2,800,047			492,660			54
55	Radiology-Therapeutic	0.288639	1,038,806			299,840			55
57	CT Scan	0.039384	3,948,521			155,509			57
59	Cardiac Catheterization	0.373538							59
60	Laboratory	0.181484	2,090,608			379,412			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.197087	1,527,233			300,998			65
66	Physical Therapy	0.437472							66
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	0.422647	267,174			112,920			72
73	Drugs Charged to Patients	0.327395	2,475,587		52,504	810,495		17,190	73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.480150	869,922			417,693			76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	3.636445							90.03
90.04	WOUND CARE	0.471204	820			386			90.04
91	Emergency	0.262720	1,897,467			498,503			91
92	Observation Beds (Non-Distinct	0.397045	948,843			376,733			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		22,860,073		52,504	4,903,994		17,190	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		22,860,073		52,504	4,903,994		17,190	202

(A) Worksheet A line numbers

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 SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	722,064		722,064	5,144	140.37	197	27,653	30
31	Intensive Care Unit	150,094		150,094	1,091	137.57	86	11,831	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	6,476		6,476	633	10.23			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	878,634		878,634	6,868		283	39,484	200

(A) Worksheet A line numbers

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

Check Applicable Boxes: **[ ] Title V** **[ ] 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	688,275	29,545,628	0.023295	1,211,069	28,212	50
52	Delivery Room & Labor Room	6,797	1,144,884	0.005937	608,510	3,613	52
54	Radiology-Diagnostic	261,970	13,236,479	0.019792	111,306	2,203	54
55	Radiology-Therapeutic	297,777	3,734,558	0.079736			55
57	CT Scan	30,772	15,858,181	0.001940	170,509	331	57
59	Cardiac Catheterization	69,726	677,554	0.102908			59
60	Laboratory	205,144	27,614,101	0.007429	384,859	2,859	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	122,671	6,974,003	0.017590	135,447	2,383	65
66	Physical Therapy	208,598	4,917,196	0.042422	30,541	1,296	66
71	Medical Supplies Charged to Pat						71
72	Impl. Dev. Charged to Patients	14,800	3,027,150	0.004889	262,015	1,281	72
73	Drugs Charged to Patients	73,366	9,483,097	0.007737	646,155	4,999	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	26,111	1,654,461	0.015782			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION	16					90.01
90.02	ATHLETIC TRAINERS	2,437					90.02
90.03	SAINT JOSEPH HEALTH CENTER	5,450	135,523	0.040215			90.03
90.04	WOUND CARE	89,142	1,432,129	0.062244			90.04
91	Emergency	278,244	14,276,011	0.019490	97,982	1,910	91
92	Observation Beds (Non-Distinct	140,511	2,554,176	0.055012	16,749	921	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,521,807	136,265,131		3,675,142	50,008	200

(A) Worksheet A line numbers

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 [ ] Other

		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 SERVICE 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

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 [ ] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	5,144		197		30
31	Intensive Care Unit	1,091		86		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	633				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	6,868		283		200

(A) Worksheet A line numbers

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/IID
[XX] PPS **[ ] TEFRA** **[ ] Other**

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient 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
71	Medical Supplies Charged to Pat							71
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							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	Emergency			14,799		14,799	14,799	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			14,799		14,799	14,799	200

(A) Worksheet A line numbers

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

Check Applicable Boxes:
[ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [XX] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [ ] Other

(A)	Cost Center Description	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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	29,545,628			1,211,069				50
52	Delivery Room & Labor Room	1,144,884			608,510				52
54	Radiology-Diagnostic	13,236,479			111,306				54
55	Radiology-Therapeutic	3,734,558							55
57	CT Scan	15,858,181			170,509				57
59	Cardiac Catheterization	677,554							59
60	Laboratory	27,614,101			384,859				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	6,974,003			135,447				65
66	Physical Therapy	4,917,196			30,541				66
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	3,027,150			262,015				72
73	Drugs Charged to Patients	9,483,097			646,155				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,654,461							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	135,523							90.03
90.04	WOUND CARE	1,432,129							90.04
91	Emergency	14,276,011	0.001037	0.001037	97,982	102			91
92	Observation Beds (Non-Distinct	2,554,176			16,749				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	136,265,131			3,675,142	102			200

