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: 11/28/2016 Time: 16:52 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 ST. JOSEPH'S REG MED CENTER PLYMOUT (15-0076) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ECR Encryption: 11/28/2016 16:52
YhsuB3OCt2xl1EZpYlvo.XV1pJeVt0
WkaSl0GNe6qaRDXyn5SludBsoeh0b7
91YM1TtRi70bpl2.

PI Encryption: 11/28/2016 16:52
.GCg6XerxTdCI.PgDhBOcwS00UUyF0
8J3eW0Fgyqn3mrmjMJIQLZQBP1ceuJ
pICb0OT7gx02Dg0R

(Signed) Janice L. Dunn
Officer or Administrator of Provider(s)

CFO
Title

11/29/16
Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		83,890	8,389		135	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		83,890	8,389		135	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 / 2015	To: 06 / 30 / 2016	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.	106	28	2		1,060	39	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
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
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)	Y	Y	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:				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
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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 transition factor. (see instructions)	9.99			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 / 2015	06 / 30 / 2016	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 Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those 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	09/30/2016	Y	09/30/2016	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 services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

	Cost Report Preparer Contact Information			
41	First name: MAUREEN	Last name: DELAHANTY	Title: REIMBURSEMENT MANAGER	41
42	Employer: SAINT JOSEPH REGIONAL MEDICAL CENTER			42
43	Phone number: 574-335-4652	E-mail Address: NIETCHC@SJRMC.COM		43

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	13,908			1,669		4,072	1
2	HMO and other (see instructions)						714	1,129		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		38	13,908			1,669		4,072	7
8	Intensive Care Unit	31	7	2,562			516	4	1,179	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						38	588	13
14	Total (see instructions)		45	16,470			2,185	42	5,839	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116							28	24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		45							27
28	Observation Bed Days							226	1,287	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							64	71	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								129	32.01
33	LTCH non-covered days									33

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)					696	18	1,871	1
2	HMO and other (see instructions)					221	337		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)		268.27	4.50		696	18	1,871	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)		268.27	4.50					24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		536.54	9.00					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	Reclassification 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	15,717,248		15,717,248	557,171.00	28.21	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative		70,943		70,943	384.00	184.75	4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B		42,884		42,884	1,056.00	40.61	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)		800,974		800,974	7,921.00	101.12	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		279,994		279,994	4,798.00	58.36	11
12	Contract management and administrative services		80,608		80,608	1,292.00	62.39	12
13	Contract labor: Physician-Part A - Administrative		302,054		302,054	1,970.00	153.33	13
14	Home office salaries & wage-related costs		4,533,798		4,533,798	91,880.00	49.34	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)		5,029,603		5,029,603			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		102,977		102,977			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative		19,155		19,155			22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		11,579		11,579			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		72,925		72,925	2,139.00	34.09	26
27	Administrative & General		1,585,623		1,585,623	66,303.00	23.91	27
28	Administrative & General under contract (see instructions)		77,145		77,145	508.00	151.86	28
29	Maintenance & Repairs							29
30	Operation of Plant		381,671		381,671	14,219.00	26.84	30
31	Laundry & Linen Service							31
32	Housekeeping		365,040		365,040	30,252.00	12.07	32
33	Housekeeping under contract (see instructions)		26,523		26,523	629.00	42.17	33
34	Dietary		227,404		227,404	16,832.00	13.51	34
35	Dietary under contract (see instructions)		24,628		24,628	616.00	39.98	35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		513,717		513,717	10,836.00	47.41	38
39	Central Services and Supply							39
40	Pharmacy		563,507		563,507	13,298.00	42.38	40
41	Medical Records & Medical Records Library		207,606		207,606	10,482.00	19.81	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		15,802,660		15,802,660	557,868.00	28.33	1
2	Excluded area salaries (see instructions)		800,974		800,974	7,921.00	101.12	2
3	Subtotal salarles (line 1 minus line 2)		15,001,686		15,001,686	549,947.00	27.28	3
4	Subtotal other wages & related costs (see instructions)		5,196,454		5,196,454	99,940.00	52.00	4
5	Subtotal wage-related costs (see instructions)		5,048,758		5,048,758		33.65%	5
6	Total (sum of lines 3 through 5)		25,246,898		25,246,898	649,887.00	38.85	6
7	Total overhead cost (see instructions)		4,045,789		4,045,789	166,114.00	24.36	7

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	238,737	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)	1,398,538	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	156,051	7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	1,625,652	8
9	Prescription Drug Plan	283,972	9
10	Dental, Hearing and Vision Plan	116,505	10
11	Life Insurance (If employee is owner or beneficiary)	38,229	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	152,668	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	86,987	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	-26,189	16
	TAXES		
17	FICA-Employers Portion Only	1,077,086	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	10,137	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	4,941	23
24	Total Wage Related cost (Sum of lines 1-23)	5,163,314	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	-4,420	25

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

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)	0.262792	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	4,906,000	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	24,783,000	6
7	Medicaid cost (line 1 times line 6)	6,512,774	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.	1,606,774	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)			1,606,774	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	2,509,877	827,542	3,337,419	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	659,576	217,471	877,047	21
22	Partial payment by patients approved for charity care	28,151	30,649	58,800	22
23	Cost of charity care (line 21 minus line 22)	631,425	186,822	818,247	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?	N	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)	5,906,130	26
27	Medicare bad debts for the entire hospital complex (see instructions)	170,033	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,736,097	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,507,400	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	2,325,647	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,932,421	31

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 16:52 Version: 2016.05 (09/21/2016)

