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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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: 11/29/2017 Time: 11:16 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 07/01/2016 and ending 06/30/2017, 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: 11/29/2017 11:16
Ro0A2hKDw.MDDEoC92gjyqt1UUyEB0
.W9Ox03y25Qvj8P1gB0jEMiJwlr1X8
yxk513A3Iq0y83cD

PI Encryption: 11/29/2017 11:16
1gP8I1GzueUp.PJmOxSzXPP0rnTAB0
Or4VH0R4:v9Czc0KVcqlEcu28.BJOM
welz0nYu8Q0NNUFr

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

CFO
Title

11/29/17
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		24,788	40,058		5,026,390	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		24,788	40,058		5,026,390	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 / 2016	To: 06 / 30 / 2017	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.	122	28		2	1,026	45	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)	N			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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	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	11/01/2017	Y	11/01/2017	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: DELAHANTYM@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	13,870			1,913	80	4,287	1
2	HMO and other (see instructions)						1,161	1,035		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		38	13,870			1,913	80	4,287	7
8	Intensive Care Unit	31	7	2,555			486	9	1,181	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						46	554	13
14	Total (see instructions)		45	16,425			2,399	135	6,022	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		45							27
28	Observation Bed Days							241	1,427	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								60	30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)						2	53	72	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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)					734	20	2,044	1
2	HMO and other (see instructions)					354	289		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)		287.40	100.00		734	20	2,044	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		287.40	100.00					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	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	17,809,997		17,809,997	622,403.00	28.61	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative		91,416		91,416	2,469.00	37.03	4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		127,016		127,016	2,395.00	53.03	5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		1,157,229	-2,424	1,154,805	11,480.00	100.59	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		274,357		274,357	4,398.00	62.38	11
12	Contract management and administrative services		661,086		661,086	9,842.00	67.17	12
13	Contract labor: Physician-Part A - Administrative		509,537		509,537	3,003.00	169.68	13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		8,185,565		8,185,565	96,070.00	85.20	14.01
14.02	Related organization salaries							14.02
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)		3,468,765		3,468,765			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		196,729		196,729			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative		15,541		15,541			22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		21,593		21,593			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related		1,676,561		1,676,561			25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		73,288		73,288	2,160.00	33.93	26
27	Administrative & General		2,222,572	2,424	2,224,996	73,440.00	30.30	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		382,109		382,109	14,904.00	25.64	30
31	Laundry & Linen Service							31
32	Housekeeping		367,864		367,864	31,303.00	11.75	32
33	Housekeeping under contract (see instructions)		365,040		365,040	30,252.00	12.07	33
34	Dietary		233,318		233,318	18,023.00	12.95	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		407,741		407,741	11,013.00	37.02	38
39	Central Services and Supply							39
40	Pharmacy		577,068		577,068	14,301.00	40.35	40
41	Medical Records & Medical Records Library		190,613		190,613	9,814.00	19.42	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	18,149,794		18,149,794	651,384.00	27.86	1
2	Excluded area salaries (see instructions)	1,157,229	-2,424	1,154,805	11,480.00	100.59	2
3	Subtotal salarles (line 1 minus line 2)	16,992,565	2,424	16,994,989	639,904.00	26.56	3
4	Subtotal other wages & related costs (see instructions)	9,630,545		9,630,545	113,313.00	84.99	4
5	Subtotal wage-related costs (see instructions)	5,160,867		5,160,867		30.37%	5
6	Total (sum of lines 3 through 5)	31,783,977	2,424	31,786,401	753,217.00	42.20	6
7	Total overhead cost (see instructions)	4,921,386	2,424	4,923,810	206,334.00	23.86	7

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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	242,090	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)	157,206	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	178,122	7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	965,146	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan	933,633	9
10	Dental, Hearing and Vision Plan	114,859	10
11	Life Insurance (If employee is owner or beneficiary)	27,866	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	108,980	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	159,537	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	812,763	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	2,424	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		23
24	Total Wage Related cost (Sum of lines 1-23)	3,702,626	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	14,885	25

