

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. [X] ELECTRONICALLY FILED COST REPORT DATE: 01-20-2014 TIME: 14:13
 2. [X] MANUALLY SUBMITTED COST REPORT
 3. [1] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. [F] 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 07/01/2011 AND ENDING 06/30/2012, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(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		49,362	-97,198	1,368,728	197	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		49,362	-97,198	1,368,728	197	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
 2 CITY: PLYMOUTH

STATE: IN

P.O.BOX: 670
 ZIP CODE: 46563

COUNTY: MARSHALL

1
 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 PL	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: 07/01/2011			TO: 06/30/2012					20
21	TYPE OF CONTROL									21

INPATIENT PPS INFORMATION

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID UNPAID DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID UNPAID DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
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 Y N 22
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
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	1,718						24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2			26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				2			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)							1 2 Y Y 39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

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

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 2148? IF YES, COMPLETE WORKSHEET D-5.	N		58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	Y		60
		Y/N	IME	DIRECT GME
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(SEE INSTRUCTIONS)	N		61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)			61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY FTEs, AND PRIMARY CARE FTEs ADDED UNDER SECTION 5503). (SEE INSTRUCTIONS)			61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)			61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)			61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)			61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)			61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.		UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT
	PROGRAM NAME 1	PROGRAM CODE 2	3	4
				61.10
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.			61.20
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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS
 THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER
 JULY 1, 2009 AND BEFORE JUNE 30, 2010.

UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
64		64

ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED
 RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY
 CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL
 NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED
 NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN
 COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE
 INSTRUCTIONS)

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR
 FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME.
 ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF
 UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS
 OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER
 OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL.
 ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)).
 (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.3+COL.4) 5
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS
 EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010

UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
66		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)

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)) 5
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? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE 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? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE 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
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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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

		V	XIX	
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.	1	2	
		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)?	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- SICAL ATIONAL N	RESPI- RATORY 109
MISCELLANEOUS COST REPORTING INFORMATION				
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-18 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 186,336 PAID LOSSES: 447,400 SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	Y	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR 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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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. 1 2
 Y 15H034 140

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND
 ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141 NAME: SAINT JOSEPH REG MEDICAL CTR CONTRACTOR'S NAME: WISCONSIN PHYSICIANS SERVICE I CONTRACTOR'S NUMBER: 08102 141
 142 STREET: 5215 HOLY CROSS PARKWAY P.O. BOX: 142
 143 CITY: MISHAWAKA STATE: IN ZIP CODE: 46545 143
 144 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y 144
 145 IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT
 SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO. N 145
 146 HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y'
 FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE
 APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2. N 146
 147 WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO. N 147
 148 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO. N 148
 149 WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO. N 149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE
 APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO

	TITLE XVIII		TITLE	TITLE
	PART A	PART B	V	XIX
FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)	1	2	3	4
155 HOSPITAL	N	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		161
161.10 CORF				161.10

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs?
 ENTER 'Y' FOR YES OR 'N' FOR NO. N 165

166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN
 COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO. Y 167
 168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND 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
 170 IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE
 FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyymm) (SEE INSTRUCTIONS) 170

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)	1 N	2	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.	1 N	2	3 2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3
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.	1 Y	2 A	3 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?	1 N	2	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
			Y/N	Y/N
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		1	2
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.		Y	12 N 13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N	14
BED COMPLEMENT				
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15
PART A				
		Y/N	DATE	
PS&R REPORT DATA				
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)	1 Y	2 10/10/2012	3 4 16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		21

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 | |

COST REPORT PREPARER CONTACT INFORMATION

- | | | | |
|--|-----------------------------------|-----------------------------|----|
| 41 FIRST NAME: CRAIG | LAST NAME: NIETCH | TITLE: DIRECTOR OF REIMBURS | 41 |
| 42 EMPLOYER: SAINT JOSEPH REGIONAL MEDICAL | | | 42 |
| 43 PHONE NUMBER: 574-472-6073 | E-MAIL ADDRESS: NIETCHC@SJRCM.COM | | 43 |

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	13,563,101	-62,896	13,500,205	541,828.00	24.92
2	NON-PHYSICIAN ANESTHETIST PART A						1
3	NON-PHYSICIAN ANESTHETIST PART B						2
4	PHYSICIAN-PART A ADMINISTRATIVE		37,179		37,179	232.00	160.25
4.01	PHYSICIAN-PART A - TEACHING						4
5	PHYSICIAN-PART B						4.01
6	NON-PHYSICIAN-PART B						5
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					6
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7
8	HOME OFFICE PERSONNEL						7.01
9	SNF	44					8
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		6,978	16,055	23,033	504.00	45.70
	OTHER WAGES & RELATED COSTS						9
11	CONTRACT LABOR (SEE INSTRUCTIONS)		123,675		123,675	4,097.00	30.19
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						10
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		103,605		103,605	1,286.00	80.56
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		3,730,727		3,730,727	76,857.00	48.54
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						13
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						14
	WAGE-RELATED COSTS						15
17	WAGE-RELATED COSTS (CORE)		3,487,674	62,896	3,550,570		16
18	WAGE-RELATED COSTS (OTHER)						17
19	EXCLUDED AREAS		1,223		1,223		18
20	NON-PHYSICIAN ANESTHETIST PART A						19
21	NON-PHYSICIAN ANESTHETIST PART B						20
22	PHYSICIAN PART A - ADMINISTRATIVE		9,592		9,592		21
22.01	PHYSICIAN PART A - TEACHING						22
23	PHYSICIAN PART B						22.01
24	WAGE-RELATED COSTS (RHC/FQHC)						23
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						24
	OVERHEAD COSTS - DIRECT SALARIES						25
26	EMPLOYEE BENEFITS DEPARTMENT		62,896	-62,896			26
27	ADMINISTRATIVE & GENERAL		1,565,972	-24,028	1,541,944	63,119.00	24.43
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)						27
29	MAINTENANCE & REPAIRS						28
30	OPERATION OF PLANT		358,581		358,581	14,673.00	24.44
31	LAUNDRY & LINEN SERVICE		28,648		28,648	2,176.00	13.17
32	HOUSEKEEPING		405,553		405,553	33,762.00	12.01
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						30
34	DIETARY		221,518		221,518	16,852.00	13.14
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						31
36	CAFETERIA						32
37	MAINTENANCE OF PERSONNEL						33
38	NURSING ADMINISTRATION		407,450		407,450	11,640.00	35.00
39	CENTRAL SERVICES AND SUPPLY						34
40	PHARMACY		435,530		435,530	11,298.00	38.55
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		261,044		261,044	13,556.00	19.26
42	SOCIAL SERVICE						35
43	OTHER GENERAL SERVICE						36

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	13,563,101	-62,896	13,500,205	541,828.00	24.92	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	6,978	16,055	23,033	504.00	45.70	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	13,556,123	-78,951	13,477,172	541,324.00	24.90	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	3,958,007		3,958,007	82,240.00	48.13	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	3,497,266	62,896	3,560,162		26.42%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	21,011,396	-16,055	20,995,341	623,564.00	33.67	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	3,747,192	-86,924	3,660,268	167,076.00	21.91	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
RETIREMENT COST			
1	401K EMPLOYER CONTRIBUTIONS	285,968	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	598,934	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)	1,356,561	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	144,285	10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	46,209	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	124,721	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE	95,370	15
16	RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	-173,390	16
TAXES			
17	FICA-EMPLOYERS PORTION ONLY	976,420	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	27,289	20
OTHER			
21	EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	4,485	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	3,486,852	24
PART B - OTHER THAN CORE RELATED COST			
25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)	18,880	25

