

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. ELECTRONICALLY FILED COST REPORT DATE: 01-24-2012 TIME: 09:48
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
 2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
 3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
 4 - REOPENED
 5 - AMENDED

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. JOSEPH'S REG MED CENTER-PLYMOUTH (15-0076) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2010 AND ENDING 06/30/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDE IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		-33,238	-195,699	1,461,360	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		-33,238	-195,699	1,461,360	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 RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE 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.

HOSPITAL AND 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 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)				
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	ST. JOSEPH'S REG MED CENTER-P	15-0076	46563	1	07/01/1966	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: 07/01/2010			TO: 06/30/2011					20
21	TYPE OF CONTROL				1					21

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND '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.							1	2	
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 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPFS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	450	974				24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.						25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2		26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2		27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.						35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.						37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:	38

	V 1	XVIII 2	XIX 3	
45	PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL			
46	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	45
47	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	46
48	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	47
49	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

	1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N	57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? IF YES, COMPLETE WORKSHEET D-5.			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N		60

	Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N		61

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 RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)			62.01

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49, 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.1/ (COL.3+COL.4))
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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.1 / (COL.3+COL.4))
1	2	3	4	5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER?			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER?			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
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/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 N 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
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.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	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.	Y		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
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.		250,000 7,500,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	Y	Y	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED 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 CERTIFIED 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

ALL PROVIDERS

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.	Y	15H034	140
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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: NATIONAL GOVERNMENT SERVICE IN CONTRACTOR'S NUMBER: 00130			141
142	STREET: 5215 HOLY CROSS PARKWAY P.O. BOX:			142
143	CITY: MISHAWAKA STATE: IN ZIP CODE: 46545			143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B.
 SEE 42 CFR §413.13)

155	HOSPITAL	N	N	155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC	N	N	161

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.			
	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(m)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.		1.00	169

HOSPITAL AND 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	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	
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)	Y		3	
FINANCIAL DATA AND REPORTS					
		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N		Y/N	
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.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
BED COMPLEMENT					
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	
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	09/30/2011	Y	09/30/2011
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	
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	
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	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND 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 RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS. | 22 |
| 23 | HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 23 |
| 24 | WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 24 |
| 25 | HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 25 |
| 26 | WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 26 |
| 27 | HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 27 |

INTEREST EXPENSE

- | | | |
|----|---|----|
| 28 | WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 28 |
| 29 | DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS. | 29 |
| 30 | HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. | 30 |
| 31 | HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. | 31 |

PURCHASED SERVICES

- | | | |
|----|---|----|
| 32 | HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. | 32 |
| 33 | IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. | 33 |

PROVIDER-BASED PHYSICIANS

- | | | |
|----|--|----|
| 34 | ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. | 34 |
| 35 | IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 35 |

HOME OFFICE COSTS

- | | | Y/N | DATE | |
|----|--|-----|------|----|
| | | 1 | 2 | |
| 36 | WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? | | | 36 |
| 37 | IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. | | | 37 |
| 38 | IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE. | | | 38 |
| 39 | IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS. | | | 39 |
| 40 | IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. | | | 40 |

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	13,068,961	13,068,961	543,211.00	24.06	1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A		60,558	60,558	428.50	141.33	4
4.01	PHYSICIANS-PART A - DIRECT TEACHING						4.01
5	PHYSICIAN-PART B		7,324	7,324	65.50	111.82	5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44					9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		6,486	6,486	320.00	20.27	10
OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)						11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A		71,761	71,761	886.00	80.99	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		2,999,377	2,999,377	61,156.00	49.04	14
15	HOME OFFICE: PHYSICIAN-PART A						15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						16
WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		3,896,969	3,896,969			17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		1,187	1,187			19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A		18,167	18,167			22
23	PHYSICIAN PART B		2,197	2,197			23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS		-20,662	20,662			26
27	ADMINISTRATIVE & GENERAL		1,380,355	-20,662	1,359,693	62,152.00	21.88
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)						28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT		345,055	345,055	14,289.00	24.15	30
31	LAUNDRY & LINEN SERVICE						31
32	HOUSEKEEPING		407,183	407,183	34,612.00	11.76	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		217,055	217,055	16,978.00	12.78	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA						36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		421,350	421,350	11,765.00	35.81	38
39	CENTRAL SERVICES AND SUPPLY						39
40	PHARMACY		422,439	422,439	11,652.00	36.25	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		275,441	275,441	13,512.00	20.38	41
42	SOCIAL SERVICE						42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	13,061,637		13,061,637	543,145.50	24.05	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	6,486		6,486	320.00	20.27	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	13,055,151		13,055,151	542,825.50	24.05	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	3,071,138		3,071,138	62,042.00	49.50	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	3,915,136		3,915,136		29.99%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	20,041,425		20,041,425	604,867.50	33.13	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	3,448,216		3,448,216	164,960.00	20.90	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS		1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	848,319	3
4 PRIOR YEAR PENSION SERVICE COST		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	1,877,932	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN		10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	38,516	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	169,428	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	41,448	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	8,233	16
TAXES		
17 FICA-EMPLOYERS PORTION ONLY	961,427	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE		19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	37,039	20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT		23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	3,982,342	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	-101,033	25

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER-PL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
01/24/2012 09:48

