KPMG LLP	COMPU	-Max	
ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

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

WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER US		1 [37]	DIDOTRONI								
PROVIDER US	E ONLY	1. [X]	ELECTRON.	CALLY F	ILED COST R	LEPORT	DATE	S: (03/13/2015	TIME:	10:22
		2. []	MANUALLY	SUBMITT	ED COST REP	PORT					
		3. [1]			ENDED REPOR		HE NUMBER	OF	TIMES THE	PROVIDER	
			RESUBMIT	ED THE	COST REPORT	2					
		4. [F]	MEDICARE	UTILIZA	TION. ENTE	ER 'F' FOR	FULL OR '	L'	FOR LOW.		
CONTRACTOR	5. [] COS	r report	STATUS	6. DA	TE RECEIVED	:	1	.0.	NPR DATE:		
USE ONLY					TRACTOR NO:			1.	CONTRACTOR	'S VENDOR	CODE :
	2 - SET	LED WII	HOUT AUDI	г 8. []	INITIAL RE	EPORT FOR	THIS 1	2.	[] IF LIN	E 5, COLU	MN 1 IS 4:
	3 - SET	FLED WIT	H AUDIT		PROVIDER (CCN				NUMBER OF	
	4 - REO	PENED		9. []	FINAL REPO	ORT FOR TH	IS			IED = 0 - 9.	
	5 - AME	NDED			PROVIDER (CCN	294-284-2840				

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. JOSEPH'S REG MED CENTER PLYMOUT (15-0076) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNIG 07/01/2013 AND ENDING 06/30/2014, 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.

ECR Encryption: 03/13/2015 10:22 qxs2diuj86RRH0E26LGy3am:q9coM0 WNsRs0PUgzKaGfSUTfTTiyYs0RzZZR G1LV0XzDve0VXMeP

PI Encryption: 03/13/2015 10:22 KF9KMRnFaRVEJ3wotPgY3vg0Qy9R80 Wo1m50IxlrwOQiIBFfWl9AkrolsZs6 wRa703pH6:04XA2s

(SIGNED) (FO) (FO)(FO

PART III - SETTLEMENT SUMMARY

			TITLE X	(VIII			
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		1,185	3.373	608.626	188	1
2	SUBPROVIDER - IPF			No.		100	2
3	SUBPROVIDER - IRF			100	Contractor and		3
4	SUBPROVIDER (OTHER)		States to state of the		Constant States of States of States		1 4
5	SWING BED - SNF	ben to the second se					5
6	SWING BED - NF				CALLS TO DE LA CALL		6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY		The second second second second	Contraction of the local division of the loc	and the second		8
9	HOME HEALTH AGENCY		and the second se		A COLOR OF THE PARTY OF THE PAR		0
10	HEALTH CLINIC - RHC				Rectored and the second		10
11	HEALTH CLINIC - FOHC		A DESCRIPTION OF THE PARTY OF THE	0.0			11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		1,185	3,373	608,626	188	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 OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ISSUMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW 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.

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

	and Hospital Health Care Complex Address:										
1 2	Street: 1915 LAKE AVENUE City: PLYMOUTH	P.O. Box: 670	71	D.C. 1. 46562	6		DCILALI				2
	and Hospital-Based Component Identification:	State: IN	ZI	P Code: 46563	C	County: MA	RSHALL				2
HOSPITAL	and Hospital-Based Component Identification.							Pa	yment Syst	em	
									P, T, O, or l		
	Component	Component Name		CCN Number	CBSA Number	Prov- ider Type	Date Certified	v	XVIII	XIX	
	0	1		2	3	4	5	6	7	8	
3	Hospital	ST. JOSEPH'S REG MED CENTER PLYMOUT		15-0076	43780	1	07/01/1996	N	Р	Р	3
4	Subprovider - IPF	TETMOOT									4
5	Subprovider - IRF										5
6	Subprovider - (OTHER)										6
7	Swing Beds - SNF										7
8	Swing Beds - NF						-				8
9 10	Hospital-Based SNF										9 10
10	Hospital-Based NF Hospital-Based OLTC										10
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 / 2013		To: 06 / 30 / 2	2014						20
20	Type of control (see instructions)	1		10.0073072	2014						20
	t PPS Information	· ·		1					1	2	21
22	Does this facility qualify for and receive disproportion	nate share hospital payments	in accordan	ce with 42 CFF	\$412.106? I	in column 1	, enter 'Y' for ye	s or 'N' for	Y		22
22	no. Is this facility subject to 42 CFR§412.06(c)(2)(Pic						o for the portion	a of the	Y	N	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost October 1. (see instructions)								N	Y	22.01
23	Which method is used to determine Medicaid days on discharge. Is the method of identifying the days in this								3	N	23
	'Y' for yes or 'N' for no.						Out-of-				
				In-Sta		ut-of-	State				
			In-State		aid	State	Medicaid	Medicaid		Other	
			Medicai paid day			dicaid	eligible	HMO day	10	edicaid days	
			paid day	s unpai days		d days	unpaid			uays	
				-	·		days				
		<u> </u>	1	2		3	4	5		6	
	If this provider is an IPPS hospital, enter the in-state M 1, in-state Medicaid eligible unpaid days in col. 2, out										
24	days in col. 3, out-of-state Medicaid eligible unpaid da		,	214	34	3	6	\$	353	46	24
24	HMO paid and eligible but unpaid days in col. 5, and			-14	54	5	0	, c	,55	40	24
	col. 6.										
	If this provider is an IRF, enter the in-state Medicaid p	paid days in col. 1, in-state									
25	Medicaid eligible unpaid days in col. 2, out-of-state M										25
25	of-state Medicaid eligible unpaid days in col. 4, Medic										2.5
	eligible but unpaid days in col. 5, and other Medicaid	days in col. 6.									
26	Enter your standard geographic classification (not wag	ge) status at the beginning of	the cost rep	orting period. I	Enter	2					26
26	'1' for urban and '2' for rural.		•	01		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				2					27	
35	column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting			ing						35	
36	period. Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of			of Begin	ning:		Ending:			36	
37	one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter	the number of periods MDH	I status in ef	fect in the cost				0			37
	reporting period. Enter applicable beginning and ending dates of MDH	status. Subscript line 38 for	number of p	eriods in exces	s of p			E. P.			-
38	one and enter subsequent dates.		P		Begin	nning:		Ending:	1	2	38
39	Does this facility qualify for the inpatient hospital pay 1 'Y' for yes or 'N' for no. Does the facility meet the m no. (see instructions)								Y	Y	39

KPMG LLP	C ΩMPU-MAX	X	
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		V	XVIII	XIX	
Prospect	ive Payment System (PPS)-Capital	1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional paymetn 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
					1.0
Teaching	g 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.	Ν			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	Ν			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)	Ν			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new pr enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GM			the program name,	
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	
	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each exprogram name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in colu	spanded program (see		in column 1 the	
ACA Pro	ovisions Affecting the Health Resources and Services Administration (HRSA)				
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01
Teaching	g 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	N			63

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	5504 of the ACA Base Year FTE Resi on or after July 1, 2009 and before June	dents in Nonprovider settings-This base year is your cost repo 30, 2010.	orting period that	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 +	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted					col. 2))	64
	3 the number of unweighted primary	f line 63 is yes, or your facility trained residents in the base y care FTE residents attributable to rotations occurring in all ne spital. Enter in column 5 the ratio of (column 3 divided by (co	on-provider settings. E	nter in column 4 the			
	resident PTES that trained in your no	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65 Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on after July 1, 2010 TEs Nonprovider Site						RATIO (col. 1/ col. 1 + col. 2))	65
66	non-provider settings. Enter in colum	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					66
		program name. Enter in column 2 the program code. Enter in r settings. Enter in column 4 the number of unweighted prim lumn 4). (see instructions)					
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67
Inpatier	t Psychiatric Faciltiy PPS			1	2	3	
70		c Facility (IPF), or does it contain an IPF subprovider? Enter	'Y' for yes or 'N' for	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 resident: in a new teaching program in accordance with 42 CEP.						71
Inpatien	t Rehabilitation Facility PPS			1	2	3	
75		tion Facility (IRF), or does it contain an IRF subprovider? En	ter 'Y' for yes or 'N'	N	2	5	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 5th or subsequent academic years of the new teaching program in existence, enter 5.						76
Logim	erm Care Hospital PPS						
Long Te 80	erm Care Hospital PPS Is this a Long Term Care Hospital (L	TCH)? Enter 'Y' for yes or 'N' for no.			N		80
	Providers						
85		\$413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	0.E		N		85
86	Did this facility establish a new Othe	r subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)	enter Y for yes, or	N IOP nO.			86

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				V	XIX	
Title V a	nd XIX Services			1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for	or no in applicable c	olumn.	Ν	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part applicable column.	or 'N' for no in the	Ν	N	91	
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for ye	s or 'N' for no in the	appilcable column.		N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes			N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable col	lumn.	••	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 Pro	oviders			1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?			Ν		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpat	nstructions)			106	
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R train no in column 1. If yes, the GME elinination would not be on Worksheet B, Part I, column 25 a If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an app the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.	nd the program wou proved medical educ	ld be cost reimbursed. ation program train in			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §41			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.					109
Missalla	neous Cost Reporting Information					
	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the	e method used (A				
115	B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term		N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.					116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.			N 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	e policy is occurrence.	1		118
			Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:		1			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrati supporting schedule listing cost centers and amounts contained therein.	ve and General cost	center? If yes, submit	Ν		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §312 instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in col	s that qualifies for the	e Outpatient Hold	Ν	Y	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? E			Y		121
125	nt Center Information Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certific	action data(a)(mm/d	d/mmu) balow	N		125
125	If this is a Medicare certified kidney transplant center in for yes of iv for no. If yes, ener certification date in column 1 a column 2.			IN		125
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and 2	d termination date, if	f applicable in column			127
128	2. If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column					128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and	I termination date, if	applicable in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 column 2.	and termination dat	te, if applicable in			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 column 2.	1 and termination da	te, if applicable in			131
100	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and					132
132			C	-		
132 133	If this is a Medicare certified other transplant center enter the certification date in column 1 and 2.	d termination date, i	r applicable in column			133

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All Prov	viders				1			
					1	2		
140	Are there any related organization or home office costs as defi- column 1. If yes, and home office costs are claimed, enter in co				Y	15H034	140	
16 d 1 - C	· '''' · · · · · · · · · · · · · · · ·	42 (1	C (1 - 1					
	acility is part of a chain organization, enter on lines 141 through 1					actor number.		
141	Name: SAINT JOSEPH REG MEDICAL CTR		CONSIN PHYSICIANS	S SERVICE I Contractor's	Number: 08102		141	
142	Street: 5215 HOLY CROSS PARKWAY	P.O. Box: State: IN	ZIP Code: 46545				142	
143	City: MISHAWAKA				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				N		145	
146	Has the cost allocation methodology changed from the previou Pub. 15-2, section 4020). If yes, enter the approval date (mm/d		er 'Y' for yes and 'N' for r	no in column 1. (see CMS	N		146	
1.47		D.T. C			N		1.47	
147	Was there a change in the statistical basis? Enter 'Y' for yes or				N		147	
148	Was there a change in the order of allocation? Enter 'Y' for yes		N		148			
149	Was there a change to the simplified cost finding method? Ent	N		149				
CFR §4	13.13)			Title XVIII	T'd. V	T'd. VIV		
			Part A	Part B	Title V 2	Title XIX 3		
155	Hospital		N	N N	<u>2</u> N	N	155	
156	Subprovider - IPF		N	N	19	IN	156	
157	Subprovider - IRF		N	N			157	
158	Subprovider - Other		IN	IN IN			157	
158	SNF		N	N			158	
159	HHA		N	N			160	
160	СМНС		N	N			160	
161.10	CORF			N			161.10	
101.10	COM						101.10	
Multica	mpus							
165	Is this hospital part of a multicampus hospital that has one or n 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, stat	e in column 2, ZIP in co	lumn 3, CBSA in column 4	, FTE/campus in co		166	
	Name	County	State	ZIP Code	CBSA	FTE/Campus		
	0	1	2	3	4	5		
T 1.1 T		10						
<u>Health I</u> 167	dth Information Technology (HIT) incentive in the American Recovery and Reinvestment Act Is this provider a meaningful user under \$1886(n)? Enter 'Y' for yes or 'N' for no. Y							
	Is this provider a meaningful user under §1886(n)? Enter 1 10 If this provider is a CAH (line 105 is 'Y') and is a meaningful u		the reasonable cost incu				167	
168	for the HIT assets. (see instructions)						168	
169	If this provider is a meaningful user (line 167 is 'Y') and is not (see instructions)			0.50			169	
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yvyy) 07/01/2013 06/30/2014						170	

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES. ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