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2013.11
01/20/2014 14:13

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	123,675	1
2	HOSPITAL	123,675	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 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.281170	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID					2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					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					6
7	MEDICAID COST (LINE 1 TIMES LINE 6)					7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.					8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED 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 FACILITY				0	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)				0	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				0	22
23	COST OF CHARITY CARE				0	23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)					26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				81,410	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				-81,410	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				-22,890	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				-22,890	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				-22,890	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100				1,582,890	1
2	00200				1,511,943	2
3	00300					3
4	00400	62,896		62,896	442,049	4
5	00500	1,565,972	14,867,243	16,433,215	-1,677,549	5
6	00600					6
7	00700	358,581	1,364,259	1,722,840	-271,592	7
8	00800	28,648	212,425	241,073		8
9	00900	405,553	254,752	660,305	-211	9
10	01000	221,518	534,794	756,312	-4,173	10
11	01100					11
12	01200					12
13	01300	407,450	112,579	520,029	-3,273	13
14	01400					14
15	01500	435,530	1,383,458	1,818,988	-1,278,650	15
16	01600	261,044	320,339	581,383	-3,950	16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300				16,055	23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	2,272,658	1,146,793	3,419,451	-1,002,191	30
31	03100	789,254	320,170	1,109,424	-14,574	31
43	04300				413,506	43
ANCILLARY SERVICE COST CENTERS						
50	05000	1,706,632	3,195,573	4,902,205	-942,007	50
52	05200				413,506	52
54	05400	799,886	502,332	1,302,218	-194,761	54
55	05500	256,407	511,953	768,360	-282,498	55
57	05700	57,453	71,943	129,396		57
59	05900	81,542	780,337	861,879	-447,172	59
60	06000	1,034,455	1,940,194	2,974,649	-64,074	60
62.30	06250					62.30
65	06500	470,504	456,131	926,635	-37,560	65
66	06600	762,298	421,657	1,183,955	-59,902	66
68	06800				-432	68
69	06900				-16,395	69
72	07200				877,486	72
73	07300				1,231,461	73
76.97	07697					76.97
76.98	07698				221,794	76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	8,616	1,904	10,520		90.01
90.02	09002	178,267	67,285	245,552		90.02
90.03	09003	188,279	105,272	293,551		90.03
90.04	09004	155,878	739,047	894,925	-368,890	90.04
91	09100	1,046,802	491,756	1,538,558	-40,836	91
92	09200					92
OBSERVATION BEDS (NON-DISTINCT PART)						
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113	11300					113
118		13,556,123	29,802,196	43,358,319		118
SUBTOTALS (SUM OF LINES 1-117)						
NONREIMBURSABLE COST CENTERS						
190	19000					190
190.01	19001					190.01
190.02	19002		99,278	99,278		190.02
192	19200		600	600		192
192.02	19201	6,978	1,223	8,201		192.02
200		13,563,101	29,903,297	43,466,398		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	
1	00100 GENERAL SERVICE COST CENTERS				
2	00200 CAP REL COSTS-BLDG & FIXT	1,582,890	731,716	2,314,606	1
3	00300 CAP REL COSTS-MVBLE EQUIP	1,511,943		1,511,943	2
4	00400 OTHER CAP REL COSTS				3
5	00400 EMPLOYEE BENEFITS DEPARTMENT	504,945	-1,029	503,916	4
6	00500 ADMINISTRATIVE & GENERAL	14,755,666	-6,006,526	8,749,140	5
7	00600 MAINTENANCE & REPAIRS				6
8	00700 OPERATION OF PLANT	1,451,248	-3,071	1,448,177	7
9	00800 LAUNDRY & LINEN SERVICE	241,073		241,073	8
10	00900 HOUSEKEEPING	660,094	-62,560	597,534	9
11	01000 DIETARY	752,139	-147,700	604,439	10
12	01100 CAFETERIA				11
13	01200 MAINTENANCE OF PERSONNEL				12
14	01300 NURSING ADMINISTRATION	516,756		516,756	13
15	01400 CENTRAL SERVICES & SUPPLY				14
16	01500 PHARMACY	540,338		540,338	15
17	01600 MEDICAL RECORDS & LIBRARY	577,433	-35	577,398	16
18	01700 SOCIAL SERVICE				17
19	01900 NONPHYSICIAN ANESTHETISTS				19
20	02000 NURSING SCHOOL				20
21	02100 I&R SERVICES-SALARY & FRINGES APPRVD				21
22	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD				22
23	02300 PARAMED ED PRGM-(SPECIFY)	16,055	-7,560	8,495	23
	INPATIENT ROUTINE SERV COST CENTERS				
30	03000 ADULTS & PEDIATRICS	2,417,260	498	2,417,758	30
31	03100 INTENSIVE CARE UNIT	1,094,850	-8,667	1,086,183	31
43	04300 NURSERY	413,506		413,506	43
	ANCILLARY SERVICE COST CENTERS				
50	05000 OPERATING ROOM	3,960,198	-25,686	3,934,512	50
52	05200 DELIVERY ROOM & LABOR ROOM	413,506		413,506	52
54	05400 RADIOLOGY-DIAGNOSTIC	1,107,457	-53	1,107,404	54
55	05500 RADIOLOGY-THERAPEUTIC	485,862	-94,853	391,009	55
57	05700 CT SCAN	129,396		129,396	57
59	05900 CARDIAC CATHETERIZATION	414,707		414,707	59
60	06000 LABORATORY	2,910,575	-5,295	2,905,280	60
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500 RESPIRATORY THERAPY	889,075	-14,788	874,287	65
66	06600 PHYSICAL THERAPY	1,124,053	-212	1,123,841	66
68	06800 SPEECH PATHOLOGY	-432		-432	68
69	06900 ELECTROCARDIOLOGY	-16,395		-16,395	69
72	07200 IMPL. DEV. CHARGED TO PATIENTS	877,486		877,486	72
73	07300 DRUGS CHARGED TO PATIENTS	1,231,461		1,231,461	73
76.97	07697 CARDIAC REHABILITATION				76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	221,794		221,794	76.98
76.99	07699 LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	09001 CLINIC	10,520	-6,299	4,221	90.01
90.02	09002 ATHLETIC TRAINERS	245,552	-45,050	200,502	90.02
90.03	09003 SAINT JOSEPH HEALTH CENTER	293,551	-95,867	197,684	90.03
90.04	09004 WOUND CARE	526,035	-27	526,008	90.04
91	09100 EMERGENCY	1,497,722	-17,148	1,480,574	91
92	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92
	OTHER REIMBURSABLE COST CENTERS				
	SPECIAL PURPOSE COST CENTERS				
113	11300 INTEREST EXPENSE				113
118	SUBTOTALS (SUM OF LINES 1-117)	43,358,319	-5,810,212	37,548,107	118
	NONREIMBURSABLE COST CENTERS				
190	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
190.01	19001 PLYMOUTH MOB-4				190.01
190.02	19002 HOSPITALIST	99,278		99,278	190.02
192	19200 PHYSICIANS' PRIVATE OFFICES	600		600	192
192.02	19201 PHYSICIAN PRIVATE OFFICE	8,201		8,201	192.02
200	TOTAL (SUM OF LINES 118-199)	43,466,398	-5,810,212	37,656,186	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER
1	2	3	4	5	
1 BLDG & EQUIP RENT/DEPRECIATION EXP	A	CAP REL COSTS-MVBLE EQUIP	2		1,182 1
2		CAP REL COSTS-MVBLE EQUIP	2		41 2
3		CAP REL COSTS-MVBLE EQUIP	2		1,056 3
4		CAP REL COSTS-MVBLE EQUIP	2		31,054 4
5		CAP REL COSTS-BLDG & FIXT	1		883,656 5
6		CAP REL COSTS-BLDG & FIXT	1		189,376 6
7		CAP REL COSTS-MVBLE EQUIP	2		82,216 7
8		CAP REL COSTS-MVBLE EQUIP	2		211 8
9		CAP REL COSTS-MVBLE EQUIP	2		30 9
10		CAP REL COSTS-BLDG & FIXT	1		2,225 10
11		CAP REL COSTS-MVBLE EQUIP	2		1,918 11
12		CAP REL COSTS-MVBLE EQUIP	2		3,273 12
13		CAP REL COSTS-MVBLE EQUIP	2		47,189 13
14		CAP REL COSTS-MVBLE EQUIP	2		3,950 14
15		CAP REL COSTS-MVBLE EQUIP	2		9,727 15
16		CAP REL COSTS-BLDG & FIXT	1		10,236 16
17		CAP REL COSTS-MVBLE EQUIP	2		155,216 17
18		CAP REL COSTS-MVBLE EQUIP	2		6,714 18
19		CAP REL COSTS-MVBLE EQUIP	2		11,193 19
20		CAP REL COSTS-MVBLE EQUIP	2		32,744 20
21		CAP REL COSTS-BLDG & FIXT	1		7,846 21
22		CAP REL COSTS-MVBLE EQUIP	2		114,302 22
23		CAP REL COSTS-MVBLE EQUIP	2		194,761 23
24		CAP REL COSTS-BLDG & FIXT	1		1,679 24
25		CAP REL COSTS-MVBLE EQUIP	2		280,819 25
26		CAP REL COSTS-BLDG & FIXT	1		513 26
27		CAP REL COSTS-MVBLE EQUIP	2		356,288 27
28		CAP REL COSTS-BLDG & FIXT	1		707 28
29		CAP REL COSTS-MVBLE EQUIP	2		3,989 29
30		CAP REL COSTS-MVBLE EQUIP	2		59,378 30
31		CAP REL COSTS-MVBLE EQUIP	2		9,627 31
32		CAP REL COSTS-MVBLE EQUIP	2		27,933 32
33		CAP REL COSTS-BLDG & FIXT	1		47,040 33
34		CAP REL COSTS-MVBLE EQUIP	2		6,023 34
35		CAP REL COSTS-BLDG & FIXT	1		5,692 35
36		CAP REL COSTS-MVBLE EQUIP	2		1,147 36
37		CAP REL COSTS-MVBLE EQUIP	2		432 37
38		CAP REL COSTS-MVBLE EQUIP	2		16,395 38
39		CAP REL COSTS-BLDG & FIXT	1		118,260 39
40		CAP REL COSTS-BLDG & FIXT	1		21,177 40
41		CAP REL COSTS-MVBLE EQUIP	2		7,659 41
42		CAP REL COSTS-MVBLE EQUIP	2		538 42
43		CAP REL COSTS-MVBLE EQUIP	2		44,938 43
500 TOTAL RECLASSIFICATIONS					2,800,350 500
CODE LETTER - A					
1 PHARMACY DRUG RECLASS	B	DRUGS CHARGED TO PATIENTS	73		1,231,461 1
500 TOTAL RECLASSIFICATIONS					1,231,461 500
CODE LETTER - B					
1 INTEREST EXPENSE RECLASS	C	INTEREST EXPENSE	113		266,835 1
2		CAP REL COSTS-BLDG & FIXT	1		266,835 2
500 TOTAL RECLASSIFICATIONS					533,670 500
CODE LETTER - C					
1 NURSERY-LABOR/DELIVERY RECLASS	D	NURSERY	43	308,303	105,203 1
2		DELIVERY ROOM & LABOR ROOM	52	308,303	105,203 2
500 TOTAL RECLASSIFICATIONS				616,606	210,406 500
CODE LETTER - D					
1 IMPLANT RECLASS	E	IMPL. DEV. CHARGED TO PATIENT	72		787,115 1
2		IMPL. DEV. CHARGED TO PATIENT	72		90,371 2
500 TOTAL RECLASSIFICATIONS					877,486 500
CODE LETTER - E					
1 NEGATIVE WKST A AMOUNT RECLASS	F	EMPLOYEE BENEFITS DEPARTMENT	4		442,049 1
500 TOTAL RECLASSIFICATIONS					442,049 500
CODE LETTER - F					

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 PROPERTY INSURANCE RECLASS	G	CAP REL COSTS-BLDG & FIXT	1			27,648 1
500 TOTAL RECLASSIFICATIONS						27,648 500
CODE LETTER - G						
1 MEDICAL DIRECTOR RECLASSIFICATIONS	H	EMERGENCY	91		4,640	1
2		INTENSIVE CARE UNIT	31		3,333	2
3		PARAMED ED PRGM-(SPECIFY)	23		16,055	3
500 TOTAL RECLASSIFICATIONS					24,028	500
CODE LETTER - H						
1 WOUND CARE TO HYPERBARIC RECLASS	I	HYPERBARIC OXYGEN THERAPY	76.98		62,240	159,554 1
500 TOTAL RECLASSIFICATIONS					62,240	159,554 500
CODE LETTER - I						
1 SHORT TERM DISABILITY TO OTHER EXP	J	EMPLOYEE BENEFITS DEPARTMENT	4			62,896 1
500 TOTAL RECLASSIFICATIONS						62,896 500
CODE LETTER - J						
GRAND TOTAL (INCREASES)					702,874	6,345,520