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	BENEFIT
0		LABOR	COST
		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 CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.279047	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,907,030	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				5,227,000	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				1,458,579	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)					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)					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)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)					19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	4,141,000	538,000	4,679,000		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	1,155,534	150,127	1,305,661		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	61,500	68,800	130,300		22
23	COST OF CHARITY CARE	1,094,034	81,327	1,175,361		23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			3,757,100		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			313,653		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			3,443,447		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			960,884		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			2,136,245		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			2,136,245		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100				1,571,623	1
2	00200				1,453,062	2
3	00300					3
4	00400	-20,662	-224,025	-244,687	244,687	4
5	00500	1,380,355	13,389,314	14,769,669	-1,512,926	5
6	00600					6
7	00700	345,055	1,298,155	1,643,210	-228,794	7
8	00800		178,340	178,340		8
9	00900	407,183	270,934	678,117	-211	9
10	01000	217,055	582,424	799,479	-6,871	10
11	01100					11
12	01200					12
13	01300	421,350	128,580	549,930	-5,812	13
14	01400					14
15	01500	422,439	1,369,243	1,791,682	-1,215,212	15
16	01600	275,441	324,730	600,171	-5,422	16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	2,255,159	1,113,451	3,368,610	-893,581	30
31	03100	803,795	323,132	1,126,927	-17,135	31
43	04300				393,918	43
ANCILLARY SERVICE COST CENTERS						
50	05000	1,745,584	3,649,728	5,395,312	-1,053,894	50
52	05200				393,918	52
54	05400	772,864	540,591	1,313,455	-192,688	54
55	05500	245,372	408,676	654,048	-211,900	55
57	05700	63,384	86,199	149,583		57
59	05900	72,651	552,293	624,944	-405,253	59
60	06000	962,241	1,818,391	2,780,632	-60,708	60
62.30	06250					62.30
65	06500	442,334	489,949	932,283	-51,711	65
66	06600	783,325	422,079	1,205,404	-54,439	66
72	07200				858,420	72
73	07300				1,165,747	73
74	07400					74
76.97	07697					76.97
76.98	07698				267,049	76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90.02	04950	178,854	71,684	250,538		90.02
90.03	04951	183,825	108,691	292,516	-4,190	90.03
90.04	04952	146,390	729,316	875,706	-414,145	90.04
91	09100	958,481	643,382	1,601,863	-13,532	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
94	09400					94
SPECIAL PURPOSE COST CENTERS						
118		13,062,475	28,275,257	41,337,732		118
NONREIMBURSABLE COST CENTERS						
190.01	19001		99,498	99,498		190.01
190.02	19002	6,486	1,185	7,671		190.02
192	19200					192
200		13,068,961	28,375,940	41,444,901		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	1,571,623	990,489	2,562,112	1
2	00200	CAP REL COSTS-MVBLE EQUIP	1,453,062		1,453,062	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS				4
5	00500	ADMINISTRATIVE & GENERAL	13,256,743	-6,051,534	7,205,209	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	1,414,416		1,414,416	7
8	00800	LAUNDRY & LINEN SERVICE	178,340		178,340	8
9	00900	HOUSEKEEPING	677,906	-62,532	615,374	9
10	01000	DIETARY	792,608	-164,187	628,421	10
11	01100	CAFETERIA				11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	544,118		544,118	13
14	01400	CENTRAL SERVICES & SUPPLY				14
15	01500	PHARMACY	576,470		576,470	15
16	01600	MEDICAL RECORDS & LIBRARY	594,749		594,749	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	2,475,029	-69	2,474,960	30
31	03100	INTENSIVE CARE UNIT	1,109,792		1,109,792	31
43	04300	NURSERY	393,918		393,918	43
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	4,341,418	-863,275	3,478,143	50
52	05200	DELIVERY ROOM & LABOR ROOM	393,918		393,918	52
54	05400	RADIOLOGY-DIAGNOSTIC	1,120,767		1,120,767	54
55	05500	RADIOLOGY-THERAPEUTIC	442,148	-1,496	440,652	55
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	149,583		149,583	57
59	05900	CARDIAC CATHETERIZATION	219,691		219,691	59
60	06000	LABORATORY	2,719,924	-8,147	2,711,777	60
62.30	06250	BLOOD CLOTTING FACTORS ADMIN COSTS				62.30
65	06500	RESPIRATORY THERAPY	880,572		880,572	65
66	06600	PHYSICAL THERAPY	1,150,965		1,150,965	66
72	07200	IMPL. DEV. CHARGED TO PATIENT	858,420		858,420	72
73	07300	DRUGS CHARGED TO PATIENTS	1,165,747		1,165,747	73
74	07400	RENAL DIALYSIS				74
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	267,049		267,049	76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
90.02	04950	SPORTS MED ATHLETIC TRAINERS	250,538	-46,500	204,038	90.02
90.03	04951	SAINT JOSEPH HEALTH CENTER	288,326	-15,212	273,114	90.03
90.04	04952	WOUND CARE	461,561	-196	461,365	90.04
91	09100	EMERGENCY	1,588,331	-157,962	1,430,369	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
94	09400	HOME PROGRAM DIALYSIS				94
SPECIAL PURPOSE COST CENTERS						
118		SUBTOTALS (SUM OF LINES 1-117)	41,337,732	-6,380,621	34,957,111	118
NONREIMBURSABLE COST CENTERS						
190.01	19001	PLYMOUTH MOB-4	99,498		99,498	190.01
190.02	19002	HOSPITALIST	7,671		7,671	190.02
192	19200	PHYSICIANS' PRIVATE OFFICES				192
200		TOTAL (SUM OF LINES 118-199)	41,444,901	-6,380,621	35,064,280	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER		INCREASE	SALARY	OTHER	
		1	2	LINE #			
1 DEPRECIATION EXPENSE	A	CAP REL COSTS-BLDG & FIXT		1		1,294,686	1
2		CAP REL COSTS-MVBLE EQUIP		2		1,453,062	2
3							3
4							4
5							5
6							6
7							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
21							21
500 TOTAL RECLASSIFICATIONS						2,747,748	500
CODE LETTER - A							
1 PHARMACY DRUG RECLASS	B	DRUGS CHARGED TO PATIENTS		73		1,165,747	1
500 TOTAL RECLASSIFICATIONS						1,165,747	500
CODE LETTER - B							
1 INTEREST EXPENSE RECLASS	C	CAP REL COSTS-BLDG & FIXT		1		259,878	1
500 TOTAL RECLASSIFICATIONS						259,878	500
CODE LETTER - C							
1 NURSERY-LABOR/DELIVERY RECLASS	D	NURSERY		43	276,344	117,574	1
2		DELIVERY ROOM & LABOR ROOM		52	276,344	117,574	2
500 TOTAL RECLASSIFICATIONS					552,688	235,148	500
CODE LETTER - D							
1 IMPLANT RECLASS	E	IMPL. DEV. CHARGED TO PATIENT		72		858,420	1
2							2
500 TOTAL RECLASSIFICATIONS						858,420	500
CODE LETTER - E							
1 PROPERTY INSURANCE RECLASS	F	CAP REL COSTS-BLDG & FIXT		1		17,059	1
500 TOTAL RECLASSIFICATIONS						17,059	500
CODE LETTER - F							
1 NEGATIVE AMOUNT RECLASS	G	EMPLOYEE BENEFITS		4	20,662	224,025	1
500 TOTAL RECLASSIFICATIONS					20,662	224,025	500
CODE LETTER - G							
1 RECLASS HYBERBARIC THERAPY EXP	H	HYPERBARIC OXYGEN THERAPY		76.98	85,924	181,125	1
500 TOTAL RECLASSIFICATIONS					85,924	181,125	500
CODE LETTER - H							
1 MEDICAL DIRECTOR RECLASSIFICATION	I	EMERGENCY		91		25,056	1
500 TOTAL RECLASSIFICATIONS						25,056	500
CODE LETTER - I							
GRAND TOTAL (INCREASES)					659,274	5,714,206	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	10
1 DEPRECIATION EXPENSE	A	ADMINISTRATIVE & GENERAL	5		1,182	9 1
2		ADMINISTRATIVE & GENERAL	5		883,413	9 2
3		OPERATION OF PLANT	7		228,794	10 3
4		HOUSEKEEPING	9		211	9 4
5		DIETARY	10		6,871	9 5
6		NURSING ADMINISTRATION	13		5,812	9 6
7		PHARMACY	15		49,465	10 7
8		MEDICAL RECORDS & LIBRARY	16		5,422	9 8
9		ADULTS & PEDIATRICS	30		105,745	10 9
10		INTENSIVE CARE UNIT	31		17,135	9 10
11		OPERATING ROOM	50		243,503	10 11
12		RADIOLOGY-DIAGNOSTIC	54		192,688	9 12
13		RADIOLOGY-THERAPEUTIC	55		211,900	9 13
14		CARDIAC CATHETERIZATION	59		357,224	9 14
15		LABORATORY	60		60,708	9 15
16		RESPIRATORY THERAPY	65		51,711	10 16
17		PHYSICAL THERAPY	66		54,439	10 17
18		SAINT JOSEPH HEALTH CENTER	90.03		4,190	10 18
19		WOUND CARE	90.04		147,096	10 19
20		EMERGENCY	91		38,588	10 20
21		ADMINISTRATIVE & GENERAL	5		81,651	9 21
500 TOTAL RECLASSIFICATIONS					2,747,748	500
CODE LETTER - A						
1 PHARMACY DRUG RECLASS	B	PHARMACY	15		1,165,747	1
500 TOTAL RECLASSIFICATIONS					1,165,747	500
CODE LETTER - B						
1 INTEREST EXPENSE RECLASS	C	ADMINISTRATIVE & GENERAL	5		259,878	11 1
500 TOTAL RECLASSIFICATIONS					259,878	500
CODE LETTER - C						
1 NURSERY-LABOR/DELIVERY RECLASS	D	ADULTS & PEDIATRICS	30	552,688	235,148	1
2						2
500 TOTAL RECLASSIFICATIONS				552,688	235,148	500
CODE LETTER - D						
1 IMPLANT RECLASS	E	OPERATING ROOM	50		810,391	1
2		CARDIAC CATHETERIZATION	59		48,029	2
500 TOTAL RECLASSIFICATIONS					858,420	500
CODE LETTER - E						
1 PROPERTY INSURANCE RECLASS	F	ADMINISTRATIVE & GENERAL	5		17,059	11 1
500 TOTAL RECLASSIFICATIONS					17,059	500
CODE LETTER - F						
1 NEGATIVE AMOUNT RECLASS	G	ADMINISTRATIVE & GENERAL	5	20,662	224,025	1
500 TOTAL RECLASSIFICATIONS				20,662	224,025	500
CODE LETTER - G						
1 RECLASS HYBERBARIC THERAPY EXP	H	WOUND CARE	90.04	85,924	181,125	1
500 TOTAL RECLASSIFICATIONS				85,924	181,125	500
CODE LETTER - H						
1 MEDICAL DIRECTOR RECLASSIFICATION	I	ADMINISTRATIVE & GENERAL	5		25,056	1
500 TOTAL RECLASSIFICATIONS					25,056	500
CODE LETTER - I						
GRAND TOTAL (DECREASES)				659,274	5,714,206	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
		PURCHASE 2	DONATION 3	TOTAL 4			
1 LAND	477,930					477,930	1
2 LAND IMPROVEMENTS							2
3 BUILDINGS AND FIXTURES	32,682,977	208,575		208,575		32,891,552	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	20,534,323	2,977,825		2,977,825	367,378	23,144,770	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	53,695,230	3,186,400		3,186,400	367,378	56,514,252	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	53,695,230	3,186,400		3,186,400	367,378	56,514,252	20,601,297 10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1) (SUM OF COLS. 9-14) 15
							1 CAP REL COSTS-BLDG & FIXT
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)							3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 7	TOTAL (SUM OF COLS. 5-7) 8
								1 CAP REL COSTS-BLDG & FIXT
2 CAP REL COSTS-MVBLE EQUIP								2
3 TOTAL (SUM OF LINES 1-2)								3