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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)	0.256529	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	6,382,000	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	29,192,000	6
7	Medicaid cost (line 1 times line 6)	7,488,595	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.	1,106,595	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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (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)	1,106,595	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,340,188	487,548	2,827,736	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	600,326	487,548	1,087,874	21
22	Payments received from patients for amounts previously written off as charity care	15,916	28,556	44,472	22
23	Cost of charity care (line 21 minus line 22)	584,410	458,992	1,043,402	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, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	5,906,510	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	203,304	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	312,775	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	5,593,735	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,544,426	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	2,587,828	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,694,423	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				1,924,854	1,924,854	354,438	2,279,292	1
2	00200	Cap Rel Costs-Mvble Equip				2,118,834	2,118,834		2,118,834	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	73,288	571,585	644,873		644,873	-1,386	643,487	4
5	00500	Administrative & General	2,222,572	11,001,305	13,223,877	-1,133,646	12,090,231	1,744,405	13,834,636	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	382,109	2,345,747	2,727,856	-393,005	2,334,851	-4,950	2,329,901	7
8	00800	Laundry & Linen Service		146,699	146,699		146,699		146,699	8
9	00900	Housekeeping	367,864	278,603	646,467	-1,741	644,726	-62,500	582,226	9
10	01000	Dietary	233,318	494,370	727,688	-22,845	704,843	-216,399	488,444	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	407,741	115,251	522,992	-51,307	471,685		471,685	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	577,068	1,749,245	2,326,313	-1,635,074	691,239		691,239	15
16	01600	Medical Records & Library	190,613	154,019	344,632		344,632		344,632	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)	2,424	846	3,270	-3,270		-1,158	-1,158	23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	2,553,205	873,331	3,426,536	-904,301	2,522,235		2,522,235	30
31	03100	Intensive Care Unit	840,993	302,190	1,143,183	-7,521	1,135,662	-35,423	1,100,239	31
43	04300	Nursery				387,517	387,517		387,517	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,924,632	3,716,715	5,641,347	-1,299,683	4,341,664	-1,050,490	3,291,174	50
52	05200	Delivery Room & Labor Room				387,517	387,517		387,517	52
54	05400	Radiology-Diagnostic	973,158	712,209	1,685,367	-309,103	1,376,264	-21,499	1,354,765	54
55	05500	Radiology-Therapeutic	416,533	1,079,630	1,496,163	-328,751	1,167,412	-152,696	1,014,716	55
57	05700	CT Scan	87,182	255,624	342,806	-161,472	181,334		181,334	57
59	05900	Cardiac Catheterization	54,692	213,138	267,830	-165,966	101,864		101,864	59
60	06000	Laboratory	1,221,874	2,176,197	3,398,071	-77,990	3,320,081	-4,206	3,315,875	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	458,137	357,665	815,802	-47,270	768,532	-17,880	750,652	65
66	06600	Physical Therapy	755,375	223,696	979,071	-82,153	896,918		896,918	66
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	631,516	225,547	857,063	-105,898	751,165		751,165	66.01
71	07100	Medical Supplies Charged to Patients				200,242	200,242		200,242	71
72	07200	Impl. Dev. Charged to Patients				986,089	986,089		986,089	72
73	07300	Drugs Charged to Patients				1,579,601	1,579,601		1,579,601	73
76.97	07697	CARDIAC REHABILITATION	51,012	42,639	93,651	-26,480	67,171		67,171	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				60,645	60,645		60,645	76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	1,882	700	2,582		2,582		2,582	90.01
90.02	09002	ATHLETIC TRAINERS	241,290	73,041	314,331		314,331	-112,861	201,470	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	323,492	272,873	596,365	-128,819	467,546	-109,066	358,480	90.03
90.04	09004	WOUND CARE	168,668	697,042	865,710	-151,511	714,199		714,199	90.04
91	09100	Emergency	1,494,554	1,854,985	3,349,539	-607,493	2,742,046	-45,970	2,696,076	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)	16,655,192	29,934,892	46,590,084		46,590,084	262,359	46,852,443	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	326,181	5,671	331,852		331,852		331,852	192
192.01	19201	FOUNDATION ADMINISTATION								192.01
192.02	19202	HOSPITALIST	765,648	1,121,881	1,887,529		1,887,529		1,887,529	192.02
192.03	19203	INTENSIVIST		1,268,919	1,268,919		1,268,919		1,268,919	192.03
194	07950	PLYMOUTH MOB-4		145,621	145,621		145,621		145,621	194
194.01	07951	COMMUNITY OUTREACH & PARTNERSHIP	62,976	13,572	76,548		76,548		76,548	194.01
200		TOTAL (sum of lines 118-199)	17,809,997	32,490,556	50,300,553		50,300,553	262,359	50,562,912	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-Bldg & Fixt	1		528,418	1
2			Cap Rel Costs-Mvble Equip	2		171,307	2
3			Cap Rel Costs-Bldg & Fixt	1		328,974	3
4			Cap Rel Costs-Mvble Equip	2		64,031	4
5			Cap Rel Costs-Mvble Equip	2		1,741	5
6			Cap Rel Costs-Mvble Equip	2		2,472	6
7			Cap Rel Costs-Bldg & Fixt	1		1,377	7
8			Cap Rel Costs-Mvble Equip	2		18,996	8
9			Cap Rel Costs-Bldg & Fixt	1		25,316	9
10			Cap Rel Costs-Mvble Equip	2		25,991	10
11			Cap Rel Costs-Bldg & Fixt	1		825	11
12			Cap Rel Costs-Mvble Equip	2		54,648	12
13			Cap Rel Costs-Bldg & Fixt	1		17,395	13
14			Cap Rel Costs-Mvble Equip	2		111,872	14
15			Cap Rel Costs-Mvble Equip	2		7,521	15
16			Cap Rel Costs-Mvble Equip	2		10,800	16
17			Cap Rel Costs-Bldg & Fixt	1		25,831	17
18			Cap Rel Costs-Mvble Equip	2		277,410	18
19			Cap Rel Costs-Bldg & Fixt	1		14,079	19
20			Cap Rel Costs-Mvble Equip	2		295,024	20
21			Cap Rel Costs-Bldg & Fixt	1		12,185	21
22			Cap Rel Costs-Mvble Equip	2		316,566	22
23			Cap Rel Costs-Mvble Equip	2		161,472	23
24			Cap Rel Costs-Bldg & Fixt	1		513	24
25			Cap Rel Costs-Mvble Equip	2		165,032	25
26			Cap Rel Costs-Bldg & Fixt	1		1,653	26
27	.	A	Cap Rel Costs-Mvble Equip	2		124	27
28			Cap Rel Costs-Mvble Equip	2		76,187	28
29			Cap Rel Costs-Mvble Equip	2		53	29
30			Cap Rel Costs-Bldg & Fixt	1		408	30
31			Cap Rel Costs-Mvble Equip	2		2,000	31
32			Cap Rel Costs-Mvble Equip	2		44,809	32
33			Cap Rel Costs-Bldg & Fixt	1		73,525	33
34			Cap Rel Costs-Bldg & Fixt	1		4,774	34
35			Cap Rel Costs-Mvble Equip	2		3,854	35
36			Cap Rel Costs-Bldg & Fixt	1		93,068	36
37			Cap Rel Costs-Bldg & Fixt	1		4,612	37
38			Cap Rel Costs-Mvble Equip	2		8,218	38
39			Cap Rel Costs-Bldg & Fixt	1		22,266	39
40			Cap Rel Costs-Mvble Equip	2		4,214	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		24,061	45
46			Cap Rel Costs-Mvble Equip	2		164	46
47			Cap Rel Costs-Bldg & Fixt	1		323,342	47
48			Cap Rel Costs-Mvble Equip	2		2,975	48
49			Cap Rel Costs-Mvble Equip	2		281,176	49
500	Total reclassifications					3,806,739	500
	Code Letter - A						
1	DRUGS CHARGED TO PATIENTS	B	Drugs Charged to Patients	73		1,579,601	1
500	Total reclassifications					1,579,601	500
	Code Letter - B						
1	INTEREST EXPENSE	C	Interest Expense	113		236,949	1
2			Cap Rel Costs-Bldg & Fixt	1		236,949	2
500	Total reclassifications					473,898	500
	Code Letter - C						
1	NURSERY - LABOR/DELIVERY RECLASS	D	Nursery	43	291,721	95,796	1
2			Delivery Room & Labor Room	52	291,721	95,796	2
500	Total reclassifications				583,442	191,592	500
	Code Letter - D						
1	IMPLANTS RECLASS	E	Impl. Dev. Charged to Patient	72		985,642	1
2			Impl. Dev. Charged to Patient	72		421	2
3			Impl. Dev. Charged to Patient	72		26	3
500	Total reclassifications					986,089	500
	Code Letter - E						
1	RECLASS A6 NEGATIVE AMOUNT LINE 71	F	Medical Supplies Charged to P	71		200,242	1
500	Total reclassifications					200,242	500
	Code Letter - F						

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS HBO COST FROM WOUND CARE	G	HYPERBARIC OXYGEN THERAPY	76.98	59,474	1,171	1
500	Total reclassifications				59,474	1,171	500
	Code Letter - G						
1	PARAMEDIC EDUCATION EXPENSE RECLASS	H	Administrative & General	5	2,424	846	1
500	Total reclassifications				2,424	846	500
	Code Letter - H						
	GRAND TOTAL (Increases)				645,340	7,240,178	

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

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DEPRECIATION RECLASSIFICATONS	A	Administrative & General	5		528,418	9	1
2			Administrative & General	5		171,307	9	2
3			Operation of Plant	7		328,974	9	3
4			Operation of Plant	7		64,031	9	4
5			Housekeeping	9		1,741	9	5
6			Dietary	10		2,472	10	6
7			Dietary	10		1,377	9	7
8			Dietary	10		18,996	9	8
9			Nursing Administration	13		25,316	9	9
10			Nursing Administration	13		25,991	9	10
11			Pharmacy	15		825	9	11
12			Pharmacy	15		54,648	9	12
13			Adults & Pediatrics	30		17,395	9	13
14			Adults & Pediatrics	30		111,872	9	14
15			Intensive Care Unit	31		7,521	9	15
16			Operating Room	50		10,800	10	16
17			Operating Room	50		25,831	9	17
18			Operating Room	50		277,410	9	18
19			Radiology-Diagnostic	54		14,079	9	19
20			Radiology-Diagnostic	54		295,024	9	20
21			Radiology-Therapeutic	55		12,185	9	21
22			Radiology-Therapeutic	55		316,566	9	22
23			CT Scan	57		161,472	9	23
24			Cardiac Catheterization	59		513	9	24
25			Cardiac Catheterization	59		165,032	9	25
26			Laboratory	60		1,653	9	26
27	.	A	Laboratory	60		124	9	27
28			Laboratory	60		76,187	9	28
29			Respiratory Therapy	65		53	10	29
30			Respiratory Therapy	65		408	9	30
31			Respiratory Therapy	65		2,000	9	31
32			Respiratory Therapy	65		44,809	9	32
33			Physical Therapy	66		73,525	10	33
34			Physical Therapy	66		4,774	9	34
35			Physical Therapy	66		3,854	9	35
36			PHYSICAL THERAPY - LIFEPLEX	66.01		93,068	10	36
37			PHYSICAL THERAPY - LIFEPLEX	66.01		4,612	9	37
38			PHYSICAL THERAPY - LIFEPLEX	66.01		8,218	9	38
39			CARDIAC REHABILITATION	76.97		22,266	10	39
40			CARDIAC REHABILITATION	76.97		4,214	9	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		24,061	9	45
46			WOUND CARE	90.04		164	9	46
47			Emergency	91		323,342	9	47
48			Emergency	91		2,975	9	48
49			Emergency	91		281,176	9	49
500	Total reclassifications					3,806,739		500
	Code letter - A							
1	DRUGS CHARGED TO PATIENTS	B	Pharmacy	15		1,579,601		1
500	Total reclassifications					1,579,601		500
	Code letter - B							
1	INTEREST EXPENSE	C	Administrative & General	5		236,949	11	1
2			Interest Expense	113		236,949	11	2
500	Total reclassifications					473,898		500
	Code letter - C							
1	NURSERY - LABOR/DELIVERY RECLASS	D	Adults & Pediatrics	30	291,721	95,796		1
2			Adults & Pediatrics	30	291,721	95,796		2
500	Total reclassifications				583,442	191,592		500
	Code letter - D							
1	IMPLANTS RECLASS	E	Operating Room	50		985,642		1
2			Cardiac Catheterization	59		421		2
3			Laboratory	60		26		3
500	Total reclassifications					986,089		500
	Code letter - E							
1	RECLASS A6 NEGATIVE AMOUNT LINE 71	F	Administrative & General	5		200,242		1
500	Total reclassifications					200,242		500
	Code letter - F							