			MAL	DATE		
POV	IDER ORGANIZATION AND OPERATION		<u>Y/N</u>	DATE 2		
ROVI	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING	G OF THE COST		2		
	REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see ins		N			1
			Y/N	DATE	V/I	
			1	2	3	_
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF Y COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR ' INVOLUNTARY.		Ν			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMEL WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies), RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERS MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAM. OTHER SIMILAR RELATIONSHIPS? (see instructions)) THAT ARE SONNEL, OR	N			3
			Y/N	TYPE	DATE	
INAN	ICIAL DATA AND REPORTS		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWEE COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, S). SUBMIT	Y	A		4
5	INSTRUCTIONS. ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	THOSE ON THE	N			5
			1			
				Y/N	Y/N	
APPR(OVED EDUCATIONAL ACTIVITIES			1	2	_
5	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?			N		6
,	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.			Y		7
	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR R	ENEWED DURIN	G THE COST			l '
	REPORTING PERIOD?	ENEWED DOMIN	5 11E CO51	N		8
)	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURREN INSTRUCTIONS.	T COST REPORT?	IF YES, SEE	N		9
0	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT CO SEE INSTRUCTIONS.			N		10
1	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN A ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	APPROVED TEACI	HING PROGRAM	N		11
SAD F	DEBTS				Y/N	
2	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUC	TIONS.			Y	12
3	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DU SUBMIT COPY.		REPORTING PERIC	DD? IF YES,	Ν	13
4	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF	YES, SEE INSTRU	JCTIONS.		N	14
	OMPLEMENT					-
5	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD?	IF YES, SEE INST	RUCTIONS.		N	15
			RT A		ART B	
<u></u>		Y/N	DATE	Y/N	DATE	
S&R	REPORT DATA WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER	1	2	3	4	+
6	COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	09/30/2014	Y	09/30/2014	16
	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND	N		N		17
7	THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES,					1
	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) 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	N		N		18
7 8 9	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) 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. 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	N		N		
8	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) 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. IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR					18

KPMG LLP	Compu-Max							
	In Lieu of Form	Period :	Run Date: 03/13/2015					
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22					
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10					

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES. ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPI	TAL RELATED COSTS						
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.			22			
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST PERIOD? IF YES, SEE INSTRUCTIONS.	I REPORTING		23			
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIC INSTRUCTIONS.	D? IF YES, SEE		24			
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INS'	TRUCTIONS.		25			
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION OF DURING THE COST REPORTING PERIOD?	CTIONS.		26			
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION	DNS.		27			
DUTT							
INTE	REST EXPENSE WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING F			_			
28	SEE INSTRUCTIONS.	PERIOD / IF YES,		28			
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	AS A FUNDED		29			
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIO	NS.		30			
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUC	TIONS.		31			
PUR	CHASED SERVICES						
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.						
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SE	E INSTRUCTIONS.		33			
PROV	/IDER-BASED PHYSICIANS						
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIAL INSTRUCTIONS.	NS? IF YES, SEE		34			
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED	PHYSICIANS		35			
55	DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			35			
		NAL	DATE				
HOM	E OFFICE COSTS	Y/N 1	DATE 2				
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2	36			
	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT: IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE						
37	INSTRUCTIONS.			37			
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF			38			
	YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.						
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.			39			
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.			40			
COCT	P DEADT DEEDADED INFORMATION						
41	REORT PREPARER INFORMATION	ECTOR OF REIMBU	PSEMENT	41			
41 42	PIRST NAME: CKAIO 111LE: DIR EMPLOYER: SAINT JOSEPH REGIONAL MEDICAL CENTER 111LE: DIR	LUTOK OF KEIMBU	REPRENT	41 42			
42	PHONE NUMBER: 574-335-4653 E-MAIL ADDRESS: NIETCHC@SJRMC.COM			42			
+5	THORE RUBER, 577-555-7655 E-MAIL ADDRESS, METCHC@5JKMC.COM						

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

		INPATIENT DAYS/OUTPATIENT VISITS/TRIPS							1	
		NULOT				INPATIE	INT DAYS/OUT	PATIENT VISIT	5/1RIPS	
	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	38	13,870			1,693	890	4,000	1
2	HMO AND OTHER (see instructions)						696			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		38	13,870			1,693	890	4,000	7
8	INTENSIVE CARE UNIT	31	7	2,555			487	108	1,074	8
9	CORONARY CARE UNIT	32		2,000				100	1,071	9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						158	606	13
14	TOTAL (see instructions)		45	16,425			2.180	1,156	5,680	14
15	CAH VISITS						,	,	.,	15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	СМНС	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		45							27
28	OBSERVATION BED DAYS							110	907	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY									32.01
	ROOM OUTPATIENT DAYS (see instructions)									
33	LTCH NON-COVERED DAYS									33

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

		FULL	TIME EQUIVAL	ENTS		DISCHA	ARGES		
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					640	300	1,767	1
2	HMO AND OTHER (see instructions)					203			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		259.00	2.77		640	300	1,767	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	СМНС								25
26	RHC								26
27	TOTAL (sum of lines 14-26)		259.00	2.77					27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

KPMG LLP	Compu-Max						
	In Lieu of Form	Period :	Run Date: 03/13/2015				
ST. JOSEPH'S REG MED CENTER PLYM	OUT CMS-2552-10	From: 07/01/2013	Run Time: 10:22				
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10				

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3 PARTS II-III

PART II - WAGE DATA

NUMBER NUMBER NUMBER NUMBER NUMBER ADDITION ADDIT	FART	II - WAGE DATA			DECLASSIE				
subscription 1 2 3 4 5 6 1 TOTAL SALARIES (see instruction) 20 14,885.994 552.902.00 26.99 1 2 NOM-PHYSICIAN ANSTITUTIST PART A 20 14,885.994 552.902.00 28.95 1 3 NOV-PHYSICIAN ANSTITUTIST PART A 208.30 28.93.30 1.001.00 28.12 1 10 PHYSICIAN-PART A 18.999 1.80.999 1.60.00 180.13 4 5 NON-PHYSICIAN-PART B 2 2 7.01 20.70.00 7.01 7.01 CONTRACTED INTERNS & RESIDENTS (in an approved program) 21 21 7.01 20.70.00 20.70.00 9.90.90 9.01.00 9.90.90 9.01.00 9.01.00 9.01.00 9.01.00 9.01.00 9.01.00 9.01.00 9.01.00 9.01.00 9.01.00 9.00 9.01.00 9.01.00 9.00 9.01.00 9.01.00 9.02.1.00 9.00 9.01.00 9.01.00 9.01.00 9.01.00 9.01.00 9.01.00			A LINE		OF SALARIES (from Worksheet	SALARIES (column 2 ±	RELATED TO SALARIES	HOURLY WAGE (column 4 ±	
I TOTAL SALARIES (see instructions) 200 14.383.594 14.383.594 522.002.00 26.09 1 3 NON-PHYSICIAN ANISTINETIST PART B -			1	2		4	5	6	
I OTAL SALARIS (see instructions) 200 14.383.594 14.383.594 522.002.00 26.09 1 3 NON-PHYSICIAN ANISTRETIST PART IA -		SALARIES		-					
3 NON-PHYSICIAN ARX 5. NOMINISTRATIVE 208,330 1,001.00 208,121 3 4.00 PHYSICIAN-PART B 18,999 15,999 146,00 130,13 401 5 PHYSICIAN-PART B 6 7 6 7 7 6 NON-PHYSICIAN-PART B 6 7	1		200	14,383,594		14,383,594	532,902.00	26.99	1
Image: 14 PHYSICLAN-PART A - ADMINISTRATIVE 208,330 1,001,00 202,12 4 0.0 PHYSICLAN-PART B - TACRIING 18,099 146,00 150,13 4 5 NON-PHYSICLAN-PART B 6 6 6 6 7 160,00 7 <t< td=""><td>2</td><td>NON-PHYSICIAN ANESTHETIST PART A</td><td></td><td></td><td></td><td></td><td></td><td></td><td>2</td></t<>	2	NON-PHYSICIAN ANESTHETIST PART A							2
14.00 PHYSICLAN-PART B 18.999 146.00 130.13 4.01 5 PHYSICLAN-PART B 6 7 6 NON-PHYSICLAN-PART B 7 7.01 CONTRACTED INTERNS & RESIDENTS (in an approved program) 21 7.01 7.01 CONTRACTED INTERNS & RESIDENTS (in an approved program) 7.01 7.01 8 IDEO FILE PERSONNEL 44 9 9 10 FINELIDED AREA SALARIES (see instructions) 44 9 19 11 CONTRACT MANGEMENT AND ADMINISTRATIVE 130.225 130.225 2.080.00 62.61 12 12 CONTRACT MANGEMENT AND ADMINISTRATIVE 130.225 130.225 2.080.00 62.61 12 13 CONTRACT MANGEMENT AND ADMINISTRATIVE 130.225 130.225 2.080.00 62.61 12 14 HOME OFFICE & CONTS 4.579.32 4.579.32 9.399.00 50.66 14 15 HOME OFFICE & CONTS 4.579.32 9.399.00 50.61 15 16 MORE RELATED CON	3	NON-PHYSICIAN ANESTHETIST PART B							3
5 PHYSICIAN-PART B 5 6 NOK-PHYSICIAN-PART B 6 7.01 INTERNS & RESIDENTS (in an approved program) 21 7 7.01 CONTRACTED INTERNS & RESIDENTS (in an approved program) 21 7 8 HOME OFFICE PERSONNEL 8 8 9 SNP 32,259 1,766.00 194.03 10 EXCURPTS AREA SALARTES (or instructions) 44 32,259 1,766.00 194.03 11 CONTRACT LABOR (sc instructions) 44 32,259 1,30.225 2,080.00 62,61 12 12 CONTRACT LABOR (sc instructions) 117,695 117,695 113,0225 2,080.00 62,61 12 13 CONTRACT LABOR (sc instructions) 4,579,332 90,399.00 90.06 14 14 HOME OFFICE SALARES & WAGE-RELATED COSTS 4,579,332 90,399.00 90.66 14 15 HOME OFFICE & ALARES & WAGE-RELATED COSTS 4,579,332 90,399.00 90.66 14 16 WAGE-RELATED COSTS (scher)(sc instructions) <td></td> <td></td> <td></td> <td></td> <td></td> <td>208,330</td> <td>1,001.00</td> <td>208.12</td> <td></td>						208,330	1,001.00	208.12	
6 NON-PHYSICIAN-PART B 6 7 NOTRACTED INTERNS & RESIDENTS (in an approved program) 21 70 7.0 NORSACTED INTERNS & RESIDENTS (in an approved program) 8 70 8 HOME OFFICE PERSONNEL 8 8 9 SNF AREA SALABES (see instructions) 44 342,659 1,766.00 190.01 10 DEXCLUDED AREA SALABES (see instructions) 44 342,659 1,766.00 10 11 11 CONTRACT LABOR (see instructions) 44 342,659 1,766.00 10.01 11 12 CONTRACT LABOR (see instructions) 10 10.225 130,225 2,080.00 6,6.6 12 13 ADMINISTRATIVE 10,025 117,095 1,256.00 93.71 13 14 HOME OFFICE PHYSICIAN PART A - ADMINISTRATIVE 4,579,332 4,579,332 90.399.00 50.66 14 15 HOME OFFICE PHYSICIAN PART A - ADMINISTRATIVE 150.722 150.722 150.723 19 14 MORE-RELATED COSTS	4.01	PHYSICIAN-PART A - TEACHING		18,999		18,999	146.00	130.13	4.01
7. INTERNS & RESIDENTS (in an approved program) 21 7.0 7.01 CONTRACTED INTERNS & RESIDENTS (in an approved program) 7.0 8 HOME OFFICE PERSONNEL 8 9 SNF 1.0 01 EXCLUEDD AREA SALARIES (see instructions) 44 01 CONTRACT MANGEMENT AND ADMINISTRATIVE 10.0 11 CONTRACT MANGEMENT AND ADMINISTRATIVE 10.0225 12 CONTRACT MANGEMENT AND ADMINISTRATIVE 10.0225 13 CONTRACT MANGEMENT AND ADMINISTRATIVE 10.0225 14 HOME OFFICE. PMSICIAN-PART A - 117.005 15 HOME OFFICE. PMSICIAN-PART A - 117.005 16 HOME OFFICE. PMSICIAN PART A - ADMINISTRATIVE 4.579.332 16 HOME OFFICE. PMSICIAN PART A - 15 17 WAGE-RELATED COSTS 4.579.332 17 WAGE-RELATED COSTS 4.579.332 18 MAGE RELATED COSTS 15 19 EXCLUPED AREAS 15 10 WAGE-RELATED COSTS 4.579.332 14 HOME OF	5								
7.01 CONTRACTED INTERNS & RESIDENTS (in an approved mysmal) 7.01 8 HOME OFFICE PERSONNEL 8 9 SNF 84 342,659 342,659 1,766.00 19.00 10 EXCLUDED AREA SALARIES (see instructions) 44 342,659 342,659 1,766.00 19.00 11 CONTRACT LABOR (see instructions) 44 342,659 130,225 2.080.00 6.26.11 12 CONTRACT MANGENEENT AND ADMINISTRATIVE 130,225 110,225 2.080.00 6.26.11 12 13 GOMENTER ANTRE 130,225 117,695 1.25.60 9.37.11 13 14 HOME OFFICE PHYSICIAN PART A - ADMINISTRATIVE 4.579,332 90,399.00 50.66 14 15 HOME OFFICE PHYSICIAN PART A - ADMINISTRATIVE 4.579,332 19,03 16 17 WAGE RELATED COSTS 7.701 7.701 17 18 WAGE RELATED COSTS (order)scie instructions) 7.701 7.701 12 19 EXCLUBED AREAS 150.722 150.701 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>									
1/10 program 1/10 8 HOME OFFICE PERSONNEL 8 9 SNF 44 9 8 9 SNF 44 9 9 10 EXCLUDED AREA SALARES (see instructions) 342,659 342,659 17,65,00 194,03 10 11 CONTRACT MARCE See instructions) 11 <t< td=""><td>7</td><td></td><td>21</td><td></td><td></td><td></td><td></td><td></td><td>7</td></t<>	7		21						7
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OVERHEAD COSTS - DIRECT SALARIES Image: Cost of the second s	24	WAGE-RELATED COSTS (RHC/FQHC)							24
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Instructions) 0 0 0 29 MAINTENANCE & REPAIRS 357,877 357,877 14,435.00 24.79 30 31 LAUNDRY & LINEN SERVICE 29,935 29,935 2,104.00 14.23 31 32 HOUSEKEEPING 392,911 392,911 312,867.00 12.33 32 33 HOUSEKEEPING UNDER CONTRACT (see instructions) 33 34 DIETARY 333 34 35 0 207,600 207,600 15,869.00 13.08 34 35 DIETARY 207,600 207,600 15,869.00 13.08 34 36 CAFETERIA 87,841 87,841 3,495.00 25.13 35 37 MAINTENANCE OF PERSONNEL 9 37 38 NURSING ADMINISTRATION 439,250 439,250 11,666.00 37.65 38 39 CENTRAL SERVICES AND SUPPLY 9 39 39.40 433,800 443,800 443,800 32,316.00 39.2.8 40 41 </td <td>28</td> <td></td> <td></td> <td>39,241</td> <td></td> <td>39,241</td> <td>115.00</td> <td>341.23</td> <td>28</td>	28			39,241		39,241	115.00	341.23	28
30 OPERATION OF PLANT 357,877 14,435.00 24.79 30 31 LAUNDRY & LINEN SERVICE 29,935 29,935 21,04.00 14.23 31 32 HOUSEKEEPING 392,911 31,867.00 12.23 32 33 HOUSEKEEPING UNDER CONTRACT (see instructions) 392,911 31,867.00 12.33 32 34 DIETARY 207,600 207,600 15,869.00 13.08 34 35 DIETARY UNDER CONTRACT (see instructions) 87,841 87,841 3,495.00 25.13 35 36 CAFETERIA 36 36 37 3,495.00 25.13 35 37 MAINTENANCE OF PERSONNEL 36 37 36 37.00 37.05 38 39 CENTRAL SERVICES AND SUPPLY 39 36.00 37.05 38 40 PHARMACY 483,800 483,800 12,316.00 39.28 40 41 MEDICAL RE				57,211		57,211	110.00	511.25	-
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35 DIETARY UNDER CONTRACT (see instructions) 87,841 87,841 3,495.00 25.13 35 36 CAFETERIA 36 37 MAINTENANCE OF PERSONNEL 36 37 38 NURSING ADMINISTRATION 439,250 439,250 11,666.00 37.65 38 39 CENTRAL SERVICES AND SUPPLY				207 600		207 600	15 860 00	12.00	
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38 NURSING ADMINISTRATION 439,250 439,250 11,666.00 37.65 38 39 CENTRAL SERVICES AND SUPPLY - - - 39 40 PHARMACY 483,800 483,800 12,316.00 39.28 40 41 MEDICAL RECORDS & MEDICAL RECORDS LIBRARY 216,412 216,412 12,592.00 17.19 41 42 SOCIAL SERVICE - - 42									
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41 MEDICAL RECORDS & MEDICAL RECORDS LIBRARY 216,412 216,412 12,592.00 17.19 41 42 SOCIAL SERVICE 42				483 800		483 800	12 316 00	39.28	
42 SOCIAL SERVICE 42									
				210,112		210,112	12,092.00	1,	
	43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	14,491,677	14,491,677	536,366.00	27.02	1
2	EXCLUDED AREA SALARIES (see instructions)	342,659	342,659	1,766.00	194.03	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	14,149,018	14,149,018	534,600.00	26.47	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see	4,827,252	4,827,252	93,735.00	51.50	4
	instructions)		 			
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	4,891,231	4,891,231		34.57%	5
6	TOTAL (sum of lines 3 through 5)	23,867,501	23,867,501	628,335.00	37.99	6
7	TOTAL OVERHEAD COST (see instructions)	3,950,774	3,950,774	168,017.00	23.51	7