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 BLDG & EQUIP RENT/DEPRECIATION EXP	A	ADMINISTRATIVE & GENERAL	5		1,182	9 1
2		ADMINISTRATIVE & GENERAL	5		41	9 2
3		ADMINISTRATIVE & GENERAL	5		1,056	10 3
4		ADMINISTRATIVE & GENERAL	5		31,054	9 4
5		ADMINISTRATIVE & GENERAL	5		883,656	9 5
6		OPERATION OF PLANT	7		189,376	9 6
7		OPERATION OF PLANT	7		82,216	9 7
8		HOUSEKEEPING	9		211	9 8
9		DIETARY	10		30	10 9
10		DIETARY	10		2,225	9 10
11		DIETARY	10		1,918	9 11
12		NURSING ADMINISTRATION	13		3,273	9 12
13		PHARMACY	15		47,189	9 13
14		MEDICAL RECORDS & LIBRARY	16		3,950	9 14
15		ADULTS & PEDIATRICS	30		9,727	10 15
16		ADULTS & PEDIATRICS	30		10,236	9 16
17		ADULTS & PEDIATRICS	30		155,216	9 17
18		INTENSIVE CARE UNIT	31		6,714	10 18
19		INTENSIVE CARE UNIT	31		11,193	9 19
20		OPERATING ROOM	50		32,744	10 20
21		OPERATING ROOM	50		7,846	9 21
22		OPERATING ROOM	50		114,302	9 22
23		RADIOLOGY-DIAGNOSTIC	54		194,761	9 23
24		RADIOLOGY-THERAPEUTIC	55		1,679	10 24
25		RADIOLOGY-THERAPEUTIC	55		280,819	9 25
26		CARDIAC CATHETERIZATION	59		513	10 26
27		CARDIAC CATHETERIZATION	59		356,288	9 27
28		LABORATORY	60		707	10 28
29		LABORATORY	60		3,989	9 29
30		LABORATORY	60		59,378	9 30
31		RESPIRATORY THERAPY	65		9,627	10 31
32		RESPIRATORY THERAPY	65		27,933	9 32
33		PHYSICAL THERAPY	66		47,040	10 33
34		PHYSICAL THERAPY	66		6,023	9 34
35		PHYSICAL THERAPY	66		5,692	9 35
36		PHYSICAL THERAPY	66		1,147	9 36
37		SPEECH PATHOLOGY	68		432	9 37
38		ELECTROCARDIOLOGY	69		16,395	9 38
39		WOUND CARE	90.04		118,260	10 39
40		WOUND CARE	90.04		21,177	9 40
41		WOUND CARE	90.04		7,659	9 41
42		EMERGENCY	91		538	10 42
43		EMERGENCY	91		44,938	9 43
500 TOTAL RECLASSIFICATIONS					2,800,350	500
CODE LETTER - A						
1 PHARMACY DRUG RECLASS	B	PHARMACY	15		1,231,461	1
500 TOTAL RECLASSIFICATIONS					1,231,461	500
CODE LETTER - B						
1 INTEREST EXPENSE RECLASS	C	ADMINISTRATIVE & GENERAL	5		266,835	11 1
2		INTEREST EXPENSE	113		266,835	11 2
500 TOTAL RECLASSIFICATIONS					533,670	500
CODE LETTER - C						
1 NURSERY-LABOR/DELIVERY RECLASS	D	ADULTS & PEDIATRICS	30	308,303	105,203	1
2		ADULTS & PEDIATRICS	30	308,303	105,203	2
500 TOTAL RECLASSIFICATIONS				616,606	210,406	500
CODE LETTER - D						
1 IMPLANT RECLASS	E	OPERATING ROOM	50		787,115	1
2		CARDIAC CATHETERIZATION	59		90,371	2
500 TOTAL RECLASSIFICATIONS					877,486	500
CODE LETTER - E						
1 NEGATIVE WKST A AMOUNT RECLASS	F	ADMINISTRATIVE & GENERAL	5		442,049	1
500 TOTAL RECLASSIFICATIONS					442,049	500
CODE LETTER - F						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 PROPERTY INSURANCE RECLASS	G	ADMINISTRATIVE & GENERAL	5		27,648	11 1
500 TOTAL RECLASSIFICATIONS					27,648	500
CODE LETTER - G						
1 MEDICAL DIRECTOR RECLASSIFICATIONS	H	ADMINISTRATIVE & GENERAL	5	4,640		1
2		ADMINISTRATIVE & GENERAL	5	3,333		2
3		ADMINISTRATIVE & GENERAL	5	16,055		3
500 TOTAL RECLASSIFICATIONS				24,028		500
CODE LETTER - H						
1 WOUND CARE TO HYPERBARIC RECLASS	I	WOUND CARE	90.04	62,240	159,554	1
500 TOTAL RECLASSIFICATIONS				62,240	159,554	500
CODE LETTER - I						
1 SHORT TERM DISABILITY TO OTHER EXP	J	EMPLOYEE BENEFITS DEPARTMENT	4	62,896		1
500 TOTAL RECLASSIFICATIONS				62,896		500
CODE LETTER - J						
GRAND TOTAL (DECREASES)				765,770	6,282,624	

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	32,891,552	756,827		756,827	774,516	32,873,863	9,152,276	3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	23,144,770	1,538,903		1,538,903	3,673,728	21,009,945	9,851,414	6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	56,514,252	2,295,730		2,295,730	4,448,244	54,361,738	19,003,690	8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	56,514,252	2,295,730		2,295,730	4,448,244	54,361,738	19,003,690	10

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

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPREC- IATION 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							1
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 ----- ALLOCATION OF OTHER CAPITAL -----

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 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT								1
2 CAP REL COSTS-MVBLE EQUIP								2
3 TOTAL (SUM OF LINES 1-2)								3

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPREC- IATION 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	1,867,185	168,199	294,483	-15,261			2,314,606
2 CAP REL COSTS-MVBLE EQUIP	1,451,507	60,436					1,511,943
3 TOTAL	3,318,692	228,635	294,483	-15,261			3,826,549

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	121,882	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	-45,850			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-410,192			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-147,700	DIETARY	10	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 BAD DEBT EXPENSE	A	-3,043,374	ADMINISTRATIVE & GENERAL	5	33
33.01 BAD DEBT EXPENSE	A	50	EMERGENCY	91	33.01
34 DONATIONS	A	-1,100	ADMINISTRATIVE & GENERAL	5	34
35 ENTERTAINMENT EXP	A	-727	ADMINISTRATIVE & GENERAL	5	35
35.01 ENTERTAINMENT EXP	A	-60	HOUSEKEEPING	9	35.01
35.02 ENTERTAINMENT EXP	A	-254	ADULTS & PEDIATRICS	30	35.02
35.03 ENTERTAINMENT EXP	A	-365	INTENSIVE CARE UNIT	31	35.03
35.04 ENTERTAINMENT EXP	A	-42	OPERATING ROOM	50	35.04
35.05 ENTERTAINMENT EXP	A	-53	RADIOLOGY-DIAGNOSTIC	54	35.05
35.06 ENTERTAINMENT EXP	A	-212	PHYSICAL THERAPY	66	35.06
35.07 ENTERTAINMENT EXP	A	-27	WOUND CARE	90.04	35.07
36 PROPERTY TAX EXPENSE	A	-599	LABORATORY	60	36
37 OTHER INTEREST INCOME ADJ	B	7,163	ADULTS & PEDIATRICS	30	11 37
38 OTHER REVENUE ADJ	B	-1,029	EMPLOYEE BENEFITS DEPARTMENT	4	38
39 OTHER REVENUE ADJ	B	-20,339	ADMINISTRATIVE & GENERAL	5	39
40 OTHER REVENUE ADJ	B	-3,071	OPERATION OF PLANT	7	40
41 OTHER REVENUE ADJ	B	-62,500	HOUSEKEEPING	9	41
42 OTHER REVENUE ADJ	B	-35	MEDICAL RECORDS & LIBRARY	16	42
43 OTHER REVENUE ADJ	B	-6,411	ADULTS & PEDIATRICS	30	43
44 OTHER REVENUE ADJ	B	-6,750	INTENSIVE CARE UNIT	31	44
45 OTHER REVENUE ADJ	B	-25,644	OPERATING ROOM	50	45
46 OTHER REVENUE ADJ	B	-94,853	RADIOLOGY-THERAPEUTIC	55	46
47 OTHER REVENUE ADJ	B	-4,696	LABORATORY	60	47
48 OTHER REVENUE ADJ	B	-14,788	RESPIRATORY THERAPY	65	48
49 OTHER REVENUE ADJ	B	-6,299	CLINIC	90.01	49
49.01 OTHER REVENUE ADJ	B	-45,050	ATHLETIC TRAINERS	90.02	49.01
49.02 OTHER REVENUE ADJ	B	-95,867	SAINT JOSEPH HEALTH CENTER	90.03	49.02
49.03 OTHER REVENUE ADJ	B	-193	EMERGENCY	91	49.03
49.04 MEDICAID PROV BED TAX ADJ	A	-1,901,227	ADMINISTRATIVE & GENERAL	5	49.04

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-5,810,212			50

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. 1	COST CENTER 2	EXPENSE ITEMS 3	AMOUNT OF ALLOWABLE COST 4	AMOUNT (INCL IN WKST A, COL. 5) 5	NET ADJ- USTMENTS (COL. 4-5) 6	WKST A-7 REF 7	
1	5	ADMINISTRATIVE & GENERAL	HO NON CAPITAL COSTS	6,729,048	8,061,640	-1,332,592	1
2	5	ADMINISTRATIVE & GENERAL	EMPOYEE HEALTH STOP LOSS	52,026	7,377	44,649	2
3	5	ADMINISTRATIVE & GENERAL	WORKERS COMP	59,470	95,370	-35,900	3
4	1	CAP REL COSTS-BLDG & FIXT	PROPERTY INSURANCE	12,387	27,648	-15,261	12 4
4.01	5	ADMINISTRATIVE & GENERAL	MALPRACTICE INSURANCE	214,602	186,336	28,266	4.01
4.02	5	ADMINISTRATIVE & GENERAL	RISK INSURANCE	18,603	36,049	-17,446	4.02
4.03	5	ADMINISTRATIVE & GENERAL	PENSION	594,941	598,934	-3,993	4.03
4.04	5	ADMINISTRATIVE & GENERAL	RETIREE HEALTH COSTS	1,718	-173,390	175,108	4.04
4.05	1	CAP REL COSTS-BLDG & FIXT	HO CAPITAL COSTS	746,977		746,977	9 4.05
5		TOTALS (SUM OF LINES 1-4)		8,429,772	8,839,964	-410,192	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 2	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----			
		PERCENT OF OWNERSHIP 3	NAME 4	PERCENT OF OWNERSHIP 5	TYPE OF BUSINESS 6
6	G	100.00	TRINITY HEALTH	100.00	HO OF PARENT COMPANY
7	G	100.00	SJRMCM - INC	100.00	PARENT COMPANY
8	G	100.00	SJRMCM-SOUTH BEND CAMPUS	100.00	HOSPITAL
9					
10					