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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	RECLASS HBO COST FROM WOUND CARE	G	WOUND CARE	90.04	59,474	1,171		1
500	Total reclassifications				59,474	1,171		500
	Code letter - G							
1	PARAMEDIC EDUCATION EXPENSE RECLASS	H	PARAMED ED PRGM-(SPECIFY)	23	2,424	846		1
500	Total reclassifications				2,424	846		500
	Code letter - H							
	GRAND TOTAL (Decreases)				645,340	7,240,178		

(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	42,652,438	1,538,670		1,538,670	116,737	44,074,371	13,883,514	3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	25,486,912	1,445,422		1,445,422	663,022	26,269,312	9,886,827	6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	68,617,280	2,984,092		2,984,092	779,759	70,821,613	23,770,341	8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	68,617,280	2,984,092		2,984,092	779,759	70,821,613	23,770,341	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	1,981,332	297,960					2,279,292	1
2	Cap Rel Costs-Mvble Equip	2,105,509	13,325					2,118,834	2
3	Total (sum of lines 1-2)	4,086,841	311,285					4,398,126	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)	B	-236,949	Cap Rel Costs-Bldg & Fixt	1	11	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	-1,148,355				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	826,192				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-216,399	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	1,522,925	Administrative & General	5		33
34	HOSPITAL DONATION EXPENSE	A	36,341	Administrative & General	5		34
34.01	HOSPITAL DONATION EXPENSE	A	2,940	ATHLETIC TRAINERS	90.02		34.01
35	OFFSET OTHER REVENUE	B	-1,386	Employee Benefits Department	4		35
35.01	OFFSET OTHER REVENUE	B	-49,666	Administrative & General	5		35.01
35.02	OFFSET OTHER REVENUE	B	-4,950	Operation of Plant	7		35.02
35.03	OFFSET OTHER REVENUE	B	-62,500	Housekeeping	9		35.03
35.05	OFFSET OTHER REVENUE	B	-1,158	PARAMED ED PRGM-(SPECIFY)	23		35.05
35.06	OFFSET OTHER REVENUE	B	-198	Operating Room	50		35.06
35.07	OFFSET OTHER REVENUE	B	-10,046	Radiology-Diagnostic	54		35.07
35.08	OFFSET OTHER REVENUE	B	-152,590	Radiology-Therapeutic	55		35.08
35.09	OFFSET OTHER REVENUE	B	-4,206	Laboratory	60		35.09
35.10	OFFSET OTHER REVENUE	B	-17,880	Respiratory Therapy	65		35.10
35.11	OFFSET OTHER REVENUE	B	-109,250	ATHLETIC TRAINERS	90.02		35.11
35.12	OFFSET OTHER REVENUE	B	-109,066	SAINT JOSEPH HEALTH CENTER	90.03		35.12
35.13	OFFSET OTHER REVENUE	B	-1,440	Emergency	91		35.13
36							36
37							37
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		262,359				50

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	

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

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

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	HO NON CAPITAL COSTS	8,705,230	8,361,139	344,091		1
2	5	Administrative & General	WORKER'S COMP	159,537	58,619	100,918		2
3	5	Administrative & General	INSURANCE	200,470	683,820	-483,350		3
3.01	5	Administrative & General	PENSION	157,206	-80,418	237,624		3.01
3.02	5	Administrative & General	RETIREE HEALTH COSTS		-35,522	35,522		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			9,813,830	8,987,638	826,192		5

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

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	G			CHE TRINITY HEALTH		HO OF PARENT COMPANY	6
7	G			SJRMC - INC		PARENT COMPANY	7
8	G	SJRMC - SOUTH BEND CAMPUS					8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify: FINANCIAL

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	31	Intensive Care Unit A	72,944		72,944	192,700	405	37,521	1,876	1
2	50	Operating Room B	1,050,292	1,050,292		240,300				2
3	54	Radiology-Diagnostic C	27,263		27,263	265,200	124	15,810	791	3
4	55	Radiology-Therapeuti D	13,000		13,000	206,300	130	12,894	645	4
5	60	Laboratory E	25,001		25,001	253,900	384	46,874	2,344	5
6	90.02	ATHLETIC TRAINERS F	19,445		19,445	206,300	130	12,894	645	6
7	91	Emergency G	117,231		117,231	206,300	733	72,701	3,635	7
8										8
9										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	1,325,176	1,050,292	274,884		1,906	198,694	9,936	200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	31	Intensive Care Unit A					37,521	35,423	35,423	1
2	50	Operating Room B							1,050,292	2
3	54	Radiology-Diagnostic C					15,810	11,453	11,453	3
4	55	Radiology-Therapeuti D					12,894	106	106	4
5	60	Laboratory E					46,874			5
6	90.02	ATHLETIC TRAINERS F					12,894	6,551	6,551	6
7	91	Emergency G					72,701	44,530	44,530	7
8										8
9										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					198,694	98,063	1,148,355	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	2,279,292	2,279,292					1
2	Cap Rel Costs-Mvble Equip	2,118,834		2,118,834				2
4	Employee Benefits Department	643,487			643,487			4
5	Administrative & General	13,834,636	255,863	237,850	80,721	14,409,070	14,409,070	5
6	Maintenance & Repairs							6
7	Operation of Plant	2,329,901	483,902	449,838	13,863	3,277,504	1,306,203	7
8	Laundry & Linen Service	146,699	8,664	8,054		163,417	65,128	8
9	Housekeeping	582,226	4,289	3,987	13,346	603,848	240,655	9
10	Dietary	488,444	29,979	27,869	8,465	554,757	221,091	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	471,685			14,793	486,478	193,879	13
14	Central Services & Supply							14
15	Pharmacy	691,239	17,742	16,493	20,936	746,410	297,471	15
16	Medical Records & Library	344,632	35,941	33,411	6,915	420,899	167,743	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)	-1,158				-1,158		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,522,235	277,178	257,665	71,463	3,128,541	1,246,836	30
31	Intensive Care Unit	1,100,239	53,154	49,412	30,511	1,233,316	491,521	31
43	Nursery	387,517			10,584	398,101	158,658	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,291,174	275,206	255,832	69,826	3,892,038	1,551,116	50
52	Delivery Room & Labor Room	387,517			10,584	398,101	158,658	52
54	Radiology-Diagnostic	1,354,765	103,849	96,538	35,306	1,590,458	633,855	54
55	Radiology-Therapeutic	1,014,716	129,383	120,274	15,112	1,279,485	509,921	55
57	CT Scan	181,334	5,990	5,568	3,163	196,055	78,135	57
59	Cardiac Catheterization	101,864	30,352	28,215	1,984	162,415	64,728	59
60	Laboratory	3,315,875	62,133	57,759	44,330	3,480,097	1,386,944	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	750,652	47,421	44,083	16,621	858,777	342,254	65
66	Physical Therapy	896,918	83,591	77,706	27,405	1,085,620	432,659	66
66.01	PHYSICAL THERAPY - LIFEPLEX	751,165			22,911	774,076	308,497	66.01
71	Medical Supplies Charged to Patients	200,242				200,242	79,804	71
72	Impl. Dev. Charged to Patients	986,089				986,089	392,992	72
73	Drugs Charged to Patients	1,579,601				1,579,601	629,528	73
76.97	CARDIAC REHABILITATION	67,171			1,851	69,022	27,508	76.97
76.98	HYPERBARIC OXYGEN THERAPY	60,645	7,763	7,217	2,158	77,783	30,999	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR	2,582			68	2,650	1,056	90.01
90.02	ATHLETIC TRAINERS	201,470			8,754	210,224	83,782	90.02
90.03	SAINT JOSEPH HEALTH CENTER	358,480			11,736	370,216	147,544	90.03
90.04	WOUND CARE	714,199	36,928	34,328	3,962	789,417	314,611	90.04
91	Emergency	2,696,076	117,333	109,073	54,222	2,976,704	1,186,324	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)	46,852,443	2,066,661	1,921,172	601,590	46,400,253	12,750,100	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,716	2,525		5,241	2,089	190
192	Physicians' Private Offices	331,852	209,915	195,137	11,834	748,738	298,399	192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST	1,887,529			27,778	1,915,307	763,319	192.02
192.03	INTENSIVIST	1,268,919				1,268,919	505,710	192.03
194	PLYMOUTH MOB-4	145,621				145,621	58,035	194
194.01	COMMUNITY OUTREACH & PARTNERSHIP	76,548			2,285	78,833	31,418	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	50,562,912	2,279,292	2,118,834	643,487	50,562,912	14,409,070	202