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				1,762,862	1,762,862	591,387	2,354,249	1
2	00200	Cap Rel Costs-Mvble Equip				2,240,528	2,240,528		2,240,528	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	72,925	725,111	798,036		798,036	-650	797,386	4
5	00500	Administrative & General	1,585,623	10,287,910	11,873,533	-926,384	10,947,149	2,260,718	13,207,867	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	381,671	2,305,910	2,687,581	-357,677	2,329,904	-60,002	2,269,902	7
8	00800	Laundry & Linen Service		160,115	160,115		160,115		160,115	8
9	00900	Housekeeping	365,040	293,944	658,984	-3,969	655,015	-52,500	602,515	9
10	01000	Dietary	227,404	448,771	676,175		676,175	-201,903	474,272	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	513,717	161,670	675,387	-25,973	649,414		649,414	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	563,507	1,989,956	2,553,463	-1,838,540	714,923	-18	714,905	15
16	01600	Medical Records & Library	207,606	155,225	362,831		362,831		362,831	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)	4,639	1,476	6,115		6,115		6,115	23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	2,191,640	1,062,756	3,254,396	-1,005,836	2,248,560	-7,724	2,240,836	30
31	03100	Intensive Care Unit	824,219	361,323	1,185,542	-10,188	1,175,354	-68,644	1,106,710	31
43	04300	Nursery				429,436	429,436		429,436	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,880,858	3,416,174	5,297,032	-1,166,346	4,130,686	-1,026,194	3,104,492	50
52	05200	Delivery Room & Labor Room				429,436	429,436		429,436	52
54	05400	Radiology-Diagnostic	921,536	739,443	1,660,979	-338,175	1,322,804	-13,698	1,309,106	54
55	05500	Radiology-Therapeutic	340,507	729,171	1,069,678	-282,660	787,018	-107,024	679,994	55
57	05700	CT Scan	85,222	257,391	342,613	-163,672	178,941		178,941	57
59	05900	Cardiac Catheterization	53,530	440,352	493,882	-396,933	96,949	-139	96,810	59
60	06000	Laboratory	1,155,150	2,322,350	3,477,500	-71,230	3,406,270	-8,052	3,398,218	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	470,048	338,910	808,958	-42,094	766,864	-16,836	750,028	65
66	06600	Physical Therapy	744,912	280,116	1,025,028	-78,747	946,281	-1,006	945,275	66
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	319,777	143,345	463,122	-56,051	407,071		407,071	66.01
72	07200	Impl. Dev. Charged to Patients				923,722	923,722		923,722	72
73	07300	Drugs Charged to Patients				1,799,703	1,799,703		1,799,703	73
76.97	07697	CARDIAC REHABILITATION	286	9,033	9,319	-8,499	820		820	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				161,781	161,781		161,781	76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	4,779	1,177	5,956		5,956	96	6,052	90.01
90.02	09002	ATHLETIC TRAINERS	164,010	70,121	234,131		234,131	-114,817	119,314	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	245,637	267,028	512,665	-128,819	383,846	-237,195	146,651	90.03
90.04	09004	WOUND CARE	171,114	678,507	849,621	-250,708	598,913		598,913	90.04
91	09100	Emergency	1,425,556	1,720,733	3,146,289	-594,967	2,551,322	-45,838	2,505,484	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)	14,920,913	29,368,018	44,288,931		44,288,931	889,961	45,178,892	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	61,951	9,469	71,420		71,420		71,420	192
192.01	19201	FOUNDATION ADMINISTATION								192.01
192.02	19202	HOSPITALIST	688,553	516,376	1,204,929		1,204,929		1,204,929	192.02
192.03	19203	INTENSIVIST		1,392,004	1,392,004		1,392,004		1,392,004	192.03
194	07950	PLYMOUTH MOB-4								194
194.01	07951	COMMUNITY OUTREACH & PARTNERSHIP	45,831	169,693	215,524		215,524		215,524	194.01
200		TOTAL (sum of lines 118-199)	15,717,248	31,455,560	47,172,808		47,172,808	889,961	48,062,769	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		200	1
2			Cap Rel Costs-Bldg & Fixt	1		551,809	2
3			Cap Rel Costs-Mvble Equip	2		170,688	3
4			Cap Rel Costs-Mvble Equip	2		2,453	4
5			Cap Rel Costs-Bldg & Fixt	1		275,776	5
6			Cap Rel Costs-Mvble Equip	2		79,448	6
7			Cap Rel Costs-Mvble Equip	2		1,741	7
8			Cap Rel Costs-Mvble Equip	2		1,012	8
9			Cap Rel Costs-Mvble Equip	2		1,216	9
10			Cap Rel Costs-Mvble Equip	2		25,973	10
11			Cap Rel Costs-Bldg & Fixt	1		750	11
12			Cap Rel Costs-Mvble Equip	2		38,087	12
13			Cap Rel Costs-Mvble Equip	2		11	13
14			Cap Rel Costs-Bldg & Fixt	1		25,866	14
15			Cap Rel Costs-Mvble Equip	2		121,087	15
16			Cap Rel Costs-Mvble Equip	2		18	16
17			Cap Rel Costs-Mvble Equip	2		10,170	17
18			Cap Rel Costs-Mvble Equip	2		11,630	18
19			Cap Rel Costs-Bldg & Fixt	1		11,907	19
20			Cap Rel Costs-Mvble Equip	2		262,456	20
21			Cap Rel Costs-Bldg & Fixt	1		14,079	21
22			Cap Rel Costs-Mvble Equip	2		324,096	22
23			Cap Rel Costs-Bldg & Fixt	1		10,163	23
24			Cap Rel Costs-Mvble Equip	2		272,497	24
25			Cap Rel Costs-Mvble Equip	2		163,672	25
26			Cap Rel Costs-Bldg & Fixt	1		513	26
27	.	A	Cap Rel Costs-Mvble Equip	2		353,051	27
28			Cap Rel Costs-Bldg & Fixt	1		1,308	28
29			Cap Rel Costs-Mvble Equip	2		69,922	29
30			Cap Rel Costs-Mvble Equip	2		1,429	30
31			Cap Rel Costs-Bldg & Fixt	1		408	31
32			Cap Rel Costs-Mvble Equip	2		40,257	32
33			Cap Rel Costs-Bldg & Fixt	1		73,525	33
34			Cap Rel Costs-Mvble Equip	2		366	34
35			Cap Rel Costs-Bldg & Fixt	1		4,774	35
36			Cap Rel Costs-Mvble Equip	2		82	36
37			Cap Rel Costs-Bldg & Fixt	1		50,499	37
38			Cap Rel Costs-Bldg & Fixt	1		2,114	38
39			Cap Rel Costs-Mvble Equip	2		3,438	39
40			Cap Rel Costs-Bldg & Fixt	1		8,499	40
41			Cap Rel Costs-Bldg & Fixt	1		42,460	41
42			Cap Rel Costs-Bldg & Fixt	1		76,182	42
43			Cap Rel Costs-Mvble Equip	2		10,177	43
44			Cap Rel Costs-Bldg & Fixt	1		66,641	44
45			Cap Rel Costs-Bldg & Fixt	1		21,177	45
46			Cap Rel Costs-Mvble Equip	2		1,109	46
47			Cap Rel Costs-Bldg & Fixt	1		320,725	47
48			Cap Rel Costs-Mvble Equip	2		2,975	48
49			Cap Rel Costs-Mvble Equip	2		271,267	49
500	Total reclassifications					3,799,703	500
	Code Letter - A						
1	DRUGS CHARGED TO PATIENTS	B	Drugs Charged to Patients	73		1,799,703	1
500	Total reclassifications					1,799,703	500
	Code Letter - B						
1	INTEREST EXPENSE	C	Interest Expense	113		203,687	1
2			Cap Rel Costs-Bldg & Fixt	1		203,687	2
500	Total reclassifications					407,374	500
	Code Letter - C						
1	NURSERY - LABOR/DELIVERY RECLASS	D	Nursery	43	280,955	148,481	1
2			Delivery Room & Labor Room	52	280,955	148,481	2
500	Total reclassifications				561,910	296,962	500
	Code Letter - D						
1	IMPLANTS RECLASS	E	Impl. Dev. Charged to Patient	72		880,353	1
2			Impl. Dev. Charged to Patient	72		43,369	2
500	Total reclassifications					923,722	500
	Code Letter - E						
1	RECLASS HBO COST FROM WOUND CARE	G	HYPERBARIC OXYGEN THERAPY	76.98	59,474	102,307	1
500	Total reclassifications				59,474	102,307	500
	Code Letter - G						
	GRAND TOTAL (Increases)				621,384	7,329,771	

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	

(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.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DEPRECIATION RECLASSIFICATONS	A	Administrative & General	5		200	10	1
2			Administrative & General	5		551,809	9	2
3			Administrative & General	5		170,688	9	3
4			Operation of Plant	7		2,453	10	4
5			Operation of Plant	7		275,776	9	5
6			Operation of Plant	7		79,448	9	6
7			Housekeeping	9		1,741	9	7
8			Housekeeping	9		1,012	10	8
9			Housekeeping	9		1,216	9	9
10			Nursing Administration	13		25,973	9	10
11			Pharmacy	15		750	9	11
12			Pharmacy	15		38,087	9	12
13			Adults & Pediatrics	30		11	10	13
14			Adults & Pediatrics	30		25,866	9	14
15			Adults & Pediatrics	30		121,087	9	15
16			Intensive Care Unit	31		18	10	16
17			Intensive Care Unit	31		10,170	9	17
18			Operating Room	50		11,630	10	18
19			Operating Room	50		11,907	9	19
20			Operating Room	50		262,456	9	20
21			Radiology-Diagnostic	54		14,079	9	21
22			Radiology-Diagnostic	54		324,096	9	22
23			Radiology-Therapeutic	55		10,163	9	23
24			Radiology-Therapeutic	55		272,497	9	24
25			CT Scan	57		163,672	9	25
26			Cardiac Catheterization	59		513	9	26
27	.	A	Cardiac Catheterization	59		353,051	9	27
28			Laboratory	60		1,308	9	28
29			Laboratory	60		69,922	9	29
30			Respiratory Therapy	65		1,429	10	30
31			Respiratory Therapy	65		408	9	31
32			Respiratory Therapy	65		40,257	9	32
33			Physical Therapy	66		73,525	10	33
34			Physical Therapy	66		366	10	34
35			Physical Therapy	66		4,774	9	35
36			Physical Therapy	66		82	9	36
37			PHYSICAL THERAPY - LIFEPLEX	66.01		50,499	10	37
38			PHYSICAL THERAPY - LIFEPLEX	66.01		2,114	9	38
39			PHYSICAL THERAPY - LIFEPLEX	66.01		3,438	9	39
40			CARDIAC REHABILITATION	76.97		8,499	10	40
41			SAINT JOSEPH HEALTH CENTER	90.03		42,460	10	41
42			SAINT JOSEPH HEALTH CENTER	90.03		76,182	9	42
43			SAINT JOSEPH HEALTH CENTER	90.03		10,177	9	43
44			WOUND CARE	90.04		66,641	10	44
45			WOUND CARE	90.04		21,177	9	45
46			WOUND CARE	90.04		1,109	9	46
47			Emergency	91		320,725	9	47
48			Emergency	91		2,975	9	48
49			Emergency	91		271,267	9	49
500	Total reclassifications					3,799,703		500
	Code letter - A							
1	DRUGS CHARGED TO PATIENTS	B	Pharmacy	15		1,799,703		1
500	Total reclassifications					1,799,703		500
	Code letter - B							
1	INTEREST EXPENSE	C	Administrative & General	5		203,687	11	1
2			Interest Expense	113		203,687	11	2
500	Total reclassifications					407,374		500
	Code letter - C							
1	NURSERY - LABOR/DELIVERY RECLASS	D	Adults & Pediatrics	30	280,955	148,481		1
2			Adults & Pediatrics	30	280,955	148,481		2
500	Total reclassifications				561,910	296,962		500
	Code letter - D							
1	IMPLANTS RECLASS	E	Operating Room	50		880,353		1
2			Cardiac Catheterization	59		43,369		2
500	Total reclassifications					923,722		500
	Code letter - E							
1	RECLASS HBO COST FROM WOUND CARE	G	WOUND CARE	90.04	59,474	102,307		1
500	Total reclassifications				59,474	102,307		500
	Code letter - G							

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	
	GRAND TOTAL (Decreases)				621,384	7,329,771		