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2) (SUM OF COLS. 9-14) 15
							1 CAP REL COSTS-BLDG & FIXT
2 CAP REL COSTS-MVBLE EQUIP	1,453,062					1,453,062	2
3 TOTAL	3,736,633		276,937	1,604		4,015,174	3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)	B	-259,878	ADMINISTRATIVE & GENERAL	5	11 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	-998,700			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-1,042,868			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-161,288	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	B	-2,899	DIETARY	10	20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				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				30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33					33
34 BAD DEBT EXPENSE	A	-3,717,100	ADMINISTRATIVE & GENERAL	5	34
35 BAD DEBT EXPENSE	A	-40,000	EMERGENCY	91	35
36 DONATIONS	B	-6,192	ADMINISTRATIVE & GENERAL	5	36
37 ENTERTAINMENT ADJUSTMENT	A	-90	ADMINISTRATIVE & GENERAL	5	37
38 ENTERTAINMENT ADJUSTMENT	A	-863	ADMINISTRATIVE & GENERAL	5	38
39 ENTERTAINMENT ADJUSTMENT	A	-32	HOUSEKEEPING	9	39
40 ENTERTAINMENT ADJUSTMENT	A	-69	ADULTS & PEDIATRICS	30	40
41 ENTERTAINMENT ADJUSTMENT	A	-52	OPERATING ROOM	50	41
42 ENTERTAINMENT ADJUSTMENT	A	-48	LABORATORY	60	42
43 ENTERTAINMENT ADJUSTMENT	A	-196	WOUND CARE	90.04	43
44 ENTERTAINMENT ADJUSTMENT	A	-5,071	EMERGENCY	91	44
45					45
46 PROPERTY TAX ADJUSTMENT	A	-40	ADMINISTRATIVE & GENERAL	5	46
46.01 PROPERTY TAX ADJUSTMENT	A	-5,826	LABORATORY	60	46.01
47 OTHER REVENUE ADJUSTMENT	B	-1,496	RADIOLOGY-THERAPEUTIC	55	47
47.01 OTHER REVENUE ADJUSTMENT	B	-2,273	LABORATORY	60	47.01
47.02 OTHER REVENUE ADJUSTMENT	B	-282	EMERGENCY	91	47.02
47.03 OTHER REVENUE ADJUSTMENT	B	-5,188	OPERATING ROOM	50	47.03
47.04 OTHER REVENUE ADJUSTMENT	B	-5,958	ADMINISTRATIVE & GENERAL	5	47.04
47.05 OTHER REVENUE ADJUSTMENT	B	-62,500	HOUSEKEEPING	9	47.05
47.06 OTHER REVENUE ADJUSTMENT	B	-46,500	SPORTS MED ATHLETIC TRAINERS	90.02	47.06
47.07 OTHER REVENUE ADJUSTMENT	B	-15,212	SAINT JOSEPH HEALTH CENTER	90.03	47.07
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-6,380,621			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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 THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF	
1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	HO NON CAPITAL COSTS	5,564,711	7,613,932	-2,049,221	1
2	5	ADMINISTRATIVE & GENERAL	EMPLOYEE HEALTH STOP LOSS	64,411	27,202	37,209	2
3	5	ADMINISTRATIVE & GENERAL	WORKERS COMP	41,448	23,485	17,963	3
4	1	CAP REL COSTS-BLDG & FIXT	PROPERTY INSURANCE	18,663	17,059	1,604	12 4
4.01	5	ADMINISTRATIVE & GENERAL	MALPRACTICE INSURANCE	138,987	206,285	-67,298	4.01
4.02	5	ADMINISTRATIVE & GENERAL	RISK INSURANCE	45,065	56,339	-11,274	4.02
4.03	5	ADMINISTRATIVE & GENERAL	PENSION	848,319	937,658	-89,339	4.03
4.04	5	ADMINISTRATIVE & GENERAL	RETIREE HEALTH COSTS	8,233	-120,370	128,603	4.04
4.05	1	CAP REL COSTS-BLDG & FIXT	HO CAPITAL COSTS	988,885		988,885	9 4.05
5		TOTALS (SUM OF LINES 1-4)		7,718,722	8,761,590	-1,042,868	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					

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

THE SECRETARY, BY VIRTUE OF 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.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES 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.

SYMBOL (1)	NAME	PERCENT OF OWNERSHIP		NAME	PERCENT OF OWNERSHIP		TYPE OF BUSINESS	
		3	4		5	6		
6	G	100.00	TRINITY HEALTH	100.00	HO OF PARENT COMPANY		6	
7	G	100.00	SJRM - INC	100.00	PARENT COMPANY		7	
8	G	100.00	SJRM-SOUTH BEND CAMPUS	100.00	HOSPITAL		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 PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
1	2	3	4	5	6	7	8	9	
1	5 ADMINISTRATIVE & GENERAL	37,044		37,044	142,500	206	14,113	706	1
2	50 OPERATING ROOM	858,035	858,035		208,000				2
3	60 LABORATORY	41,664		41,664	142,500	703	48,162	2,408	3
4	91 EMERGENCY	126,240	49,999	76,241	142,500	456	31,240	1,562	4
5	91 EMERGENCY	17,609	17,609		142,500				5
6	5 ADMINISTRATIVE & GENERAL	5,125	5,125		142,500				6
200	TOTAL	1,085,717	930,768	154,949		1,365	93,515	4,676	200

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER-PL
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 01/24/2012 09:48