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
 - D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY: FINANCIAL

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PROVIDER-BASED 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	
LINE NO.		2	3	4	5	6	7	8	9	
1	60	LABORATORY DR A	50,000		50,000	142,500	920	63,029	3,151	1
2	91	EMERGENCY DR B	53,605		53,605	208,000	366	36,600	1,830	2
3	31	INTENSIVE CARE UNIT DR C	3,333		3,333	142,500	26	1,781	89	3
4	5	ADMINISTRATIVE & GENERAL AGGREGATE	33,846		30,468	142,500	206	14,113	706	4
5	23	PARAMED ED PRGM-(SPECIFY AGGREGATE	16,055		16,055	142,500	124	8,495	425	5
200		TOTAL	156,839		153,461		1,642	124,018	6,201	200

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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 60	LABORATORY DR A					63,029		1
2 91	EMERGENCY DR B					36,600	17,005	17,005 2
3 31	INTENSIVE CARE UNIT DR C					1,781	1,552	1,552 3
4 5	ADMINISTRATIVE & GENERAL AGGREGATE					14,113	16,355	19,733 4
5 23	PARAMED ED PRGM-(SPECIFY AGGREGATE					8,495	7,560	7,560 5
200	TOTAL					124,018	42,472	45,850 200

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	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	2,314,606	2,314,606				1
2 CAP REL COSTS-MVBLE EQUIP	1,511,943		1,511,943			2
4 EMPLOYEE BENEFITS DEPARTMENT	503,916		1,238	505,154		4
5 ADMINISTRATIVE & GENERAL	8,749,140	261,249	32,580	58,596	9,101,565	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,448,177	494,094	86,141	13,417	2,041,829	7
8 LAUNDRY & LINEN SERVICE	241,073	8,846		1,072	250,991	8
9 HOUSEKEEPING	597,534	4,379	221	15,175	617,309	9
10 DIETARY	604,439	30,611	2,010	8,289	645,349	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	516,756		3,429	15,246	535,431	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	540,338	18,115	49,442	16,297	624,192	15
16 MEDICAL RECORDS & LIBRARY	577,398	36,698	4,139	9,768	628,003	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)	8,495				8,495	23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,417,758	283,014	162,627	85,042	2,948,441	30
31 INTENSIVE CARE UNIT	1,086,183	54,273	11,727	29,532	1,181,715	31
43 NURSERY	413,506				413,506	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,934,512	281,000	119,759	63,859	4,399,130	50
52 DELIVERY ROOM & LABOR ROOM	413,506				413,506	52
54 RADIOLOGY-DIAGNOSTIC	1,107,404	112,152	204,060	29,930	1,453,546	54
55 RADIOLOGY-THERAPEUTIC	391,009	132,106	294,227	9,594	826,936	55
57 CT SCAN	129,396			2,150	131,546	57
59 CARDIAC CATHETERIZATION	414,707	30,990	373,300	3,051	822,048	59
60 LABORATORY	2,905,280	63,440	62,213	38,707	3,069,640	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	874,287	48,420	46,444	17,605	986,756	65
66 PHYSICAL THERAPY	1,123,841	85,351	1,654	28,524	1,239,370	66
68 SPEECH PATHOLOGY	-432				-432	68
69 ELECTROCARDIOLOGY	-16,395				-16,395	69
72 IMPL. DEV. CHARGED TO PATIENTS	877,486				877,486	72
73 DRUGS CHARGED TO PATIENTS	1,231,461				1,231,461	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	221,794	7,926			229,720	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC	4,221			322	4,543	90.01
90.02 ATHLETIC TRAINERS	200,502			6,670	207,172	90.02
90.03 SAINT JOSEPH HEALTH CENTER	197,684		1,623	7,045	206,352	90.03
90.04 WOUND CARE	526,008	37,705	8,025	5,833	577,571	90.04
91 EMERGENCY	1,480,574	107,130	47,084	39,169	1,673,957	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	37,548,107	2,097,499	1,511,943	504,893	37,330,739	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,774			2,774	190
190.01 PLYMOUTH MOB-4						190.01
190.02 HOSPITALIST	99,278				99,278	190.02
192 PHYSICIANS' PRIVATE OFFICES	600	214,333			214,933	192
192.02 PHYSICIAN PRIVATE OFFICE	8,201			261	8,462	192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	37,656,186	2,314,606	1,511,943	505,154	37,656,186	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY + LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	9,101,565					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	650,435	2,692,264				7
8 LAUNDRY & LINEN SERVICE	79,954	15,274	346,219			8
9 HOUSEKEEPING	196,647	7,561		821,517		9
10 DIETARY	205,579	52,853		16,266	920,047	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	170,564					13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	198,839	31,278		9,626		15
16 MEDICAL RECORDS & LIBRARY	200,053	63,363		19,500		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)	2,706					23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	939,241	488,660	41,559	150,384	740,210	30
31 INTENSIVE CARE UNIT	376,441	93,709	14,433	28,839	147,046	31
43 NURSERY	131,724					43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,401,353	485,181	110,161	149,315	21,546	50
52 DELIVERY ROOM & LABOR ROOM	131,724					52
54 RADIOLOGY-DIAGNOSTIC	463,034	193,644	47,685	59,594		54
55 RADIOLOGY-THERAPEUTIC	263,425	228,098	20,301	70,197		55
57 CT SCAN	41,905		58,466			57
59 CARDIAC CATHETERIZATION	261,868	53,509	9,350	16,467		59
60 LABORATORY	977,849	109,538		33,710		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	314,336	83,602		25,729		65
66 PHYSICAL THERAPY	394,808	147,369		45,353		66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
72 IMPL. DEV. CHARGED TO PATIENTS	279,528					72
73 DRUGS CHARGED TO PATIENTS	392,288					73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	73,178	13,686		4,212		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC	1,447					90.01
90.02 ATHLETIC TRAINERS	65,996					90.02
90.03 SAINT JOSEPH HEALTH CENTER	65,734					90.03
90.04 WOUND CARE	183,988	65,102	9,746	20,035		90.04
91 EMERGENCY	533,247	184,974	34,518	56,926	11,245	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	8,997,891	2,317,401	346,219	706,153	920,047	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	884	4,789		1,474		190
190.01 PLYMOUTH MOB-4						190.01
190.02 HOSPITALIST	31,626					190.02
192 PHYSICIANS' PRIVATE OFFICES	68,468	370,074		113,890		192
192.02 PHYSICIAN PRIVATE OFFICE	2,696					192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	9,101,565	2,692,264	346,219	821,517	920,047	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	PARAMED EDUCATION 23	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	705,995					13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		863,935				15
16 MEDICAL RECORDS & LIBRARY			910,919			16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)				11,201		23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	221,604	2,947	47,278		5,580,324	30
31 INTENSIVE CARE UNIT	78,635	312	24,313		1,945,443	31
43 NURSERY	32,426		5,349		583,005	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	195,514	3,066	175,207		6,940,473	50
52 DELIVERY ROOM & LABOR ROOM	32,426		17,206		594,862	52
54 RADIOLOGY-DIAGNOSTIC		49,668	84,423		2,351,594	54
55 RADIOLOGY-THERAPEUTIC			35,999		1,444,956	55
57 CT SCAN		22,864	103,300		358,081	57
59 CARDIAC CATHETERIZATION	8,960	1,194	14,204		1,187,600	59
60 LABORATORY			156,367		4,347,104	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		160	43,722		1,454,305	65
66 PHYSICAL THERAPY		349	27,189		1,854,438	66
68 SPEECH PATHOLOGY					-432	68
69 ELECTROCARDIOLOGY					-16,395	69
72 IMPL. DEV. CHARGED TO PATIENTS			21,455		1,178,469	72
73 DRUGS CHARGED TO PATIENTS		761,568	75,776		2,461,093	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	9,994				330,790	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC					5,990	90.01
90.02 ATHLETIC TRAINERS					273,168	90.02
90.03 SAINT JOSEPH HEALTH CENTER		18,772	725		291,583	90.03
90.04 WOUND CARE	11,625	2,647	17,280		887,994	90.04
91 EMERGENCY	114,811	388	61,126	11,201	2,682,393	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	705,995	863,935	910,919	11,201	36,736,838	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					9,921	190
190.01 PLYMOUTH MOB-4						190.01
190.02 HOSPITALIST					130,904	190.02
192 PHYSICIANS' PRIVATE OFFICES					767,365	192
192.02 PHYSICIAN PRIVATE OFFICE					11,158	192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	705,995	863,935	910,919	11,201	37,656,186	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	I&R COST & POST STEP-		TOTAL
	DOWN ADJS	25	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS DEPARTMENT		4
5	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SERVICES-SALARY & FRINGES APPRVD		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS	5,580,324	30
31	INTENSIVE CARE UNIT	1,945,443	31
43	NURSERY	583,005	43
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	6,940,473	50
52	DELIVERY ROOM & LABOR ROOM	594,862	52
54	RADIOLOGY-DIAGNOSTIC	2,351,594	54
55	RADIOLOGY-THERAPEUTIC	1,444,956	55
57	CT SCAN	358,081	57
59	CARDIAC CATHETERIZATION	1,187,600	59
60	LABORATORY	4,347,104	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	1,454,305	65
66	PHYSICAL THERAPY	1,854,438	66
68	SPEECH PATHOLOGY	-432	68
69	ELECTROCARDIOLOGY	-16,395	69
72	IMPL. DEV. CHARGED TO PATIENTS	1,178,469	72
73	DRUGS CHARGED TO PATIENTS	2,461,093	73
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY	330,790	76.98
76.99	LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS			
90.01	CLINIC	5,990	90.01
90.02	ATHLETIC TRAINERS	273,168	90.02
90.03	SAINT JOSEPH HEALTH CENTER	291,583	90.03
90.04	WOUND CARE	887,994	90.04
91	EMERGENCY	2,682,393	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		92
OTHER REIMBURSABLE COST CENTERS			
SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE		113
118	SUBTOTALS (SUM OF LINES 1-117)	36,736,838	118
NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,921	190
190.01	PLYMOUTH MOB-4		190.01
190.02	HOSPITALIST	130,904	190.02
192	PHYSICIANS' PRIVATE OFFICES	767,365	192
192.02	PHYSICIAN PRIVATE OFFICE	11,158	192.02
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	37,656,186	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS	BLDGS & FIXTURES	MOVABLE EQUIPMENT		BENEFITS DEPARTMENT	