KPMG LLP	<u> Compu-Max</u>	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

HOSPITAL WAGE RELATED COSTS

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	761,339	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	1,289,121	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)	1,860,655	8
)	PRESCRIPTION DRUG PLAN		9
0	DENTAL, HEARING AND VISION PLAN	154,865	10
1	LIFE INSURANCE (If employee is owner or beneficiary)	55,311	11
2	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
3	DISABILITY INSURANCE (If employee is owner or beneficiary)	33,610	13
4	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
5	WORKERS' COMPENSATION INSURANCE		15
6	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	-155,086	16
	TAXES		
7	FICA-EMPLOYERS PORTION ONLY	997,075	17
8	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
9	UNEMPLOYMENT INSURANCE		19
0	STATE OR FEDERAL UNEMPLOYMENT TAXES	12,989	20
	OTHER		
1	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
2	DAY CARE COSTS AND ALLOWANCES		22
3	TUITION REIMBURSEMENT	24,323	23
4	TOTAL WAGE RELATED COST (Sum of lines 1-23)	5,034,202	24
ART	F B - OTHER THAN CORE RELATED COST		
25	OTHER WAGE RELATED (OTHER WAGE REL	7.761	25

KPMG LLP	C ΩMPU-MAX	X	
	Supporting Exhibit for Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

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

EXHIBIT 3

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE	06/30/2017		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)	07/01/2013	06/30/2014	2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH	1/01/2014		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)	7/01/2012		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)	7/01/2015		5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE	7/01/2012		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5	7/01/2015		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIB- UTION(S)	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)	36		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	12		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)	1,289,121		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)	1,289,121		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	1,289,121		19

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		In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MI	ED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076			To: 06/30/2014	Version: 2014.10

WORKSHEET S-3 PART V

HOSPITAL CONTRACT LABOR AND BENEFIT COST

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPI	TAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:			
	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

ALL		C9mpu-Max				
	SEPH'S REG MED CENTER PLYMOUT r CCN: 15-0076	CMS-2552-10 Fr	riod : om: 07/01/2013 o: 06/30/2014	Run Date: 03/13 Run Time: 10:2 Version: 2014.1	2	
101140			. 00/30/2014	Version: 2014.1	.0	
OSPIT	AL UNCOMPENSATED AND INDIGENT CARE DA	ТА			WORKSHEE	т
	PENSATED AND INDIGENT CARE COST COMPUTA ST TO CHARGE RATIO (Worksheet C, Part I, line 202,				0.266191	T
	ID (see instructions for each line)			1		
	T REVENUE FROM MEDICAID				4,692,000	+
	O YOU RECEIVE DSH OR SUPPLEMENTAL PAYME		112.2		N	
	LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PA		AID?			+
	LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PA EDICAID CHARGES	I MEN 15 FROM MEDICAID			16,179,000	-
	EDICAID COARGES				4,306,704	_
	FERENCE BETWEEN NET REVENUE AND COSTS	FOR MEDICAID PROGRAM (line 7 minus the su	m of lines 2 and 5)		.,	
IFI	LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5,	THEN ENTER ZERO.				
	HILDREN'S HEALTH INSURANCE PROGRAM (SCH T REVENUE FROM STAND-ALONE SCHIP	IIP)(see instructions for each line)				Т
	AND-ALONE SCHIP CHARGES					+
	AND-ALONE SCHIP COST (line 1 times line 10)					t
DI	FERENCE BETWEEN NET REVENUE AND COSTS	FOR STAND-ALONE SCHIP (line 11 minus line	2)			+
	LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO		9)			
IF I	TATE OR LOCAL GOVERNMENT INDIGENT CARE	PROGRAM (see instructions for each line)	·			
IF I	STATE OR LOCAL GOVERNMENT INDIGENT CARE T REVENUE FROM STATE OR LOCAL INDIGENT C	PROGRAM (see instructions for each line) ARE PROGRAM (not included on lines 2, 5, or 9)				
IF I THER S NE CH	STATE OR LOCAL GOVERNMENT INDIGENT CARE T REVENUE FROM STATE OR LOCAL INDIGENT C ARGES FOR PATIENTS COVERED UNDER STATE (PROGRAM (see instructions for each line) ARE PROGRAM (not included on lines 2, 5, or 9) DR LOCAL INDIGENT CARE PROGRAM (not i				
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IF 1 IF 1 NE ST. DII IF 1 NCOMI PR GO TO TO TO PA DO PA	STATE OR LOCAL GOVERNMENT INDIGENT CARE T REVENUE FROM STATE OR LOCAL INDIGENT C ARGES FOR PATIENTS COVERED UNDER STATE (ATE OR LOCAL INDIGENT CARE PROGRAM COST FERENCE BETWEEN NET REVENUE AND COSTS LINE 15 IS LESS THAN LINE 13, THEN ENTER ZER(PENSATED AND INDIGENT CARE COST COMPUTA IVATE GRANTS, DONATIONS, OR ENDOWMENT II WERNMENT GRANTS, APPROPRIATIONS OF TRAN TAL UNREIMBURSED COST FOR MEDICAID, SCHI TAL INITIAL OBLIGATION OF PATIENTS APPROV nbursable cost centers) FOR THE ENTIRE FACILITY ST OF INITIAL OBLIGATION OF PATIENTS APPROR RTIAL PAYMENT BY PATIENTS APPROVED FOR C ST OF CHARITY CARE (line 21 minus line 22)	E PROGRAM (see instructions for each line) ARE PROGRAM (not included on lines 2, 5, or 9) OR LOCAL INDIGENT CARE PROGRAM (not in (line 1 times line 14) FOR STATE OR LOCAL INDIGENT CARE PRO). TION COME RESTRICTED TO FUNDING CHARITY SFERS FOR SUPPORT OF HOSPITAL OPERA' P AND STATE AND LOCAL INDIGENT CARE ED FOR CHARITY CARE (at full charges excluded VED FOR CHARITY CARE (line 1 times line 20) HARITY CARE 5 CHARGES FOR PATIENT DAYS BEYOND A GENT CARE PROGRAM?	ncluded in lines 6 or 10) GRAM (line 15 minus line 13) 7 CARE TIONS PROGRAMS (sum of lines 8, 1 UNINSURED PATIENTS 1 ing non- 4,034,74 0 1,074,01 41,20 1,032,810 LENGTH OF STAY LIMIT IM	INSURED PATIENTS 2 9 131,345 4 34,963 4 34,963 4 34,963 POSED ON IPOSED ON	(col. 1 + col. 2) 3 4,166,094 1,108,977 41,204	
IF 1 IF 1 NEE S 2 CHA ST. DII IF 1 NCOMI PR GO TO FO FO CO PA TO PO PA TO PI PI TO PI PI TO PI PI TO PI PI TO PI PI TO PI PI TO PI PI PI PI PI PI PI PI PI PI	STATE OR LOCAL GOVERNMENT INDIGENT CARE T REVENUE FROM STATE OR LOCAL INDIGENT C ARGES FOR PATIENTS COVERED UNDER STATE (ATE OR LOCAL INDIGENT CARE PROGRAM COST FERENCE BETWEEN NET REVENUE AND COSTS LINE 15 IS LESS THAN LINE 13, THEN ENTER ZER(PENSATED AND INDIGENT CARE COST COMPUTA IVATE GRANTS, DONATIONS, OR ENDOWMENT II VERNMENT GRANTS, APPROPRIATIONS OF TRAN TAL UNREIMBURSED COST FOR MEDICAID, SCHI TAL INITIAL OBLIGATION OF PATIENTS APPROV nbursable cost centers) FOR THE ENTIRE FACILITY ST OF INITIAL OBLIGATION OF PATIENTS APPROVE RTIAL PAYMENT BY PATIENTS APPROVED FOR C ST OF CHARITY CARE (line 21 minus line 22) ES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDD TIENTS COVERED BY MEDICAID OR OTHER INDIG LINE 24 IS YES, ENTER CHARGES FOR PATIENT D. TAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPI	PROGRAM (see instructions for each line) ARE PROGRAM (not included on lines 2, 5, or 9) DR LOCAL INDIGENT CARE PROGRAM (not i (line 1 times line 14) FOR STATE OR LOCAL INDIGENT CARE PRO D. TION COME RESTRICTED TO FUNDING CHARITY AND STATE AND LOCAL INDIGENT CARE P AND STATE AND LOCAL INDIGENT CARE ED FOR CHARITY CARE (at full charges exclud) VED FOR CHARITY CARE (line 1 times line 20) HARITY CARE ECHARGES FOR PATIENT DAYS BEYOND A GENT CARE PROGRAM? AYS BEYOND AN INDIGENT CARE PROGRAM TAL COMPLEX (see instructions)	ncluded in lines 6 or 10) GRAM (line 15 minus line 13) 7 CARE TIONS PROGRAMS (sum of lines 8, 1 UNINSURED PATIENTS 1 ing non- 4,034,74 0 1,074,01 41,20 1,032,810 LENGTH OF STAY LIMIT IN	INSURED PATIENTS 2 9 131,345 4 34,963 4 34,963 4 34,963 POSED ON IPOSED ON	(col. 1 + col. 2) 3 4,166,094 1,108,977 41,204 1,067,773 4,514,000	
IF 1 IF 1 NE S 5. CH ST. DII IF 1 NCOMI PR GO TO PR GO TO PR GO CO PR GO CO PR GO TO TO TO TO TO TO TO TO TO T	STATE OR LOCAL GOVERNMENT INDIGENT CARE T REVENUE FROM STATE OR LOCAL INDIGENT C ARGES FOR PATIENTS COVERED UNDER STATE C ATE OR LOCAL INDIGENT CARE PROGRAM COST FERENCE BETWEEN NET REVENUE AND COSTS LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERC PENSATED AND INDIGENT CARE COST COMPUTA IVATE GRANTS, DONATIONS, OR ENDOWMENT II WERNMENT GRANTS, APPROPRIATIONS OF TRAN TAL UNREIMBURSED COST FOR MEDICAID, SCHI TAL INITIAL OBLIGATION OF PATIENTS APPROV nbursable cost centers) FOR THE ENTIRE FACILITY ST OF INITIAL OBLIGATION OF PATIENTS APPROVED RTIAL PAYMENT BY PATIENTS APPROVED FOR C ST OF CHARITY CARE (line 21 minus line 22) DES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDI TIENTS COVERED BY MEDICAID OR OTHER INDI- LINE 24 IS YES, ENTER CHARGES FOR PATIENT D. TAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL DICARE BAD DEBTS FOR THE ENTIRE HOSPITAL	PROGRAM (see instructions for each line) ARE PROGRAM (not included on lines 2, 5, or 9) PR LOCAL INDIGENT CARE PROGRAM (not i (line 1 times line 14) FOR STATE OR LOCAL INDIGENT CARE PRO). TION COME RESTRICTED TO FUNDING CHARITY SIFERS FOR SUPPORT OF HOSPITAL OPERA' P AND STATE AND LOCAL INDIGENT CARE ED FOR CHARITY CARE (at full charges exclude VED FOR CHARITY CARE (line 1 times line 20) HARITY CARE E CHARGES FOR PATIENT DAYS BEYOND A GENT CARE PROGRAM? AYS BEYOND AN INDIGENT CARE PROGRAI TAL COMPLEX (see instructions) COMPLEX (see instructions)	ncluded in lines 6 or 10) OGRAM (line 15 minus line 13) CARE TIONS PROGRAMS (sum of lines 8, 1 UNINSURED PATIENTS 1 ing non- 4,034,74 1,074,01- 41,20- 1,032,810 LENGTH OF STAY LIMIT IN M'S LENGTH OF STAY LIMIT	INSURED PATIENTS 2 9 131,345 4 34,963 4 34,963 4 34,963 POSED ON IPOSED ON	(col. 1 + col. 2) 3 4,166,094 1,108,977 41,204 1,067,773 41,204 1,067,773	
IF 1 THER 5 NE IF 1 NE IF 1 ST. IF 1 ST. IF 1 IF 1 ST. IF 1	STATE OR LOCAL GOVERNMENT INDIGENT CARE T REVENUE FROM STATE OR LOCAL INDIGENT C ARGES FOR PATIENTS COVERED UNDER STATE ATE OR LOCAL INDIGENT CARE PROGRAM COST FERENCE BETWEEN NET REVENUE AND COSTS LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERC PENSATED AND INDIGENT CARE COST COMPUTA IVATE GRANTS, DONATIONS, OR ENDOWMENT II WERNMENT GRANTS, APPROPRIATIONS OF TRAN TAL UNREIMBURSED COST FOR MEDICAID, SCH TAL UNREIMBURSED COST FOR MEDICAID, SCH STOF INITIAL OBLIGATION OF PATIENTS APPROV nbursable cost centers) FOR THE ENTIRE FACILITY ST OF INITIAL OBLIGATION OF PATIENTS APPROV RTIAL PAYMENT BY PATIENTS APPROVED FOR C ST OF CHARITY CARE (line 21 minus line 22) DES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDD TIENTS COVERED BY MEDICAID OR OTHER INDIF LINE 24 IS YES, ENTER CHARGES FOR PATIENT D. TAL BAD DEBTS FOR THE ENTIRE HOSPITAL IN-MEDICARE AND NON-REIMBURSABLE MEDIC.	E PROGRAM (see instructions for each line) ARE PROGRAM (not included on lines 2, 5, or 9) OR LOCAL INDIGENT CARE PROGRAM (not in (line 1 times line 14) FOR STATE OR LOCAL INDIGENT CARE PRO). TION VCOME RESTRICTED TO FUNDING CHARITY VSFERS FOR SUPPORT OF HOSPITAL OPERA' P AND STATE AND LOCAL INDIGENT CARE ED FOR CHARITY CARE (at full charges excluded VED FOR CHARITY CARE (line 1 times line 20) HARITY CARE E CHARGES FOR PATIENT DAYS BEYOND A GENT CARE PROGRAM? AYS BEYOND AN INDIGENT CARE PROGRAM TAL COMPLEX (see instructions) COMPLEX (see instructions) COMPLEX (see instructions) ARE BAD DEBT EXPENSE (line 26 minus line 27) VER SAD VER SA	ncluded in lines 6 or 10) GRAM (line 15 minus line 13) (CARE TIONS PROGRAMS (sum of lines 8, 1 UNINSURED PATIENTS 1 ing non- 4,034,74 1,074,01 41,20 1,032,810 LENGTH OF STAY LIMIT IM M'S LENGTH OF STAY LIMIT 7)	INSURED PATIENTS 2 9 131,345 4 34,963 4 34,963 4 34,963 POSED ON IPOSED ON	(col. 1 + col. 2) 3 4,166,094 1,108,977 41,204 1,067,773 4,514,000 102,819 4,411,181	
2 IF J THER \$ S 3 NE 4 CH 5 ST. 5 DH 5 ST. 6 DH 7 PR 8 GO 9 TO	STATE OR LOCAL GOVERNMENT INDIGENT CARE T REVENUE FROM STATE OR LOCAL INDIGENT C ARGES FOR PATIENTS COVERED UNDER STATE C ATE OR LOCAL INDIGENT CARE PROGRAM COST FERENCE BETWEEN NET REVENUE AND COSTS LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERC PENSATED AND INDIGENT CARE COST COMPUTA IVATE GRANTS, DONATIONS, OR ENDOWMENT II WERNMENT GRANTS, APPROPRIATIONS OF TRAN TAL UNREIMBURSED COST FOR MEDICAID, SCHI TAL INITIAL OBLIGATION OF PATIENTS APPROV nbursable cost centers) FOR THE ENTIRE FACILITY ST OF INITIAL OBLIGATION OF PATIENTS APPROVED RTIAL PAYMENT BY PATIENTS APPROVED FOR C ST OF CHARITY CARE (line 21 minus line 22) DES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDI TIENTS COVERED BY MEDICAID OR OTHER INDI- LINE 24 IS YES, ENTER CHARGES FOR PATIENT D. TAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL DICARE BAD DEBTS FOR THE ENTIRE HOSPITAL	E PROGRAM (see instructions for each line) ARE PROGRAM (not included on lines 2, 5, or 9) OR LOCAL INDIGENT CARE PROGRAM (not in (line 1 times line 14) FOR STATE OR LOCAL INDIGENT CARE PRO). 	ncluded in lines 6 or 10) GRAM (line 15 minus line 13) (CARE TIONS PROGRAMS (sum of lines 8, 1 UNINSURED PATIENTS 1 ing non- 4,034,74 1,074,01 41,20 1,032,810 LENGTH OF STAY LIMIT IM M'S LENGTH OF STAY LIMIT 7)	INSURED PATIENTS 2 9 131,345 4 34,963 4 34,963 4 34,963 POSED ON IPOSED ON	(col. 1 + col. 2) 3 4,166,094 1,108,977 41,204 1,067,773 41,204 1,067,773	