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
10	11	12	13	14	15	16	17	18	
1	5 ADMINISTRATIVE & GENERAL	AGGREGATE				14,113	22,931	22,931	1
2	50 OPERATING ROOM	AGGREGATE						858,035	2
3	60 LABORATORY	AGGREGATE				48,162			3
4	91 EMERGENCY	AGGREGATE				31,240	45,001	95,000	4
5	91 EMERGENCY	AGGREGATE LABOR						17,609	5
6	5 ADMINISTRATIVE & GENERAL	AGGREGATE LABOR						5,125	6
200	TOTAL					93,515	67,932	998,700	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL (COLS.0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	2,562,112	2,562,112				1
2 CAP REL COSTS-MVBLE EQUIP	1,453,062		1,453,062			2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	7,205,209	299,714	37,366	7,542,289	7,542,289	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,414,416	566,838	66,408	2,047,662	561,154	7
8 LAUNDRY & LINEN SERVICE	178,340	10,148		188,488	51,654	8
9 HOUSEKEEPING	615,374	5,024	217	620,615	170,077	9
10 DIETARY	628,421	68,745	4,720	701,886	192,349	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	544,118		5,983	550,101	150,753	13
14 CENTRAL SERVICES & SUPPLY		78,223		78,223	21,437	14
15 PHARMACY	576,470	20,783	50,917	648,170	177,628	15
16 MEDICAL RECORDS & LIBRARY	594,749	65,546	5,581	665,876	182,481	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,474,960	303,716	108,574	2,887,250	791,239	30
31 INTENSIVE CARE UNIT	1,109,792	62,264	17,638	1,189,694	326,031	31
43 NURSERY	393,918	6,866		400,784	109,833	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,478,143	244,149	209,282	3,931,574	1,077,428	50
52 DELIVERY ROOM & LABOR ROOM	393,918	14,101		408,019	111,816	52
54 RADIOLOGY-DIAGNOSTIC	1,120,767	152,495	197,965	1,471,227	403,184	54
55 RADIOLOGY-THERAPEUTIC	440,652	151,557	216,392	808,601	221,594	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	149,583			149,583	40,993	57
59 CARDIAC CATHETERIZATION	219,691		367,181	586,872	160,830	59
60 LABORATORY	2,711,777	61,058	59,024	2,831,859	776,060	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	880,572	40,895	52,139	973,606	266,813	65
66 PHYSICAL THERAPY	1,150,965	41,197	1,757	1,193,919	327,189	66
72 IMPL. DEV. CHARGED TO PATIENT	858,420			858,420	235,247	72
73 DRUGS CHARGED TO PATIENTS	1,165,747			1,165,747	319,468	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	267,049			267,049	73,184	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.02 SPORTS MED ATHLETIC TRAINERS	204,038			204,038	55,916	90.02
90.03 SAINT JOSEPH HEALTH CENTER	273,114		4,313	277,427	76,028	90.03
90.04 WOUND CARE	461,365		7,884	469,249	128,596	90.04
91 EMERGENCY	1,430,369	122,903	39,721	1,592,993	436,553	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	34,957,111	2,316,222	1,453,062	34,711,221	7,445,535	118
NONREIMBURSABLE COST CENTERS						
190.01 PLYMOUTH MOB-4	99,498			99,498	27,267	190.01
190.02 HOSPITALIST	7,671			7,671	2,102	190.02
192 PHYSICIANS' PRIVATE OFFICES		245,890		245,890	67,385	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	35,064,280	2,562,112	1,453,062	35,064,280	7,542,289	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	NURSING ADMINIS- TRATION 13	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	2,608,816					7
8 LAUNDRY & LINEN SERVICE	15,615	255,757				8
9 HOUSEKEEPING	7,730		798,422			9
10 DIETARY	105,772		32,664	1,032,671		10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					700,854	13
14 CENTRAL SERVICES & SUPPLY	120,356		37,167			14
15 PHARMACY	31,976		9,875			15
16 MEDICAL RECORDS & LIBRARY	100,850		31,144			16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	467,303	9,046	144,308	833,674	222,702	30
31 INTENSIVE CARE UNIT	95,800	56,138	29,584	177,891	78,600	31
43 NURSERY	10,564		3,262		26,200	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	375,651	56,091	116,005	9,799	196,501	50
52 DELIVERY ROOM & LABOR ROOM	21,695	2,778	6,700		26,200	52
54 RADIOLOGY-DIAGNOSTIC	234,631	27,523	72,457			54
55 RADIOLOGY-THERAPEUTIC	233,188	12,538	72,011			55
57 COMPUTED TOMOGRAPHY (CT) SCAN		35,154				57
59 CARDIAC CATHETERIZATION		4,948				59
60 LABORATORY	93,945		29,011			60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	62,922	15,335	19,431			65
66 PHYSICAL THERAPY	63,386	10,168	19,574			66
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY		3,187				76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.02 SPORTS MED ATHLETIC TRAINERS						90.02
90.03 SAINT JOSEPH HEALTH CENTER		222			26,200	90.03
90.04 WOUND CARE		2,188			19,650	90.04
91 EMERGENCY	189,101	20,441	58,396	11,307	104,801	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	2,230,485	255,757	681,589	1,032,671	700,854	118
NONREIMBURSABLE COST CENTERS						
190.01 PLYMOUTH MOB-4						190.01
190.02 HOSPITALIST						190.02
192 PHYSICIANS' PRIVATE OFFICES	378,331		116,833			192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,608,816	255,757	798,422	1,032,671	700,854	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					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	257,183				14
15 PHARMACY		867,649			15
16 MEDICAL RECORDS & LIBRARY	195		980,546		16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	15,672	1,478	62,111	5,434,783	30
31 INTENSIVE CARE UNIT	4,867	70	29,144	1,987,819	31
43 NURSERY	2,239			552,882	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	92,671	1,304	180,673	6,037,697	50
52 DELIVERY ROOM & LABOR ROOM	2,239		8,948	588,395	52
54 RADIOLOGY-DIAGNOSTIC	10,805	55,593	88,669	2,364,089	54
55 RADIOLOGY-THERAPEUTIC	779		40,392	1,389,103	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	6,230	24,660	113,255	369,875	57
59 CARDIAC CATHETERIZATION	15,964	1,416	15,942	785,972	59
60 LABORATORY	72,327		162,451	3,965,653	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY	5,646	169	49,403	1,393,325	65
66 PHYSICAL THERAPY	3,310	456	32,757	1,650,759	66
72 IMPL. DEV. CHARGED TO PATIENT			23,240	1,116,907	72
73 DRUGS CHARGED TO PATIENTS		779,044	82,610	2,346,869	73
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY			17,333	360,753	76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90.02 SPORTS MED ATHLETIC TRAINERS				259,954	90.02
90.03 SAINT JOSEPH HEALTH CENTER			716	380,593	90.03
90.04 WOUND CARE	9,832	3,237	7,048	639,800	90.04
91 EMERGENCY	14,407	222	65,854	2,494,075	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	257,183	867,649	980,546	34,119,303	118
NONREIMBURSABLE COST CENTERS					
190.01 PLYMOUTH MOB-4				126,765	190.01
190.02 HOSPITALIST				9,773	190.02
192 PHYSICIANS' PRIVATE OFFICES				808,439	192
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	257,183	867,649	980,546	35,064,280	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION		TOTAL	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		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 SRVCES-SALARY & FRINGES APPRVD		21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS	5,434,783	30
31	INTENSIVE CARE UNIT	1,987,819	31
43	NURSERY	552,882	43
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	6,037,697	50
52	DELIVERY ROOM & LABOR ROOM	588,395	52
54	RADIOLOGY-DIAGNOSTIC	2,364,089	54
55	RADIOLOGY-THERAPEUTIC	1,389,103	55
57	COMPUTED TOMOGRAPHY (CT) SCAN	369,875	57
59	CARDIAC CATHETERIZATION	785,972	59
60	LABORATORY	3,965,653	60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS		62.30
65	RESPIRATORY THERAPY	1,393,325	65
66	PHYSICAL THERAPY	1,650,759	66
72	IMPL. DEV. CHARGED TO PATIENT	1,116,907	72
73	DRUGS CHARGED TO PATIENTS	2,346,869	73
74	RENAL DIALYSIS		74
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY	360,753	76.98
76.99	LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS			
90.02	SPORTS MED ATHLETIC TRAINERS	259,954	90.02
90.03	SAINT JOSEPH HEALTH CENTER	380,593	90.03
90.04	WOUND CARE	639,800	90.04
91	EMERGENCY	2,494,075	91
92	OBSERVATION BEDS		92
OTHER REIMBURSABLE COST CENTERS			
94	HOME PROGRAM DIALYSIS		94
SPECIAL PURPOSE COST CENTERS			
118	SUBTOTALS (SUM OF LINES 1-117)	34,119,303	118
NONREIMBURSABLE COST CENTERS			
190.01	PLYMOUTH MOB-4	126,765	190.01
190.02	HOSPITALIST	9,773	190.02
192	PHYSICIANS' PRIVATE OFFICES	808,439	192
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	35,064,280	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL		299,714	37,366	337,080	337,080	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		566,838	66,408	633,246	25,080	7
8 LAUNDRY & LINEN SERVICE		10,148		10,148	2,309	8
9 HOUSEKEEPING		5,024	217	5,241	7,601	9
10 DIETARY		68,745	4,720	73,465	8,597	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION			5,983	5,983	6,738	13
14 CENTRAL SERVICES & SUPPLY		78,223		78,223	958	14
15 PHARMACY		20,783	50,917	71,700	7,939	15
16 MEDICAL RECORDS & LIBRARY		65,546	5,581	71,127	8,156	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		303,716	108,574	412,290	35,363	30
31 INTENSIVE CARE UNIT		62,264	17,638	79,902	14,571	31
43 NURSERY		6,866		6,866	4,909	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		244,149	209,282	453,431	48,142	50
52 DELIVERY ROOM & LABOR ROOM		14,101		14,101	4,997	52
54 RADIOLOGY-DIAGNOSTIC		152,495	197,965	350,460	18,020	54
55 RADIOLOGY-THERAPEUTIC		151,557	216,392	367,949	9,904	55
57 COMPUTED TOMOGRAPHY (CT) SCAN					1,832	57
59 CARDIAC CATHETERIZATION			367,181	367,181	7,188	59
60 LABORATORY		61,058	59,024	120,082	34,685	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		40,895	52,139	93,034	11,925	65
66 PHYSICAL THERAPY		41,197	1,757	42,954	14,623	66
72 IMPL. DEV. CHARGED TO PATIENT					10,514	72
73 DRUGS CHARGED TO PATIENTS					14,278	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY					3,271	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.02 SPORTS MED ATHLETIC TRAINERS					2,499	90.02
90.03 SAINT JOSEPH HEALTH CENTER			4,313	4,313	3,398	90.03
90.04 WOUND CARE			7,884	7,884	5,747	90.04
91 EMERGENCY		122,903	39,721	162,624	19,511	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)		2,316,222	1,453,062	3,769,284	332,755	118
NONREIMBURSABLE COST CENTERS						
190.01 PLYMOUTH MOB-4					1,219	190.01
190.02 HOSPITALIST					94	190.02
192 PHYSICIANS' PRIVATE OFFICES		245,890		245,890	3,012	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		2,562,112	1,453,062	4,015,174	337,080	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	NURSING ADMINIS- TRATION 13	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	658,326					7
8 LAUNDRY & LINEN SERVICE	3,940	16,397				8
9 HOUSEKEEPING	1,951		14,793			9
10 DIETARY	26,691		605	109,358		10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					12,721	13
14 CENTRAL SERVICES & SUPPLY	30,371		689			14
15 PHARMACY	8,069		183			15
16 MEDICAL RECORDS & LIBRARY	25,449		577			16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	117,923	580	2,674	88,285	4,040	30
31 INTENSIVE CARE UNIT	24,175	3,609	548	18,838	1,427	31
43 NURSERY	2,666		60		476	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	94,794	3,594	2,149	1,038	3,567	50
52 DELIVERY ROOM & LABOR ROOM	5,475	178	124		476	52
54 RADIOLOGY-DIAGNOSTIC	59,208	1,763	1,342			54
55 RADIOLOGY-THERAPEUTIC	58,844	803	1,334			55
57 COMPUTED TOMOGRAPHY (CT) SCAN		2,252				57
59 CARDIAC CATHETERIZATION		317				59
60 LABORATORY	23,707		538			60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	15,878	982	360			65
66 PHYSICAL THERAPY	15,995	651	363			66
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY		204				76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.02 SPORTS MED ATHLETIC TRAINERS						90.02
90.03 SAINT JOSEPH HEALTH CENTER		14			476	90.03
90.04 WOUND CARE		140			357	90.04
91 EMERGENCY	47,719	1,310	1,082	1,197	1,902	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	562,855	16,397	12,628	109,358	12,721	118
NONREIMBURSABLE COST CENTERS						
190.01 PLYMOUTH MOB-4						190.01
190.02 HOSPITALIST						190.02
192 PHYSICIANS' PRIVATE OFFICES	95,471		2,165			192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	658,326	16,397	14,793	109,358	12,721	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					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	110,241				14
15 PHARMACY		87,891			15
16 MEDICAL RECORDS & LIBRARY	83		105,392		16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	6,718	150	6,675	674,698	30
31 INTENSIVE CARE UNIT	2,086	7	3,132	148,295	31
43 NURSERY	960			15,937	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	39,724	132	19,437	666,008	50
52 DELIVERY ROOM & LABOR ROOM	960		962	27,273	52
54 RADIOLOGY-DIAGNOSTIC	4,632	5,631	9,528	450,584	54
55 RADIOLOGY-THERAPEUTIC	334		4,341	443,509	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	2,670	2,498	12,170	21,422	57
59 CARDIAC CATHETERIZATION	6,843	143	1,713	383,385	59
60 LABORATORY	31,003		17,457	227,472	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY	2,420	17	5,309	129,925	65
66 PHYSICAL THERAPY	1,419	46	3,520	79,571	66
72 IMPL. DEV. CHARGED TO PATIENT			2,497	13,011	72
73 DRUGS CHARGED TO PATIENTS		78,917	8,877	102,072	73
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY			1,863	5,338	76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90.02 SPORTS MED ATHLETIC TRAINERS				2,499	90.02
90.03 SAINT JOSEPH HEALTH CENTER			77	8,278	90.03
90.04 WOUND CARE	4,214	328	757	19,427	90.04
91 EMERGENCY	6,175	22	7,077	248,619	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	110,241	87,891	105,392	3,667,323	118
NONREIMBURSABLE COST CENTERS					
190.01 PLYMOUTH MOB-4				1,219	190.01
190.02 HOSPITALIST				94	190.02
192 PHYSICIANS' PRIVATE OFFICES				346,538	192
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	110,241	87,891	105,392	4,015,174	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION		TOTAL	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		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 SRVCES-SALARY & FRINGES APPRVD		21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS	674,698	30