(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	39,839,201	2,802,755		2,802,755	116,373	42,525,583	617,005	3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	21,873,517	3,693,272		3,693,272	79,877	25,486,912	684,899	6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	62,190,648	6,496,027		6,496,027	196,250	68,490,425	1,301,904	8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	62,190,648	6,496,027		6,496,027	196,250	68,490,425	1,301,904	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	1,908,938	241,624	203,687				2,354,249	1
2	Cap Rel Costs-Mvble Equip	2,223,409	17,119					2,240,528	2
3	Total (sum of lines 1-2)	4,132,347	258,743	203,687				4,594,777	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)						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	-1,163,013				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	1,657,547				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-201,903	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	1,216,187	Administrative & General	5		33
34	HOSPITAL DONATION EXPENSE	A	50,706	Administrative & General	5		34
35	OFFSET OTHER REVENUE	B	-650	Employee Benefits Department	4		35
35.01	OFFSET OTHER REVENUE	B	-49,533	Administrative & General	5		35.01
35.02	OFFSET OTHER REVENUE	B	-60,002	Operation of Plant	7		35.02
35.03	OFFSET OTHER REVENUE	B	-52,500	Housekeeping	9		35.03
35.05	OFFSET OTHER REVENUE	B	-18	Pharmacy	15		35.05
35.06	OFFSET OTHER REVENUE	B	-4,010	Adults & Pediatrics	30		35.06
35.07	OFFSET OTHER REVENUE	B	-20,142	Operating Room	50		35.07
35.08	OFFSET OTHER REVENUE	B	-2,019	Radiology-Diagnostic	54		35.08
35.09	OFFSET OTHER REVENUE	B	-106,986	Radiology-Therapeutic	55		35.09
35.10	OFFSET OTHER REVENUE	B	-139	Cardiac Catheterization	59		35.10
35.11	OFFSET OTHER REVENUE	B	-8,052	Laboratory	60		35.11
35.12	OFFSET OTHER REVENUE	B	-16,836	Respiratory Therapy	65		35.12
35.13	OFFSET OTHER REVENUE	B	-1,006	Physical Therapy	66		35.13
36	OFFSET OTHER REVENUE	B	96	OUTPATIENT TREATMENT & INFUSION CTR	90.01		36
37	OFFSET OTHER REVENUE	B	-106,940	ATHLETIC TRAINERS	90.02		37
38	OFFSET OTHER REVENUE	B	-237,195	SAINT JOSEPH HEALTH CENTER	90.03		38
39	OFFSET OTHER REVENUE	B	-3,631	Emergency	91		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)		889,961				50

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.

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 16:52 Version: 2016.05 (09/21/2016)

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	8,705,230	8,361,139	344,091		1
2	5	Administrative & General	WORKER'S COMP	63,861	91,608	-27,747		2
3	5	Administrative & General	INSURANCE	260,254	449,853	-189,599		3
3.01	5	Administrative & General	PENSION	837,079	-76,147	913,226		3.01
3.02	5	Administrative & General	RETIREE HEALTH COSTS		-26,189	26,189		3.02
3.03	1	Cap Rel Costs-Bldg & Fixt	HO CAPITAL COSTS	591,387		591,387	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			10,457,811	8,800,264	1,657,547		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	5	Administrative & Gen A	45,614		45,614	206,300	230	22,812	1,141	1
2	30	Adults & Pediatrics B	12,740		12,740	206,300	91	9,026	451	2
3	31	Intensive Care Unit C	85,320		85,320	192,700	180	16,676	834	3
4	50	Operating Room D	1,013,330	1,000,741	12,589	240,300	63	7,278	364	4
5	54	Radiology-Diagnostic E	27,744		27,744	265,200	126	16,065	803	5
6	55	Radiology-Therapeuti F	4,700		4,700	206,300	47	4,662	233	6
7	60	Laboratory G	49,999		49,999	253,900	768	93,748	4,687	7
8	90.02	ATHLETIC TRAINERS H	23,250		23,250	206,300	155	15,373	769	8
9	91	Emergency I	111,040		111,040	206,300	694	68,833	3,442	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,373,737	1,000,741	372,996		2,354	254,473	12,724	200

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 16:52 Version: 2016.05 (09/21/2016)

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	5	Administrative & Gen A					22,812	22,802	22,802	1
2	30	Adults & Pediatrics B					9,026	3,714	3,714	2
3	31	Intensive Care Unit C					16,676	68,644	68,644	3
4	50	Operating Room D					7,278	5,311	1,006,052	4
5	54	Radiology-Diagnostic E					16,065	11,679	11,679	5
6	55	Radiology-Therapeuti F					4,662	38	38	6
7	60	Laboratory G					93,748			7
8	90.02	ATHLETIC TRAINERS H					15,373	7,877	7,877	8
9	91	Emergency I					68,833	42,207	42,207	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					254,473	162,272	1,163,013	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	2,354,249	2,354,249					1
2	Cap Rel Costs-Mvble Equip	2,240,528		2,240,528				2
4	Employee Benefits Department	797,386			797,386			4
5	Administrative & General	13,207,867	264,277	251,511	80,819	13,804,474	13,804,474	5
6	Maintenance & Repairs							6
7	Operation of Plant	2,269,902	499,819	475,672	19,454	3,264,847	1,315,580	7
8	Laundry & Linen Service	160,115	8,949	8,517		177,581	71,557	8
9	Housekeeping	602,515	4,430	4,216	18,606	629,767	253,767	9
10	Dietary	474,272	30,965	29,470	11,591	546,298	220,132	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	649,414			26,184	675,598	272,234	13
14	Central Services & Supply							14
15	Pharmacy	714,905	18,326	17,441	28,722	779,394	314,059	15
16	Medical Records & Library	362,831	37,123	35,330	10,582	445,866	179,663	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)	6,115			236	6,351	2,559	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,240,836	286,293	272,464	83,067	2,882,660	1,161,576	30
31	Intensive Care Unit	1,106,710	54,902	52,250	42,010	1,255,872	506,057	31
43	Nursery	429,436			14,320	443,756	178,813	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,104,492	284,256	270,526	95,862	3,755,136	1,513,136	50
52	Delivery Room & Labor Room	429,436			14,320	443,756	178,813	52
54	Radiology-Diagnostic	1,309,106	107,264	102,083	46,971	1,565,424	630,792	54
55	Radiology-Therapeutic	679,994	133,637	127,182	17,356	958,169	386,097	55
57	CT Scan	178,941	6,187	5,888	4,344	195,360	78,721	57
59	Cardiac Catheterization	96,810	31,350	29,835	2,728	160,723	64,764	59
60	Laboratory	3,398,218	64,176	61,076	58,878	3,582,348	1,443,518	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	750,028	48,980	46,615	23,958	869,581	350,400	65
66	Physical Therapy	945,275	86,340	82,169	37,968	1,151,752	464,102	66
66.01	PHYSICAL THERAPY - LIFEPLEX	407,071			16,299	423,370	170,598	66.01
72	Impl. Dev. Charged to Patients	923,722				923,722	372,217	72
73	Drugs Charged to Patients	1,799,703				1,799,703	725,196	73
76.97	CARDIAC REHABILITATION	820			15	835	336	76.97
76.98	HYPERBARIC OXYGEN THERAPY	161,781	8,018	7,631	3,031	180,461	72,717	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR	6,052			244	6,296	2,537	90.01
90.02	ATHLETIC TRAINERS	119,314			8,360	127,674	51,447	90.02
90.03	SAINT JOSEPH HEALTH CENTER	146,651			12,520	159,171	64,138	90.03
90.04	WOUND CARE	598,913	38,142	36,300	5,690	679,045	273,623	90.04
91	Emergency	2,505,484	121,191	115,337	72,661	2,814,673	1,134,181	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)	45,178,892	2,134,625	2,031,513	756,796	44,709,663	12,453,330	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,806	2,670		5,476	2,207	190
192	Physicians' Private Offices	71,420	216,818	206,345	3,158	497,741	200,566	192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST	1,204,929			35,096	1,240,025	499,672	192.02
192.03	INTENSIVIST	1,392,004				1,392,004	560,912	192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP	215,524			2,336	217,860	87,787	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	48,062,769	2,354,249	2,240,528	797,386	48,062,769	13,804,474	202