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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	4,583,707						7
8	Laundry & Linen Service	25,796	254,341					8
9	Housekeeping	12,770		857,273				9
10	Dietary	89,259		16,835	881,942			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration					680,357		13
14	Central Services & Supply							14
15	Pharmacy	52,825		9,963			1,106,669	15
16	Medical Records & Library	107,008		20,183				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	825,256	16,215	155,655	661,456	196,655	189	30
31	Intensive Care Unit	158,259	5,982	29,850	220,486	65,273		31
43	Nursery					23,307		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	819,385	45,406	154,547		153,037	6,896	50
52	Delivery Room & Labor Room		2,532			23,307		52
54	Radiology-Diagnostic	309,194	23,233	58,318			60,560	54
55	Radiology-Therapeutic	385,217	11,865	72,657		29,973		55
57	CT Scan	17,834	29,692	3,364			21,415	57
59	Cardiac Catheterization	90,367	1,124	17,044		3,942	202	59
60	Laboratory	184,991	46,275	34,892			52	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	141,189	11,892	26,630			14	65
66	Physical Therapy	248,879	5,791	46,942				66
66.01	PHYSICAL THERAPY - LIFEPLEX		4,938					66.01
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients		4,361					72
73	Drugs Charged to Patients		12,589				1,004,547	73
76.97	CARDIAC REHABILITATION		549			3,937		76.97
76.98	HYPERBARIC OXYGEN THERAPY	23,114	1,807	4,360		3,977		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR					355		90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER		456			27,912	2,142	90.03
90.04	WOUND CARE	109,947	2,670	20,737		12,681	10,619	90.04
91	Emergency	349,341	26,964	65,890		136,001	32	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)	3,950,631	254,341	737,867	881,942	680,357	1,106,668	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	8,087		1,525				190
192	Physicians' Private Offices	624,989		117,881				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						1	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,583,707	254,341	857,273	881,942	680,357	1,106,669	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	715,833						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)		-1,158					23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	45,638		6,276,441		6,276,441		30
31	Intensive Care Unit	16,837		2,221,524		2,221,524		31
43	Nursery			580,066		580,066		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	127,797		6,750,222		6,750,222		50
52	Delivery Room & Labor Room	7,127		589,725		589,725		52
54	Radiology-Diagnostic	65,392		2,741,010		2,741,010		54
55	Radiology-Therapeutic	33,394		2,322,512		2,322,512		55
57	CT Scan	83,569		430,064		430,064		57
59	Cardiac Catheterization	3,163		342,985		342,985		59
60	Laboratory	130,217		5,263,468		5,263,468		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	33,472		1,414,228		1,414,228		65
66	Physical Therapy	16,298		1,836,189		1,836,189		66
66.01	PHYSICAL THERAPY - LIFEPLEX	13,899		1,101,410		1,101,410		66.01
71	Medical Supplies Charged to Patients			280,046		280,046		71
72	Impl. Dev. Charged to Patients	12,275		1,395,717		1,395,717		72
73	Drugs Charged to Patients	35,432		3,261,697		3,261,697		73
76.97	CARDIAC REHABILITATION	1,546		102,562		102,562		76.97
76.98	HYPERBARIC OXYGEN THERAPY	5,087		147,127		147,127		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR			4,061		4,061		90.01
90.02	ATHLETIC TRAINERS			294,006		294,006		90.02
90.03	SAINT JOSEPH HEALTH CENTER	1,283		549,553		549,553		90.03
90.04	WOUND CARE	7,515		1,268,197		1,268,197		90.04
91	Emergency	75,892		4,817,148		4,817,148		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)	715,833		43,989,958		43,989,958		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			16,942		16,942		190
192	Physicians' Private Offices			1,790,007		1,790,007		192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST			2,678,626		2,678,626		192.02
192.03	INTENSIVIST			1,774,629		1,774,629		192.03
194	PLYMOUTH MOB-4			203,656		203,656		194
194.01	COMMUNITY OUTREACH & PARTNERSHIP			110,252		110,252		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers		-1,158	-1,158		-1,158		201
202	TOTAL (sum of lines 118-201)	715,833	-1,158	50,562,912		50,562,912		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		255,863	237,850	493,713	493,713		5
6	Maintenance & Repairs							6
7	Operation of Plant		483,902	449,838	933,740	44,754	978,494	7
8	Laundry & Linen Service		8,664	8,054	16,718	2,231	5,507	8
9	Housekeeping		4,289	3,987	8,276	8,246	2,726	9
10	Dietary		29,979	27,869	57,848	7,575	19,054	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration					6,643		13
14	Central Services & Supply							14
15	Pharmacy		17,742	16,493	34,235	10,192	11,277	15
16	Medical Records & Library		35,941	33,411	69,352	5,747	22,843	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		277,178	257,665	534,843	42,720	176,169	30
31	Intensive Care Unit		53,154	49,412	102,566	16,841	33,784	31
43	Nursery					5,436		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		275,206	255,832	531,038	53,165	174,916	50
52	Delivery Room & Labor Room					5,436		52
54	Radiology-Diagnostic		103,849	96,538	200,387	21,718	66,004	54
55	Radiology-Therapeutic		129,383	120,274	249,657	17,471	82,233	55
57	CT Scan		5,990	5,568	11,558	2,677	3,807	57
59	Cardiac Catheterization		30,352	28,215	58,567	2,218	19,291	59
60	Laboratory		62,133	57,759	119,892	47,521	39,490	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		47,421	44,083	91,504	11,727	30,140	65
66	Physical Therapy		83,591	77,706	161,297	14,824	53,129	66
66.01	PHYSICAL THERAPY - LIFEPLEX					10,570		66.01
71	Medical Supplies Charged to Patients					2,734		71
72	Impl. Dev. Charged to Patients					13,465		72
73	Drugs Charged to Patients					21,569		73
76.97	CARDIAC REHABILITATION					942		76.97
76.98	HYPERBARIC OXYGEN THERAPY		7,763	7,217	14,980	1,062	4,934	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR					36		90.01
90.02	ATHLETIC TRAINERS					2,871		90.02
90.03	SAINT JOSEPH HEALTH CENTER					5,055		90.03
90.04	WOUND CARE		36,928	34,328	71,256	10,779	23,471	90.04
91	Emergency		117,333	109,073	226,406	40,647	74,575	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)		2,066,661	1,921,172	3,987,833	436,872	843,350	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,716	2,525	5,241	72	1,726	190
192	Physicians' Private Offices		209,915	195,137	405,052	10,224	133,418	192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST					26,154		192.02
192.03	INTENSIVIST					17,327		192.03
194	PLYMOUTH MOB-4					1,988		194
194.01	COMMUNITY OUTREACH & PARTNERSHIP					1,076		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,279,292	2,118,834	4,398,126	493,713	978,494	202

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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	24,456						8
9	Housekeeping		19,248					9
10	Dietary		378	84,855				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration				6,643			13
14	Central Services & Supply							14
15	Pharmacy		224			55,928		15
16	Medical Records & Library		453				98,395	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	1,564	3,495	63,641	1,920	10	6,276	30
31	Intensive Care Unit	577	670	21,214	637		2,315	31
43	Nursery				228			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,378	3,470		1,494	348	17,574	50
52	Delivery Room & Labor Room	244			228		980	52
54	Radiology-Diagnostic	2,240	1,309			3,061	8,993	54
55	Radiology-Therapeutic	1,144	1,631		293		4,592	55
57	CT Scan	2,863	76			1,082	11,492	57
59	Cardiac Catheterization	108	383		38	10	435	59
60	Laboratory	4,394	783			3	17,864	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,147	598			1	4,603	65
66	Physical Therapy	558	1,054				2,241	66
66.01	PHYSICAL THERAPY - LIFEPLEX	476					1,911	66.01
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	421					1,688	72
73	Drugs Charged to Patients	1,214				50,766	4,872	73
76.97	CARDIAC REHABILITATION	53			38		213	76.97
76.98	HYPERBARIC OXYGEN THERAPY	174	98		39		700	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR				3			90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER	44			273	108	176	90.03
90.04	WOUND CARE	257	466		124	537	1,033	90.04
91	Emergency	2,600	1,479		1,328	2	10,437	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)	24,456	16,567	84,855	6,643	55,928	98,395	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		34					190
192	Physicians' Private Offices		2,647					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)	24,456	19,248	84,855	6,643	55,928	98,395	202