31	INTENSIVE CARE UNIT	148,295	31
43	NURSERY	15,937	43
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	666,008	50
52	DELIVERY ROOM & LABOR ROOM	27,273	52
54	RADIOLOGY-DIAGNOSTIC	450,584	54
55	RADIOLOGY-THERAPEUTIC	443,509	55
57	COMPUTED TOMOGRAPHY (CT) SCAN	21,422	57
59	CARDIAC CATHETERIZATION	383,385	59
60	LABORATORY	227,472	60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS		62.30
65	RESPIRATORY THERAPY	129,925	65
66	PHYSICAL THERAPY	79,571	66
72	IMPL. DEV. CHARGED TO PATIENT	13,011	72
73	DRUGS CHARGED TO PATIENTS	102,072	73
74	RENAL DIALYSIS		74
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY	5,338	76.98
76.99	LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS			
90.02	SPORTS MED ATHLETIC TRAINERS	2,499	90.02
90.03	SAINT JOSEPH HEALTH CENTER	8,278	90.03
90.04	WOUND CARE	19,427	90.04
91	EMERGENCY	248,619	91
92	OBSERVATION BEDS		92
OTHER REIMBURSABLE COST CENTERS			
94	HOME PROGRAM DIALYSIS		94
SPECIAL PURPOSE COST CENTERS			
118	SUBTOTALS (SUM OF LINES 1-117)	3,667,323	118
NONREIMBURSABLE COST CENTERS			
190.01	PLYMOUTH MOB-4	1,219	190.01
190.02	HOSPITALIST	94	190.02
192	PHYSICIANS' PRIVATE OFFICES	346,538	192
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	4,015,174	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
	1	2	5A	5	7	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	152,993					1
2 CAP REL COSTS-MVBLE EQUIP		1,411,625				2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	17,897	36,300	-7,542,289	27,521,991		5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	33,848	64,514		2,047,662	101,248	7
8 LAUNDRY & LINEN SERVICE	606			188,488	606	8
9 HOUSEKEEPING	300	211		620,615	300	9
10 DIETARY	4,105	4,585		701,886	4,105	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		5,812		550,101		13
14 CENTRAL SERVICES & SUPPLY	4,671			78,223	4,671	14
15 PHARMACY	1,241	49,465		648,170	1,241	15
16 MEDICAL RECORDS & LIBRARY	3,914	5,422		665,876	3,914	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	18,136	105,478		2,887,250	18,136	30
31 INTENSIVE CARE UNIT	3,718	17,135		1,189,694	3,718	31
43 NURSERY	410			400,784	410	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	14,579	203,314		3,931,574	14,579	50
52 DELIVERY ROOM & LABOR ROOM	842			408,019	842	52
54 RADIOLOGY-DIAGNOSTIC	9,106	192,320		1,471,227	9,106	54
55 RADIOLOGY-THERAPEUTIC	9,050	210,221		808,601	9,050	55
57 COMPUTED TOMOGRAPHY (CT) SCAN				149,583		57
59 CARDIAC CATHETERIZATION		356,711		586,872		59
60 LABORATORY	3,646	57,341		2,831,859	3,646	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	2,442	50,652		973,606	2,442	65
66 PHYSICAL THERAPY	2,460	1,707		1,193,919	2,460	66
72 IMPL. DEV. CHARGED TO PATIENT				858,420		72
73 DRUGS CHARGED TO PATIENTS				1,165,747		73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY				267,049		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.02 SPORTS MED ATHLETIC TRAINERS				204,038		90.02
90.03 SAINT JOSEPH HEALTH CENTER		4,190		277,427		90.03
90.04 WOUND CARE		7,659		469,249		90.04
91 EMERGENCY	7,339	38,588		1,592,993	7,339	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	138,310	1,411,625	-7,542,289	27,168,932	86,565	118
NONREIMBURSABLE COST CENTERS						
190.01 PLYMOUTH MOB-4				99,498		190.01
190.02 HOSPITALIST				7,671		190.02
192 PHYSICIANS' PRIVATE OFFICES	14,683			245,890	14,683	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,562,112	1,453,062		7,542,289	2,608,816	202
203 UNIT COST MULT-WS B PT I	16.746596	1.029354		0.274046	25.766593	203
204 COST TO BE ALLOC PER B PT II				337,080	658,326	204
205 UNIT COST MULT-WS B PT II				0.012248	6.502114	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING SQUARE FEET 9	DIETARY MEALS SERVED 10	NURSING ADMINISTRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS						5
6 OPERATION OF PLANT						6
7 LAUNDRY & LINEN SERVICE	101,754,368					7
8 HOUSEKEEPING		100,342				8
9 DIETARY		4,105	2,740			9
10 CAFETERIA						10
11 MAINTENANCE OF PERSONNEL						11
12 NURSING ADMINISTRATION				107		12
13 CENTRAL SERVICES & SUPPLY		4,671			2,642	13
14 PHARMACY		1,241				14
15 MEDICAL RECORDS & LIBRARY		3,914			2	15
16 SOCIAL SERVICE						16
17 NONPHYSICIAN ANESTHETISTS						17
19 NURSING SCHOOL						19
20 I&R SRVCES-SALARY & FRINGES APPRVD						20
21 I&R SRVCES-OTHER PRGM COSTS APPRVD						21
22 PARAMED ED PRGM-(SPECIFY)						22
23 INPATIENT ROUTINE SERV COST CENTERS						23
30 ADULTS & PEDIATRICS	3,599,789	18,136	2,212	34	161	30
31 INTENSIVE CARE UNIT	22,320,182	3,718	472	12	50	31
43 NURSERY		410		4	23	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	22,320,182	14,579	26	30	952	50
52 DELIVERY ROOM & LABOR ROOM	1,105,253	842		4	23	52
54 RADIOLOGY-DIAGNOSTIC	10,952,154	9,106			111	54
55 RADIOLOGY-THERAPEUTIC	4,989,125	9,050			8	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	13,988,954				64	57
59 CARDIAC CATHETERIZATION	1,969,119				164	59
60 LABORATORY		3,646			743	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	6,102,188	2,442			58	65
66 PHYSICAL THERAPY	4,046,015	2,460			34	66
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	1,268,280					76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.02 SPORTS MED ATHLETIC TRAINERS						90.02
90.03 SAINT JOSEPH HEALTH CENTER	88,395			4		90.03
90.04 WOUND CARE	870,599			3	101	90.04
91 EMERGENCY	8,134,133	7,339	30	16	148	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	101,754,368	85,659	2,740	107	2,642	118
NONREIMBURSABLE COST CENTERS						
190.01 PLYMOUTH MOB-4						190.01
190.02 HOSPITALIST						190.02
192 PHYSICIANS' PRIVATE OFFICES		14,683				192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	255,757	798,422	1,032,671	700,854	257,183	202
203 UNIT COST MULT-WS B PT I	0.002513	7.957007	376.887226	6,550.037383	97.344058	203
204 COST TO BE ALLOC PER B PT II	16,397	14,793	109,358	12,721	110,241	204
205 UNIT COST MULT-WS B PT II	0.000161	0.147426	39.911679	118.887850	41.726344	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PHARMACY	MEDICAL	
	COSTED REQUIS. 15	RECORDS + LIBRARY GROSS REVENUE 16	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			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	1,298,335		15
16 MEDICAL RECORDS & LIBRARY		121,118,661	16
17 SOCIAL SERVICE			17
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS	2,211	7,671,853	30
31 INTENSIVE CARE UNIT	105	3,599,789	31
43 NURSERY			43
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	1,951	22,320,182	50
52 DELIVERY ROOM & LABOR ROOM		1,105,253	52
54 RADIOLOGY-DIAGNOSTIC	83,189	10,952,154	54
55 RADIOLOGY-THERAPEUTIC		4,989,125	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	36,901	13,988,954	57
59 CARDIAC CATHETERIZATION	2,119	1,969,119	59
60 LABORATORY		20,065,587	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS			62.30
65 RESPIRATORY THERAPY	253	6,102,188	65
66 PHYSICAL THERAPY	683	4,046,015	66
72 IMPL. DEV. CHARGED TO PATIENT		2,870,492	72
73 DRUGS CHARGED TO PATIENTS	1,165,747	10,203,843	73
74 RENAL DIALYSIS			74
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY		2,140,980	76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
90.02 SPORTS MED ATHLETIC TRAINERS			90.02
90.03 SAINT JOSEPH HEALTH CENTER		88,395	90.03
90.04 WOUND CARE	4,844	870,599	90.04
91 EMERGENCY	332	8,134,133	91
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
94 HOME PROGRAM DIALYSIS			94
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)	1,298,335	121,118,661	118
NONREIMBURSABLE COST CENTERS			
190.01 PLYMOUTH MOB-4			190.01
190.02 HOSPITALIST			190.02
192 PHYSICIANS' PRIVATE OFFICES			192
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 COST TO BE ALLOC PER B PT I	867,649	980,546	202
203 UNIT COST MULT-WS B PT I	0.668278	0.008096	203
204 COST TO BE ALLOC PER B PT II	87,891	105,392	204
205 UNIT COST MULT-WS B PT II	0.067695	0.000870	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT				
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,434,783		5,434,783		5,434,783	30
31 INTENSIVE CARE UNIT	1,987,819		1,987,819		1,987,819	31
43 NURSERY	552,882		552,882		552,882	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,037,697		6,037,697		6,037,697	50
52 DELIVERY ROOM & LABOR ROOM	588,395		588,395		588,395	52
54 RADIOLOGY-DIAGNOSTIC	2,364,089		2,364,089		2,364,089	54
55 RADIOLOGY-THERAPEUTIC	1,389,103		1,389,103		1,389,103	55
57 COMPUTED TOMOGRAPHY (CT) SC	369,875		369,875		369,875	57
59 CARDIAC CATHETERIZATION	785,972		785,972		785,972	59
60 LABORATORY	3,965,653		3,965,653		3,965,653	60
62.30 BLOOD CLOTTING FACTORS ADMI						62.30
65 RESPIRATORY THERAPY	1,393,325		1,393,325		1,393,325	65
66 PHYSICAL THERAPY	1,650,759		1,650,759		1,650,759	66
72 IMPL. DEV. CHARGED TO PATIE	1,116,907		1,116,907		1,116,907	72
73 DRUGS CHARGED TO PATIENTS	2,346,869		2,346,869		2,346,869	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	360,753		360,753		360,753	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.02 SPORTS MED ATHLETIC TRAINER	259,954		259,954		259,954	90.02
90.03 SAINT JOSEPH HEALTH CENTER	380,593		380,593		380,593	90.03
90.04 WOUND CARE	639,800		639,800		639,800	90.04
91 EMERGENCY	2,494,075		2,494,075	45,001	2,539,076	91
92 OBSERVATION BEDS	289,508		289,508		289,508	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 SUBTOTAL (SEE INSTRUCTIONS)	34,408,811		34,408,811	45,001	34,453,812	200
201 LESS OBSERVATION BEDS	289,508		289,508		289,508	201
202 TOTAL (SEE INSTRUCTIONS)	34,119,303		34,119,303	45,001	34,164,304	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	7,030,156		7,030,156			30
31 INTENSIVE CARE UNIT	3,599,789		3,599,789			31
43 NURSERY	641,697		641,697			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	8,593,884	15,893,769	24,487,653	0.246561	0.246561	0.246561 50
52 DELIVERY ROOM & LABOR ROOM	1,048,262	56,991	1,105,253	0.532362	0.532362	0.532362 52
54 RADIOLOGY-DIAGNOSTIC	1,861,971	9,090,580	10,952,551	0.215848	0.215848	0.215848 54
55 RADIOLOGY-THERAPEUTIC	113,958	4,875,167	4,989,125	0.278426	0.278426	0.278426 55
57 COMPUTED TOMOGRAPHY (CT) SC	2,881,679	11,107,275	13,988,954	0.026441	0.026441	0.026441 57
59 CARDIAC CATHETERIZATION	719,312	1,664,070	2,383,382	0.329772	0.329772	0.329772 59
60 LABORATORY	3,777,827	16,287,761	20,065,588	0.197635	0.197635	0.197635 60
62.30 BLOOD CLOTTING FACTORS ADMI						62.30
65 RESPIRATORY THERAPY	2,380,587	3,721,601	6,102,188	0.228332	0.228332	0.228332 65
66 PHYSICAL THERAPY	770,472	3,275,543	4,046,015	0.407996	0.407996	0.407996 66
72 IMPL. DEV. CHARGED TO PATIE	2,476,562	393,930	2,870,492	0.389099	0.389099	0.389099 72
73 DRUGS CHARGED TO PATIENTS	6,061,696	4,146,309	10,208,005	0.229905	0.229905	0.229905 73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	15,936	1,252,344	1,268,280	0.284443	0.284443	0.284443 76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.02 SPORTS MED ATHLETIC TRAINER						90.02
90.03 SAINT JOSEPH HEALTH CENTER		88,395	88,395	4.305594	4.305594	4.305594 90.03
90.04 WOUND CARE	13,668	856,930	870,598	0.734897	0.734897	0.734897 90.04
91 EMERGENCY	1,502,036	6,719,496	8,221,532	0.303359	0.303359	0.308832 91
92 OBSERVATION BEDS	16,268	372,505	388,773	0.744671	0.744671	0.744671 92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 SUBTOTAL (SEE INSTRUCTIONS)	43,505,760	79,802,666	123,308,426			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	43,505,760	79,802,666	123,308,426			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST	SWING-BED ADJUSTMENT	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)		(COL.1 MINUS COL.2)		(COL.3 + COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	674,698		674,698	6,270	107.61	3,038	326,919	30
31 INTENSIVE CARE UNIT	148,295		148,295	1,507	98.40	848	83,443	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	15,937		15,937	651	24.48			43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	838,930		838,930	8,428		3,886	410,362	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-0076) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT	CAPITAL	
	COST	CHARGES	COST TO			
	(FROM WKST	(FROM WKST	CHARGES	PROGRAM	(COL.3 x	
	B, PT. II,	C, PT. I,	(COL.1 +	CHARGES	COL.4)	
	COL. 26)	COL. 8)	COL.2)			
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	666,008	24,487,653	0.027198	3,014,863	81,998	50
52 DELIVERY ROOM & LABOR ROOM	27,273	1,105,253	0.024676	10,686	264	52
54 RADIOLOGY-DIAGNOSTIC	450,584	10,952,551	0.041140	1,123,058	46,203	54
55 RADIOLOGY-THERAPEUTIC	443,509	4,989,125	0.088895	59,052	5,249	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	21,422	13,988,954	0.001531	1,481,637	2,268	57
59 CARDIAC CATHETERIZATION	383,385	2,383,382	0.160858	243,681	39,198	59
60 LABORATORY	227,472	20,065,588	0.011336	2,174,537	24,651	60
62.30 BLOOD CLOTTING FACTORS ADMIN						62.30
65 RESPIRATORY THERAPY	129,925	6,102,188	0.021292	1,447,037	30,810	65
66 PHYSICAL THERAPY	79,571	4,046,015	0.019667	521,556	10,257	66
72 IMPL. DEV. CHARGED TO PATIENT	13,011	2,870,492	0.004533	1,464,078	6,637	72
73 DRUGS CHARGED TO PATIENTS	102,072	10,208,005	0.009999	3,398,656	33,983	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	5,338	1,268,280	0.004209	1,992	8	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.02 SPORTS MED ATHLETIC TRAINERS	2,499					90.02
90.03 SAINT JOSEPH HEALTH CENTER	8,278	88,395	0.093648			90.03
90.04 WOUND CARE	19,427	870,598	0.022315	4,961	111	90.04
91 EMERGENCY	248,619	8,221,532	0.030240	695,996	21,047	91
92 OBSERVATION BEDS	35,941	388,773	0.092447	15,319	1,416	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)	2,864,334	112,036,784	112,036,784	15,657,109	304,100	200