	0	1	2	2A	4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT			1,238	1,238	1,238	4
5 ADMINISTRATIVE & GENERAL		261,249	32,580	293,829	144	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		494,094	86,141	580,235	33	7
8 LAUNDRY & LINEN SERVICE		8,846		8,846	3	8
9 HOUSEKEEPING		4,379	221	4,600	37	9
10 DIETARY		30,611	2,010	32,621	20	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION			3,429	3,429	37	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		18,115	49,442	67,557	40	15
16 MEDICAL RECORDS & LIBRARY		36,698	4,139	40,837	24	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		283,014	162,627	445,641	206	30
31 INTENSIVE CARE UNIT		54,273	11,727	66,000	73	31
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		281,000	119,759	400,759	157	50
52 DELIVERY ROOM & LABOR ROOM						52
54 RADIOLOGY-DIAGNOSTIC		112,152	204,060	316,212	74	54
55 RADIOLOGY-THERAPEUTIC		132,106	294,227	426,333	24	55
57 CT SCAN					5	57
59 CARDIAC CATHETERIZATION		30,990	373,300	404,290	8	59
60 LABORATORY		63,440	62,213	125,653	95	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		48,420	46,444	94,864	43	65
66 PHYSICAL THERAPY		85,351	1,654	87,005	70	66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY		7,926		7,926		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC					1	90.01
90.02 ATHLETIC TRAINERS					16	90.02
90.03 SAINT JOSEPH HEALTH CENTER			1,623	1,623	17	90.03
90.04 WOUND CARE		37,705	8,025	45,730	14	90.04
91 EMERGENCY		107,130	47,084	154,214	96	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		2,097,499	1,511,943	3,609,442	1,237	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,774		2,774		190
190.01 PLYMOUTH MOB-4						190.01
190.02 HOSPITALIST						190.02
192 PHYSICIANS' PRIVATE OFFICES		214,333		214,333		192
192.02 PHYSICIAN PRIVATE OFFICE					1	192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		2,314,606	1,511,943	3,826,549	1,238	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY + LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	293,973					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	21,008	601,276				7
8 LAUNDRY & LINEN SERVICE	2,582	3,411	14,842			8
9 HOUSEKEEPING	6,351	1,689		12,677		9
10 DIETARY	6,640	11,804		251	51,336	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	5,509					13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	6,422	6,986		149		15
16 MEDICAL RECORDS & LIBRARY	6,462	14,151		301		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)	87					23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	30,337	109,133	1,777	2,321	41,302	30
31 INTENSIVE CARE UNIT	12,159	20,929	617	445	8,205	31
43 NURSERY	4,255					43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	45,263	108,358	4,750	2,304	1,202	50
52 DELIVERY ROOM & LABOR ROOM	4,255					52
54 RADIOLOGY-DIAGNOSTIC	14,956	43,247	2,038	920		54
55 RADIOLOGY-THERAPEUTIC	8,508	50,942	868	1,083		55
57 CT SCAN	1,353		2,499			57
59 CARDIAC CATHETERIZATION	8,458	11,950	400	254		59
60 LABORATORY	31,584	24,464		520		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	10,153	18,671		397		65
66 PHYSICAL THERAPY	12,752	32,913		700		66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
72 IMPL. DEV. CHARGED TO PATIENTS	9,028					72
73 DRUGS CHARGED TO PATIENTS	12,671					73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	2,364	3,057		65		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC	47					90.01
90.02 ATHLETIC TRAINERS	2,132					90.02
90.03 SAINT JOSEPH HEALTH CENTER	2,123					90.03
90.04 WOUND CARE	5,943	14,540	417	309		90.04
91 EMERGENCY	17,223	41,311	1,476	878	627	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	290,625	517,556	14,842	10,897	51,336	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	29	1,070		23		190
190.01 PLYMOUTH MOB-4						190.01
190.02 HOSPITALIST	1,021					190.02
192 PHYSICIANS' PRIVATE OFFICES	2,211	82,650		1,757		192
192.02 PHYSICIAN PRIVATE OFFICE	87					192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	293,973	601,276	14,842	12,677	51,336	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	PARAMED EDUCATION 23	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	8,975					13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		81,154				15
16 MEDICAL RECORDS & LIBRARY			61,775			16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)				87		23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,817	277	3,209		637,020	30
31 INTENSIVE CARE UNIT	1,000	29	1,650		111,107	31
43 NURSERY	412		363		5,030	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,485	288	11,842		577,408	50
52 DELIVERY ROOM & LABOR ROOM	412		1,168		5,835	52
54 RADIOLOGY-DIAGNOSTIC		4,666	5,730		387,843	54
55 RADIOLOGY-THERAPEUTIC			2,443		490,201	55
57 CT SCAN		2,148	7,011		13,016	57
59 CARDIAC CATHETERIZATION	114	112	964		426,550	59
60 LABORATORY			10,613		192,929	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		15	2,967		127,110	65
66 PHYSICAL THERAPY		33	1,845		135,318	66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
72 IMPL. DEV. CHARGED TO PATIENTS			1,456		10,484	72
73 DRUGS CHARGED TO PATIENTS		71,538	5,143		89,352	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	127				13,539	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC					48	90.01
90.02 ATHLETIC TRAINERS					2,148	90.02
90.03 SAINT JOSEPH HEALTH CENTER		1,763	49		5,575	90.03
90.04 WOUND CARE	148	249	1,173		68,523	90.04
91 EMERGENCY	1,460	36	4,149		221,470	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	8,975	81,154	61,775		3,520,506	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					3,896	190
190.01 PLYMOUTH MOB-4						190.01
190.02 HOSPITALIST					1,021	190.02
192 PHYSICIANS' PRIVATE OFFICES					300,951	192
192.02 PHYSICIAN PRIVATE OFFICE					88	192.02
200 CROSS FOOT ADJUSTMENTS				87	87	200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	8,975	81,154	61,775	87	3,826,549	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	25	26	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS DEPARTMENT			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE			17
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SERVICES-SALARY & FRINGES APPRVD			21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS		637,020	30
31 INTENSIVE CARE UNIT		111,107	31
43 NURSERY		5,030	43
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM		577,408	50
52 DELIVERY ROOM & LABOR ROOM		5,835	52
54 RADIOLOGY-DIAGNOSTIC		387,843	54
55 RADIOLOGY-THERAPEUTIC		490,201	55
57 CT SCAN		13,016	57
59 CARDIAC CATHETERIZATION		426,550	59
60 LABORATORY		192,929	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY		127,110	65
66 PHYSICAL THERAPY		135,318	66
68 SPEECH PATHOLOGY			68
69 ELECTROCARDIOLOGY			69
72 IMPL. DEV. CHARGED TO PATIENTS		10,484	72
73 DRUGS CHARGED TO PATIENTS		89,352	73
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY		13,539	76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
90.01 CLINIC		48	90.01
90.02 ATHLETIC TRAINERS		2,148	90.02
90.03 SAINT JOSEPH HEALTH CENTER		5,575	90.03
90.04 WOUND CARE		68,523	90.04
91 EMERGENCY		221,470	91
92 OBSERVATION BEDS (NON-DISTINCT PART)			92
OTHER REIMBURSABLE COST CENTERS			
SPECIAL PURPOSE COST CENTERS			
113 INTEREST EXPENSE			113
118 SUBTOTALS (SUM OF LINES 1-117)		3,520,506	118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,896	190
190.01 PLYMOUTH MOB-4			190.01
190.02 HOSPITALIST		1,021	190.02
192 PHYSICIANS' PRIVATE OFFICES		300,951	192
192.02 PHYSICIAN PRIVATE OFFICE		88	192.02
200 CROSS FOOT ADJUSTMENTS		87	200
201 NEGATIVE COST CENTER			201
202 TOTAL (SUM OF LINES 118-201)		3,826,549	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	158,563					1
2 CAP REL COSTS-MVBLE EQUIP		1,443,044				2
4 EMPLOYEE BENEFITS DEPARTMENT		1,182	13,500,205			4
5 ADMINISTRATIVE & GENERAL	17,897	31,095	1,565,972	-9,101,565	28,571,448	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	33,848	82,216	358,581		2,041,829	7
8 LAUNDRY & LINEN SERVICE	606		28,648		250,991	8
9 HOUSEKEEPING	300	211	405,553		617,309	9
10 DIETARY	2,097	1,918	221,518		645,349	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		3,273	407,450		535,431	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	1,241	47,189	435,530		624,192	15
16 MEDICAL RECORDS & LIBRARY	2,514	3,950	261,044		628,003	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)					8,495	23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	19,388	155,216	2,272,658		2,948,441	30
31 INTENSIVE CARE UNIT	3,718	11,193	789,254		1,181,715	31
43 NURSEY					413,506	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	19,250	114,302	1,706,632		4,399,130	50
52 DELIVERY ROOM & LABOR ROOM					413,506	52
54 RADIOLOGY-DIAGNOSTIC	7,683	194,761	799,886		1,453,546	54
55 RADIOLOGY-THERAPEUTIC	9,050	280,819	256,407		826,936	55
57 CT SCAN			57,453		131,546	57
59 CARDIAC CATHETERIZATION	2,123	356,288	81,542		822,048	59
60 LABORATORY	4,346	59,378	1,034,455		3,069,640	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,317	44,328	470,504		986,756	65
66 PHYSICAL THERAPY	5,847	1,579	762,298		1,239,370	66
68 SPEECH PATHOLOGY				432		68
69 ELECTROCARDIOLOGY				16,395		69
72 IMPL. DEV. CHARGED TO PATIENTS					877,486	72
73 DRUGS CHARGED TO PATIENTS					1,231,461	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	543				229,720	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC			8,616		4,543	90.01
90.02 ATHLETIC TRAINERS			178,267		207,172	90.02
90.03 SAINT JOSEPH HEALTH CENTER		1,549	188,279		206,352	90.03
90.04 WOUND CARE	2,583	7,659	155,878		577,571	90.04
91 EMERGENCY	7,339	44,938	1,046,802		1,673,957	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	143,690	1,443,044	13,493,227	-9,084,738	28,246,001	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	190				2,774	190
190.01 PLYMOUTH MOB-4						190.01
190.02 HOSPITALIST					99,278	190.02
192 PHYSICIANS' PRIVATE OFFICES	14,683				214,933	192