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

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	830,638		830,638				30
31	Intensive Care Unit	178,604		178,604				31
43	Nursery	5,664		5,664				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	786,383		786,383				50
52	Delivery Room & Labor Room	6,888		6,888				52
54	Radiology-Diagnostic	303,712		303,712				54
55	Radiology-Therapeutic	357,021		357,021				55
57	CT Scan	33,555		33,555				57
59	Cardiac Catheterization	81,050		81,050				59
60	Laboratory	229,947		229,947				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	139,720		139,720				65
66	Physical Therapy	233,103		233,103				66
66.01	PHYSICAL THERAPY - LIFEPLEX	12,957		12,957				66.01
71	Medical Supplies Charged to Patients	2,734		2,734				71
72	Impl. Dev. Charged to Patients	15,574		15,574				72
73	Drugs Charged to Patients	78,421		78,421				73
76.97	CARDIAC REHABILITATION	1,246		1,246				76.97
76.98	HYPERBARIC OXYGEN THERAPY	21,987		21,987				76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR	39		39				90.01
90.02	ATHLETIC TRAINERS	2,871		2,871				90.02
90.03	SAINT JOSEPH HEALTH CENTER	5,656		5,656				90.03
90.04	WOUND CARE	107,923		107,923				90.04
91	Emergency	357,474		357,474				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)	3,793,167		3,793,167				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	7,073		7,073				190
192	Physicians' Private Offices	551,341		551,341				192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST	26,154		26,154				192.02
192.03	INTENSIVIST	17,327		17,327				192.03
194	PLYMOUTH MOB-4	1,988		1,988				194
194.01	COMMUNITY OUTREACH & PARTNERSHIP	1,076		1,076				194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,398,126		4,398,126				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			17,736,709				4
5	Administrative & General	225,502	225,502	2,224,996	-14,409,070	36,155,000		5
6	Maintenance & Repairs							6
7	Operation of Plant	426,483	426,483	382,109		3,277,504	1,356,845	7
8	Laundry & Linen Service	7,636	7,636			163,417	7,636	8
9	Housekeeping	3,780	3,780	367,864		603,848	3,780	9
10	Dietary	26,422	26,422	233,318		554,757	26,422	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration			407,741		486,478		13
14	Central Services & Supply							14
15	Pharmacy	15,637	15,637	577,068		746,410	15,637	15
16	Medical Records & Library	31,676	31,676	190,613		420,899	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)				1,158			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	244,288	244,288	1,969,763		3,128,541	244,288	30
31	Intensive Care Unit	46,847	46,847	840,993		1,233,316	46,847	31
43	Nursery			291,721		398,101		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	242,550	242,550	1,924,632		3,892,038	242,550	50
52	Delivery Room & Labor Room			291,721		398,101		52
54	Radiology-Diagnostic	91,526	91,526	973,158		1,590,458	91,526	54
55	Radiology-Therapeutic	114,030	114,030	416,533		1,279,485	114,030	55
57	CT Scan	5,279	5,279	87,182		196,055	5,279	57
59	Cardiac Catheterization	26,750	26,750	54,692		162,415	26,750	59
60	Laboratory	54,760	54,760	1,221,874		3,480,097	54,760	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	41,794	41,794	458,137		858,777	41,794	65
66	Physical Therapy	73,672	73,672	755,375		1,085,620	73,672	66
66.01	PHYSICAL THERAPY - LIFEPLEX			631,516		774,076		66.01
71	Medical Supplies Charged to Patients					200,242		71
72	Impl. Dev. Charged to Patients					986,089		72
73	Drugs Charged to Patients					1,579,601		73
76.97	CARDIAC REHABILITATION			51,012		69,022		76.97
76.98	HYPERBARIC OXYGEN THERAPY	6,842	6,842	59,474		77,783	6,842	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR			1,882		2,650		90.01
90.02	ATHLETIC TRAINERS			241,290		210,224		90.02
90.03	SAINT JOSEPH HEALTH CENTER			323,492		370,216		90.03
90.04	WOUND CARE	32,546	32,546	109,194		789,417	32,546	90.04
91	Emergency	103,410	103,410	1,494,554		2,976,704	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	16,581,904	-14,407,912	31,992,341	1,169,445	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,394	2,394			5,241	2,394	190
192	Physicians' Private Offices	185,006	185,006	326,181		748,738	185,006	192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST			765,648		1,915,307		192.02
192.03	INTENSIVIST					1,268,919		192.03
194	PLYMOUTH MOB-4					145,621		194
194.01	COMMUNITY OUTREACH & PARTNERSHIP			62,976		78,833		194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,279,292	2,118,834	643,487		14,409,070	4,583,707	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.134637	1.054760	0.036280		0.398536	3.378210	203
204	Cost to be allocated (Per Wkst. B, Part II)					493,713	978,494	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.013655	0.721154	205

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE GROSS REVENUE	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		8	9	10	13	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	171,481,752						8
9	Housekeeping		1,345,429					9
10	Dietary		26,422	100				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration				272,006			13
14	Central Services & Supply							14
15	Pharmacy		15,637			1,740,182		15
16	Medical Records & Library		31,676				171,481,752	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	10,933,813	244,288	75	78,623	297	10,933,813	30
31	Intensive Care Unit	4,033,817	46,847	25	26,096		4,033,817	31
43	Nursery				9,318			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	30,617,489	242,550		61,184	10,843	30,617,489	50
52	Delivery Room & Labor Room	1,707,442			9,318		1,707,442	52
54	Radiology-Diagnostic	15,666,512	91,526			95,228	15,666,512	54
55	Radiology-Therapeutic	8,000,399	114,030		11,983		8,000,399	55
57	CT Scan	20,021,266	5,279			33,674	20,021,266	57
59	Cardiac Catheterization	757,753	26,750		1,576	318	757,753	59
60	Laboratory	31,180,669	54,760			81	31,180,669	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	8,019,214	41,794			22	8,019,214	65
66	Physical Therapy	3,904,752	73,672				3,904,752	66
66.01	PHYSICAL THERAPY - LIFEPLEX	3,330,019					3,330,019	66.01
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	2,940,884					2,940,884	72
73	Drugs Charged to Patients	8,488,667				1,579,601	8,488,667	73
76.97	CARDIAC REHABILITATION	370,442			1,574		370,442	76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,218,698	6,842		1,590		1,218,698	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR				142			90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER	307,450			11,159	3,368	307,450	90.03
90.04	WOUND CARE	1,800,399	32,546		5,070	16,698	1,800,399	90.04
91	Emergency	18,182,067	103,410		54,373	50	18,182,067	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	171,481,752	1,158,029	100	272,006	1,740,180	171,481,752	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					2		194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	254,341	857,273	881,942	680,357	1,106,669	715,833	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.001483	0.637174	8,819.420000	2.501257	0.635950	0.004174	203
204	Cost to be allocated (Per Wkst. B, Part II)	24,456	19,248	84,855	6,643	55,928	98,395	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000143	0.014306	848.550000	0.024422	0.032139	0.000574	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
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	Emergency	100						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST							192.02
192.03	INTENSIVIST							192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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	6,276,441		6,276,441		6,276,441	30
31	Intensive Care Unit	2,221,524		2,221,524	35,423	2,256,947	31
43	Nursery	580,066		580,066		580,066	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,750,222		6,750,222		6,750,222	50
52	Delivery Room & Labor Room	589,725		589,725		589,725	52
54	Radiology-Diagnostic	2,741,010		2,741,010	11,453	2,752,463	54
55	Radiology-Therapeutic	2,322,512		2,322,512	106	2,322,618	55
57	CT Scan	430,064		430,064		430,064	57
59	Cardiac Catheterization	342,985		342,985		342,985	59
60	Laboratory	5,263,468		5,263,468		5,263,468	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,414,228		1,414,228		1,414,228	65
66	Physical Therapy	1,836,189		1,836,189		1,836,189	66
66.01	PHYSICAL THERAPY - LIFEPLEX	1,101,410		1,101,410		1,101,410	66.01
71	Medical Supplies Charged to Patients	280,046		280,046		280,046	71
72	Impl. Dev. Charged to Patients	1,395,717		1,395,717		1,395,717	72
73	Drugs Charged to Patients	3,261,697		3,261,697		3,261,697	73
76.97	CARDIAC REHABILITATION	102,562		102,562		102,562	76.97
76.98	HYPERBARIC OXYGEN THERAPY	147,127		147,127		147,127	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION CTR	4,061		4,061		4,061	90.01
90.02	ATHLETIC TRAINERS	294,006		294,006	6,551	300,557	90.02
90.03	SAINT JOSEPH HEALTH CENTER	549,553		549,553		549,553	90.03
90.04	WOUND CARE	1,268,197		1,268,197		1,268,197	90.04
91	Emergency	4,817,148		4,817,148	44,530	4,861,678	91
92	Observation Beds (Non-Distinct Part)	1,567,460		1,567,460		1,567,460	92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	45,557,418		45,557,418	98,063	45,655,481	200
201	Less Observation Beds	1,567,460		1,567,460		1,567,460	201
202	Total (line 200 minus line 201)	43,989,958		43,989,958		44,088,021	202