(A) Worksheet A line numbers

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/IID**

			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	0.211979		3,008,387			637,715		50
52	Delivery Room & Labor Room	0.527558		15,442			8,147		52
54	Radiology-Diagnostic	0.175947		2,051,123			360,889		54
55	Radiology-Therapeutic	0.288639		396,237			114,369		55
57	CT Scan	0.039384		1,826,217			71,924		57
59	Cardiac Catheterization	0.373538							59
60	Laboratory	0.181484		3,194,224			579,701		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.197087		437,170			86,161		65
66	Physical Therapy	0.437472		955,506			418,007		66
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	0.422647		96,391			40,739		72
73	Drugs Charged to Patients	0.327395		676,930			221,623		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.480150		232,982			111,866		76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	3.636445							90.03
90.04	WOUND CARE	0.471204							90.04
91	Emergency	0.262720		2,663,633			699,790		91
92	Observation Beds (Non-Distinct	0.397045		405,756			161,103		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			15,959,998			3,512,034		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			15,959,998			3,512,034		202

(A) Worksheet A line numbers

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/IID**	**[XX] PPS**	
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[ ] 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)	5,144	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,144	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)	4,143	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	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,541	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 XIX only)		15
16	Nursery days (title V or 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)	5,211,414	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 (line 21 minus line 26)	5,211,414	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 minus line 36)	5,211,414	37

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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)	1,013.11	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,561,203	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)	1,561,203	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	2,168,382	1,091	1,987.52	513	1,019,598	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 (Wkst. D-3, col. 3, line 200)	2,444,787	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	5,025,588	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	286,883	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	145,164	51
52	Total Program excludable cost (sum of lines 50 and 51)	432,047	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	4,593,541	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 etner 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

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [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)					1,001	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,013.11	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,014,123	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	722,064	5,211,414	0.138554	1,014,123	140,511	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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/IID**	**[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)	5,144	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,144	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)	4,143	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	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	197	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 XIX only)	633	15
16	Nursery days (title V or 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)	5,211,414	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 (line 21 minus line 26)	5,211,414	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 minus line 36)	5,211,414	37

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

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [XX] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [ ] 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)	1,013.11	38
39	Program general inpatient routine service cost (line 9 x line 38)	199,583	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)	199,583	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)	600,715	633	949.00			42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	2,168,382	1,091	1,987.52	86	170,927	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 (Wkst. D-3, col. 3, line 200)	1,068,882	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,439,392	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	39,484	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	50,110	51
52	Total Program excludable cost (sum of lines 50 and 51)	89,594	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,349,798	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 etner 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

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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/IID [XX] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [ ] NF [ ] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,001	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)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] 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		1,967,027		30
31	Intensive Care Unit		1,467,056		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.211979	1,958,993	415,265	50
52	Delivery Room & Labor Room	0.527558			52
54	Radiology-Diagnostic	0.176797	637,504	112,709	54
55	Radiology-Therapeutic	0.288639	2,746	793	55
57	CT Scan	0.039384	830,420	32,705	57
59	Cardiac Catheterization	0.373538			59
60	Laboratory	0.181484	1,789,335	324,736	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.197087	887,573	174,929	65
66	Physical Therapy	0.437472	368,304	161,123	66
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.422647	1,009,801	426,789	72
73	Drugs Charged to Patients	0.327395	1,692,814	554,219	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.480150	5,735	2,754	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	3.636445			90.03
90.04	WOUND CARE	0.471204			90.04
91	Emergency	0.264366	661,661	174,921	91
92	Observation Beds (Non-Distinct Part)	0.397045	160,797	63,844	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		10,005,683	2,444,787	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		10,005,683		202

(A) Worksheet A line numbers

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/IID**
[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		749,919		30
31	Intensive Care Unit		192,372		31
43	Nursery		483,571		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.211979	1,211,069	256,721	50
52	Delivery Room & Labor Room	0.527558	608,510	321,024	52
54	Radiology-Diagnostic	0.176797	111,306	19,679	54
55	Radiology-Therapeutic	0.288639			55
57	CT Scan	0.039384	170,509	6,715	57
59	Cardiac Catheterization	0.373538			59
60	Laboratory	0.181484	384,859	69,846	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.197087	135,447	26,695	65
66	Physical Therapy	0.437472	30,541	13,361	66
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.422647	262,015	110,740	72
73	Drugs Charged to Patients	0.327395	646,155	211,548	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.480150			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	3.636445			90.03
90.04	WOUND CARE	0.471204			90.04
91	Emergency	0.264366	97,982	25,903	91
92	Observation Beds (Non-Distinct Part)	0.397045	16,749	6,650	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,675,142	1,068,882	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,675,142		202