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER-PL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK [] TITLE V
APPLICABLE [XX] TITLE XVIII-PT A
BOXES [] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					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 (SUM OF LINES 30-199)					200

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER-PL
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	6,270		3,038		30
31 INTENSIVE CARE UNIT	1,507		848		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	651				43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	8,428		3,886		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0076) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FACTORS ADMIN						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.02 SPORTS MED ATHLETIC TRAINERS						90.02
90.03 SAINT JOSEPH HEALTH CENTER						90.03
90.04 WOUND CARE						90.04
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0076) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO				
	(FROM WKST	CHARGES	CHARGES	INPAT	COSTS	CHARGES	COSTS
	C, PT. I,	(COL. 5 +	(COL. 6 +	PGM	(COL. 8 x		(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)	CHARGES	COL. 10)		COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	24,487,653			3,014,863		3,453,302	50
52 DELIVERY ROOM & LABOR ROOM	1,105,253			10,686			52
54 RADIOLOGY-DIAGNOSTIC	10,952,551			1,123,058		2,059,311	54
55 RADIOLOGY-THERAPEUTIC	4,989,125			59,052		1,983,790	55
57 COMPUTED TOMOGRAPHY (CT) SCA	13,988,954			1,481,637		3,351,878	57
59 CARDIAC CATHETERIZATION	2,383,382			243,681		260,698	59
60 LABORATORY	20,065,588			2,174,537		381,480	60
62.30 BLOOD CLOTTING FACTORS ADMIN							62.30
65 RESPIRATORY THERAPY	6,102,188			1,447,037		1,600,203	65
66 PHYSICAL THERAPY	4,046,015			521,556			66
72 IMPL. DEV. CHARGED TO PATIEN	2,870,492			1,464,078		249,819	72
73 DRUGS CHARGED TO PATIENTS	10,208,005			3,398,656		1,284,039	73
74 RENAL DIALYSIS							74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY	1,268,280			1,992		611,544	76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90.02 SPORTS MED ATHLETIC TRAINERS							90.02
90.03 SAINT JOSEPH HEALTH CENTER	88,395						90.03
90.04 WOUND CARE	870,598			4,961		466,518	90.04
91 EMERGENCY	8,221,532			695,996		1,235,943	91
92 OBSERVATION BEDS	388,773			15,319		103,353	92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	112,036,784			15,657,109		17,041,878	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0076) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO CHARGE FROM WKST C, PT I, COL. 9	RATIO	PPS REIMBURSED SERVICES	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCS NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES SUBJECT TO DED & COINS	
	1		2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.246561		3,453,302			851,450		50
52 DELIVERY ROOM & LABOR ROOM	0.532362							52
54 RADIOLOGY-DIAGNOSTIC	0.215848		2,059,311			444,498		54
55 RADIOLOGY-THERAPEUTIC	0.278426		1,983,790			552,339		55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.026441		3,351,878			88,627		57
59 CARDIAC CATHETERIZATION	0.329772		260,698			85,971		59
60 LABORATORY	0.197635		381,480			75,394		60
62.30 BLOOD CLOTTING FACTORS ADMIN CO								62.30
65 RESPIRATORY THERAPY	0.228332		1,600,203			365,378		65
66 PHYSICAL THERAPY	0.407996							66
72 IMPL. DEV. CHARGED TO PATIENT	0.389099		249,819			97,204		72
73 DRUGS CHARGED TO PATIENTS	0.229905		1,284,039		54,881	295,207		73
74 RENAL DIALYSIS								74
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.284443		611,544			173,949		76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
90.02 SPORTS MED ATHLETIC TRAINERS								90.02
90.03 SAINT JOSEPH HEALTH CENTER	4.305594							90.03
90.04 WOUND CARE	0.734897		466,518			342,843		90.04
91 EMERGENCY	0.303359		1,235,943			374,934		91
92 OBSERVATION BEDS	0.744671		103,353			76,964		92
OTHER REIMBURSABLE COST CENTERS								
94 HOME PROGRAM DIALYSIS								94
200 SUBTOTAL (SEE INSTRUCTIONS)			17,041,878		54,881	3,824,758		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			17,041,878		54,881	3,824,758		202