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	7,628,866		7,628,866				30
31	Intensive Care Unit	4,033,817		4,033,817				31
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,018,679	23,598,810	30,617,489	0.220469	0.220469	0.220469	50
52	Delivery Room & Labor Room	1,661,656	45,786	1,707,442	0.345385	0.345385	0.345385	52
54	Radiology-Diagnostic	1,647,271	14,019,241	15,666,512	0.174960	0.174960	0.175691	54
55	Radiology-Therapeutic	57,716	7,942,683	8,000,399	0.290300	0.290300	0.290313	55
57	CT Scan	2,268,985	17,752,281	20,021,266	0.021480	0.021480	0.021480	57
59	Cardiac Catheterization	52,436	705,317	757,753	0.452634	0.452634	0.452634	59
60	Laboratory	4,690,564	26,490,105	31,180,669	0.168805	0.168805	0.168805	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,111,714	5,907,500	8,019,214	0.176355	0.176355	0.176355	65
66	Physical Therapy	711,747	3,193,005	3,904,752	0.470245	0.470245	0.470245	66
66.01	PHYSICAL THERAPY - LIFEPLEX	348	3,329,671	3,330,019	0.330752	0.330752	0.330752	66.01
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	2,272,910	667,974	2,940,884	0.474591	0.474591	0.474591	72
73	Drugs Charged to Patients	3,619,180	4,869,487	8,488,667	0.384241	0.384241	0.384241	73
76.97	CARDIAC REHABILITATION		370,442	370,442	0.276864	0.276864	0.276864	76.97
76.98	HYPERBARIC OXYGEN THERAPY	25,278	1,193,420	1,218,698	0.120725	0.120725	0.120725	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		307,450	307,450	1.787455	1.787455	1.787455	90.03
90.04	WOUND CARE	9,597	1,790,802	1,800,399	0.704398	0.704398	0.704398	90.04
91	Emergency	2,752,110	15,429,957	18,182,067	0.264940	0.264940	0.267389	91
92	Observation Beds (Non-Distinct Part)	511,737	2,793,210	3,304,947	0.474277	0.474277	0.474277	92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	41,074,611	130,407,141	171,481,752				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	41,074,611	130,407,141	171,481,752				202

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	830,638		830,638	5,714	145.37	1,913	278,093	30
31	Intensive Care Unit	178,604		178,604	1,181	151.23	486	73,498	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	5,664		5,664	554	10.22			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,014,906		1,014,906	7,449		2,399	351,591	200

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	786,383	30,617,489	0.025684	2,368,522	60,833	50
52	Delivery Room & Labor Room	6,888	1,707,442	0.004034	14,301	58	52
54	Radiology-Diagnostic	303,712	15,666,512	0.019386	789,535	15,306	54
55	Radiology-Therapeutic	357,021	8,000,399	0.044625	54,979	2,453	55
57	CT Scan	33,555	20,021,266	0.001676	1,109,971	1,860	57
59	Cardiac Catheterization	81,050	757,753	0.106961			59
60	Laboratory	229,947	31,180,669	0.007375	2,279,347	16,810	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	139,720	8,019,214	0.017423	1,079,097	18,801	65
66	Physical Therapy	233,103	3,904,752	0.059697	446,017	26,626	66
66.01	PHYSICAL THERAPY - LIFEPLEX	12,957	3,330,019	0.003891			66.01
71	Medical Supplies Charged to Pat	2,734					71
72	Impl. Dev. Charged to Patients	15,574	2,940,884	0.005296	1,063,727	5,633	72
73	Drugs Charged to Patients	78,421	8,488,667	0.009238	1,485,920	13,727	73
76.97	CARDIAC REHABILITATION	1,246	370,442	0.003364			76.97
76.98	HYPERBARIC OXYGEN THERAPY	21,987	1,218,698	0.018041	25,278	456	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION	39					90.01
90.02	ATHLETIC TRAINERS	2,871					90.02
90.03	SAINT JOSEPH HEALTH CENTER	5,656	307,450	0.018396			90.03
90.04	WOUND CARE	107,923	1,800,399	0.059944			90.04
91	Emergency	357,474	18,182,067	0.019661	938,374	18,449	91
92	Observation Beds (Non-Distinct	207,441	3,304,947	0.062767	268,910	16,879	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,985,702	159,819,069		11,923,978	197,891	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	5,714		1,913		30
31	Intensive Care Unit	1,181		486		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	554				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	7,449		2,399		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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
66.01	PHYSICAL THERAPY - LIFEPLEX							66.01
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	30,617,489			2,368,522		6,030,940		50
52	Delivery Room & Labor Room	1,707,442			14,301				52
54	Radiology-Diagnostic	15,666,512			789,535		3,239,176		54
55	Radiology-Therapeutic	8,000,399			54,979		3,577,760		55
57	CT Scan	20,021,266			1,109,971		5,389,499		57
59	Cardiac Catheterization	757,753							59
60	Laboratory	31,180,669			2,279,347		2,531,403		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	8,019,214			1,079,097		1,816,210		65
66	Physical Therapy	3,904,752			446,017		40,668		66
66.01	PHYSICAL THERAPY - LIFEPLEX	3,330,019							66.01
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	2,940,884			1,063,727		170,099		72
73	Drugs Charged to Patients	8,488,667			1,485,920		1,612,457		73
76.97	CARDIAC REHABILITATION	370,442							76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,218,698			25,278		925,329		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	307,450							90.03
90.04	WOUND CARE	1,800,399					1,740		90.04
91	Emergency	18,182,067			938,374		2,504,292		91
92	Observation Beds (Non-Distinct	3,304,947			268,910		1,332,791		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	159,819,069			11,923,978		29,172,364		200

(A) Worksheet A line numbers

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

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P**
[XX] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[ ] Swing Bed SNF **[ ] Swing Bed NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.220469	6,030,940			1,329,635			50
52	Delivery Room & Labor Room	0.345385							52
54	Radiology-Diagnostic	0.174960	3,239,176			566,726			54
55	Radiology-Therapeutic	0.290300	3,577,760			1,038,624			55
57	CT Scan	0.021480	5,389,499			115,766			57
59	Cardiac Catheterization	0.452634							59
60	Laboratory	0.168805	2,531,403			427,313			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.176355	1,816,210			320,298			65
66	Physical Therapy	0.470245	40,668			19,124			66
66.01	PHYSICAL THERAPY - LIFEPLEX	0.330752							66.01
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	0.474591	170,099			80,727			72
73	Drugs Charged to Patients	0.384241	1,612,457	35,215		619,572	13,531		73
76.97	CARDIAC REHABILITATION	0.276864							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.120725	925,329			111,710			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	1.787455							90.03
90.04	WOUND CARE	0.704398	1,740			1,226			90.04
91	Emergency	0.264940	2,504,292			663,487			91
92	Observation Beds (Non-Distinct	0.474277	1,332,791			632,112			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		29,172,364	35,215		5,926,320	13,531		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		29,172,364	35,215		5,926,320	13,531		202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	830,638		830,638	5,714	145.37	80	11,630	30
31	Intensive Care Unit	178,604		178,604	1,181	151.23	9	1,361	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	5,664		5,664	554	10.22	46	470	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,014,906		1,014,906	7,449		135	13,461	200