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	$\begin{array}{c} \text{RECLASSI-}\\ \text{FIED TRIAL}\\ \text{BALANCE}\\ (\text{col. 3} \pm\\ \text{col. 4}) \end{array}$	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT				1,495,897	1,495,897	396,769	1,892,666	1
2	00200	CAP REL COSTS-MVBLE EQUIP				1,510,482	1,510,482		1,510,482	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	69,619	79,527	149,146	-1,182	147,964	-4,149	143,815	4
5	00500	ADMINISTRATIVE & GENERAL	1,626,288	11,847,075	13,473,363	-1,090,141	12,383,222	-2,464,692	9,918,530	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	357,877	1,508,053	1,865,930	-300,632	1,565,298	-5,369	1,559,929	7
8	00800	LAUNDRY & LINEN SERVICE	29,935	171,727	201,662		201,662		201,662	8
9	00900	HOUSEKEEPING	392,911	211,835	604,746	-1,445	603,301	-62,500	540,801	9
10	01000	DIETARY	207,600	480,463	688,063	-3,626	684,437	-164,314	520,123	10
11	01100	CAFETERIA								11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	439,250	114,548	553,798	-9,255	544,543		544,543	13
14	01400	CENTRAL SERVICES & SUPPLY								14
15	01500	PHARMACY	483,800	1,691,810	2,175,610	-1,547,604	628,006	234	628,240	15
16	01600	MEDICAL RECORDS & LIBRARY	216,412	278,979	495,391	-34	495,357		495,357	16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)	20,939	1,583	22,522		22,522	-8,997	13,525	23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	1,979,809	1,060,005	3,039,814	-1,057,656	1,982,158	-8,150	1,974,008	30
31	03100	INTENSIVE CARE UNIT	1,092,960	358,348	1,451,308	-15,151	1,436,157	-95,966	1,340,191	31
43	04300	NURSERY				436,135	436,135		436,135	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	1,713,149	3,069,469	4,782,618	-683,187	4,099,431	-1,032,589	3,066,842	50
52	05200	DELIVERY ROOM & LABOR ROOM				436,135	436,135		436,135	
54	05400	RADIOLOGY-DIAGNOSTIC	818,023	596,050	1,414,073	-280,122	1,133,951	-175	1,133,776	
55	05500	RADIOLOGY-THERAPEUTIC	289,996	343,625	633,621	-60,934	572,687	-96,786	475,901	
57	05700	CT SCAN	73,420	159,673	233,093	-75,666	157,427		157,427	
59	05900	CARDIAC CATHETERIZATION	74,672	530,112	604,784	-380,280	224,504		224,504	59
60	06000	LABORATORY	1,075,899	1,988,728	3,064,627	-94,139	2,970,488	-2,209	2,968,279	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	454,215	383,316	837,531	-56,387	781,144	-13,071	768,073	65
66	06600	PHYSICAL THERAPY	878,277	382,163	1,260,440	-51,609	1,208,831	-24,000	1,184,831	66
72	07200	IMPL. DEV. CHARGED TO PATIENTS				571,841	571,841		571,841	72
73	07300	DRUGS CHARGED TO PATIENTS				1,500,078	1,500,078		1,500,078	73
76.97	07697	CARDIAC REHABILITATION				203.531	202 521		202 521	76.97
76.98 76.99	07698	HYPERBARIC OXYGEN THERAPY LITHOTRIPSY				203,531	203,531		203,531	76.98 76.99
/0.99	07099	OUTPATIENT SERVICE COST CENTERS								/0.99
90.01	09001		EEAF	1,197	6,742	-6,742				90.01
90.01		OUTPATIENT TREATMENT & INFUSION CTR ATHLETIC TRAINERS	5,545 144,843	67,975	6,742	-0,/42	212,818	-55,080	157,738	90.01
	09002	SAINT JOSEPH HEALTH CENTER				64.042		-55,080		
90.03	09003		239,471	204,916	444,387	-64,943	379,444	-30,206	323,178	90.03
90.04	09004	WOUND CARE EMERCENCY	148,546	762,548	911,094	-349,573	561,521	-21.480	561,521 1.841,169	
91 92	09100	EMERGENCY	1,228,418	658,022	1,886,440	-23,791	1,862,649	-21,480	1,841,169	91 92
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
112	11300	SPECIAL PURPOSE COST CENTERS								113
113 118	11300	INTEREST EXPENSE SUBTOTALS (sum of lines 1-117)	14,061,874	26,951,747	41.013.621		41,013,621	-3,718,790	37,294,831	113
110		NONREIMBURSABLE COST CENTERS	14,001,874	20,931,747	41,015,621		41,013,621	-3,/18,/90	57,294,831	118
		GIFT, FLOWER, COFFEE SHOP & CANTEEN								190
100	10000									190
190	19000	, , , , , , , , , , , , , , , , , , , ,		1					1 1	
192	19200	PHYSICIANS' PRIVATE OFFICES		1 157	1 157		1 157		1 157	
192 192.01	19200 19201	PHYSICIANS' PRIVATE OFFICES FOUNDATION ADMINISTATION	321 720	1,157	1,157		1,157			192.01
192	19200 19201	PHYSICIANS' PRIVATE OFFICES	321,720	1,157 1,533,566 116,889	1,157 1,855,286 116,889		1,157 1,855,286 116,889		1,855,286	192.01 192.02

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	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