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	4,580,427						7
8	Laundry & Linen Service	25,778	274,916					8
9	Housekeeping	12,760		896,294				9
10	Dietary	89,195		17,602	873,227			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration					947,832		13
14	Central Services & Supply							14
15	Pharmacy	52,787		10,417			1,156,657	15
16	Medical Records & Library	106,932		21,102				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	824,665	18,015	162,739	654,920	247,824		30
31	Intensive Care Unit	158,146	6,741	31,208	218,307	99,532		31
43	Nursery					35,124		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	818,798	51,105	161,581		234,487	5,175	50
52	Delivery Room & Labor Room		2,084			35,124		52
54	Radiology-Diagnostic	308,973	25,745	60,973			50,558	54
55	Radiology-Therapeutic	384,942	10,806	75,964		37,938		55
57	CT Scan	17,821	31,846	3,517			17,971	57
59	Cardiac Catheterization	90,302	1,296	17,820		6,577	166	59
60	Laboratory	184,858	50,144	36,480			48	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	141,088	13,066	27,842			6	65
66	Physical Therapy	248,701	7,969	49,079			5	66
66.01	PHYSICAL THERAPY - LIFEPLEX		2,179					66.01
72	Impl. Dev. Charged to Patients		3,872					72
73	Drugs Charged to Patients		17,447				1,072,956	73
76.97	CARDIAC REHABILITATION					411		76.97
76.98	HYPERBARIC OXYGEN THERAPY	23,097	2,208	4,558		10,061		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR					1,310		90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER		298			34,500	2,531	90.03
90.04	WOUND CARE	109,869	2,607	21,681		15,843	7,241	90.04
91	Emergency	349,091	27,488	68,889		189,101		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)	3,947,803	274,916	771,452	873,227	947,832	1,156,657	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	8,082		1,595				190
192	Physicians' Private Offices	624,542		123,247				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)	4,580,427	274,916	896,294	873,227	947,832	1,156,657	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	753,563						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)		8,910					23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	49,371		6,001,770		6,001,770		30
31	Intensive Care Unit	18,473		2,294,336		2,294,336		31
43	Nursery			657,693		657,693		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	140,196		6,679,614		6,679,614		50
52	Delivery Room & Labor Room	5,712		665,489		665,489		52
54	Radiology-Diagnostic	70,555		2,713,020		2,713,020		54
55	Radiology-Therapeutic	29,615		1,883,531		1,883,531		55
57	CT Scan	87,275		432,511		432,511		57
59	Cardiac Catheterization	3,551		345,199		345,199		59
60	Laboratory	137,423		5,434,819		5,434,819		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	35,809		1,437,792		1,437,792		65
66	Physical Therapy	21,839		1,943,447		1,943,447		66
66.01	PHYSICAL THERAPY - LIFEPLEX	5,973		602,120		602,120		66.01
72	Impl. Dev. Charged to Patients	10,610		1,310,421		1,310,421		72
73	Drugs Charged to Patients	47,815		3,663,117		3,663,117		73
76.97	CARDIAC REHABILITATION	1		1,583		1,583		76.97
76.98	HYPERBARIC OXYGEN THERAPY	6,051		299,153		299,153		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR			10,143		10,143		90.01
90.02	ATHLETIC TRAINERS			179,121		179,121		90.02
90.03	SAINT JOSEPH HEALTH CENTER	817		261,455		261,455		90.03
90.04	WOUND CARE	7,145		1,117,054		1,117,054		90.04
91	Emergency	75,332	8,910	4,667,665		4,667,665		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)	753,563	8,910	42,601,053		42,601,053		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			17,360		17,360		190
192	Physicians' Private Offices			1,446,096		1,446,096		192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST			1,739,697		1,739,697		192.02
192.03	INTENSIVIST			1,952,916		1,952,916		192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP			305,647		305,647		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	753,563	8,910	48,062,769		48,062,769		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		264,277	251,511	515,788	515,788		5
6	Maintenance & Repairs							6
7	Operation of Plant		499,819	475,672	975,491	49,156	1,024,647	7
8	Laundry & Linen Service		8,949	8,517	17,466	2,674	5,766	8
9	Housekeeping		4,430	4,216	8,646	9,482	2,855	9
10	Dietary		30,965	29,470	60,435	8,225	19,953	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration					10,172		13
14	Central Services & Supply							14
15	Pharmacy		18,326	17,441	35,767	11,735	11,809	15
16	Medical Records & Library		37,123	35,330	72,453	6,713	23,921	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)					96		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		286,293	272,464	558,757	43,401	184,476	30
31	Intensive Care Unit		54,902	52,250	107,152	18,908	35,377	31
43	Nursery					6,681		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		284,256	270,526	554,782	56,532	183,166	50
52	Delivery Room & Labor Room					6,681		52
54	Radiology-Diagnostic		107,264	102,083	209,347	23,569	69,118	54
55	Radiology-Therapeutic		133,637	127,182	260,819	14,426	86,112	55
57	CT Scan		6,187	5,888	12,075	2,941	3,987	57
59	Cardiac Catheterization		31,350	29,835	61,185	2,420	20,201	59
60	Laboratory		64,176	61,076	125,252	53,936	41,353	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		48,980	46,615	95,595	13,092	31,562	65
66	Physical Therapy		86,340	82,169	168,509	17,341	55,635	66
66.01	PHYSICAL THERAPY - LIFEPLEX					6,374		66.01
72	Impl. Dev. Charged to Patients					13,908		72
73	Drugs Charged to Patients					27,096		73
76.97	CARDIAC REHABILITATION					13		76.97
76.98	HYPERBARIC OXYGEN THERAPY		8,018	7,631	15,649	2,717	5,167	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR					95		90.01
90.02	ATHLETIC TRAINERS					1,922		90.02
90.03	SAINT JOSEPH HEALTH CENTER					2,396		90.03
90.04	WOUND CARE		38,142	36,300	74,442	10,224	24,578	90.04
91	Emergency		121,191	115,337	236,528	42,378	78,092	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		2,134,625	2,031,513	4,166,138	465,304	883,128	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,806	2,670	5,476	82	1,808	190
192	Physicians' Private Offices		216,818	206,345	423,163	7,494	139,711	192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST					18,670		192.02
192.03	INTENSIVIST					20,958		192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP					3,280		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,354,249	2,240,528	4,594,777	515,788	1,024,647	202

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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 16:52 Version: 2016.05 (09/21/2016)

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	25,906						8
9	Housekeeping		20,983					9
10	Dietary		412	89,025				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration				10,172			13
14	Central Services & Supply							14
15	Pharmacy		244			59,555		15
16	Medical Records & Library		494				103,581	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	1,700	3,810	66,769	2,661		6,787	30
31	Intensive Care Unit	636	731	22,256	1,068		2,540	31
43	Nursery				377			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,791	3,783		2,516	266	19,257	50
52	Delivery Room & Labor Room	197			377		785	52
54	Radiology-Diagnostic	2,429	1,427			2,603	9,700	54
55	Radiology-Therapeutic	1,019	1,778		407		4,071	55
57	CT Scan	3,004	82			925	11,998	57
59	Cardiac Catheterization	122	417		71	9	488	59
60	Laboratory	4,731	854			2	18,893	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,233	652				4,923	65
66	Physical Therapy	752	1,149				3,002	66
66.01	PHYSICAL THERAPY - LIFEPLEX	206					821	66.01
72	Impl. Dev. Charged to Patients	365					1,459	72
73	Drugs Charged to Patients	1,646				55,247	6,574	73
76.97	CARDIAC REHABILITATION				4			76.97
76.98	HYPERBARIC OXYGEN THERAPY	208	107		108		832	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR				14			90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER	28			370	130	112	90.03
90.04	WOUND CARE	246	508		170	373	982	90.04
91	Emergency	2,593	1,613		2,029		10,357	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)	25,906	18,061	89,025	10,172	59,555	103,581	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		37					190
192	Physicians' Private Offices		2,885					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)	25,906	20,983	89,025	10,172	59,555	103,581	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)	96						23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		868,361		868,361			30
31	Intensive Care Unit		188,668		188,668			31
43	Nursery		7,058		7,058			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		825,093		825,093			50
52	Delivery Room & Labor Room		8,040		8,040			52
54	Radiology-Diagnostic		318,193		318,193			54
55	Radiology-Therapeutic		368,632		368,632			55
57	CT Scan		35,012		35,012			57
59	Cardiac Catheterization		84,913		84,913			59
60	Laboratory		245,021		245,021			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		147,057		147,057			65
66	Physical Therapy		246,388		246,388			66
66.01	PHYSICAL THERAPY - LIFEPLEX		7,401		7,401			66.01
72	Impl. Dev. Charged to Patients		15,732		15,732			72
73	Drugs Charged to Patients		90,563		90,563			73
76.97	CARDIAC REHABILITATION		17		17			76.97
76.98	HYPERBARIC OXYGEN THERAPY		24,788		24,788			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR		109		109			90.01
90.02	ATHLETIC TRAINERS		1,922		1,922			90.02
90.03	SAINT JOSEPH HEALTH CENTER		3,036		3,036			90.03
90.04	WOUND CARE		111,523		111,523			90.04
91	Emergency		373,590		373,590			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)		3,971,117		3,971,117			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		7,403		7,403			190
192	Physicians' Private Offices		573,253		573,253			192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST		18,670		18,670			192.02
192.03	INTENSIVIST		20,958		20,958			192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP		3,280		3,280			194.01
200	Cross Foot Adjustments	96	96		96			200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	96	4,594,777		4,594,777			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	2,008,830						1
2	Cap Rel Costs-Mvble Equip		2,008,830					2
4	Employee Benefits Department			15,644,323				4
5	Administrative & General	225,502	225,502	1,585,623	-13,804,474	34,258,295		5
6	Maintenance & Repairs							6
7	Operation of Plant	426,483	426,483	381,671		3,264,847	1,356,845	7
8	Laundry & Linen Service	7,636	7,636			177,581	7,636	8
9	Housekeeping	3,780	3,780	365,040		629,767	3,780	9
10	Dietary	26,422	26,422	227,404		546,298	26,422	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration			513,717		675,598		13
14	Central Services & Supply							14
15	Pharmacy	15,637	15,637	563,507		779,394	15,637	15
16	Medical Records & Library	31,676	31,676	207,606		445,866	31,676	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)			4,639		6,351		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	244,288	244,288	1,629,730		2,882,660	244,288	30
31	Intensive Care Unit	46,847	46,847	824,219		1,255,872	46,847	31
43	Nursery			280,955		443,756		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	242,550	242,550	1,880,858		3,755,136	242,550	50
52	Delivery Room & Labor Room			280,955		443,756		52
54	Radiology-Diagnostic	91,526	91,526	921,536		1,565,424	91,526	54
55	Radiology-Therapeutic	114,030	114,030	340,507		958,169	114,030	55
57	CT Scan	5,279	5,279	85,222		195,360	5,279	57
59	Cardiac Catheterization	26,750	26,750	53,530		160,723	26,750	59
60	Laboratory	54,760	54,760	1,155,150		3,582,348	54,760	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	41,794	41,794	470,048		869,581	41,794	65
66	Physical Therapy	73,672	73,672	744,912		1,151,752	73,672	66
66.01	PHYSICAL THERAPY - LIFEPLEX			319,777		423,370		66.01
72	Impl. Dev. Charged to Patients					923,722		72
73	Drugs Charged to Patients					1,799,703		73
76.97	CARDIAC REHABILITATION			286		835		76.97
76.98	HYPERBARIC OXYGEN THERAPY	6,842	6,842	59,474		180,461	6,842	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR			4,779		6,296		90.01
90.02	ATHLETIC TRAINERS			164,010		127,674		90.02
90.03	SAINT JOSEPH HEALTH CENTER			245,637		159,171		90.03
90.04	WOUND CARE	32,546	32,546	111,640		679,045	32,546	90.04
91	Emergency	103,410	103,410	1,425,556		2,814,673	103,410	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,821,430	1,821,430	14,847,988	-13,804,474	30,905,189	1,169,445	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,394	2,394			5,476	2,394	190
192	Physicians' Private Offices	185,006	185,006	61,951		497,741	185,006	192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST			688,553		1,240,025		192.02
192.03	INTENSIVIST					1,392,004		192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP			45,831		217,860		194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,354,249	2,240,528	797,386		13,804,474	4,580,427	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.171950	1.115340	0.050970		0.402953	3.375792	203
204	Cost to be allocated (Per Wkst. B, Part II)					515,788	1,024,647	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.015056	0.755169	205