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	786,383	30,617,489	0.025684	1,265,810	32,511	50
52	Delivery Room & Labor Room	6,888	1,707,442	0.004034	514,514	2,076	52
54	Radiology-Diagnostic	303,712	15,666,512	0.019386	142,196	2,757	54
55	Radiology-Therapeutic	357,021	8,000,399	0.044625			55
57	CT Scan	33,555	20,021,266	0.001676	260,384	436	57
59	Cardiac Catheterization	81,050	757,753	0.106961			59
60	Laboratory	229,947	31,180,669	0.007375	518,212	3,822	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	139,720	8,019,214	0.017423	141,304	2,462	65
66	Physical Therapy	233,103	3,904,752	0.059697	29,785	1,778	66
66.01	PHYSICAL THERAPY - LIFEPLEX	12,957	3,330,019	0.003891			66.01
71	Medical Supplies Charged to Pat	2,734					71
72	Impl. Dev. Charged to Patients	15,574	2,940,884	0.005296	320,739	1,699	72
73	Drugs Charged to Patients	78,421	8,488,667	0.009238	515,683	4,764	73
76.97	CARDIAC REHABILITATION	1,246	370,442	0.003364			76.97
76.98	HYPERBARIC OXYGEN THERAPY	21,987	1,218,698	0.018041			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION	39					90.01
90.02	ATHLETIC TRAINERS	2,871					90.02
90.03	SAINT JOSEPH HEALTH CENTER	5,656	307,450	0.018396			90.03
90.04	WOUND CARE	107,923	1,800,399	0.059944			90.04
91	Emergency	357,474	18,182,067	0.019661	252,520	4,965	91
92	Observation Beds (Non-Distinct	207,441	3,304,947	0.062767	45,628	2,864	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,985,702	159,819,069		4,006,775	60,134	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	5,714		80		30
31	Intensive Care Unit	1,181		9		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	554		46		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	7,449		135		200

(A) Worksheet A line numbers

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

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
66.01	PHYSICAL THERAPY - LIFEPLEX							66.01
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	30,617,489			1,265,810				50
52	Delivery Room & Labor Room	1,707,442			514,514				52
54	Radiology-Diagnostic	15,666,512			142,196				54
55	Radiology-Therapeutic	8,000,399							55
57	CT Scan	20,021,266			260,384				57
59	Cardiac Catheterization	757,753							59
60	Laboratory	31,180,669			518,212				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	8,019,214			141,304				65
66	Physical Therapy	3,904,752			29,785				66
66.01	PHYSICAL THERAPY - LIFEPLEX	3,330,019							66.01
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	2,940,884			320,739				72
73	Drugs Charged to Patients	8,488,667			515,683				73
76.97	CARDIAC REHABILITATION	370,442							76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,218,698							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	307,450							90.03
90.04	WOUND CARE	1,800,399							90.04
91	Emergency	18,182,067			252,520				91
92	Observation Beds (Non-Distinct	3,304,947			45,628				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	159,819,069			4,006,775				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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[ ] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[XX] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.220469		3,762,921			829,607		50
52	Delivery Room & Labor Room	0.345385		25,828			8,921		52
54	Radiology-Diagnostic	0.174960		2,685,114			469,788		54
55	Radiology-Therapeutic	0.290300		624,146			181,190		55
57	CT Scan	0.021480		2,770,341			59,507		57
59	Cardiac Catheterization	0.452634		56,218			25,446		59
60	Laboratory	0.168805		4,213,490			711,258		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.176355		776,686			136,972		65
66	Physical Therapy	0.470245		947,499			445,557		66
66.01	PHYSICAL THERAPY - LIFEPLEX	0.330752		555,332			183,677		66.01
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	0.474591		71,077			33,733		72
73	Drugs Charged to Patients	0.384241		631,068			242,482		73
76.97	CARDIAC REHABILITATION	0.276864		47,864			13,252		76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.120725		78,706			9,502		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	1.787455							90.03
90.04	WOUND CARE	0.704398		242,822			171,043		90.04
91	Emergency	0.264940		4,466,184			1,183,271		91
92	Observation Beds (Non-Distinct	0.474277		677,207			321,184		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			22,632,503			5,026,390		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			22,632,503			5,026,390		202

(A) Worksheet A line numbers

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

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,714	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,714	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)	4,287	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)	1,913	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)	6,276,441	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)	6,276,441	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)	6,276,441	37

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,098.43	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,101,297	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)	2,101,297	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	2,256,947	1,181	1,911.05	486	928,770	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)	2,947,735	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	5,977,802	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	351,591	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	197,891	51
52	Total Program excludable cost (sum of lines 50 and 51)	549,482	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	5,428,320	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

Check	**[ ] 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)					1,427	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,098.43	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,567,460	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	830,638	6,276,441	0.132342	1,567,460	207,441	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,714	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,714	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)	4,287	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)	80	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)	554	15
16	Nursery days (title V or XIX only)	46	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)	6,276,441	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)	6,276,441	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)	6,276,441	37

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,098.43	38
39	Program general inpatient routine service cost (line 9 x line 38)					87,874	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)					87,874	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)	580,066	554	1,047.05	46	48,164	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	2,256,947	1,181	1,911.05	9	17,199	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,053,284	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,206,521	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	13,461	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	60,134	51
52	Total Program excludable cost (sum of lines 50 and 51)	73,595	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,132,926	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,427	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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

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

		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		3,036,265		30
31	Intensive Care Unit		1,656,996		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.220469	2,368,522	522,186	50
52	Delivery Room & Labor Room	0.345385	14,301	4,939	52
54	Radiology-Diagnostic	0.175691	789,535	138,714	54
55	Radiology-Therapeutic	0.290313	54,979	15,961	55
57	CT Scan	0.021480	1,109,971	23,842	57
59	Cardiac Catheterization	0.452634			59
60	Laboratory	0.168805	2,279,347	384,765	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.176355	1,079,097	190,304	65
66	Physical Therapy	0.470245	446,017	209,737	66
66.01	PHYSICAL THERAPY - LIFEPLEX	0.330752			66.01
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.474591	1,063,727	504,835	72
73	Drugs Charged to Patients	0.384241	1,485,920	570,951	73
76.97	CARDIAC REHABILITATION	0.276864			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.120725	25,278	3,052	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	1.787455			90.03
90.04	WOUND CARE	0.704398			90.04
91	Emergency	0.267389	938,374	250,911	91
92	Observation Beds (Non-Distinct Part)	0.474277	268,910	127,538	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		11,923,978	2,947,735	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		11,923,978		202

(A) Worksheet A line numbers

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

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] 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		1,634,796		30
31	Intensive Care Unit		370,573		31
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.220469	1,265,810	279,072	50
52	Delivery Room & Labor Room	0.345385	514,514	177,705	52
54	Radiology-Diagnostic	0.175691	142,196	24,983	54
55	Radiology-Therapeutic	0.290313			55
57	CT Scan	0.021480	260,384	5,593	57
59	Cardiac Catheterization	0.452634			59
60	Laboratory	0.168805	518,212	87,477	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.176355	141,304	24,920	65
66	Physical Therapy	0.470245	29,785	14,006	66
66.01	PHYSICAL THERAPY - LIFEPLEX	0.330752			66.01
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.474591	320,739	152,220	72
73	Drugs Charged to Patients	0.384241	515,683	198,147	73
76.97	CARDIAC REHABILITATION	0.276864			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.120725			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	1.787455			90.03
90.04	WOUND CARE	0.704398			90.04
91	Emergency	0.267389	252,520	67,521	91
92	Observation Beds (Non-Distinct Part)	0.474277	45,628	21,640	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,006,775	1,053,284	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,006,775		202