192.02 PHYSICIAN PRIVATE OFFICE			6,978		8,462	192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,314,606	1,511,943	505,154		9,101,565	202
203 UNIT COST MULT-WS B PT I	14.597390	1.047746	0.037418		0.318555	203
204 COST TO BE ALLOC PER B PT II			1,238		293,973	204
205 UNIT COST MULT-WS B PT II			0.000092		0.010289	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	NURSING	
	OF PLANT	+ LINEN	KEEPING		ADMINIS-	
	SQUARE	SERVICE	SQUARE	MEALS	TRATION	
	FEET	GROSS	FEET	SERVED	DIRECT	
	7	REVENUE	9	10	NRSNG HRS	13
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	106,818					7
8 LAUNDRY & LINEN SERVICE	606	88,085,452				8
9 HOUSEKEEPING	300		105,912			9
10 DIETARY	2,097		2,097	21,436		10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					219,839	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	1,241		1,241			15
16 MEDICAL RECORDS & LIBRARY	2,514		2,514			16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	19,388	10,574,840	19,388	17,246	69,005	30
31 INTENSIVE CARE UNIT	3,718	3,672,625	3,718	3,426	24,486	31
43 NURSEY					10,097	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	19,250	28,019,856	19,250	502	60,881	50
52 DELIVERY ROOM & LABOR ROOM					10,097	52
54 RADIOLOGY-DIAGNOSTIC	7,683	12,133,635	7,683			54
55 RADIOLOGY-THERAPEUTIC	9,050	5,165,596	9,050			55
57 CT SCAN		14,876,804				57
59 CARDIAC CATHETERIZATION	2,123	2,379,052	2,123		2,790	59
60 LABORATORY	4,346		4,346			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,317		3,317			65
66 PHYSICAL THERAPY	5,847		5,847			66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	543		543		3,112	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC						90.01
90.02 ATHLETIC TRAINERS						90.02
90.03 SAINT JOSEPH HEALTH CENTER						90.03
90.04 WOUND CARE	2,583	2,479,832	2,583		3,620	90.04
91 EMERGENCY	7,339	8,783,212	7,339	262	35,751	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	91,945	88,085,452	91,039	21,436	219,839	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	190		190			190
190.01 PLYMOUTH MOB-4						190.01
190.02 HOSPITALIST						190.02
192 PHYSICIANS' PRIVATE OFFICES	14,683		14,683			192
192.02 PHYSICIAN PRIVATE OFFICE						192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,692,264	346,219	821,517	920,047	705,995	202
203 UNIT COST MULT-WS B PT I	25.204217	0.003930	7.756600	42.920648	3.211418	203
204 COST TO BE ALLOC PER B PT II	601,276	14,842	12,677	51,336	8,975	204
205 UNIT COST MULT-WS B PT II	5.628976	0.000168	0.119694	2.394850	0.040825	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION	
	COSTED REQUIS. 15	GROSS REVENUE 16	ASSIGNED TIME 23	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS DEPARTMENT				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY	1,396,988			15
16 MEDICAL RECORDS & LIBRARY		130,716,631		16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SERVICES-SALARY & FRINGES APPRVD				21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)			100	23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	4,766	6,784,078		30
31 INTENSIVE CARE UNIT	504	3,488,762		31
43 NURSEY		767,484		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	4,958	25,147,187		50
52 DELIVERY ROOM & LABOR ROOM		2,468,960		52
54 RADIOLOGY-DIAGNOSTIC	80,314	12,114,065		54
55 RADIOLOGY-THERAPEUTIC		5,165,596		55
57 CT SCAN	36,971	14,822,828		57
59 CARDIAC CATHETERIZATION	1,930	2,038,188		59
60 LABORATORY		22,437,543		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	258	6,273,740		65
66 PHYSICAL THERAPY	565	3,901,428		66
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY				69
72 IMPL. DEV. CHARGED TO PATIENTS		3,078,687		72
73 DRUGS CHARGED TO PATIENTS	1,231,461	10,873,325		73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90.01 CLINIC				90.01
90.02 ATHLETIC TRAINERS				90.02
90.03 SAINT JOSEPH HEALTH CENTER	30,354	104,070		90.03
90.04 WOUND CARE	4,280	2,479,553		90.04
91 EMERGENCY	627	8,771,137	100	91
92 OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	1,396,988	130,716,631	100	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
190.01 PLYMOUTH MOB-4				190.01
190.02 HOSPITALIST				190.02
192 PHYSICIANS' PRIVATE OFFICES				192
192.02 PHYSICIAN PRIVATE OFFICE				192.02
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 COST TO BE ALLOC PER B PT I	863,935	910,919	11,201	202
203 UNIT COST MULT-WS B PT I	0.618427	0.006969	112.010000	203
204 COST TO BE ALLOC PER B PT II	81,154	61,775	87	204
205 UNIT COST MULT-WS B PT II	0.058092	0.000473	0.870000	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,580,324		5,580,324		5,580,324	30
31 INTENSIVE CARE UNIT	1,945,443		1,945,443	1,552	1,946,995	31
43 NURSERY	583,005		583,005		583,005	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,940,473		6,940,473		6,940,473	50
52 DELIVERY ROOM & LABOR ROOM	594,862		594,862		594,862	52
54 RADIOLOGY-DIAGNOSTIC	2,351,594		2,351,594		2,351,594	54
55 RADIOLOGY-THERAPEUTIC	1,444,956		1,444,956		1,444,956	55
57 CT SCAN	358,081		358,081		358,081	57
59 CARDIAC CATHETERIZATION	1,187,600		1,187,600		1,187,600	59
60 LABORATORY	4,347,104		4,347,104		4,347,104	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	1,454,305		1,454,305		1,454,305	65
66 PHYSICAL THERAPY	1,854,438		1,854,438		1,854,438	66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
72 IMPL. DEV. CHARGED TO PATIE	1,178,469		1,178,469		1,178,469	72
73 DRUGS CHARGED TO PATIENTS	2,461,093		2,461,093		2,461,093	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	330,790		330,790		330,790	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC	5,990		5,990		5,990	90.01
90.02 ATHLETIC TRAINERS	273,168		273,168		273,168	90.02
90.03 SAINT JOSEPH HEALTH CENTER	291,583		291,583		291,583	90.03
90.04 WOUND CARE	887,994		887,994		887,994	90.04
91 EMERGENCY	2,682,393		2,682,393	17,005	2,699,398	91
92 OBSERVATION BEDS (NON-DISTI OTHER REIMBURSABLE COST CENTERS	423,331		423,331		423,331	92
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	37,176,996		37,176,996	18,557	37,195,553	200
201 LESS OBSERVATION BEDS	423,331		423,331		423,331	201
202 TOTAL (SEE INSTRUCTIONS)	36,753,665		36,753,665		36,772,222	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	6,051,940		6,051,940			30
31 INTENSIVE CARE UNIT	3,488,762		3,488,762			31
43 NURSERY	767,484		767,484			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	7,795,869	17,351,318	25,147,187	0.275994	0.275994	0.275994 50
52 DELIVERY ROOM & LABOR ROOM	2,400,760	68,200	2,468,960	0.240936	0.240936	0.240936 52
54 RADIOLOGY-DIAGNOSTIC	1,799,741	10,314,324	12,114,065	0.194121	0.194121	0.194121 54
55 RADIOLOGY-THERAPEUTIC	89,419	5,076,177	5,165,596	0.279727	0.279727	0.279727 55
57 CT SCAN	2,676,504	12,146,324	14,822,828	0.024157	0.024157	0.024157 57
59 CARDIAC CATHETERIZATION	353,014	1,685,174	2,038,188	0.582674	0.582674	0.582674 59
60 LABORATORY	4,129,568	18,307,975	22,437,543	0.193742	0.193742	0.193742 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	2,305,702	3,968,038	6,273,740	0.231808	0.231808	0.231808 65
66 PHYSICAL THERAPY	667,153	3,234,275	3,901,428	0.475323	0.475323	0.475323 66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
72 IMPL. DEV. CHARGED TO PATIE	2,327,050	751,637	3,078,687	0.382783	0.382783	0.382783 72
73 DRUGS CHARGED TO PATIENTS	5,680,137	5,193,188	10,873,325	0.226342	0.226342	0.226342 73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	15,936	1,252,344	1,268,280	0.260818	0.260818	0.260818 76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC						90.01
90.02 ATHLETIC TRAINERS						90.02
90.03 SAINT JOSEPH HEALTH CENTER		104,070	104,070	2.801797	2.801797	2.801797 90.03
90.04 WOUND CARE	21,973	1,189,579	1,211,552	0.732939	0.732939	0.732939 90.04
91 EMERGENCY	1,431,076	7,340,061	8,771,137	0.305820	0.305820	0.307759 91
92 OBSERVATION BEDS (NON-DISTI OTHER REIMBURSABLE COST CENTERS	62,779	669,359	732,138	0.578212	0.578212	0.578212 92
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	42,064,867	88,652,043	130,716,910			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	42,064,867	88,652,043	130,716,910			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		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(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	637,020		637,020	6,156	103.48	2,721	281,569	30
31 INTENSIVE CARE UNIT	111,107		111,107	1,380	80.51	782	62,959	31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY	5,030		5,030	738	6.82			43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	753,157		753,157	8,274		3,503	344,528	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 COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	577,408	25,147,187	0.022961	2,809,118	64,500	50
52 DELIVERY ROOM & LABOR ROOM	5,835	2,468,960	0.002363	8,139	19	52
54 RADIOLOGY-DIAGNOSTIC	387,843	12,114,065	0.032016	1,025,833	32,843	54
55 RADIOLOGY-THERAPEUTIC	490,201	5,165,596	0.094897			55
57 CT SCAN	13,016	14,822,828	0.000878	1,444,734	1,268	57
59 CARDIAC CATHETERIZATION	426,550	2,038,188	0.209279	65,483	13,704	59
60 LABORATORY	192,929	22,437,543	0.008598	2,265,085	19,475	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	127,110	6,273,740	0.020261	1,351,455	27,382	65
66 PHYSICAL THERAPY	135,318	3,901,428	0.034684	443,266	15,374	66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
72 IMPL. DEV. CHARGED TO PATIENT	10,484	3,078,687	0.003405	1,264,751	4,306	72
73 DRUGS CHARGED TO PATIENTS	89,352	10,873,325	0.008218	3,098,566	25,464	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	13,539	1,268,280	0.010675	9,164	98	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC	48					90.01
90.02 ATHLETIC TRAINERS	2,148					90.02
90.03 SAINT JOSEPH HEALTH CENTER	5,575	104,070	0.053570			90.03
90.04 WOUND CARE	68,523	1,211,552	0.056558	11,470	649	90.04
91 EMERGENCY	221,470	8,771,137	0.025250	661,878	16,712	91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS	48,325	732,138	0.066005	33,831	2,233	92
200 TOTAL (SUM OF LINES 50-199)	2,815,674	120,408,724		14,492,773	224,027	200