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 16:52 Version: 2016.05 (09/21/2016)

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	162,109,342						8
9	Housekeeping		1,345,429					9
10	Dietary		26,422	100				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration				244,566			13
14	Central Services & Supply							14
15	Pharmacy		15,637			1,940,101		15
16	Medical Records & Library		31,676				162,109,342	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	10,622,053	244,288	75	63,945		10,622,053	30
31	Intensive Care Unit	3,974,444	46,847	25	25,682		3,974,444	31
43	Nursery				9,063			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	30,145,617	242,550		60,504	8,681	30,145,617	50
52	Delivery Room & Labor Room	1,228,856			9,063		1,228,856	52
54	Radiology-Diagnostic	15,179,698	91,526			84,803	15,179,698	54
55	Radiology-Therapeutic	6,371,451	114,030		9,789		6,371,451	55
57	CT Scan	18,776,903	5,279			30,143	18,776,903	57
59	Cardiac Catheterization	763,922	26,750		1,697	279	763,922	59
60	Laboratory	29,566,009	54,760			81	29,566,009	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	7,704,218	41,794			10	7,704,218	65
66	Physical Therapy	4,698,665	73,672			9	4,698,665	66
66.01	PHYSICAL THERAPY - LIFEPLEX	1,285,014					1,285,014	66.01
72	Impl. Dev. Charged to Patients	2,282,755					2,282,755	72
73	Drugs Charged to Patients	10,287,297				1,799,703	10,287,297	73
76.97	CARDIAC REHABILITATION	155			106		155	76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,301,845	6,842		2,596		1,301,845	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR				338			90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER	175,815			8,902	4,246	175,815	90.03
90.04	WOUND CARE	1,537,196	32,546		4,088	12,146	1,537,196	90.04
91	Emergency	16,207,429	103,410		48,793		16,207,429	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	162,109,342	1,158,029	100	244,566	1,940,101	162,109,342	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,394					190
192	Physicians' Private Offices		185,006					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)	274,916	896,294	873,227	947,832	1,156,657	753,563	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.001696	0.666177	8,732.270000	3.875567	0.596184	0.004648	203
204	Cost to be allocated (Per Wkst. B, Part II)	25,906	20,983	89,025	10,172	59,555	103,581	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000160	0.015596	890.250000	0.041592	0.030697	0.000639	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
66.01	PHYSICAL THERAPY - LIFEPLEX		66.01
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)	8,910	202
203	Unit Cost Multiplier (Wkst. B, Part I)	89.100000	203
204	Cost to be allocated (Per Wkst. B, Part II)	96	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.960000	205

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	6,001,770		6,001,770	3,714	6,005,484	30
31	Intensive Care Unit	2,294,336		2,294,336	68,644	2,362,980	31
43	Nursery	657,693		657,693		657,693	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,679,614		6,679,614	5,311	6,684,925	50
52	Delivery Room & Labor Room	665,489		665,489		665,489	52
54	Radiology-Diagnostic	2,713,020		2,713,020	11,679	2,724,699	54
55	Radiology-Therapeutic	1,883,531		1,883,531	38	1,883,569	55
57	CT Scan	432,511		432,511		432,511	57
59	Cardiac Catheterization	345,199		345,199		345,199	59
60	Laboratory	5,434,819		5,434,819		5,434,819	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,437,792		1,437,792		1,437,792	65
66	Physical Therapy	1,943,447		1,943,447		1,943,447	66
66.01	PHYSICAL THERAPY - LIFEPLEX	602,120		602,120		602,120	66.01
72	Impl. Dev. Charged to Patients	1,310,421		1,310,421		1,310,421	72
73	Drugs Charged to Patients	3,663,117		3,663,117		3,663,117	73
76.97	CARDIAC REHABILITATION	1,583		1,583		1,583	76.97
76.98	HYPERBARIC OXYGEN THERAPY	299,153		299,153		299,153	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION CTR	10,143		10,143		10,143	90.01
90.02	ATHLETIC TRAINERS	179,121		179,121	7,877	186,998	90.02
90.03	SAINT JOSEPH HEALTH CENTER	261,455		261,455		261,455	90.03
90.04	WOUND CARE	1,117,054		1,117,054		1,117,054	90.04
91	Emergency	4,667,665		4,667,665	42,207	4,709,872	91
92	Observation Beds (Non-Distinct Part)	1,442,264		1,442,264		1,442,264	92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	44,043,317		44,043,317	139,470	44,182,787	200
201	Less Observation Beds	1,442,264		1,442,264		1,442,264	201
202	Total (line 200 minus line 201)	42,601,053		42,601,053		42,740,523	202

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C PART I**

	COST CENTER DESCRIPTIONS	CHARGES 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	7,469,290		7,469,290				30
31	Intensive Care Unit	3,974,444		3,974,444				31
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,164,802	22,980,815	30,145,617	0.221578	0.221578	0.221754	50
52	Delivery Room & Labor Room	1,178,747	50,109	1,228,856	0.541552	0.541552	0.541552	52
54	Radiology-Diagnostic	1,435,649	13,744,049	15,179,698	0.178727	0.178727	0.179496	54
55	Radiology-Therapeutic	17,905	6,353,546	6,371,451	0.295620	0.295620	0.295626	55
57	CT Scan	2,326,465	16,450,438	18,776,903	0.023034	0.023034	0.023034	57
59	Cardiac Catheterization	71,237	692,685	763,922	0.451877	0.451877	0.451877	59
60	Laboratory	4,299,925	25,266,084	29,566,009	0.183820	0.183820	0.183820	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,074,061	5,630,157	7,704,218	0.186624	0.186624	0.186624	65
66	Physical Therapy	626,654	4,072,011	4,698,665	0.413617	0.413617	0.413617	66
66.01	PHYSICAL THERAPY - LIFEPLEX	339	1,284,675	1,285,014	0.468571	0.468571	0.468571	66.01
72	Impl. Dev. Charged to Patients	1,691,235	591,520	2,282,755	0.574052	0.574052	0.574052	72
73	Drugs Charged to Patients	3,512,421	6,774,876	10,287,297	0.356082	0.356082	0.356082	73
76.97	CARDIAC REHABILITATION		155	155	10.212903	10.212903	10.212903	76.97
76.98	HYPERBARIC OXYGEN THERAPY		1,301,845	1,301,845	0.229792	0.229792	0.229792	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		175,815	175,815	1.487103	1.487103	1.487103	90.03
90.04	WOUND CARE	6,860	1,530,336	1,537,196	0.726683	0.726683	0.726683	90.04
91	Emergency	2,319,099	13,888,330	16,207,429	0.287995	0.287995	0.290600	91
92	Observation Beds (Non-Distinct Part)	287,285	2,865,478	3,152,763	0.457460	0.457460	0.457460	92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	38,456,418	123,652,924	162,109,342				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	38,456,418	123,652,924	162,109,342				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