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER-PL
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST	SWING-BED ADJUSTMENT	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)		(COL.1 MINUS COL.2)		(COL.3 + COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	674,698		674,698	6,270	107.61	884	95,127	30
31 INTENSIVE CARE UNIT	148,295		148,295	1,507	98.40			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	15,937		15,937	651	24.48	540	13,219	43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	838,930		838,930	8,428		1,424	108,346	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-0076) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] OTHER

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT	CAPITAL	
	COST	CHARGES	COST TO			
	(FROM WKST	(FROM WKST	CHARGES	PROGRAM	(COL.3 x	
	B, PT. II,	C, PT. I,	(COL.1 +	CHARGES	COL.4)	
	COL. 26)	COL. 8)	COL.2)			
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	666,008	24,487,653	0.027198	1,156,260	31,448	50
52 DELIVERY ROOM & LABOR ROOM	27,273	1,105,253	0.024676	609,122	15,031	52
54 RADIOLOGY-DIAGNOSTIC	450,584	10,952,551	0.041140	136,262	5,606	54
55 RADIOLOGY-THERAPEUTIC	443,509	4,989,125	0.088895			55
57 COMPUTED TOMOGRAPHY (CT) SCAN	21,422	13,988,954	0.001531	211,479	324	57
59 CARDIAC CATHETERIZATION	383,385	2,383,382	0.160858	33,687	5,419	59
60 LABORATORY	227,472	20,065,588	0.011336	386,085	4,377	60
62.30 BLOOD CLOTTING FACTORS ADMIN						62.30
65 RESPIRATORY THERAPY	129,925	6,102,188	0.021292	165,344	3,521	65
66 PHYSICAL THERAPY	79,571	4,046,015	0.019667	44,805	881	66
72 IMPL. DEV. CHARGED TO PATIENT	13,011	2,870,492	0.004533			72
73 DRUGS CHARGED TO PATIENTS	102,072	10,208,005	0.009999	702,139	7,021	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	5,338	1,268,280	0.004209			76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.02 SPORTS MED ATHLETIC TRAINERS	2,499					90.02
90.03 SAINT JOSEPH HEALTH CENTER	8,278	88,395	0.093648			90.03
90.04 WOUND CARE	19,427	870,598	0.022315	25	1	90.04
91 EMERGENCY	248,619	8,221,532	0.030240	130,237	3,938	91
92 OBSERVATION BEDS		388,773	388,773			92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)	2,828,393	112,036,784	112,036,784	3,575,445	77,567	200

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER-PL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK [] TITLE V
APPLICABLE [] TITLE XVIII-PT A
BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					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 (SUM OF LINES 30-199)					200

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER-PL
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	6,270		884		30
31 INTENSIVE CARE UNIT	1,507				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	651		540		43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	8,428		1,424		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0076) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FACTORS ADMIN						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.02 SPORTS MED ATHLETIC TRAINERS						90.02
90.03 SAINT JOSEPH HEALTH CENTER						90.03
90.04 WOUND CARE						90.04
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0076) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO				
	(FROM WKST	CHARGES	CHARGES	INPAT	COSTS	CHARGES	COSTS
	C, PT. I,	(COL. 5 +	(COL. 6 +	PGM	(COL. 8 x		(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)	CHARGES	COL. 10)	CHARGES	COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	24,487,653			1,156,260			50
52 DELIVERY ROOM & LABOR ROOM	1,105,253			609,122			52
54 RADIOLOGY-DIAGNOSTIC	10,952,551			136,262			54
55 RADIOLOGY-THERAPEUTIC	4,989,125						55
57 COMPUTED TOMOGRAPHY (CT) SCA	13,988,954			211,479			57
59 CARDIAC CATHETERIZATION	2,383,382			33,687			59
60 LABORATORY	20,065,588			386,085			60
62.30 BLOOD CLOTTING FACTORS ADMIN							62.30
65 RESPIRATORY THERAPY	6,102,188			165,344			65
66 PHYSICAL THERAPY	4,046,015			44,805			66
72 IMPL. DEV. CHARGED TO PATIEN	2,870,492						72
73 DRUGS CHARGED TO PATIENTS	10,208,005			702,139			73
74 RENAL DIALYSIS							74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY	1,268,280						76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90.02 SPORTS MED ATHLETIC TRAINERS							90.02
90.03 SAINT JOSEPH HEALTH CENTER	88,395						90.03
90.04 WOUND CARE	870,598			25			90.04
91 EMERGENCY	8,221,532			130,237			91
92 OBSERVATION BEDS	388,773						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	112,036,784			3,575,445			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0076) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	PPS	COST SERVICES	COST SVCES NOT SUBJECT TO
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.246561						50
52 DELIVERY ROOM & LABOR ROOM	0.532362						52
54 RADIOLOGY-DIAGNOSTIC	0.215848						54
55 RADIOLOGY-THERAPEUTIC	0.278426						55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.026441						57
59 CARDIAC CATHETERIZATION	0.329772						59
60 LABORATORY	0.197635						60
62.30 BLOOD CLOTTING FACTORS ADMIN CO							62.30
65 RESPIRATORY THERAPY	0.228332						65
66 PHYSICAL THERAPY	0.407996						66
72 IMPL. DEV. CHARGED TO PATIENT	0.389099						72
73 DRUGS CHARGED TO PATIENTS	0.229905						73
74 RENAL DIALYSIS							74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.284443						76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90.02 SPORTS MED ATHLETIC TRAINERS							90.02
90.03 SAINT JOSEPH HEALTH CENTER	4.305594						90.03
90.04 WOUND CARE	0.734897						90.04
91 EMERGENCY	0.303359						91
92 OBSERVATION BEDS	0.744671						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0076) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	6,270	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,270	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,270	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 (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,038	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,434,783	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	5,434,783	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	7,671,853	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	7,671,853	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.708406	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)	1,223.58	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,434,783	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0076) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 866.79 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,633,308 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) 2,633,308 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	1,987,819	1,507	1,319.06	848	1,118,563	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					3,681,993	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					7,433,864	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 410,362 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 304,100 51
 52 TOTAL PROGRAM EXCLUDABLE COST 714,462 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 6,719,402 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 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 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 O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 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 INSTRU (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 334 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 866.79 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 289,508 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	674,698	5,434,783	0.124144	289,508	35,941	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0076) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	6,270	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,270	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,270	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 (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	884	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	651	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	540	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,434,783	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	5,434,783	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	7,671,853	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	7,671,853	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.708406	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)	1,223.58	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,434,783	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0076) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 866.79 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 766,242 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) 766,242 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)	552,882	651	849.28	540	458,611 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	1,987,819	1,507	1,319.06		43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					989,476 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,214,329 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 108,346 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 77,567 51
 52 TOTAL PROGRAM EXCLUDABLE COST 185,913 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 2,028,416 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 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 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 O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 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 INSTRU (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 334 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