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2013.11
 01/20/2014 14:13

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
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 07/01/2011 TO 06/30/2012

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	6,156		2,721		30
31 INTENSIVE CARE UNIT	1,380		782		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	738				43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	8,274		3,503		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 PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P 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 CT SCAN							57
59 CARDIAC CATHETERIZATION							59
60 LABORATORY							60
62.30 BLOOD CLOTTING FOR HEMOPHILIA							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY							66
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY							69
72 IMPL. DEV. CHARGED TO PATIENT							72
73 DRUGS CHARGED TO PATIENTS							73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90.01 CLINIC							90.01
90.02 ATHLETIC TRAINERS							90.02
90.03 SAINT JOSEPH HEALTH CENTER							90.03
90.04 WOUND CARE							90.04
91 EMERGENCY			11,201		11,201	11,201	91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS							92
200 TOTAL (SUM OF LINES 50-199)			11,201		11,201	11,201	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	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	25,147,187		2,809,118		4,268,925	50
52	DELIVERY ROOM & LABOR ROOM	2,468,960		8,139			52
54	RADIOLOGY-DIAGNOSTIC	12,114,065		1,025,833		2,339,275	54
55	RADIOLOGY-THERAPEUTIC	5,165,596				1,737,689	55
57	CT SCAN	14,822,828		1,444,734		3,504,714	57
59	CARDIAC CATHETERIZATION	2,038,188		65,483		423,849	59
60	LABORATORY	22,437,543		2,265,085		771,384	60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	6,273,740		1,351,455		1,227,768	65
66	PHYSICAL THERAPY	3,901,428		443,266			66
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
72	IMPL. DEV. CHARGED TO PATIEN	3,078,687		1,264,751		316,016	72
73	DRUGS CHARGED TO PATIENTS	10,873,325		3,098,566		1,487,286	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,268,280		9,164		766,139	76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	CLINIC						90.01
90.02	ATHLETIC TRAINERS						90.02
90.03	SAINT JOSEPH HEALTH CENTER	104,070					90.03
90.04	WOUND CARE	1,211,552		11,470		443,516	90.04
91	EMERGENCY	8,771,137	0.001277	661,878	845	1,343,075	1,715 91
92	OBSERVATION BEDS (NON-DISTIN OTHER REIMBURSABLE COST CENTERS	732,138		33,831		304,465	92
200	TOTAL (SUM OF LINES 50-199)	120,408,724		14,492,773	845	18,934,101	1,715 200

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 RATIO FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.275994	4,268,925			1,178,198			50
52 DELIVERY ROOM & LABOR ROOM	0.240936							52
54 RADIOLOGY-DIAGNOSTIC	0.194121	2,339,275			454,102			54
55 RADIOLOGY-THERAPEUTIC	0.279727	1,737,689			486,079			55
57 CT SCAN	0.024157	3,504,714			84,663			57
59 CARDIAC CATHETERIZATION	0.582674	423,849			246,966			59
60 LABORATORY	0.193742	771,384			149,449			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.231808	1,227,768			284,606			65
66 PHYSICAL THERAPY	0.475323							66
68 SPEECH PATHOLOGY								68
69 ELECTROCARDIOLOGY								69
72 IMPL. DEV. CHARGED TO PATIENTS	0.382783	316,016			120,966			72
73 DRUGS CHARGED TO PATIENTS	0.226342	1,487,286		62,738	336,635		14,200	73
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.260818	766,139			199,823			76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
90.01 CLINIC								90.01
90.02 ATHLETIC TRAINERS								90.02
90.03 SAINT JOSEPH HEALTH CENTER	2.801797							90.03
90.04 WOUND CARE	0.732939	443,516			325,070			90.04
91 EMERGENCY	0.305820	1,343,075			410,739			91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.578212	304,465			176,045			92
200 SUBTOTAL (SEE INSTRUCTIONS)		18,934,101		62,738	4,453,341		14,200	200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)		18,934,101		62,738	4,453,341		14,200	202

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		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(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	637,020		637,020	6,156	103.48	1,059	109,585	30
31 INTENSIVE CARE UNIT	111,107		111,107	1,380	80.51	158	12,721	31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY	5,030		5,030	738	6.82	501	3,417	43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	753,157		753,157	8,274		1,718	125,723	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (15-0076) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	577,408	25,147,187	0.022961	1,397,881	32,097		50
52 DELIVERY ROOM & LABOR ROOM	5,835	2,468,960	0.002363				52
54 RADIOLOGY-DIAGNOSTIC	387,843	12,114,065	0.032016	110,909	3,551		54
55 RADIOLOGY-THERAPEUTIC	490,201	5,165,596	0.094897				55
57 CT SCAN	13,016	14,822,828	0.000878	264,488	232		57
59 CARDIAC CATHETERIZATION	426,550	2,038,188	0.209279	25,506	5,338		59
60 LABORATORY	192,929	22,437,543	0.008598	463,327	3,984		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA							62.30
65 RESPIRATORY THERAPY	127,110	6,273,740	0.020261	189,770	3,845		65
66 PHYSICAL THERAPY	135,318	3,901,428	0.034684	33,429	1,159		66
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY							69
72 IMPL. DEV. CHARGED TO PATIENT	10,484	3,078,687	0.003405				72
73 DRUGS CHARGED TO PATIENTS	89,352	10,873,325	0.008218	802,273	6,593		73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY	13,539	1,268,280	0.010675				76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90.01 CLINIC	48						90.01
90.02 ATHLETIC TRAINERS	2,148						90.02
90.03 SAINT JOSEPH HEALTH CENTER	5,575	104,070	0.053570				90.03
90.04 WOUND CARE	68,523	1,211,552	0.056558	331	19		90.04
91 EMERGENCY	221,470	8,771,137	0.025250	153,973	3,888		91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS	48,325	732,138	0.066005				92
200 TOTAL (SUM OF LINES 50-199)	2,815,674	120,408,724		3,441,887	60,706		200

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2013.11
01/20/2014 14:13

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 07/01/2011 TO 06/30/2012

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

VERSION: 2013.11
 01/20/2014 14:13

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	6,156		1,059		30
31 INTENSIVE CARE UNIT	1,380		158		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	738		501		43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	8,274		1,718		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 PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P 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 CT SCAN							57
59 CARDIAC CATHETERIZATION							59
60 LABORATORY							60
62.30 BLOOD CLOTTING FOR HEMOPHILIA							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY							66
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY							69
72 IMPL. DEV. CHARGED TO PATIENT							72
73 DRUGS CHARGED TO PATIENTS							73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90.01 CLINIC							90.01
90.02 ATHLETIC TRAINERS							90.02
90.03 SAINT JOSEPH HEALTH CENTER							90.03
90.04 WOUND CARE							90.04
91 EMERGENCY			11,201		11,201	11,201	91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS							92
200 TOTAL (SUM OF LINES 50-199)			11,201		11,201	11,201	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	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	25,147,187			1,397,881			50
52 DELIVERY ROOM & LABOR ROOM	2,468,960						52
54 RADIOLOGY-DIAGNOSTIC	12,114,065			110,909			54
55 RADIOLOGY-THERAPEUTIC	5,165,596						55
57 CT SCAN	14,822,828			264,488			57
59 CARDIAC CATHETERIZATION	2,038,188			25,506			59
60 LABORATORY	22,437,543			463,327			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	6,273,740			189,770			65
66 PHYSICAL THERAPY	3,901,428			33,429			66
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY							69
72 IMPL. DEV. CHARGED TO PATIEN	3,078,687						72
73 DRUGS CHARGED TO PATIENTS	10,873,325			802,273			73
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							
90.01 CLINIC							90.01
90.02 ATHLETIC TRAINERS							90.02
90.03 SAINT JOSEPH HEALTH CENTER	104,070						90.03
90.04 WOUND CARE	1,211,552			331			90.04
91 EMERGENCY	8,771,137	0.001277	0.001277	153,973	197		91
92 OBSERVATION BEDS (NON-DISTIN OTHER REIMBURSABLE COST CENTERS	732,138						92
200 TOTAL (SUM OF LINES 50-199)	120,408,724			3,441,887	197		200

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)	6,156	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,156	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,689	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)	2,721	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)	5,580,324	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	5,580,324	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,580,324	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) 906.49 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,466,559 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) 2,466,559 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	1,946,995	1,380	1,410.87	782	1,103,300	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)					3,431,785	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					7,001,644	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 344,528 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 224,872 51
 52 TOTAL PROGRAM EXCLUDABLE COST 569,400 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 6,432,244 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 THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 467 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 906.49 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 423,331 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) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	637,020	5,580,324	0.114155	423,331	48,325	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)	6,156	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,156	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,689	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)	1,059	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)	738	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	501	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)	5,580,324	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	5,580,324	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,580,324	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) 906.49 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 959,973 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) 959,973 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42 NURSERY (TITLES V AND XIX ONLY)	583,005	738	789.98	501	395,780 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	1,946,995	1,380	1,410.87	158	222,917 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)					807,452 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,386,122 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 125,723 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 60,903 51
 52 TOTAL PROGRAM EXCLUDABLE COST 186,626 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 2,199,496 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 THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 467 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