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

(A)	Cost Center Description	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)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	868,361		868,361	5,359	162.04	1,669	270,445	30
31	Intensive Care Unit	188,668		188,668	1,179	160.02	516	82,570	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	7,058		7,058	588	12.00			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,064,087		1,064,087	7,126		2,185	353,015	200

(A) Worksheet A line numbers

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

```
Check         [  ] Title V                [XX] Hospital     [  ] SUB (Other)          [XX] PPS
Applicable    [XX] Title XVIII, Part A    [  ] IPF                                    [  ] TEFRA
Boxes:        [  ] Title XIX              [  ] IRF
```

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	825,093	30,145,617	0.027370	2,230,411	61,046	50
52	Delivery Room & Labor Room	8,040	1,228,856	0.006543			52
54	Radiology-Diagnostic	318,193	15,179,698	0.020962	759,036	15,911	54
55	Radiology-Therapeutic	368,632	6,371,451	0.057857	17,905	1,036	55
57	CT Scan	35,012	18,776,903	0.001865	1,134,588	2,116	57
59	Cardiac Catheterization	84,913	763,922	0.111154			59
60	Laboratory	245,021	29,566,009	0.008287	2,117,583	17,548	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	147,057	7,704,218	0.019088	1,047,406	19,993	65
66	Physical Therapy	246,388	4,698,665	0.052438	383,194	20,094	66
66.01	PHYSICAL THERAPY - LIFEPLEX	7,401	1,285,014	0.005759			66.01
72	Impl. Dev. Charged to Patients	15,732	2,282,755	0.006892	653,513	4,504	72
73	Drugs Charged to Patients	90,563	10,287,297	0.008803	1,394,761	12,278	73
76.97	CARDIAC REHABILITATION	17	155	0.109677			76.97
76.98	HYPERBARIC OXYGEN THERAPY	24,788	1,301,845	0.019041			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION	109					90.01
90.02	ATHLETIC TRAINERS	1,922					90.02
90.03	SAINT JOSEPH HEALTH CENTER	3,036	175,815	0.017268			90.03
90.04	WOUND CARE	111,523	1,537,196	0.072550			90.04
91	Emergency	373,590	16,207,429	0.023051	842,984	19,432	91
92	Observation Beds (Non-Distinct	208,544	3,152,763	0.066146	189,482	12,533	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,115,574	150,665,608		10,770,863	186,491	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 16:52 Version: 2016.05 (09/21/2016)

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

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Check          [  ] Title V                 [XX] PPS
Applicable     [XX] Title XVIII, Part A     [  ] TEFRA
Boxes:         [  ] 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         [  ] Title V                 [XX] PPS
Applicable    [XX] Title XVIII, Part A     [  ] TEFRA
Boxes:        [  ] 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)	5,359		1,669		30
31	Intensive Care Unit	1,179		516		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	588				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	7,126		2,185		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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 16:52 Version: 2016.05 (09/21/2016)

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

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

(A)	Cost Center Description	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)	
		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
66.01	PHYSICAL THERAPY - LIFEPLEX							66.01
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			8,910		8,910	8,910	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			8,910		8,910	8,910	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        [  ] Title V                [XX] Hospital     [  ] SUB (Other)       [  ] ICF/IID      [XX] PPS
Applicable   [XX] Title XVIII, Part A    [  ] IPF          [  ] SNF                                 [  ] TEFRA
Boxes:       [  ] 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	30,145,617			2,230,411		4,980,824		50
52	Delivery Room & Labor Room	1,228,856							52
54	Radiology-Diagnostic	15,179,698			759,036		3,258,490		54
55	Radiology-Therapeutic	6,371,451			17,905		2,957,907		55
57	CT Scan	18,776,903			1,134,588		5,001,660		57
59	Cardiac Catheterization	763,922							59
60	Laboratory	29,566,009			2,117,583		2,337,041		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	7,704,218			1,047,406		1,601,162		65
66	Physical Therapy	4,698,665			383,194		24,086		66
66.01	PHYSICAL THERAPY - LIFEPLEX	1,285,014							66.01
72	Impl. Dev. Charged to Patients	2,282,755			653,513		204,156		72
73	Drugs Charged to Patients	10,287,297			1,394,761		1,798,189		73
76.97	CARDIAC REHABILITATION	155							76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,301,845					400,355		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	175,815							90.03
90.04	WOUND CARE	1,537,196							90.04
91	Emergency	16,207,429	0.000550	0.000550	842,984	464	2,162,603	1,189	91
92	Observation Beds (Non-Distinct	3,152,763			189,482		1,194,842		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	150,665,608			10,770,863	464	25,921,315	1,189	200

(A) Worksheet A line numbers

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

```
Check         [  ] Title V - O/P          [XX] Hospital     [  ] SUB (Other)        [  ] Swing Bed SNF
Applicable    [XX] Title XVIII, Part B    [  ] IPF          [  ] SNF                [  ] Swing Bed NF
Boxes:        [  ] 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	0.221578	4,980,824			1,103,641			50
52	Delivery Room & Labor Room	0.541552							52
54	Radiology-Diagnostic	0.178727	3,258,490			582,380			54
55	Radiology-Therapeutic	0.295620	2,957,907			874,416			55
57	CT Scan	0.023034	5,001,660			115,208			57
59	Cardiac Catheterization	0.451877							59
60	Laboratory	0.183820	2,337,041			429,595			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.186624	1,601,162			298,815			65
66	Physical Therapy	0.413617	24,086			9,962			66
66.01	PHYSICAL THERAPY - LIFEPLEX	0.468571							66.01
72	Impl. Dev. Charged to Patients	0.574052	204,156			117,196			72
73	Drugs Charged to Patients	0.356082	1,798,189	27,443	11,332	640,303	9,772	4,035	73
76.97	CARDIAC REHABILITATION	10.212903							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.229792	400,355			91,998			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	1.487103							90.03
90.04	WOUND CARE	0.726683							90.04
91	Emergency	0.287995	2,162,603			622,819			91
92	Observation Beds (Non-Distinct	0.457460	1,194,842			546,592			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		25,921,315	27,443	11,332	5,432,925	9,772	4,035	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		25,921,315	27,443	11,332	5,432,925	9,772	4,035	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

```
Check        [  ] Title V                [XX] PPS
Applicable   [  ] Title XVIII, Part A    [  ] TEFRA
Boxes:       [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)	868,361		868,361	5,359	162.04			30
31	Intensive Care Unit	188,668		188,668	1,179	160.02	4	640	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	7,058		7,058	588	12.00	38	456	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,064,087		1,064,087	7,126		42	1,096	200

(A) Worksheet A line numbers

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

```
Check        [  ] Title V                [XX] Hospital     [  ] SUB (Other)          [XX] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF                                    [  ] TEFRA
Boxes:       [XX] Title XIX              [  ] IRF
```

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	825,093	30,145,617	0.027370	1,081,845	29,610	50
52	Delivery Room & Labor Room	8,040	1,228,856	0.006543			52
54	Radiology-Diagnostic	318,193	15,179,698	0.020962	137,795	2,888	54
55	Radiology-Therapeutic	368,632	6,371,451	0.057857			55
57	CT Scan	35,012	18,776,903	0.001865	218,200	407	57
59	Cardiac Catheterization	84,913	763,922	0.111154	1,409	157	59
60	Laboratory	245,021	29,566,009	0.008287	513,925	4,259	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	147,057	7,704,218	0.019088	231,904	4,427	65
66	Physical Therapy	246,388	4,698,665	0.052438	25,415	1,333	66
66.01	PHYSICAL THERAPY - LIFEPLEX	7,401	1,285,014	0.005759			66.01
72	Impl. Dev. Charged to Patients	15,732	2,282,755	0.006892			72
73	Drugs Charged to Patients	90,563	10,287,297	0.008803	551,063	4,851	73
76.97	CARDIAC REHABILITATION	17	155	0.109677			76.97
76.98	HYPERBARIC OXYGEN THERAPY	24,788	1,301,845	0.019041			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION	109					90.01
90.02	ATHLETIC TRAINERS	1,922					90.02
90.03	SAINT JOSEPH HEALTH CENTER	3,036	175,815	0.017268			90.03
90.04	WOUND CARE	111,523	1,537,196	0.072550			90.04
91	Emergency	373,590	16,207,429	0.023051	244,997	5,647	91
92	Observation Beds (Non-Distinct	208,544	3,152,763	0.066146			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,115,574	150,665,608		3,006,553	53,579	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 16:52 Version: 2016.05 (09/21/2016)