(A) Worksheet A line numbers

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

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 (see instructions)	1,084,669			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,024,198			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	21,137			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	42.26			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) 64 FR 26340 (May 12, 1998), and 67 FR 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 line 8 plus lines (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 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
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
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 factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0270			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2112			31
32	Sum of lines 30 and 31	0.2382			32
33	Allowable disproportionate share percentage (see instructions)	0.0887			33
34	Disproportionate share adjustment (see instructions)	91,115			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	296,602		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	117,734	221,842		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	339,576			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
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

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	4,560,695			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 (see instructions)	4,560,695			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	327,698			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. 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 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	686			58
59	Total (sum of amounts on lines 49 through 58)	4,889,079			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	4,889,079			61
62	Deductibles billed to program beneficiaries	602,576			62
63	Coinsurance billed to program beneficiaries	912			63
64	Allowable bad debts (see instructions)	57,275			64
65	Adjusted reimbursable bad debts (see instructions)	37,229			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,426			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,322,820			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	4,880			70.93
70.96	Low volume adjustment for federal fiscal year (2014)	109,923			70.96
70.97	Low volume adjustment for federal fiscal year (2015)	304,589			70.97
71	Amount due provider (see instructions)	4,742,212			71
71.01	Sequestration adjustment (see instructions)	94,844			71.01
72	Interim payments	4,326,052			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	321,316			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	96,487			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. 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

	HSP Bonus Payment Amount	**Prior to 10/1**	**On or After 10/1**		
100	HSP bonus amount (see instructions)				100

	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

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

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Pre/Post Entitlement	10/01/2013 through 09/30/2014		10/01/2014 through 09/30/2015		Total (col. 2 through 4)	
		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 occurring prior to October 1	1,084,669		1,084,669				1,084,669	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	3,024,198				3,024,198		3,024,198	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1								1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1								1.04
2	Outlier payments for discharges	21,137				21,137		21,137	2
2.01	Outlier payment for discharges for Model 4 BPCI								2.01
3	Operating outlier reconciliation								3
4	Managed Care Simulated Payments								4
	Indirect Medical Education Adjustment								
5	Amount from Worksheet E Part A, line 21								5
6	IME payment adjustment								6
6.01	IME payment adjustment for managed care								6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7	IME payment adjustment factor								7
8	IME add-on adjustment amount								8
8.01	IME payment adjustment add-on for managed care								8.01
9	Total IME payment (sum of lines 6 and 8)								9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)								9.01
	Disproportionate Share Adjustment								
10	Allowable disproportionate share percentage	0.0887	0.0887	0.0887	0.0887	0.0887	0.0887		10
11	Disproportionate share adjustment	91,115		24,053		67,062		91,115	11
11.01	Uncompensated care payments	339,576		117,734		221,842		339,576	11.01
	Additional payment for high percentage of ESRD beneficiary discharges								
12	Total ESRD additional payment								12
13	Subtotal	4,560,695		1,226,456		3,334,239		4,560,695	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)								14
15	Total payment for inpatient operating costs SCH and MDH only	4,560,695		1,226,456		3,334,239		4,560,695	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	327,698		86,062		241,636		327,698	16
17	Special add-on payments for new technologies								17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)								17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG								17.02
18	Capital outlier reconciliation adjustment amount								18
19	**SUBTOTAL**			1,312,518		3,575,875		4,888,393	19
20	Capital DRG other than outlier	325,517		86,062		239,455		325,517	20
20.01	Model 4 BPCI Capital DRG other than outlier								20.01
21	Capital DRG outlier payments	2,181				2,181		2,181	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	327,698		86,062		241,636		327,698	26
27	**Low volume adjustment factor**			0.083750		0.085179			27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.96)(prior to 10/1)			109,923				109,923	28
29	Low Volume Adjustment (transfer amount to Worksheet E, Part A, line 70.97)(on/after 10/1)					304,589		304,589	29

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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)	17,190			1
2	Medical and other services reimbursed under OPPS (see instructions)	4,902,026			2
3	PPS payments	4,401,099			3
4	Outlier payment (see instructions)	15,570			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	1,968			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	17,190			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	52,504			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	52,504			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)	52,504			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	35,314			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)	17,190			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	4,418,637			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	971,084			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,464,743			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)	3,464,743			30
31	Primary payer payments	2,803			31
32	Subtotal (line 30 minus line 31)	3,461,940			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)	178,287			34
35	Adjusted reimbursable bad debts (see instructions)	115,887			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	120,954			36
37	Subtotal (see instructions)	3,577,827			37
38	MSP-LCC reconciliation amount from PS&R	-37			38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	3,577,864			40
40.01	Sequestration adjustment (see instructions)	71,557			40.01
41	Interim payments	3,446,476			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	59,831			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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

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

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] 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				4,326,052		3,446,476	1
2	Interim payments payable on individual bills, eitehr 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					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					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					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)				4,326,052		3,446,476	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		321,316		59,831	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				4,647,368		3,506,307	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.