WORKSHEET A-6

	CODE		NCREASES			
EXPLANATION OF RECLASS	SIFICATION(S) (1)	COST CENTER	LINE #	SALARY	OTHER	
	1	2	3	4	5	
1 DEPRECIATION RECLASSIFICAT	ONS A	CAP REL COSTS-MVBLE EQUIP	2		1,182	
2 3		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT	1		8,227 707,177	
4		CAP REL COSTS-BLDG & FIXT	1		24,292	
5		CAP REL COSTS-DEDG & HAT	2		366	
6		CAP REL COSTS-MVBLE EQUIP	2		106,363	
7		CAP REL COSTS-BLDG & FIXT	1		212,492	
8		CAP REL COSTS-MVBLE EQUIP	2		88,140	
9		CAP REL COSTS-MVBLE EQUIP	2		1,445	
10		CAP REL COSTS-BLDG & FIXT	1		2,225	
11		CAP REL COSTS-MVBLE EQUIP	2		1,266	
12		CAP REL COSTS-MVBLE EQUIP	2 2		135	
13 14		CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-BLDG & FIXT	1		9,255 58	
15		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	2		94	
16		CAP REL COSTS-MVBLE EQUIP	2		47,374	
17		CAP REL COSTS-MVBLE EQUIP	2		34	
18		CAP REL COSTS-BLDG & FIXT	1		26,262	
19		CAP REL COSTS-MVBLE EQUIP	2		10,804	
20		CAP REL COSTS-MVBLE EQUIP	2		148,320	
21		CAP REL COSTS-MVBLE EQUIP	2		4,088	
22		CAP REL COSTS-MVBLE EQUIP	2		10,890	
23		CAP REL COSTS-BLDG & FIXT	1		7,846	
24		CAP REL COSTS-MVBLE EQUIP	2		18,000	
25 26		CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-BLDG & FIXT	2		103,145 12,157	
27		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	2		997	
28		CAP REL COSTS-MVBLE EQUIP	2		266,968	
29		CAP REL COSTS-MVBLE EQUIP	2		1,052	
30		CAP REL COSTS-MVBLE EQUIP	2		59,882	
31		CAP REL COSTS-MVBLE EQUIP	2		27,928	
32		CAP REL COSTS-MVBLE EQUIP	2		47,738	
33		CAP REL COSTS-BLDG & FIXT	1		513	
34		CAP REL COSTS-MVBLE EQUIP	2		369,037	
35		CAP REL COSTS-BLDG & FIXT	1		707	
36		CAP REL COSTS-MVBLE EQUIP	2 2		3,989	
37 38		CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-BLDG & FIXT	1		89,443 442	
39		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	2		8,111	
40		CAP REL COSTS-MVBLE EQUIP	2		47,834	
41		CAP REL COSTS-BLDG & FIXT	1		46,712	
42		CAP REL COSTS-BLDG & FIXT	1		4,774	
43		CAP REL COSTS-MVBLE EQUIP	2		123	
44		CAP REL COSTS-BLDG & FIXT	1		24,768	
45		CAP REL COSTS-BLDG & FIXT	1		34,917	
46		CAP REL COSTS-MVBLE EQUIP	2		5,258	
47		CAP REL COSTS-BLDG & FIXT	1		117,435	
48 49		CAP REL COSTS-BLDG & FIXT	1 2		21,177	
50		CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP	2		7,430 23,791	
500 TOTAL RECLASSIFICATIONS		CAF REL COSTS-MVBLE EQUIF	2		2,762,663	
CODE LETTER - A					2,702,005	
1 DRUGS CHARGED TO PATIENTS	В	DRUGS CHARGED TO PATIENTS	73		1,500,078	
500 TOTAL RECLASSIFICATIONS					1,500,078	
CODE LETTER - B						
1 INTEREST EXPENSE	C	INTEREST EXPENSE	113		243,716	
2 500 TOTAL RECLASSIFICATIONS		CAP REL COSTS-BLDG & FIXT	1		243,716 487,432	
CODE LETTER - C					487,432	
1 NURSERY - LABOR/DELIVERY R	ECLASS D	NURSERY	43	283,341	152,794	
2		DELIVERY ROOM & LABOR ROOM	52	283,341	152,794	_
500 TOTAL RECLASSIFICATIONS				566,682	305,588	
CODE LETTER - D						
1 IMPLANTS RECLASS	E	IMPL. DEV. CHARGED TO PATIENT	72		173	
2 3		IMPL. DEV. CHARGED TO PATIENT	72 72		560,938 10,730	
500 TOTAL RECLASSIFICATIONS		IMPL. DEV. CHARGED TO PATIENT	12		571,841	
CODE LETTER - E					571,041	
CODE LETTER - L						
1 RECLASS OUTPT TREATMENT E	XPENSES F	OPERATING ROOM	50	5,545	1,197	_
500 TOTAL RECLASSIFICATIONS				5,545	1,197	-

KPMG LLP	Compu-Max								
	In Lieu of Form	Period :	Run Date: 03/13/2015						
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22						
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10						

WORKSHEET A-6

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS HBO COST FROM WOUND CARE	G	HYPERBARIC OXYGEN THERAPY	76.98	55,463	148,068	1
500	TOTAL RECLASSIFICATIONS				55,463	148,068	500
	CODE LETTER - G						
	GRAND TOTAL (INCREASES)				627,690	5,776,867	

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

KPMG LLP COMPU-MAX								
	In Lieu of Form	Period :	Run Date: 03/13/2015					
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22					
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10					

WORKSHEET A-6

			DECRI	EASES				
EX	XPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1 DEPR	RECIATION RECLASSIFICATONS	А	EMPLOYEE BENEFITS DEPARTMENT	4		1,182	9	
2			ADMINISTRATIVE & GENERAL	5		8,227	10	
3			ADMINISTRATIVE & GENERAL	5		707,177	9	
4			ADMINISTRATIVE & GENERAL	5		24,292	9	
5			ADMINISTRATIVE & GENERAL	5		366	10	
6			ADMINISTRATIVE & GENERAL	5		106,363	9	
7			OPERATION OF PLANT	7		212,492	9	
8			OPERATION OF PLANT	7		88,140	9	
9			HOUSEKEEPING	9		1,445	9	
10			DIETARY	10		2.225	9	-
11			DIETARY	10		1,266	10	
12			DIETARY	10		135	9	
13			NURSING ADMINISTRATION	13		9,255	9	-
14			PHARMACY	15		58	9	
15			PHARMACY	15		94	10	
16			PHARMACY	15		47,374	9	
17			MEDICAL RECORDS & LIBRARY	16		34	9	
18			ADULTS & PEDIATRICS	30		26,262	9	
19				30		10,804	10	
20		+	ADULTS & PEDIATRICS	30		,	9	
		+	ADULTS & PEDIATRICS			148,320		
21		-	INTENSIVE CARE UNIT	31		4,088	10	
22			INTENSIVE CARE UNIT	31		10,890	9	
23		+	OPERATING ROOM	50		7,846	9	
24			OPERATING ROOM	50		18,000	10	
25		-	OPERATING ROOM	50		103,145	9	
26			RADIOLOGY-DIAGNOSTIC	54		12,157	9	
27			RADIOLOGY-DIAGNOSTIC	54		997	10	
28			RADIOLOGY-DIAGNOSTIC	54		266,968	9	
29			RADIOLOGY-THERAPEUTIC	55		1,052	10	
30			RADIOLOGY-THERAPEUTIC	55		59,882	9	
31			CT SCAN	57		27,928	10	
32			CT SCAN	57		47,738	9	
33			CARDIAC CATHETERIZATION	59		513	9	
34			CARDIAC CATHETERIZATION	59		369,037	9	
35			LABORATORY	60		707	9	
36			LABORATORY	60		3,989	9	
37			LABORATORY	60		89,443	9	
38			RESPIRATORY THERAPY	65		442	9	
39			RESPIRATORY THERAPY	65		8,111	10	
40			RESPIRATORY THERAPY	65		47.834	9	
40			PHYSICAL THERAPY	66		46,712	10	
41 42			PHYSICAL THERAPY	66		40,712	9	
42			PHYSICAL THERAPY	66		123	9	
-								
44			SAINT JOSEPH HEALTH CENTER	90.03		24,768	10	
45			SAINT JOSEPH HEALTH CENTER	90.03		34,917	9	
46			SAINT JOSEPH HEALTH CENTER	90.03		5,258	9	
47			WOUND CARE	90.04		117,435	10	
48			WOUND CARE	90.04		21,177	9	
49			WOUND CARE	90.04		7,430	9	
50			EMERGENCY	91		23,791	9	
	AL RECLASSIFICATIONS					2,762,663		
CODI	E LETTER - A							
	GS CHARGED TO PATIENTS	В	PHARMACY	15		1,500,078		
	AL RECLASSIFICATIONS					1,500,078		
CODI	E LETTER - B							
1 INTE	REST EXPENSE	С	ADMINISTRATIVE & GENERAL	5		243,716	11	
2			INTEREST EXPENSE	113		243,716	11	
	AL RECLASSIFICATIONS					487,432		
	E LETTER - C							
1 NURS	SERY - LABOR/DELIVERY RECLASS	D	ADULTS & PEDIATRICS	30	283,341	152,794		
2			ADULTS & PEDIATRICS	30	283,341	152,794		
	AL RECLASSIFICATIONS			50	566,682	305,588		
	E LETTER - D				500,082	303,388		
	ELETIEK - D	+						
1 0.07	ANTE DECLASS	-				150		
	ANTS RECLASS	E	INTENSIVE CARE UNIT	31		173		
2		+	OPERATING ROOM	50		560,938		
3			CARDIAC CATHETERIZATION	59		10,730		
	AL RECLASSIFICATIONS					571,841		
CODI	E LETTER - E							
1 RECL	ASS OUTPT TREATMENT EXPENSES	F	OUTPATIENT TREATMENT & INFUSI	90.01	5,545	1,197		
	AL RECLASSIFICATIONS				5,545	1,197		

KPMG LLP	Compu-Max									
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ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22							
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10							

WORKSHEET A-6

			DECREASE	S				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
	CODE LETTER - F							
1	RECLASS HBO COST FROM WOUND CARE	G	WOUND CARE	90.04	55,463	148,068		1
500	TOTAL RECLASSIFICATIONS				55,463	148,068		500
	CODE LETTER - G							
	GRAND TOTAL (DECREASES)				627,690	5,776,867		

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

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Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10					

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

				ACQUISITIONS					1
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE- MENTS	ENDING BALANCE	FULLY DEPREC- IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	477,930					477,930		1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES	33,182,461	2,056,452		2,056,452		35,238,913	11,631,559	3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	22,387,348	2,370,903		2,370,903	912,101	23,846,150	12,200,471	6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	56,047,739	4,427,355		4,427,355	912,101	59,562,993	23,832,030	8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	56,047,739	4,427,355		4,427,355	912,101	59,562,993	23,832,030	10

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

				SUN	MARY OF CAPI	TAL			
	DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT								1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (sum of lines 1-2)								3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2. * All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

			COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
	DESCRIPTION	GROSS ASSETS	CAPITAL- IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI				0.000000					1
2	CAP REL COSTS-MVBLE EQU				0.000000					2
3	TOTAL (sum of lines 1-2)				0.000000					3

			SUMMARY OF CAPITAL						
	DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	1,695,524	197,142	243,716		-243,716		1,892,666	1
2	CAP REL COSTS-MVBLE EQUIP	1,437,776	72,706					1,510,482	2
3	TOTAL (sum of lines 1-2)	3,133,300	269,848	243,716		-243,716		3,403,148	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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	In Lieu of Form	Period :	Run Date: 03/13/2015						
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22						
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10						

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)	В	-243,716	CAP REL COSTS-BLDG & FIXT	1	9	3
4 5	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8) REFUNDS AND REBATES OF EXPENSES (chapter 8)						4 5
6	REPORDS AND REDATES OF EXTENSES (chapter 8) RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)						7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,201,920				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST	1,256,658				12
		A-8-1	1,250,050				
13	LAUNDRY AND LINEN SERVICE	D	164.214	DIFTADY	10	'	13
14 15	CAFETERIA - EMPLOYEES AND GUESTS RENTAL OF QUARTERS TO EMPLOYEES & OTHERS	В	-164,314	DIETARY	10		14 15
	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN						
16	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					ļ'	20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR	В	-243,716	CAP REL COSTS-BLDG & FIXT	1	13	21
	PENALTY CHARGES (chapter 21)	_	,		-		
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS						22
	TO REPAY MEDICARE OVERPAYMENTS ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF	WKST					
23	LIMITATION (chapter 14)	A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST					24
24	(chapter 14)	A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATIONBUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	L	26
27	DEPRECIATIONMOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28 29	NON-PHYSICIAN ANESTHETIST PHYSICIANS' ASSISTANT			NONPHYSICIAN ANESTHETISTS	19		28 29
	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF	WKST					
30	LIMITATION (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67		30
21	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION	WKST		ODEECH DATIOLOGY	(9		21
31	(chapter 14)	A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	PROVIDER TAX EXPENSE	A		ADMINISTRATIVE & GENERAL	5	ļ	33
34	HOSPITAL DONATION EXPENSE	A		ADMINISTRATIVE & GENERAL	5		34
34.01	HOSPTIAL DONATION EXPENSE	A B		ATHLETIC TRAINERS EMPLOYEE BENEFITS DEPARTMENT	90.02		34.01 35
35 35.01	OFFSET OTHER REVENUE OFFSET OTHER REVENUE	B		ADMINISTRATIVE & GENERAL	5		35.01
35.02	OFFSET OTHER REVENUE	B		ADMINISTRATIVE & GENERAL	5		35.02
35.03	OFFSET OTHER REVENUE	B		ADMINISTRATIVE & GENERAL	5		35.03
35.04	OFFSET OTHER REVENUE	В		OPERATION OF PLANT	7		35.04
35.05	OFFSET OTHER REVENUE	В	/	OPERATION OF PLANT	7		35.05
35.06	OFFSET OTHER REVENUE	В		HOUSEKEEPING	9	'	35.06
35.07	OFFSET OTHER REVENUE	B		PHARMACY	15		35.07
35.08	OFFSET OTHER REVENUE	B		ADULTS & PEDIATRICS	30	<u> </u> '	35.08
35.09 35.10	OFFSET OTHER REVENUE OFFSET OTHER REVENUE	B B		OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50 54		35.09 35.10
35.10	OFFSET OTHER REVENUE	B		RADIOLOGY-DIAGNOSTIC RADIOLOGY-THERAPEUTIC	54		35.10
35.11	OFFSET OTHER REVENUE	B		LABORATORY	60	t	35.11
35.13	OFFSET OTHER REVENUE	B		RESPIRATORY THERAPY	65		35.13
35.14	OFFSET OTHER REVENUE	B		PHYSICAL THERAPY	66		35.14
35.15	OFFSET OTHER REVENUE	В	,	SAINT JOSEPH HEALTH CENTER	90.03		35.15
35.16	OFFSET OTHER REVENUE	В		ATHLETIC TRAINERS	90.02	'	35.16
35.17	OFFSET OTHER REVENUE	B		ATHLETIC TRAINERS	90.02		35.17
35.18	OFFSET OTHER REVENUE	B		SAINT JOSEPH HEALTH CENTER	90.03		35.18
35.19 35.20	OFFSET OTHER REVENUE OFFSET OTHER REVENUE	B		SAINT JOSEPH HEALTH CENTER EMERGENCY	90.03 91		35.19 35.20
35.20	PROPERTY TAX EXPENSE ADJ	A		RESPIRATORY THERAPY	65		35.20
37			-110				37
38						L 1	38
39							39
39 40							39 40
39							39