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

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

(A)	Cost Center Description	Nursing School 1	Allied Health Cost 2	All Other Medical Education Cost 3	Swing-Bed Adjust-ment Amount (see instruct-ions) 4	Total Costs (sum of cols. 1 through 3 minus col 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         [  ] Title V                [XX] PPS
Applicable    [  ] Title XVIII, Part A    [  ] TEFRA
Boxes:        [XX] Title XIX              [  ] Other
```

(A)	Cost Center Description	Total Patient Days 6	Per Diem (col. 5÷ col. 6) 7	Inpatient Program Days 8	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	5,359				30
31	Intensive Care Unit	1,179		4		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	588		38		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	7,126		42		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        [  ] Title V                [XX] Hospital    [  ] SUB (Other)        [  ] ICF/IID     [XX] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF         [  ] SNF                                 [  ] TEFRA
Boxes:       [XX] Title XIX              [  ] IRF         [  ] NF                                  [  ] Other
```

(A)	Cost Center Description	Non Physician Anesth-etist Cost 1	Nursing School 2	Allied Health 3	All Other Medical Education Cost 4	Total Cost (sum of col. 1 through col. 4) 5	Total Outpatient Cost (sum of col. 2, 3, and 4) 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
66.01	PHYSICAL THERAPY - LIFEPLEX							66.01
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			8,910		8,910	8,910	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			8,910		8,910	8,910	200

(A) Worksheet A line numbers

	In Lieu of Form	Period :	Run Date: 11/28/2016
ST. JOSEPH'S REG MED CENTER PLYMOUT	**CMS-2552-10**	From: 07/01/2015	Run Time: 16:52
Provider CCN: 15-0076		To: 06/30/2016	Version: 2016.05 (09/21/2016)

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

```
Check        [  ] Title V                [XX] Hospital     [  ] SUB (Other)        [  ] ICF/IID      [XX] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF          [  ] SNF                                  [  ] TEFRA
Boxes:       [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	30,145,617			1,081,845				50
52	Delivery Room & Labor Room	1,228,856							52
54	Radiology-Diagnostic	15,179,698			137,795				54
55	Radiology-Therapeutic	6,371,451							55
57	CT Scan	18,776,903			218,200				57
59	Cardiac Catheterization	763,922			1,409				59
60	Laboratory	29,566,009			513,925				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	7,704,218			231,904				65
66	Physical Therapy	4,698,665			25,415				66
66.01	PHYSICAL THERAPY - LIFEPLEX	1,285,014							66.01
72	Impl. Dev. Charged to Patients	2,282,755							72
73	Drugs Charged to Patients	10,287,297			551,063				73
76.97	CARDIAC REHABILITATION	155							76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,301,845							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	175,815							90.03
90.04	WOUND CARE	1,537,196							90.04
91	Emergency	16,207,429	0.000550	0.000550	244,997	135			91
92	Observation Beds (Non-Distinct	3,152,763							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	150,665,608			3,006,553	135			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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 16:52 Version: 2016.05 (09/21/2016)

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

```
Check        [  ] Title V - O/P          [XX] Hospital    [  ] SUB (Other)        [  ] Swing Bed SNF
Applicable   [  ] Title XVIII, Part B    [  ] IPF         [  ] SNF                [  ] Swing Bed NF
Boxes:       [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	0.221578							50
52	Delivery Room & Labor Room	0.541552							52
54	Radiology-Diagnostic	0.178727							54
55	Radiology-Therapeutic	0.295620							55
57	CT Scan	0.023034							57
59	Cardiac Catheterization	0.451877							59
60	Laboratory	0.183820							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.186624							65
66	Physical Therapy	0.413617							66
66.01	PHYSICAL THERAPY - LIFEPLEX	0.468571							66.01
72	Impl. Dev. Charged to Patients	0.574052							72
73	Drugs Charged to Patients	0.356082							73
76.97	CARDIAC REHABILITATION	10.212903							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.229792							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	1.487103							90.03
90.04	WOUND CARE	0.726683							90.04
91	Emergency	0.287995							91
92	Observation Beds (Non-Distinct	0.457460							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,359	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,359	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)	4,072	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)	1,669	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)	6,005,484	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)	6,005,484	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)	6,005,484	37

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

```
Check        [  ] Title V - I/P          [XX] Hospital    [  ] SUB (Other)        [XX] PPS
Applicable   [XX] Title XVIII, Part A    [  ] IPF                                 [  ] TEFRA
Boxes:       [  ] 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)	1,120.64	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,870,348	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)	1,870,348	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	2,362,980	1,179	2,004.22	516	1,034,178	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)	2,608,945	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	5,513,471	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	353,015	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	186,955	51
52	Total Program excludable cost (sum of lines 50 and 51)	539,970	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	4,973,501	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

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,287	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,120.64	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,442,264	89
		Cost	Routine Cost (from line 21)	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	868,361	6,005,484	0.144595	1,442,264	208,544	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        [  ] Title V - I/P          [XX] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [XX] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF          [  ] SNF                                   [  ] TEFRA
Boxes:       [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)	5,359	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,359	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)	4,072	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)		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)	588	15
16	Nursery days (title V or XIX only)	38	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)	6,005,484	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)	6,005,484	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)	6,005,484	37

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

```
Check         [  ] Title V - I/P          [XX] Hospital     [  ] SUB (Other)          [XX] PPS
Applicable    [  ] Title XVIII, Part A    [  ] IPF                                    [  ] TEFRA
Boxes:        [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)	1,120.64	38
39	Program general inpatient routine service cost (line 9 x line 38)		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)		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)	657,693	588	1,118.53	38	42,504	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	2,362,980	1,179	2,004.22	4	8,017	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)	685,981	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	736,502	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,096	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	53,714	51
52	Total Program excludable cost (sum of lines 50 and 51)	54,810	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	681,692	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 16:52 Version: 2016.05 (09/21/2016)

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,287	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 21)	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 16:52 Version: 2016.05 (09/21/2016)

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

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		2,541,553		30
31	Intensive Care Unit		1,689,111		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.221754	2,230,411	494,603	50
52	Delivery Room & Labor Room	0.541552			52
54	Radiology-Diagnostic	0.179496	759,036	136,244	54
55	Radiology-Therapeutic	0.295626	17,905	5,293	55
57	CT Scan	0.023034	1,134,588	26,134	57
59	Cardiac Catheterization	0.451877			59
60	Laboratory	0.183820	2,117,583	389,254	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.186624	1,047,406	195,471	65
66	Physical Therapy	0.413617	383,194	158,496	66
66.01	PHYSICAL THERAPY - LIFEPLEX	0.468571			66.01
72	Impl. Dev. Charged to Patients	0.574052	653,513	375,150	72
73	Drugs Charged to Patients	0.356082	1,394,761	496,649	73
76.97	CARDIAC REHABILITATION	10.212903			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.229792			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	1.487103			90.03
90.04	WOUND CARE	0.726683			90.04
91	Emergency	0.290600	842,984	244,971	91
92	Observation Beds (Non-Distinct Part)	0.457460	189,482	86,680	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		10,770,863	2,608,945	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		10,770,863		202