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
90 CAPITAL-RELATED COST					90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-0076) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		3,131,275		30
31 INTENSIVE CARE UNIT		1,949,483		31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.246561	3,014,863	743,348	50
52 DELIVERY ROOM & LABOR ROOM	0.532362	10,686	5,689	52
54 RADIOLOGY-DIAGNOSTIC	0.215848	1,123,058	242,410	54
55 RADIOLOGY-THERAPEUTIC	0.278426	59,052	16,442	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.026441	1,481,637	39,176	57
59 CARDIAC CATHETERIZATION	0.329772	243,681	80,359	59
60 LABORATORY	0.197635	2,174,537	429,765	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.228332	1,447,037	330,405	65
66 PHYSICAL THERAPY	0.407996	521,556	212,793	66
72 IMPL. DEV. CHARGED TO PATIENT	0.389099	1,464,078	569,671	72
73 DRUGS CHARGED TO PATIENTS	0.229905	3,398,656	781,368	73
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.284443	1,992	567	76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90.02 SPORTS MED ATHLETIC TRAINERS				90.02
90.03 SAINT JOSEPH HEALTH CENTER	4.305594			90.03
90.04 WOUND CARE	0.734897	4,961	3,646	90.04
91 EMERGENCY	0.308832	695,996	214,946	91
92 OBSERVATION BEDS	0.744671	15,319	11,408	92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		15,657,109	3,681,993	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		15,657,109		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-0076) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		950,971		30
31 INTENSIVE CARE UNIT		251,619		31
43 NURSERY		395,097		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.246561	1,156,260	285,089	50
52 DELIVERY ROOM & LABOR ROOM	0.532362	609,122	324,273	52
54 RADIOLOGY-DIAGNOSTIC	0.215848	136,262	29,412	54
55 RADIOLOGY-THERAPEUTIC	0.278426			55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.026441	211,479	5,592	57
59 CARDIAC CATHETERIZATION	0.329772	33,687	11,109	59
60 LABORATORY	0.197635	386,085	76,304	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.228332	165,344	37,753	65
66 PHYSICAL THERAPY	0.407996	44,805	18,280	66
72 IMPL. DEV. CHARGED TO PATIENT	0.389099			72
73 DRUGS CHARGED TO PATIENTS	0.229905	702,139	161,425	73
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.284443			76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90.02 SPORTS MED ATHLETIC TRAINERS				90.02
90.03 SAINT JOSEPH HEALTH CENTER	4.305594			90.03
90.04 WOUND CARE	0.734897	25	18	90.04
91 EMERGENCY	0.308832	130,237	40,221	91
92 OBSERVATION BEDS	0.744671			92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		3,575,445	989,476	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		3,575,445		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (15-0076)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	6,351,942	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	38,485	2
3	MANAGED CARE SIMULATED PAYMENTS	487,703	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	44.08	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) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0313	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1759	31
32	SUM OF LINES 30 AND 31	0.2072	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0632	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	401,443	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
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 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)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	6,791,870	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	6,791,870	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	520,738	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (15-0076)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	7,312,608	59
60	PRIMARY PAYER PAYMENTS	3,868	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	7,308,740	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	802,356	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	7,820	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	201,295	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	140,907	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	6,639,471	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.97	LOW VOLUME PAYMENT ADJUSTMENT - 2	387,865	70.97
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	7,027,336	71
72	INTERIM PAYMENTS	7,060,574	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	-33,238	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (15-0076) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	INPATIENT PART A		PART B		
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		6,968,481		3,148,063	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					
		.01			3.01
		.02			3.02
	02/10/2011	92,093	02/10/2011	35,889	3.02
		.03			3.03
		.04			3.04
		.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.50		NONE	3.50
		.51			3.51
		.52			3.52
		.53			3.53
		.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
		.99			3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		92,093		35,889	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		7,060,574		3,183,952	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					
		.01			5.01
		.02			5.02
		.03			5.03
		.04			5.04
		.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.50			5.50
		.51			5.51
		.52			5.52
		.53			5.53
		.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
		.99			5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT					
		.01			6.01
		.02			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER-PL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
01/24/2012 09:48

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (15-0076) [] CAH
APPLICABLE BOX

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	2,244	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	3,886	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	830	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	7,443	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	123,308,426	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	4,679,000	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	1,461,360	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	1,461,360	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (15-0076) [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [] OTHER
 [] SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	1
2	MEDICAL AND OTHER SERVICES	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	3,575,445 9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	3,575,445 12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000 15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	3,575,445 16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 7 (SEE INSTRUCTIONS))	3,575,445 17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 7 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LINE 7)	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 22-26 PLUS LINE 3 MINUS LINES 5 AND 6)	27
28	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)	28
29	TITLE V OR XIX PPS, ENTER AMOUNT FROM LINE 27, NON-PPS ENTER AMOUNT FROM LINE 21	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19-20 PLUS 29 MINUS 30)	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)	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	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)	40
41	INTERIM PAYMENTS	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	25,940,000			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	7,859,000			4
5	OTHER RECEIVABLES	1,970,000			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,708,000			6
7	INVENTORY	988,000			7
8	PREPAID EXPENSES	163,000			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	35,212,000			11
FIXED ASSETS					
12	LAND	478,000			12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	33,714,000			15
16	ACCUMULATED DEPRECIATION	-21,655,000			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	23,144,000			23
24	ACCUMULATED DEPRECIATION	-17,625,000			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	18,056,000			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	296,000			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	296,000			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	53,564,000			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,770,000			37
38	SALARIES, WAGES & FEES PAYABLE	1,378,000			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	135,000			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	1,003,000			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	4,286,000			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	6,609,000			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	345,000			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	6,954,000			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	11,240,000			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	42,324,000			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	42,324,000			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	53,564,000			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		36,211,901							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		6,112,099							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		42,324,000							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		42,324,000							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		42,324,000							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	12,336,000		12,336,000	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SWING BED - NF				7
8 SKILLED NURSING FACILITY				8
9 NURSING FACILITY				9
10 OTHER LONG TERM CARE				10
TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	12,336,000		12,336,000	11
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	12,336,000		12,336,000	17
18 ANCILLARY SERVICES	31,170,000	80,153,000	111,323,000	18
19 OUTPATIENT SERVICES				19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	43,506,000	80,153,000	123,659,000	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		41,444,901	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		41,444,901	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	123,659,000	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	76,906,000	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	46,753,000	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	41,444,901	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	5,308,099	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		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 MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24		804,000	24
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	804,000	25
26	TOTAL (LINE 5 PLUS LINE 25)	6,112,099	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	6,112,099	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((15-007) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	516,037	1
2	CAPITAL DRG OUTLIER PAYMENTS	4,701	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	20.39	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	520,738	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 FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (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 FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)		17

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((15-007) [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT	
1	CAPITAL DRG OTHER THAN OUTLIER	1
2	CAPITAL DRG OUTLIER PAYMENTS	2
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 (LINE 1 TIMES LINE 5)	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	8
9	SUM OF LINES 7 AND 8	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (SEE INSTRUCTIONS)	1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (SEE INSTRUCTIONS)	2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 1 PLUS LINE 2)	3
4	CAPITAL COST PAYMENT FACTOR (SEE INSTRUCTIONS)	4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 3 TIMES LINE 4)	5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)	1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	2
3	NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)	3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)	4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)	5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)	7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (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 FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST 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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	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					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 SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
52 DELIVERY ROOM & LABOR ROOM					52
54 RADIOLOGY-DIAGNOSTIC					54
55 RADIOLOGY-THERAPEUTIC					55
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
59 CARDIAC CATHETERIZATION					59
60 LABORATORY					60
62.30 BLOOD CLOTTING FACTORS ADMIN C					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90.02 SPORTS MED ATHLETIC TRAINERS					90.02
90.03 SAINT JOSEPH HEALTH CENTER					90.03
90.04 WOUND CARE					90.04
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190.01 PLYMOUTH MOB-4					190.01
190.02 HOSPITALIST					190.02
192 PHYSICIANS' PRIVATE OFFICES					192
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204