KPMG LLP	Compu-Max	X	
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ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,718,790				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(1) Description - an enapter references in this contain pertain to CMS Fub. 15-1
 (2) Basis for adjustment (see instructions)

 A. Costs - if cost, including applicable overhead, can be determined
 B. Amount Received - if cost cannot be determined
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST- MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	HO NON CAPITAL COSTS	6,681,600	6,961,033	-279,433		1
2	5	ADMINISTRATIVE & GENERAL	WORKER'S COMP	39,268	73,039	-33,771		2
3	5	ADMINISTRATIVE & GENERAL	INSURANCE	200,377	392,000	-191,623		3
3.01	5	ADMINISTRATIVE & GENERAL	PENSION	1,495,439	779,333	716,106		3.01
3.02	5	ADMINISTRATIVE & GENERAL	RETIREE HEALTH COSTS	6,092	-155,086	161,178		3.02
3.03	1	CAP REL COSTS-BLDG & FIXT	HO CAPITAL COSTS	884,201		884,201	9	3.03
4								4
5	TOTAL	S (SUM OF LINES 1-4) TRANSFER COLUMN 6, LIN	NE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12	9,306,977	8,050,319	1,256,658		5

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

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

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

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

				RELATED ORGAN	IZATION(S) AND	/OR HOME OFFICE	
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	G		100.00	CHE TRINITY HEALTH	100.00	HO OF PARENT COMPANY	6
7	G		100.00	SJRMC - INC	100.00	PARENT COMPANY	7
8	G	SJRMC - SOUTH BEND CAMPUS	100.00		100.00		8
9							9
10							10

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.
 F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

G. Other (financial Or non-financial) specify: FINANCIAL

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	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	31	INTENSIVE CARE UNIT A	80,580		80,580	142,500	334	22,882	1,144	1
2	5	ADMINISTRATIVE & GEN B	3,000		3,000	142,500	12	822	41	2
3	30	ADULTS & PEDIATRICS C	14,980		14,980	142,500	107	7,330	367	3
4	31	INTENSIVE CARE UNIT D	57,725		57,725	142,500	284	19,457	973	4
5	5	ADMINISTRATIVE & GEN E	52,047		52,047	142,500	264	18,087	904	5
6	23	PARAMED ED PRGM-(SPE F	18,999		18,999	142,500	146	10,002	500	6
7	50	OPERATING ROOM G	1,031,744	1,031,744						7
8	5	ADMINISTRATIVE & GEN H	300	300						8
9	60	LABORATORY I	54,170		54,170	142,500	832	57,000	2,850	9
10	91	EMERGENCY J	63,525		63,525	208,000	424	42,400	2,120	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,377,070	1,032,044	345,026		2,403	177,980	8,899	200

KPMG LLP	Compu-May	ζ	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	31	INTENSIVE CARE UNIT A					22,882	57,698	57,698	1
2	5	ADMINISTRATIVE & GEN B					822	2,178	2,178	2
3	30	ADULTS & PEDIATRICS C					7,330	7,650	7,650	3
4	31	INTENSIVE CARE UNIT D					19,457	38,268	38,268	4
5	5	ADMINISTRATIVE & GEN E					18,087	33,960	33,960	5
6	23	PARAMED ED PRGM-(SPE F					10,002	8,997	8,997	6
7	50	OPERATING ROOM G							1,031,744	7
8	5	ADMINISTRATIVE & GEN H							300	8
9	60	LABORATORY I					57,000			9
10	91	EMERGENCY J					42,400	21,125	21,125	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					177,980	169,876	1,201,920	200

KPMG LLP	C ΩMPU-MAX	K	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							4
1	CAP REL COSTS-BLDG & FIXT	1,892,666	1,892,666					1
2	CAP REL COSTS-MVBLE EQUIP	1,510,482		1,510,482				2
4	EMPLOYEE BENEFITS DEPARTMENT	143,815		1,213	145,028			4
5	ADMINISTRATIVE & GENERAL	9,918,530	213,625	109,186	16,478	10,257,819	10,257,819	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,559,929	404,023	90,479	3,626	2,058,057	727,712	
8	LAUNDRY & LINEN SERVICE	201,662	7,233		303	209,198	73,971	8
9	HOUSEKEEPING	540,801	3,581	1,483	3,981	549,846	194,421	
10	DIETARY	520,123	25,031	139	2,103	547,396	193,555	
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	544,543		9,501	4,450	558,494	197,479	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	628,240	14,813	48,631	4,902	696,586	246,307	15
16	MEDICAL RECORDS & LIBRARY	495,357	30,008	35	2,193	527,593	186,553	
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)	13,525			212	13,737	4,857	23
	INPATIENT ROUTINE SERV COST CENTERS							4
30	ADULTS & PEDIATRICS	1,974,008	231,422	152,256	14,318	2,372,004	838,722	30
31	INTENSIVE CARE UNIT	1,340,191	44,379	11,179	11,074	1,406,823	497,441	31
43	NURSERY	436,135			2,871	439,006	155,229	43
	ANCILLARY SERVICE COST CENTERS							4
50	OPERATING ROOM	3,066,842	229,775	105,882	17,412	3,419,911	1,209,246	
52	DELIVERY ROOM & LABOR ROOM	436,135			2,871	439,006	155,229	
54	RADIOLOGY-DIAGNOSTIC	1,133,776	86,706	274,053	8,288	1,502,823	531,386	
55	RADIOLOGY-THERAPEUTIC	475,901	108,024	61,472	2,938	648,335	229,246	
57	CT SCAN	157,427	5,001	49,005	744	212,177	75,024	
59	CARDIAC CATHETERIZATION	224,504	25,341	378,832	757	629,434	222,563	59
60	LABORATORY	2,968,279	51,875	91,817	10,901	3,122,872	1,104,223	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	768,073	39,593	49,103	4,602	861,371	304,574	65
66	PHYSICAL THERAPY	1,184,831	69,792	126	8,899	1,263,648	446,816	
72	IMPL. DEV. CHARGED TO PATIENTS	571,841				571,841	202,198	
73	DRUGS CHARGED TO PATIENTS	1,500,078				1,500,078	530,416	
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	203,531	6,481		562	210,574	74,457	76.98
76.99	LITHOTRIPSY							76.99
00.01	OUTPATIENT SERVICE COST CENTERS							00.01
90.01	OUTPATIENT TREATMENT & INFUSION CTR	157 700			1.400	150.007		90.01
90.02	ATHLETIC TRAINERS	157,738		F 000	1,468	159,206	56,294	
90.03	SAINT JOSEPH HEALTH CENTER	323,178	20.022	5,398	2,426	331,002	117,040	
90.04	WOUND CARE	561,521	30,832	7,627	943	600,923	212,482	90.04
91	EMERGENCY	1,841,169	87,601	24,422	12,446	1,965,638	695,034	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
<u> </u>	OTHER REIMBURSABLE COST CENTERS							╉───┤
112	SPECIAL PURPOSE COST CENTERS							112
113	INTEREST EXPENSE	27 204 921	1 715 125	1 471 000	141.700	27.075.200	0 490 475	113
118	SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS	37,294,831	1,715,136	1,471,839	141,768	37,075,398	9,482,475	118
100			2 760			2 260	002	100
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	+	2,268			2,268	<u>802</u>	
192	PHYSICIANS' PRIVATE OFFICES	1.157	175,262			175,262	61,971	
192.01	FOUNDATION ADMINISTATION	1,157			2.200	1,157	409	
192.02	HOSPITALIST	1,855,286		29 642	3,260	1,858,546	657,167	
194	PLYMOUTH MOB-4 CROSS FOOT ADJUSTMENTS	116,889		38,643		155,532	54,995	
200								200
200 201	NEGATIVE COST CENTER							201

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING 9	DIETARY	NURSING ADMINIS- TRATION	PHARMACY 15	
	GENERAL SERVICE COST CENTERS	/	8	9	10	13	15	
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MUBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	2,785,769						7
8	LAUNDRY & LINEN SERVICE	16,558	299,727					8
9	HOUSEKEEPING	8,197	277,121	752,464				9
10	DIETARY	57,296		14,898	813,145			10
11	CAFETERIA			,	,			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION					755,973		13
14	CENTRAL SERVICES & SUPPLY					,		14
15	PHARMACY	33,908		8,817			985,618	15
16	MEDICAL RECORDS & LIBRARY	68,690		17,861			,	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	529,739	17,421	137,743	668,147	208,966	263	30
31	INTENSIVE CARE UNIT	101,587	6,896	26,415	126,003	68,575	187	31
43	NURSERY		1,485			79,379		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	398,342	54,540	136,764	11,310	158,758	579	50
52	DELIVERY ROOM & LABOR ROOM		2,777			79,379		52
54	RADIOLOGY-DIAGNOSTIC	198,474	27,158	51,608			38,687	54
55	RADIOLOGY-THERAPEUTIC	247,273	16,097	64,297				55
57	CT SCAN	11,448	31,665	2,977			19,964	57
59	CARDIAC CATHETERIZATION	58,007	2,371	15,083		6,417	546	59
60	LABORATORY	118,746	55,889	30,877				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	90,630	13,124	23,566			53	65
66	PHYSICAL THERAPY	159,757	9,386	41,541			450	66
72	IMPL. DEV. CHARGED TO PATIENTS		4,777				004.455	72
73	DRUGS CHARGED TO PATIENTS		21,793				891,177	73
76.97	CARDIAC REHABILITATION	14.026	2 201	2.050				76.97
76.98 76.99	HYPERBARIC OXYGEN THERAPY	14,836	2,301	3,858				76.98
/0.99	LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS							76.99
90.01	OUTPATIENT SERVICE COST CENTERS OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.01	ATHLETIC TRAINERS							90.01
90.02	SAINT JOSEPH HEALTH CENTER		375			24,415	21,731	90.02
90.03	WOUND CARE	70,575	3,358	18,351		16,929	11,842	90.03
90.04	EMERGENCY	200,523	28,314	52,141	7,685	113,155	11,842	90.04
92	OBSERVATION BEDS (NON-DISTINCT PART)	200,525	20,514	52,141	7,005	115,155	157	92
12	OTHER REIMBURSABLE COST CENTERS							<u> </u>
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	2,384,586	299,727	646,797	813,145	755,973	985,618	
	NONREIMBURSABLE COST CENTERS	, ,. .						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			1,350				190
192	PHYSICIANS' PRIVATE OFFICES	401,183		104,317				192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST							192.02
194	PLYMOUTH MOB-4							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,785,769	299,727	752,464	813,145	755,973	985,618	202

KPMG LLP	<u>Compu-May</u>	ζ	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

		MERICAL	DADANTE		LOD COOT A		
		MEDICAL	PARAMED		I&R COST &		
	COST CENTER DESCRIPTIONS	RECORDS &	EDUCATION	SUBTOTAL	POST STEP-	TOTAL	
		LIBRARY 16	23	24	DOWN ADJS 25	26	
	GENERAL SERVICE COST CENTERS	10	23	24	23	20	
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	000 105					15
16	MEDICAL RECORDS & LIBRARY	800,697					16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20 21	NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	PARAMED ED PRGM-(SPECIFY)		18,594				22
23	INPATIENT ROUTINE SERV COST CENTERS		18,394				25
30	ADULTS & PEDIATRICS	46,543		4,819,548		4,819,548	30
31	INTENSIVE CARE UNIT	18,423		2,252,350		2,252,350	31
43	NURSERY	3,968		679,067		679,067	43
-15	ANCILLARY SERVICE COST CENTERS	5,700		019,001		019,001	45
50	OPERATING ROOM	145,709		5,535,159		5,535,159	50
52	DELIVERY ROOM & LABOR ROOM	7,419		683,810		683,810	52
54	RADIOLOGY-DIAGNOSTIC	72,556		2,422,692		2,422,692	54
55	RADIOLOGY-THERAPEUTIC	43,006		1,248,254		1,248,254	55
57	CT SCAN	84,596		437,851		437,851	57
59	CARDIAC CATHETERIZATION	6,335		940,756		940,756	59
60	LABORATORY	149,256		4,581,863		4,581,863	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	35,062		1,328,380		1,328,380	65
66	PHYSICAL THERAPY	25,076		1,946,674		1,946,674	66
72	IMPL. DEV. CHARGED TO PATIENTS	12,762		791,578		791,578	72
73	DRUGS CHARGED TO PATIENTS	58,223		3,001,687		3,001,687	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	6,147		312,173		312,173	76.98
76.99	LITHOTRIPSY						76.99
00.01	OUTPATIENT SERVICE COST CENTERS						00.01
90.01	OUTPATIENT TREATMENT & INFUSION CTR			015 500		215 500	90.01
90.02	ATHLETIC TRAINERS	1.001		215,500		215,500	90.02
90.03 90.04	SAINT JOSEPH HEALTH CENTER WOUND CARE	1,001		495,564 943,432		495,564	90.03
90.04 91	EMERGENCY	8,972 75,643	18,594	3,156,866		943,432 3,156,866	90.04
91	OBSERVATION BEDS (NON-DISTINCT PART)	73,043	10,394	3,130,800		3,130,000	91
74	OBSERVATION BEDS (NON-DISTINCT PART)				-		92
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)	800,697	18,594	35,793,204		35,793,204	115
	NONREIMBURSABLE COST CENTERS			,,,			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			4,420		4,420	190
192	PHYSICIANS' PRIVATE OFFICES			742,733		742,733	192
192.01	FOUNDATION ADMINISTATION			1,566		1,566	192.01
192.02	HOSPITALIST			2,515,713		2,515,713	192.02
194	PLYMOUTH MOB-4			210,527		210,527	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	800,697	18,594	39,268,163		39,268,163	202