(A) Worksheet A line numbers

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

```
Check        [  ] Title V                [XX] Hospital    [  ] SUB (Other)       [  ] Swing Bed SNF    [XX] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF         [  ] SNF               [  ] Swing Bed NF     [  ] TEFRA
Boxes:       [XX] 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		2,104,924		30
31	Intensive Care Unit		496,596		31
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.221754	1,081,845	239,903	50
52	Delivery Room & Labor Room	0.541552			52
54	Radiology-Diagnostic	0.179496	137,795	24,734	54
55	Radiology-Therapeutic	0.295626			55
57	CT Scan	0.023034	218,200	5,026	57
59	Cardiac Catheterization	0.451877	1,409	637	59
60	Laboratory	0.183820	513,925	94,470	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.186624	231,904	43,279	65
66	Physical Therapy	0.413617	25,415	10,512	66
66.01	PHYSICAL THERAPY - LIFEPLEX	0.468571			66.01
72	Impl. Dev. Charged to Patients	0.574052			72
73	Drugs Charged to Patients	0.356082	551,063	196,224	73
76.97	CARDIAC REHABILITATION	10.212903			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.229792			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	1.487103			90.03
90.04	WOUND CARE	0.726683			90.04
91	Emergency	0.290600	244,997	71,196	91
92	Observation Beds (Non-Distinct Part)	0.457460			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,006,553	685,981	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,006,553		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)	1,041,120			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,310,425			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)	29,579			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	1,481,577			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	41.13			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)	0.0397			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2090			31
32	Sum of lines 30 and 31	0.2487			32
33	Allowable disproportionate share percentage (see instructions)	0.0973			33
34	Disproportionate share adjustment (see instructions)	105,851			34
	Uncompensated Care Adjustment	**Prior to October 1 (1.00)**	**(1.01)**	**On or after October 1 (2.00)**	
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)	296,602		246,794	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	74,760		184,758	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	259,518			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)	4,746,493			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)	4,746,493			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	349,151			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)	464			58
59	Total (sum of amounts on lines 49 through 58)	5,096,108			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	5,096,108			61
62	Deductibles billed to program beneficiaries	635,404			62
63	Coinsurance billed to program beneficiaries	1,288			63
64	Allowable bad debts (see instructions)	59,878			64
65	Adjusted reimbursable bad debts (see instructions)	38,921			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,066			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,498,337			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)	-743			70.93
70.94	HRR adjustment amount (see instructions)	-31,657			70.94
70.96	Low volume adjustment for federal fiscal year (2015)	105,240			70.96
70.97	Low volume adjustment for federal fiscal year (2016)	528,011			70.97
70.99	HAC adjustment amount (see instructions)	56,965			70.99
71	Amount due provider (see instructions)	5,042,223			71
71.01	Sequestration adjustment (see instructions)	100,844			71.01
72	Interim payments	4,857,489			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	83,890			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	64,812			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					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	1,041,120		1,041,120				1,041,120	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	3,310,425				3,310,425		3,310,425	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	29,579		10,865		18,714		29,579	2
2.01	Outlier payment for discharges for Model 4 BPCI								2.01
3	Operating outlier reconciliation								3
4	Managed Care Simulated Payments	1,481,577		209,236		1,272,341		1,481,577	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	0.0973	0.0973	0.0973	0.0973	0.0973	0.0973		10
11	Disproportionate share adjustment	105,851		25,325		80,526		105,851	11
11.01	Uncompensated care payments	259,518		74,760		184,758		259,518	11.01
	Additional payment for high percentage of ESRD beneficiary discharges								
12	Total ESRD additional payment								12
13	Subtotal	4,746,493		1,152,070		3,594,423		4,746,493	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	4,746,493		1,152,070		3,594,423		4,746,493	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	349,151		83,447		265,704		349,151	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**			1,235,517		3,860,127		5,095,644	19
20	Capital DRG other than outlier	345,802		82,435		263,367		345,802	20
20.01	Model 4 BPCI Capital DRG other than outlier								20.01
21	Capital DRG outlier payments	3,349		1,012		2,337		3,349	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	349,151		83,447		265,704		349,151	26
27	**Low volume adjustment factor**			0.085179		0.136786			27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.96)(prior to 10/1)			105,240				105,240	28
29	Low Volume Adjustment (transfer amount to Worksheet E, Part A, line 70.97)(on/after 10/1)					528,011		528,011	29

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCLUATION **EXHIBIT 5**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1		On or after 10/1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1,041,120	1,041,120				1,041,120	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	3,310,425			3,310,425		3,310,425	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	29,579	10,865		18,714		29,579	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	1,481,577	209,236		1,272,341		1,481,577	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	0.0973	0.0973	0.0973	0.0973	0.0973		10
11	Disproportionate share adjustment	105,851	25,325		80,526		105,851	11
11.01	Uncompensated care payments	259,518	74,760		184,758		259,518	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	4,746,493	1,152,070		3,594,423		4,746,493	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	4,746,493	1,152,070		3,594,423		4,746,493	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	349,151	83,448		265,703		349,151	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**		1,235,518		3,860,126		5,095,644	19
20	Capital DRG other than outlier	345,802	82,436		263,366		345,802	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	3,349	1,012		2,337		3,349	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	349,151	83,448		265,703		349,151	26
27								27
28	Low volume adjustment prior to October 1	105,240	105,240				105,240	28
29	Low volume adjustment on or after October 1	528,011			528,011		528,011	29
30	HVBP payment adjustment	-743	961		-1,704		-743	30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-31,657	-13,118		-18,539		-31,657	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment		13,286		43,679		56,965	32

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)	13,807			1
2	Medical and other services reimbursed under OPPS (see instructions)	5,431,736			2
3	PPS payments	4,690,528			3
4	Outlier payment (see instructions)	46,622			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	1,189			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	13,807			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	38,775			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)	38,775			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)	38,775			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	24,968			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)	13,807			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)	4,738,339			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,019,754			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)	3,732,392			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)	3,732,392			30
31	Primary payer payments	988			31
32	Subtotal (line 30 minus line 31)	3,731,404			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)	201,710			34
35	Adjusted reimbursable bad debts (see instructions)	131,112			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	134,007			36
37	Subtotal (see instructions)	3,862,516			37
38	MSP-LCC reconciliation amount from PS&R	-76			38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	3,862,592			40
40.01	Sequestration adjustment (see instructions)	77,252			40.01
41	Interim payments	3,776,951			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	8,389			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        [XX] Hospital     [  ] SUB (Other)
Applicable   [  ] IPF          [  ] SNF
Boxes:       [  ] IRF          [  ] Swing Bed SNF
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	DESCRIPTION			INPATIENT PART A mm/dd/yyyy	AMOUNT	PART B mm/dd/yyyy	AMOUNT	
				1	2	3	4	
1	Total interim payments paid to provider				4,857,489		3,751,851	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			01/26/2016	25,100	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				25,100	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)				4,857,489		3,776,951	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		83,890		8,389	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				4,941,379		3,785,340	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)	1,871	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	2,185	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	714	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	5,251	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	162,109,342	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	3,337,419	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)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		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        [  ] Title V          [XX] Hospital       [  ] NF          [XX] PPS
Applicable   [XX] Title XIX        [  ] SUB (Other)    [  ] ICF/IID     [  ] TEFRA
Boxes:                             [  ] SNF                             [  ] 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			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	3,006,553		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)	3,006,553		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)	3,006,553		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	3,006,553		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)			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	135		26
27	Subtotal (sum of lines 22 through 26)	135		27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	135		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)	135		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)	135		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	135		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)	135		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	135		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	36,553,891				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	9,252,056				4
5	Other receivables	-564,326				5
6	Allowances for uncollectible notes and accounts receivable	-1,847,411				6
7	Inventory	1,018,214				7
8	Prepaid expenses	47,379				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	44,459,803				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings					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	27,829,954				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)	27,829,954				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	119,704				34
35	Total other assets (sum of lines 31-34)	119,704				35
36	Total assets (sum of lines 11, 30 and 35)	72,409,461				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	2,929,020				37
38	Salaries, wages and fees payable	2,298,352				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	119,975				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	-133,386				44
45	Total current liabilities (sum of lines 37 thru 44)	5,213,961				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	6,012,136				47
48	Unsecured loans					48
49	Other long term liabilities	82,204				49
50	Total long term liabilities (sum of lines 46 thru 49)	6,094,340				50
51	Total liabilities (sum of lines 45 and 50)	11,308,301				51
	CAPITAL ACCOUNTS					
52	General fund balance	61,101,160				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)	61,101,160				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	72,409,461				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		56,081,161			1
2	Net income (loss) (from Worksheet G-3, line 29)		4,834,904			2
3	Total (sum of line 1 and line 2)		60,916,065			3
4	Additions (credit adjustments) (specify)					4
5	TOT NA REL FROM RESTR - CAP ACQ	185,095				5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		185,095			10
11	Subtotal (line 3 plus line 10)		61,101,160			11
12	Deductions (debit adjustments) (specify)					12
13	TOT UNREST NA REVENUE OVER EXP					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)		61,101,160			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	TOT NA REL FROM RESTR - CAP ACQ					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	TOT UNREST NA REVENUE OVER EXP					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	8,932,126		8,932,126	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)	8,932,126		8,932,126	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	3,998,907		3,998,907	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)	3,998,907		3,998,907	16
17	Total inpatient routine care services (sum of lines 10 and 16)	12,931,033		12,931,033	17
18	Ancillary services	26,636,017	123,553,393	150,189,410	18
19	Outpatient services		517,718	517,718	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)	39,567,050	124,071,111	163,638,161	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		47,172,808	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	NON OPERATING ITEMS			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)		47,172,808	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	163,638,161	1
2	Less contractual allowances and discounts on patients' accounts	112,180,499	2
3	Net patient revenues (line 1 minus line 2)	51,457,662	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	47,172,808	4
5	Net income from service to patients (line 3 minus line 4)	4,284,854	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)	-780,461	24
24.01	Other (RESTRICTED ASSETS RELEASED)	368,704	24.01
24.02	Other (OTHER REVENUE)	961,807	24.02
25	Total other income (sum of lines 6-24)	550,050	25
26	Total (line 5 plus line 25)	4,834,904	26
29	Net income (or loss) for the period (line 26 minus line 28)	4,834,904	29

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

```
Check        [  ] Title V                  [XX] Hospital          [XX] PPS
Applicable   [XX] Title XVIII, Part A      [  ] SUB (Other)       [  ] Cost Method
Boxes:       [  ] Title XIX
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PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	345,802	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	3,349	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)	14.54	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)	349,151	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

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

```
Check         [  ] Title V                  [XX] Hospital           [XX] PPS
Applicable    [  ] Title XVIII, Part A      [  ] SUB (Other)        [  ] Cost Method
Boxes:        [XX] Title XIX
```

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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 16:52 Version: 2016.05 (09/21/2016)

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
66.01	PHYSICAL THERAPY - LIFEPLEX							66.01
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