	ROUTINE COST (FROM LINE 27)	COL. 1 ÷ COL. 2	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
	1	2	3	4
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST				
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 TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		3,040,992			30
31 INTENSIVE CARE UNIT		1,836,246			31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.275994	2,809,118	775,300		50
52 DELIVERY ROOM & LABOR ROOM	0.240936	8,139	1,961		52
54 RADIOLOGY-DIAGNOSTIC	0.194121	1,025,833	199,136		54
55 RADIOLOGY-THERAPEUTIC	0.279727				55
57 CT SCAN	0.024157	1,444,734	34,900		57
59 CARDIAC CATHETERIZATION	0.582674	65,483	38,155		59
60 LABORATORY	0.193742	2,265,085	438,842		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.231808	1,351,455	313,278		65
66 PHYSICAL THERAPY	0.475323	443,266	210,695		66
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
72 IMPL. DEV. CHARGED TO PATIENTS	0.382783	1,264,751	484,125		72
73 DRUGS CHARGED TO PATIENTS	0.226342	3,098,566	701,336		73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.260818	9,164	2,390		76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90.01 CLINIC					90.01
90.02 ATHLETIC TRAINERS					90.02
90.03 SAINT JOSEPH HEALTH CENTER	2.801797				90.03
90.04 WOUND CARE	0.732939	11,470	8,407		90.04
91 EMERGENCY	0.307759	661,878	203,699		91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.578212	33,831	19,561		92
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		14,492,773	3,431,785		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		14,492,773			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 TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		2,425,929			30
31 INTENSIVE CARE UNIT		341,500			31
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.275994	1,397,881	385,807		50
52 DELIVERY ROOM & LABOR ROOM	0.240936				52
54 RADIOLOGY-DIAGNOSTIC	0.194121	110,909	21,530		54
55 RADIOLOGY-THERAPEUTIC	0.279727				55
57 CT SCAN	0.024157	264,488	6,389		57
59 CARDIAC CATHETERIZATION	0.582674	25,506	14,862		59
60 LABORATORY	0.193742	463,327	89,766		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.231808	189,770	43,990		65
66 PHYSICAL THERAPY	0.475323	33,429	15,890		66
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
72 IMPL. DEV. CHARGED TO PATIENTS	0.382783				72
73 DRUGS CHARGED TO PATIENTS	0.226342	802,273	181,588		73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.260818				76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90.01 CLINIC					90.01
90.02 ATHLETIC TRAINERS					90.02
90.03 SAINT JOSEPH HEALTH CENTER	2.801797				90.03
90.04 WOUND CARE	0.732939	331	243		90.04
91 EMERGENCY	0.307759	153,973	47,387		91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.578212				92
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		3,441,887	807,452		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		3,441,887			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	6,046,165	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)		2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS	1,663,127	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	43.72	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)	0.0276	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (SEE INSTRUCTIONS)	0.2194	31
32	SUM OF LINES 30 AND 31	0.2470	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0959	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	579,827	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)	6,625,992	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)	6,625,992	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	487,036	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)	845	58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	7,113,873	59
60	PRIMARY PAYER PAYMENTS	30,612	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	7,083,261	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	772,206	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	3,691	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	48,090	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	33,663	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	6,341,027	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.96	LOW VOLUME ADJUSTMENT FOR FISCAL YEAR (2011)	151,918	70.96
70.97	LOW VOLUME ADJUSTMENT FOR FISCAL YEAR (2012)	312,625	70.97
71	AMOUNT DUE PROVIDER (SEE INSTRUCTIONS)	6,805,570	71
71.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		71.01
72	INTERIM PAYMENTS	6,756,208	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS LINES 71.01, 72 AND 73)	49,362	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	177,338	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	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		6,756,208		3,250,184	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	NONE		NONE	3.01
	.02				3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.51				3.51
	PROVIDER .52				3.52
	TO .53				3.53
	PROGRAM .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		6,756,208		3,250,184	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.	PROGRAM .01				5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50				5.50
	TO .51				5.51
	PROGRAM .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	PROGRAM .01				6.01
	TO .02				6.02
	PROVIDER .01				6.01
	PROVIDER .02				6.02
	TO .02				6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2013.11
01/20/2014 14:13

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	2,257	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	3,503	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	852	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	7,069	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	130,716,910	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20		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)	1,368,728	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	1,368,728	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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES			
8			8
9			9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			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	34,400,000			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	7,971,000			4
5	OTHER RECEIVABLES	3,124,000			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,885,000			6
7	INVENTORY	1,043,000			7
8	PREPAID EXPENSES	267,000			8
9	OTHER CURRENT ASSETS	273,000			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	45,193,000			11
FIXED ASSETS					
12	LAND	478,000			12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	32,874,000			15
16	ACCUMULATED DEPRECIATION	-22,004,000			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	20,901,000			19
20	ACCUMULATED DEPRECIATION	-15,625,000			20
21	AUTOMOBILES AND TRUCKS	109,000			21
22	ACCUMULATED DEPRECIATION	-99,000			22
23	MAJOR MOVABLE EQUIPMENT				23
24	ACCUMULATED DEPRECIATION				24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	16,634,000			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	160,000			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	160,000			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	61,987,000			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,513,000			37
38	SALARIES, WAGES & FEES PAYABLE	1,476,000			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	116,000			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	1,066,000			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	4,171,000			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	6,502,000			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	6,502,000			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	10,673,000			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	51,314,000			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)	51,314,000			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	61,987,000			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		42,324,000							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		8,915,000							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		51,239,000							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 NET ASSETS RELEASED		75,000							5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		75,000							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		51,314,000							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)		51,314,000							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	12,796,922		12,796,922	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	12,796,922		12,796,922	10
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
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	12,796,922		12,796,922	18
19 ANCILLARY SERVICES	29,410,767		29,410,767	19
20 OUTPATIENT SERVICES		88,944,751	88,944,751	20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	42,207,689	88,944,751	131,152,440	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		43,466,398	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)		43,466,398	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	131,152,440	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	80,818,938	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	50,333,502	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	43,466,398	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	6,867,104	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF 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	OTHER (OTHER OPERATING REVENUE)	2,047,896	24
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	2,047,896	25
26	TOTAL (LINE 5 PLUS LINE 25)	8,915,000	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)	8,915,000	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

1	CAPITAL FEDERAL AMOUNT			
2	CAPITAL DRG OTHER THAN OUTLIER	487,036		1
3	CAPITAL DRG OUTLIER PAYMENTS			2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	19.38		3
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)			4
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)			5
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)			6
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)			7
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (SEE INSTRUCTIONS)			8
10	SUM OF LINES 7 AND 8			9
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)			10
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)			11
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	487,036		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 (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 DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES					21
22 I&R SERVICES-OTHER PRGM COSTS					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
52 DELIVERY ROOM & LABOR ROOM					52
54 RADIOLOGY-DIAGNOSTIC					54
55 RADIOLOGY-THERAPEUTIC					55
57 CT SCAN					57
59 CARDIAC CATHETERIZATION					59
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
72 IMPL. DEV. CHARGED TO PATIENTS					72
73 DRUGS CHARGED TO PATIENTS					73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90.01 CLINIC					90.01
90.02 ATHLETIC TRAINERS					90.02
90.03 SAINT JOSEPH HEALTH CENTER					90.03
90.04 WOUND CARE					90.04
91 EMERGENCY					91
92 OBSERVATION BEDS (NON-DISTINCT					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
190.01 PLYMOUTH MOB-4					190.01
190.02 HOSPITALIST					190.02
192 PHYSICIANS' PRIVATE OFFICES					192
192.02 PHYSICIAN PRIVATE OFFICE					192.02
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND					202
LINES 190-201)					
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

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

EXHIBIT 3

STEP 1: Determine the 3-Year Averaging Period		
1	Wage index fiscal year ending date	1
2	Provider's cost reporting period used for wage index year on Line 1 (FYB in Col 1, FYE in Col 2)	2
3	Midpoint of provider's cost reporting period shown on Line 2, adjusted to first of month	3
4	Date beginning the 3-year averaging period (subtract 18 months from midpoint shown on Line 3)	4
5	Date ending the 3-year averaging period (add 18 months to midpoint shown on Line 3)	5
STEP 2 (OPTIONAL): Adjust Averaging Period for a New Plan (SEE INSTRUCTIONS)		
6	Effective date of pension plan	6
7	First day of the provider cost reporting period containing the pension plan effective date	7
8	Starting date of the adjusted averaging period (date on Line 7, adjusted to first of month)	8
If this date occurs after the period shown on line 2, stop here and see instructions.		
STEP 3: Average Pension Contributions During the Averaging Period		
9	Beginning date of averaging period from Line 4 or Line 8, as applicable	9
10	Ending date of averaging period from Line 5	10
11	Enter provider contributions made during averaging period on Lines 9 & 10	11
11.01		11.01
12	Total calendar months included in averaging period (36 unless Step 2 completed)	12
13	Total contributions made during averaging period	13
14	Average monthly contribution (Line 13 divided by Line 12)	14
15	Number of months in provider cost reporting period on Line 2	15
16	Average pension contributions (Line 14 times Line 15)	16
STEP 4: Total Pension Cost for Wage Index		
17	Annual prefunding installment (SEE INSTRUCTIONS)	17
18	Reportable prefunding installment ((Line 17 times Line 15) divided by 12)	18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	19

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

EXHIBIT 4

	Amounts From E Part A (1)	Prior to 10/1/2010 or after 9/30/2013 Pre/Post Entitlement (2)	10/01/2010 through 09/30/2011 (3)	(3.01)	10/01/2011 through 09/30/2012 (4)	(4.01)	(Columns 2 through 4) TOTAL (5)	
1	DRG Amounts Other than Outlier Payments	6,046,165	1,793,724		4,252,441		6,046,165	1
2	Outlier payments for discharges							2
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	1,663,127	479,336		1,183,791		1,663,127	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT								
5	Amount from Worksheet E Part A, Line 21							5
6	IME payment adjustment							6
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422								
7	Amount from Worksheet E Part A, Line 27							7
8	IME add-on adjustment							8
9	Total IME payment							9
DISPROPORTIONATE SHARE ADJUSTMENT								
10	Allowable disproportionate share percentage	0.0959	0.0959	0.0959	0.0959	0.0959	0.0959	10
11	Disproportionate share adjustment	579,827		172,018		407,809	579,827	11
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES								
12	Total ESRD additional payment							12
13	Subtotal	6,625,992		1,965,742		4,660,250	6,625,992	13
14	Hospital specific payments							14
15	Total payment for inpatient operating costs - E Part A Line 49	6,625,992		1,965,742		4,660,250	6,625,992	15
16	Payment for inpatient program capital	487,036		145,288		341,748	487,036	16
17	Special add-on payments for new technologies							17
18	Capital outlier reconciliation adjustment amount							18
19	SUBTOTAL			2,111,030		5,001,998	7,113,028	19
CAPITAL PAYMENTS								
20	Capital DRG other than outlier	487,036		145,288		341,748	487,036	20
21	Capital DRG outlier payments							21
22	Indirect medical education percentage							22
23	Indirect medical education adjustment							23
24	Allowable disproportionate share percentage							24
25	Disproportionate share adjustment							25
26	Total prospective capital payments	487,036		145,288		341,748	487,036	26
LOW VOLUME ADJUSTMENT								
27	Low volume adjustment factor			0.071964		0.062500		27
28	Low Volume Adjustment			151,918			151,918	28
29	Low Volume Adjustment					312,625	312,625	29