KPMG LLP	C ΩMPU-MAX	K	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT			1,213	1,213	1,213		4
5	ADMINISTRATIVE & GENERAL		213,625	109,186	322,811	138	322,949	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		404,023	90,479	494,502	30	22,910	7
8	LAUNDRY & LINEN SERVICE		7,233	1.102	7,233	3	2,329	8
9	HOUSEKEEPING		3,581	1,483	5,064	33	6,121	9
10	DIETARY		25,031	139	25,170	18	6,094	10
11 12	CAFETERIA MAINTENANCE OF PERSONNEL							11 12
12	NURSING ADMINISTRATION			9.501	9,501	37	6,217	12
15	CENTRAL SERVICES & SUPPLY			9,501	9,501	57	0,217	13
15	PHARMACY		14,813	48,631	63,444	41	7,754	14
16	MEDICAL RECORDS & LIBRARY		30,008	35	30,043	18	5,873	16
17	SOCIAL SERVICE				50,045	10	5,075	10
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	153	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		231,422	152,256	383,678	120	26,405	30
31	INTENSIVE CARE UNIT		44,379	11,179	55,558	93	15,661	31
43	NURSERY					24	4,887	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		229,775	105,882	335,657	144	38,078	50
52	DELIVERY ROOM & LABOR ROOM					24	4,887	52
54	RADIOLOGY-DIAGNOSTIC		86,706	274,053	360,759	70	16,729	
55	RADIOLOGY-THERAPEUTIC		108,024	61,472	169,496	25	7,217	55
57	CT SCAN		5,001	49,005	54,006	6	2,362	57
59	CARDIAC CATHETERIZATION		25,341	378,832	404,173	6	7,007	59
60 62.30	LABORATORY		51,875	91,817	143,692	91	34,764	60 62.30
62.50	BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY		39,593	49,103	88,696	39	9,589	62.50
66	PHYSICAL THERAPY		69,792	126	69,918	75	14,067	66
72	IMPL. DEV. CHARGED TO PATIENTS		09,792	120	09,910	15	6,366	
73	DRUGS CHARGED TO PATIENTS						16,699	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY		6,481		6,481	5	2,344	76.98
76.99	LITHOTRIPSY		,		· · · ·			76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS					12	1,772	90.02
90.03	SAINT JOSEPH HEALTH CENTER			5,398	5,398	20	3,685	90.03
90.04	WOUND CARE		30,832	7,627	38,459	8	6,689	90.04
91	EMERGENCY		87,601	24,422	112,023	104	21,881	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
112	SPECIAL PURPOSE COST CENTERS							112
113	INTEREST EXPENSE		1 715 105	1 471 000	2 196 075	1 107	200 540	113
118	SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS		1,715,136	1,471,839	3,186,975	1,186	298,540	118
190	GIFT. FLOWER, COFFEE SHOP & CANTEEN		2,268		2,268		25	190
190	PHYSICIANS' PRIVATE OFFICES		2,268		175,262		1,951	
192.01	FOUNDATION ADMINISTATION		175,202		173,202			192
192.01	HOSPITALIST					27	20,689	
192.02	PLYMOUTH MOB-4			38,643	38,643	21	1,731	
1/7				50,045	50,045		1,751	200
200	CROSS FOOT ADJUSTMENTS							
200 201	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER							200

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	NURSING ADMINIS- TRATION 13	PHARMACY 15	
	GENERAL SERVICE COST CENTERS		U	Ť	10	13	15	
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-BLDG & FIAT CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	517,442						7
8	LAUNDRY & LINEN SERVICE	3,076	12,641					8
9	HOUSEKEEPING	1,523	12,041	12,741				9
10	DIETARY	10,642		252	42,176			10
11	CAFETERIA	10,012		202	12,170			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION					15,755		13
14	CENTRAL SERVICES & SUPPLY					10,700		14
15	PHARMACY	6,298		149			77,686	
16	MEDICAL RECORDS & LIBRARY	12,759		302				16
17	SOCIAL SERVICE	12,707		502				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
25	INPATIENT ROUTINE SERV COST CENTERS							23
30	ADULTS & PEDIATRICS	98,396	735	2,334	34,655	4,355	21	30
31	INTENSIVE CARE UNIT	18,869	291	447	6,535	1,429	15	
43	NURSERY	10,005	63		0,555	1,429	15	43
-15	ANCILLARY SERVICE COST CENTERS		05			1,004		-15
50	OPERATING ROOM	73,990	2,300	2,316	587	3,309	46	50
52	DELIVERY ROOM & LABOR ROOM	10,770	117	2,010	507	1,654		52
54	RADIOLOGY-DIAGNOSTIC	36,866	1.145	874		1,004	3.049	
55	RADIOLOGY-THERAPEUTIC	45,930	679	1,089			5,015	55
57	CT SCAN	2,126	1,335	50			1,574	
59	CARDIAC CATHETERIZATION	10,774	1,00	255		134	43	
60	LABORATORY	22,056	2,358	523		101		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	22,000	2,000	020				62.30
65	RESPIRATORY THERAPY	16,834	553	399			4	
66	PHYSICAL THERAPY	29,674	396	703			35	
72	IMPL. DEV. CHARGED TO PATIENTS		201					72
73	DRUGS CHARGED TO PATIENTS		919				70,242	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	2,756	97	65				76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER		16			509	1,713	
90.04	WOUND CARE	13,109	142	311		353	933	
91	EMERGENCY	37,246	1,194	883	399	2,358	11	
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)	442,924	12,641	10,952	42,176	15,755	77,686	
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			23				190
192	PHYSICIANS' PRIVATE OFFICES	74,518		1,766				192
192.01	FOUNDATION ADMINISTATION			,				192.01
192.02	HOSPITALIST							192.02
	PLYMOUTH MOB-4							194
194								
194 200	CROSS FOOT ADJUSTMENTS							200
	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER							200

KPMG LLP	C ΩMPU-MAX	K	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		16	23	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6 7	MAINTENANCE & REPAIRS OPERATION OF PLANT						6
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	48,995					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		1.7.7				22
23	PARAMED ED PRGM-(SPECIFY)		155				23
30	INPATIENT ROUTINE SERV COST CENTERS	2,845		553,544		EE2 EAA	30
31	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	1,126		100,024		553,544 100,024	31
43	NURSERY	243		6,871		6,871	43
43	ANCILLARY SERVICE COST CENTERS	243		0,871		0,871	45
50	OPERATING ROOM	8,906		465,333		465,333	50
52	DELIVERY ROOM & LABOR ROOM	453		7,135		7,135	52
54	RADIOLOGY-DIAGNOSTIC	4,435		423,927		423,927	54
55	RADIOLOGY-THERAPEUTIC	2,629		227,065		227,065	55
57	CT SCAN	5,171		66,630		66,630	57
59	CARDIAC CATHETERIZATION	387		422,879		422,879	59
60	LABORATORY	9,176		212,660		212,660	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	2,143		118,257		118,257	65
66	PHYSICAL THERAPY	1,533		116,401		116,401	66
72	IMPL. DEV. CHARGED TO PATIENTS	780		7,347		7,347	72
73	DRUGS CHARGED TO PATIENTS	3,559		91,419		91,419	73
76.97	CARDIAC REHABILITATION	276		10.104		12.124	76.97
76.98 76.99	HYPERBARIC OXYGEN THERAPY LITHOTRIPSY	376		12,124		12,124	76.98
/0.99	OUTPATIENT SERVICE COST CENTERS						/0.99
90.01	OUTPATIENT SERVICE COST CENTERS OUTPATIENT TREATMENT & INFUSION CTR						90.01
90.01	ATHLETIC TRAINERS			1,784		1,784	90.02
90.02	SAINT JOSEPH HEALTH CENTER	61		11,402		11,402	90.02
90.03	WOUND CARE	548		60,552		60,552	90.04
91	EMERGENCY	4,624		180,723		180,723	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)	48,995		3,086,077		3,086,077	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			2,316		2,316	190
192	PHYSICIANS' PRIVATE OFFICES			253,497		253,497	192
192.01	FOUNDATION ADMINISTATION			13		13	192.01
192.02	HOSPITALIST			20,716		20,716	192.02
194	PLYMOUTH MOB-4		165	40,374		40,374	194
200 201	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER		155	155		155	200 201
201	TOTAL (sum of lines 118-201)	48,995	155	3,403,148		3,403,148	201 202
202	101111 (outil 01 titleo 110-201)	40,295	155	5,405,140		5,405,140	202

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	OPERATION OF PLANT SQUARE FEET 7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	158,563						1
2	CAP REL COSTS-MVBLE EQUIP		1,471,432	11010.055				2
4	EMPLOYEE BENEFITS DEPARTMENT	17.907	1,182	14,313,975	10 257 810	29.010.344		4
5 6	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	17,897	106,363	1,626,288	-10,257,819	29,010,344		5 6
7	OPERATION OF PLANT	33,848	88,140	357,877		2,058,057	101,957	7
8	LAUNDRY & LINEN SERVICE	606	00,140	29,935		209,198	606	8
9	HOUSEKEEPING	300	1,445	392,911		549,846	300	9
10	DIETARY	2,097	135	207,600		547,396	2,097	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		9,255	439,250		558,494		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	1,241	47,374	483,800		696,586	1,241	15
16	MEDICAL RECORDS & LIBRARY	2,514	34	216,412		527,593	2,514	16
17 19	SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS							17 19
20	NURSING SCHOOL							20
20	I&R SERVICES-SALARY & FRINGES APPRVD							20
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)			20,939		13,737		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	19,388	148,320	1,413,127		2,372,004	19,388	30
31	INTENSIVE CARE UNIT	3,718	10,890	1,092,960		1,406,823	3,718	31
43	NURSERY			283,341		439,006		43
50	ANCILLARY SERVICE COST CENTERS	10.250	102 145	1 710 (04		2 410 011	14.570	50
50	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	19,250	103,145	1,718,694 283,341		3,419,911 439,006	14,579	50 52
52 54	RADIOLOGY-DIAGNOSTIC	7,264	266,968	818,023		1,502,823	7,264	52
55	RADIOLOGY-THERAPEUTIC	9,050	59,883	289,996		648,335	9,050	55
57	CT SCAN	419	47,738	73,420		212,177	419	57
59	CARDIAC CATHETERIZATION	2,123	369,037	74,672		629,434	2,123	59
60	LABORATORY	4,346	89,443	1,075,899		3,122,872	4,346	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,317	47,834	454,215		861,371	3,317	65
66	PHYSICAL THERAPY	5,847	123	878,277		1,263,648	5,847	66
72	IMPL. DEV. CHARGED TO PATIENTS					571,841		72
73 76.97	DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION					1,500,078		73 76.97
76.97	HYPERBARIC OXYGEN THERAPY	543		55,463		210,574	543	76.98
76.99	LITHOTRIPSY	545		55,405		210,574		76.99
10.77	OUTPATIENT SERVICE COST CENTERS							10.77
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS			144,843		159,206		90.02
90.03	SAINT JOSEPH HEALTH CENTER		5,258	239,471		331,002		90.03
90.04	WOUND CARE	2,583	7,430	93,083		600,923	2,583	90.04
91	EMERGENCY	7,339	23,791	1,228,418		1,965,638	7,339	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	143,690	1,433,788	13,992,255	-10,257,819	26,817,579	87,274	118
110	NONREIMBURSABLE COST CENTERS	145,090	1,755,788	13,772,233	10,237,019	20,017,373	07,274	110
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190				2,268		190
192	PHYSICIANS' PRIVATE OFFICES	14,683				175,262	14,683	192
192.01	FOUNDATION ADMINISTATION					1,157		192.01
				321,720		1,858,546		192.02
192.02	HOSPITALIST					155,532		194
194	PLYMOUTH MOB-4		37,644			155,552		
194 200	PLYMOUTH MOB-4 CROSS FOOT ADJUSTMENTS		37,644			155,552		200
194 200 201	PLYMOUTH MOB-4 CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER			145.022			2.505.550	200 201
194 200 201 202	PLYMOUTH MOB-4 CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER COST TO BE ALLOC PER B PT I	1,892,666	1,510,482	145,028		10,257,819	2,785,769	200 201 202
194 200 201	PLYMOUTH MOB-4 CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER	1,892,666 11.936366		145,028 0.010132 1,213			2,785,769 27.322979 517,442	200 201 202