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 (Wkst. S-3, Pt. I, col. 15, line 14)	1,834	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	2,054	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	754	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	5,234	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	146,445,357	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	2,509,175	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	291,594	8
9	Sequestration adjustment amount (see instructions)	5,832	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	285,762	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	330,300	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-44,538	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

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/IID** **[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	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services		3,512,034	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)		3,512,034	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)		3,512,034	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	3,675,142	15,959,998	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)	3,675,142	15,959,998	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge 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)	1.000000	1.000000	15
16	Total customary charges (see instructions)	3,675,142	15,959,998	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	3,675,142	12,447,964	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 physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)		3,512,034	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	102		26
27	Subtotal (sum of lines 22 through 26)	102		27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	102	3,512,034	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)	102	3,512,034	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)	102	3,512,034	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	102	3,512,034	38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	102	3,512,034	40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	102	3,512,034	42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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	32,656,443				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	8,814,216				4
5	Other receivables	697,209				5
6	Allowances for uncollectible notes and accounts receivable	-1,541,840				6
7	Inventory	922,291				7
8	Prepaid expenses	270,899				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	41,819,218				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	26,824,778				15
16	Accumulated depreciation					16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles 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)	26,824,778				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	119,235				34
35	Total other assets (sum of lines 31-34)	119,235				35
36	Total assets (sum of lines 11, 30 and 35)	68,763,231				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	4,688,001				37
38	Salaries, wages and fees payable	1,547,000				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	135,889				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	104,933				44
45	Total current liabilities (sum of lines 37 thru 44)	6,475,823				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	6,122,012				47
48	Unsecured loans					48
49	Other long term liabilities	84,235				49
50	Total long term liabilities (sum of lines 46 thru 49)	6,206,247				50
51	Total liabilities (sum of lines 45 and 50)	12,682,070				51
	CAPITAL ACCOUNTS					
52	General fund balance	56,081,161				52
53	Specific purpose fund					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 thru 58)	56,081,161				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	68,763,231				60

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		62,055,389			1
2	Net income (loss) (from Worksheet G-3, line 29)		3,778,799			2
3	Total (sum of line 1 and line 2)		65,834,188			3
4	Additions (credit adjustments) (specify)	246,434				4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		246,434			10
11	Subtotal (line 3 plus line 10)		66,080,622			11
12	Deductions (debit adjustments) (specify)	9,999,461				12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		9,999,461			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		56,081,161			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 (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					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) (specify)					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

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	37,331,590		37,331,590	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)	37,331,590		37,331,590	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)	37,331,590		37,331,590	17
18	Ancillary services		109,864,644	109,864,644	18
19	Outpatient services		320,837	320,837	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	37,331,590	110,185,481	147,517,071	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		43,582,290	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)		43,582,290	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	147,517,071	1
2	Less contractual allowances and discounts on patients' accounts	101,715,393	2
3	Net patient revenues (line 1 minus line 2)	45,801,678	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	43,582,290	4
5	Net income from service to patients (line 3 minus line 4)	2,219,388	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 otehr 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, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (NON-OPERATING ITEMS)	700,093	24
24.01	Other (RESTRICTED ASSETS RELEASED)	247,284	24.01
24.02	Other (OTHER REVENUE)	612,034	24.02
25	Total other income (sum of lines 6-24)	1,559,411	25
26	Total (line 5 plus line 25)	3,778,799	26
29	Net income (or loss) for the period (line 26 minus line 28)	3,778,799	29

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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	325,517	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	2,181	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)	14.53	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		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 (see instructions)		11
12	Total prospective capital payments (see instructions)	327,698	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

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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 (see instructions)		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 (see instructions)		11
12	Total prospective capital payments (see instructions)		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

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:14 Version: 2015.10 (11/24/2015)

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 SERVICE 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
71	Medical Supplies Charged to Patients							71
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
192.03	INTENSIVIST							192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202