(A) Worksheet A line numbers

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)	1,157,422			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,740,724			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)	30,600			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	2,344,523			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	41.09			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)	0.0417			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1987			31
32	Sum of lines 30 and 31	0.2404			32
33	Allowable disproportionate share percentage (see instructions)	0.0905			33
34	Disproportionate share adjustment (see instructions)	110,821			34
		Prior to		**On or after**	
	Uncompensated Care Adjustment	**October 1 (1.00)**	**(1.01)**	**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)	246,794		240,030	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	62,036		179,529	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	241,565			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)	5,281,132			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)	5,281,132			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	399,956			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)				58
59	Total (sum of amounts on lines 49 through 58)	5,681,088			59
60	Primary payer payments	11,568			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	5,669,520			61
62	Deductibles billed to program beneficiaries	693,924			62
63	Coinsurance billed to program beneficiaries	8,442			63
64	Allowable bad debts (see instructions)	79,134			64
65	Adjusted reimbursable bad debts (see instructions)	51,437			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,403			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	5,018,591			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)	-596			70.93
70.94	HRR adjustment amount (see instructions)	-37,903			70.94
70.96	Low volume adjustment for federal fiscal year (2016)	182,982			70.96
70.97	Low volume adjustment for federal fiscal year (2017)	556,107			70.97
70.99	HAC adjustment amount (see instructions)	64,202			70.99
71	Amount due provider (see instructions)	5,654,979			71
71.01	Sequestration adjustment (see instructions)	113,100			71.01
72	Interim payments	5,517,091			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	24,788			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	74,029			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	1,157,422		1,157,422				1,157,422	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	3,740,724				3,740,724		3,740,724	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	30,600				30,600		30,600	2
2.01	Outlier payment for discharges for Model 4 BPCI								2.01
3	Operating outlier reconciliation								3
4	Managed Care Simulated Payments	2,344,523		622,245		1,722,278		2,344,523	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	0.0905	0.0905	0.0905	0.0905	0.0905	0.0905		10
11	Disproportionate share adjustment	110,821		26,187		84,634		110,821	11
11.01	Uncompensated care payments	241,565		62,036		179,529		241,565	11.01
	Additional payment for high percentage of ESRD beneficiary discharges								
12	Total ESRD additional payment								12
13	Subtotal	5,281,132		1,245,645		4,035,487		5,281,132	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	5,281,132		1,245,645		4,035,487		5,281,132	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	399,956		92,081		307,875		399,956	16
17	Special add-on payments for new technologies								17
17.01	DO NOT USE THIS LINE								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**			1,337,726		4,343,362		5,681,088	19
20	Capital DRG other than outlier	395,485		92,081		303,404		395,485	20
20.01	Model 4 BPCI Capital DRG other than outlier								20.01
21	Capital DRG outlier payments	4,471				4,471		4,471	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	399,956		92,081		307,875		399,956	26
27	**Low volume adjustment factor**			0.136786		0.128036			27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.96)(prior to 10/1)			182,982				182,982	28
29	Low Volume Adjustment (transfer amount to Worksheet E, Part A, line 70.97)(on/after 10/1)					556,107		556,107	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	1,157,422	1,157,422				1,157,422	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	3,740,724			3,740,724		3,740,724	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	30,600			30,600		30,600	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	2,344,523	622,245		1,722,278		2,344,523	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	0.0905	0.0905	0.0905	0.0905	0.0905		10
11	Disproportionate share adjustment	110,821	26,187		84,634		110,821	11
11.01	Uncompensated care payments	241,565	62,036		179,529		241,565	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	5,281,132	1,245,645		4,035,487		5,281,132	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	5,281,132	1,245,645		4,035,487		5,281,132	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	399,956	92,081		307,875		399,956	16
17	Special add-on payments for new technologies							17
17.01	DO NOT USE THIS LINE							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**		1,337,726		4,343,362		5,681,088	19
20	Capital DRG other than outlier	395,485	92,081		303,404		395,485	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	4,471			4,471		4,471	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	399,956	92,081		307,875		399,956	26
27								27
28	Low volume adjustment prior to October 1	182,982	182,982				182,982	28
29	Low volume adjustment on or after October 1	556,107			556,107		556,107	29
30	HVBP payment adjustment	-596						30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-37,903						31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment		15,207		48,995		64,202	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)	13,531			1
2	Medical and other services reimbursed under OPPS (see instructions)	5,926,320			2
3	PPS payments	5,111,563			3
4	Outlier payment (see instructions)	30,523			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				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	13,531			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	35,215			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)	35,215			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)	35,215			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	21,684			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)	13,531			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)	5,142,086			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,077,656			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)	4,077,961			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)	4,077,961			30
31	Primary payer payments	2,812			31
32	Subtotal (line 30 minus line 31)	4,075,149			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)	233,641			34
35	Adjusted reimbursable bad debts (see instructions)	151,867			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	185,018			36
37	Subtotal (see instructions)	4,227,016			37
38	MSP-LCC reconciliation amount from PS&R	-17			38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	4,227,033			40
40.01	Sequestration adjustment (see instructions)	84,541			40.01
41	Interim payments	4,102,434			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	40,058			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

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				5,517,091		4,102,434	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				5,517,091		4,102,434	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		24,788		40,058	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				5,541,879		4,142,492	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)	2,044	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	2,399	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	1,161	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	5,468	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	171,481,752	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	2,827,736	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.

Check Applicable Boxes: [ ] Title V [XX] Title XIX [XX] Hospital [ ] SUB (Other) [ ] SNF [ ] NF [ ] ICF/IID [XX] PPS [ ] TEFRA [ ] Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services		5,026,390	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)		5,026,390	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)		5,026,390	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	4,006,775	22,632,503	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)	4,006,775	22,632,503	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)	4,006,775	22,632,503	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,006,775	17,606,113	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)		5,026,390	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			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)		5,026,390	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)		5,026,390	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)		5,026,390	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)		5,026,390	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)		5,026,390	40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)		5,026,390	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	1,269,670				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	9,942,115				4
5	Other receivables	-1,069,451				5
6	Allowances for uncollectible notes and accounts receivable	-1,754,288				6
7	Inventory	915,349				7
8	Prepaid expenses	50,837				8
9	Other current assets	43,549,036				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	52,903,268				11
	FIXED ASSETS					
12	Land	477,930				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	43,712,022				15
16	Accumulated depreciation	-27,466,108				16
17	Leasehold improvements	403,970				17
18	Accumulated depreciation	-270,188				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	26,227,692				23
24	Accumulated depreciation	-16,608,102				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	26,477,216				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	674,886				34
35	Total other assets (sum of lines 31-34)	674,886				35
36	Total assets (sum of lines 11, 30 and 35)	80,055,370				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	3,047,336				37
38	Salaries, wages and fees payable	1,234,227				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	271,894				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	4,553,457				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	5,882,950				47
48	Unsecured loans					48
49	Other long term liabilities	312,893				49
50	Total long term liabilities (sum of lines 46 thru 49)	6,195,843				50
51	Total liabilities (sum of lines 45 and 50)	10,749,300				51
	CAPITAL ACCOUNTS					
52	General fund balance	69,306,070				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)	69,306,070				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	80,055,370				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		61,003,063			1
2	Net income (loss) (from Worksheet G-3, line 29)		8,303,007			2
3	Total (sum of line 1 and line 2)		69,306,070			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)		69,306,070			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)		69,306,070			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

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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	42,375,744		42,375,744	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)	42,375,744		42,375,744	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	42,375,744		42,375,744	17
18	Ancillary services		133,101,096	133,101,096	18
19	Outpatient services		748,915	748,915	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)	42,375,744	133,850,011	176,225,755	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		50,300,553	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	INVESTMENT EARNINGS	-4,598,070		39
40				40
41				41
42	Total deductions (sum of lines 37-41)		-4,598,070	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		45,702,483	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	176,225,755	1
2	Less contractual allowances and discounts on patients' accounts	123,235,277	2
3	Net patient revenues (line 1 minus line 2)	52,990,478	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	45,702,483	4
5	Net income from service to patients (line 3 minus line 4)	7,287,995	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)		24
24.01	Other (OTHER REVENUE)	1,015,012	24.01
25	Total other income (sum of lines 6-24)	1,015,012	25
26	Total (line 5 plus line 25)	8,303,007	26
29	Net income (or loss) for the period (line 26 minus line 28)	8,303,007	29

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	395,485	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	4,471	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)	15.34	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)	399,956	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier		1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments		2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)		3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)		12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 11:16 Version: 2017.10 (10/12/2017)

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
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST							192.02
192.03	INTENSIVIST							192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202