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE GROSS <u>REVENUE</u> 8	HOUSE- KEEPING SQUARE FEET 9	DIETARY MEALS SERVED 10	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	124 464 506						7
8	LAUNDRY & LINEN SERVICE HOUSEKEEPING	134,464,506	105,912					8
10	DIETARY		2.097	5,608				10
10	CAFETERIA		2,097	5,008				10
12	MAINTENANCE OF PERSONNEL					1		12
13	NURSING ADMINISTRATION				282,974			13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		1,241			1,659,050		15
16	MEDICAL RECORDS & LIBRARY		2,514				134,464,506	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
20	INPATIENT ROUTINE SERV COST CENTERS	7.915.7(4	10.200	4.609	79.010	442	7.915.764	20
30 31	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	7,815,764 3,093,629	19,388 3,718	4,608	78,219 25,669	443	7,815,764 3,093,629	
43	NURSERY	666,275	5,/18	809	29,713	515	666,275	
43	ANCILLARY SERVICE COST CENTERS	000,273			29,715		000,273	43
50	OPERATING ROOM	24,468,293	19,250	78	59,426	975	24,468,293	50
52	DELIVERY ROOM & LABOR ROOM	1.245.851	17,250	/0	29,713	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1,245,851	52
54	RADIOLOGY-DIAGNOSTIC	12,183,994	7,264		27,710	65,121	12,183,994	54
55	RADIOLOGY-THERAPEUTIC	7,221,754	9,050				7,221,754	55
57	CT SCAN	14,205,829	419			33,605	14,205,829	57
59	CARDIAC CATHETERIZATION	1,063,833	2,123		2,402	919	1,063,833	59
60	LABORATORY	25,070,658	4,346				25,070,658	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	5,887,907	3,317			90	5,887,907	65
66	PHYSICAL THERAPY	4,210,941	5,847			758	4,210,941	66
72	IMPL. DEV. CHARGED TO PATIENTS	2,143,127				1 500 070	2,143,127	72
73	DRUGS CHARGED TO PATIENTS	9,777,134				1,500,078	9,777,134	73
76.97 76.98	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	1,032,270	543				1,032,270	76.97 76.98
76.99	LITHOTRIPSY	1,032,270	545				1,032,270	76.99
70.77	OUTPATIENT SERVICE COST CENTERS							70.77
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER	168,169			9,139	36,579	168,169	90.03
90.04	WOUND CARE	1,506,616	2,583		6,337	19,933	1,506,616	90.04
91	EMERGENCY	12,702,462	7,339	53	42,356	234	12,702,462	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	134,464,506	91,039	5,608	282,974	1,659,050	134,464,506	118
102	NONREIMBURSABLE COST CENTERS		10-					100
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		190					190
192	PHYSICIANS' PRIVATE OFFICES		14,683					192
192.01	FOUNDATION ADMINISTATION							192.01
192.02 194	HOSPITALIST PLYMOUTH MOB-4					 		192.02 194
								200
	CROSS FOOT A DILISTMENTS							
200	CROSS FOOT ADJUSTMENTS					\h		201
200 201	NEGATIVE COST CENTER	299 727	752 464	813 145	755 973	985.618	800 697	201
200 201 202	NEGATIVE COST CENTER COST TO BE ALLOC PER B PT I	299,727 0.002229	752,464	813,145	755,973	985,618 0,594086	800,697	202
200 201	NEGATIVE COST CENTER	299,727 0.002229 12,641	752,464 7.104615 12,741	813,145 144.997325 42,176	755,973 2.671528 15,755	985,618 0.594086 77,686	800,697 0.005955 48,995	

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTIONS	PARAMED EDUCATION			
COST CLIVIER DESCRIPTIONS	ASSIGNED TIME			
	23			

				1		
	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
20	I&R SERVICES-SALARY & FRINGES APPRVD			1		20
21	I&R SERVICES-OTHER PRGM COSTS APPRVD					21
22	PARAMED ED PRGM-(SPECIFY)	100		1		22
23	INPATIENT ROUTINE SERV COST CENTERS	100				23
30						30
	ADULTS & PEDIATRICS		 			
31	INTENSIVE CARE UNIT		 			31
43	NURSERY		 			43
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM		 			50
52	DELIVERY ROOM & LABOR ROOM		 			52
54	RADIOLOGY-DIAGNOSTIC		 			54
55	RADIOLOGY-THERAPEUTIC		 			55
57	CT SCAN					57
59	CARDIAC CATHETERIZATION					59
60	LABORATORY					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		 			62.30
65	RESPIRATORY THERAPY					65
66	PHYSICAL THERAPY					66
72	IMPL. DEV. CHARGED TO PATIENTS					72
73	DRUGS CHARGED TO PATIENTS					73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90.01	OUTPATIENT TREATMENT & INFUSION CTR					90.01
90.02	ATHLETIC TRAINERS					90.02
90.02	SAINT JOSEPH HEALTH CENTER			1		90.02
90.03	WOUND CARE			1		90.04
91	EMERGENCY	100	 			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	100				92
/2	OTHER REIMBURSABLE COST CENTERS					12
	SPECIAL PURPOSE COST CENTERS					
118		100				118
110	SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS	100				110
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
190			 	+		190
192	PHYSICIANS' PRIVATE OFFICES	+	 		+	192
	FOUNDATION ADMINISTATION					
192.02	HOSPITALIST					192.02
194	PLYMOUTH MOB-4					194
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	COST TO BE ALLOC PER B PT I	18,594				202
203	UNIT COST MULT-WS B PT I	185.940000	 			203
204	COST TO BE ALLOC PER B PT II	155	 			204
205	UNIT COST MULT-WS B PT II	1.550000	1	1	1	205

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

POST STEPDOWN ADJUSTMENTS

	WORKSHEET			
DESCRIPTION	PART	LINE NO.	AMOUNT	
1	2	3	4	

KPMG LLP	C ΩMPU-MAX	K	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I

					COSTS		
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	4,819,548		4,819,548	7,650	4,827,198	30
31	INTENSIVE CARE UNIT	2,252,350		2,252,350	95,966	2,348,316	31
43	NURSERY	679,067		679,067		679,067	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,535,159		5,535,159		5,535,159	50
52	DELIVERY ROOM & LABOR ROOM	683,810		683,810		683,810	
54	RADIOLOGY-DIAGNOSTIC	2,422,692		2,422,692		2,422,692	54
55	RADIOLOGY-THERAPEUTIC	1,248,254		1,248,254		1,248,254	55
57	CT SCAN	437,851		437,851		437,851	57
59	CARDIAC CATHETERIZATION	940,756		940,756		940,756	59
60	LABORATORY	4,581,863		4,581,863		4,581,863	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,328,380		1,328,380		1,328,380	65
66	PHYSICAL THERAPY	1,946,674		1,946,674		1,946,674	66
72	IMPL. DEV. CHARGED TO PATIENTS	791,578		791,578		791,578	72
73	DRUGS CHARGED TO PATIENTS	3,001,687		3,001,687		3,001,687	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	312,173		312,173		312,173	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION CTR						90.01
90.02	ATHLETIC TRAINERS	215,500		215,500		215,500	90.02
90.03	SAINT JOSEPH HEALTH CENTER	495,564		495,564		495,564	90.03
90.04	WOUND CARE	943,432		943,432		943,432	90.04
91	EMERGENCY	3,156,866		3,156,866	21,125	3,177,991	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	892,252		892,252		892,252	92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	36,685,456		36,685,456	124,741	36,810,197	200
201	LESS OBSERVATION BEDS	892,252		892,252		892,252	201
202	TOTAL (SEE INSTRUCTIONS)	35,793,204		35,793,204		35,917,945	202

KPMG LLP	<u>Compu-May</u>	K	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I

			CHARGES					
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,627,203		5,627,203				30
31	INTENSIVE CARE UNIT	3,093,629		3,093,629				31
43	NURSERY	666,275		666,275				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	6,642,956	17,825,337	24,468,293	0.226218	0.226218	0.226218	50
52	DELIVERY ROOM & LABOR ROOM	1,175,591	70,260	1,245,851	0.548870	0.548870	0.548870	52
54	RADIOLOGY-DIAGNOSTIC	1,270,855	10,913,139	12,183,994	0.198842	0.198842	0.198842	54
55	RADIOLOGY-THERAPEUTIC	10,154	7,211,600	7,221,754	0.172846	0.172846	0.172846	55
57	CT SCAN	2,009,164	12,196,665	14,205,829	0.030822	0.030822	0.030822	57
59	CARDIAC CATHETERIZATION	223,133	840,700	1,063,833	0.884308	0.884308	0.884308	59
60	LABORATORY	4,046,345	21,024,313	25,070,658	0.182758	0.182758	0.182758	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,684,131	4,203,776	5,887,907	0.225612	0.225612	0.225612	65
66	PHYSICAL THERAPY	497,802	3,713,139	4.210.941	0.462290	0.462290	0.462290	66
72	IMPL. DEV. CHARGED TO PATIENTS	1,705,394	437,733	2,143,127	0.369357	0.369357	0.369357	72
73	DRUGS CHARGED TO PATIENTS	3,820,524	5,956,610	9,777,134	0.307011	0.307011	0.307011	73
76.97	CARDIAC REHABILITATION	, ,	<i>, ,</i>	, ,				76.97
76.98	HYPERBARIC OXYGEN THERAPY		1.032.270	1.032.270	0.302414	0.302414	0.302414	76.98
76.99	LITHOTRIPSY		/	,,				76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER		168,169	168,169	2.946821	2,946821	2,946821	90.03
90.04	WOUND CARE	3.688	1,502,928	1,506,616	0.626193	0.626193	0.626193	90.04
91	EMERGENCY	1.933.617	10,768,845	12,702,462	0.248524	0.248524	0.250187	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	188,940	1,999,621	2,188,561	0.407689	0.407689	0.407689	92
	OTHER REIMBURSABLE COST CENTERS	1000	-,,,,,,=-			01101007		
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	34,599,401	99,865,105	134,464,506				200
201	LESS OBSERVATION BEDS			. ,,				201
202	TOTAL (SEE INSTRUCTIONS)	34,599,401	99,865,105	134,464,506				202

KPMG LLP	C ΩMPU-MAX	K	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

CHECK	[]	TITLE	v			[X3	K]	PPS
APPLICABLE	[XX]	TITLE	XVIII,	PART	Α	[1	TEFRA
BOXES:	[]	TITLE	XIX					

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST- MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	553,544		553,544	4,907	112.81	1,693	190,987	30
	(General Routine Care)	<i>'</i>		· ·	,		,	190,987	
31	INTENSIVE CARE UNIT	100,024		100,024	1,074	93.13	487	45,354	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	6,871		6,871	606	11.34			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	660,439		660,439	6,587		2,180	236,341	200

KPMG LLP	Compu-Ma	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0076

WORKSHEET D PART II

CHECK	[] TITLE V	[XX] HOSPITAL [] SUB (OTHER)	[XX] PPS
-	[XX] TITLE XVIII, PART A		[] TEFRA
BOXES:	[] TITLE XIX	[] IRF	

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	465,333	24,468,293	0.019018	2,061,792	39,211	50
52	DELIVERY ROOM & LABOR ROOM	7,135	1,245,851	0.005727			52
54	RADIOLOGY-DIAGNOSTIC	423,927	12,183,994	0.034794	67,146	2,336	54
55	RADIOLOGY-THERAPEUTIC	227,065	7,221,754	0.031442	10,154	319	55
57	CT SCAN	66,630	14,205,829	0.004690	930,995	4,366	57
59	CARDIAC CATHETERIZATION	422,879	1,063,833	0.397505	63,134	25,096	59
60	LABORATORY	212,660	25,070,658	0.008482	1,956,859	16,598	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	118,257	5,887,907	0.020085	859,719	17,267	65
66	PHYSICAL THERAPY	116,401	4,210,941	0.027643	299,454	8,278	66
72	IMPL. DEV. CHARGED TO PATIENTS	7,347	2,143,127	0.003428	718,713	2,464	72
73	DRUGS CHARGED TO PATIENTS	91,419	9,777,134	0.009350	1,907,002	17,830	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	12,124	1,032,270	0.011745			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION CTR						90.01
90.02	ATHLETIC TRAINERS	1,784					90.02
90.03	SAINT JOSEPH HEALTH CENTER	11,402	168,169	0.067801			90.03
90.04	WOUND CARE	60,552	1,506,616	0.040191			90.04
91	EMERGENCY	180,723	12,702,462	0.014227	826,400	11,757	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	102,316	2,188,561	0.046750	157,322	7,355	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	2,527,954	125,077,399		9,858,690	152,877	200

KPMG LLP	<u>Compu-May</u>	K	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

CHECK[] TITLE V[XX] PPSAPPLICABLE[XX] TITLE XVIII, PART A[] TEFRABOXES:[] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST- MENT AMOUNT (see instruct- ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
	(General Routine Care)						
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

CHECK[] TITLE V[XX] PPSAPPLICABLE[XX] TITLE XVIII, PART A[] TEFRABOXES:[] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					4
30	ADULTS & PEDIATRICS (General Routine Care)	4,907		1,693		30
31	INTENSIVE CARE UNIT	1,074		487		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	606				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	6,587		2,180		200

KPMG LLP	1G LLP COMPU-MAX						
	In Lieu of Form		Run Date: 03/13/2015				
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22				
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10				
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA OTHER PASS THROUGH COSTS	RY SERVICE	COMPONENT CCN: 15-0076	WORKSHEET D PART IV				

CHECK	[] TITLE V	[XX] HOSPITAL	[] SUB (OTHER) [] ICF/MR	[XX] PPS
APPLICABLE	[XX] TITLE XVIII, PART A	[] IPF	[] SNF	[] TEFRA
BOXES:	[] TITLE XIX	[] IRF	[] NF	

		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	EMERGENCY			18,594		18,594	18,594	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			18,594		18,594	18,594	200

KPMG LLP	Compu-Max						
	In Lieu of Form Period : Run Da		Run Date: 03/13/2015				
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22				
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10				
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA OTHER PASS THROUGH COSTS	RY SERVICE	COMPONENT CCN: 15-0076	WORKSHEET D PART IV				

CHECK	[] TITLE V	[XX] HOSPITAL	[] SUB (OTHER) [] ICF/MR	[XX] PPS
APPLICABLE	[XX] TITLE XVIII, PART A	[] IPF	[] SNF	[] TEFRA
BOXES:	[] TITLE XIX	[] IRF	[] NF	

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT- IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS- THROUGH COSTS (col. 8 x col. 10)	OUTPAT- IENT PROGRAM CHARGES	OUTPAT- IENT PROGRAM PASS- THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	24,468,293			2,061,792		4,189,929		50
52	DELIVERY ROOM & LABOR ROOM	1,245,851							52
54	RADIOLOGY-DIAGNOSTIC	12,183,994			67,146		2,324,152		54
55	RADIOLOGY-THERAPEUTIC	7,221,754			10,154		2,651,744		55
57	CT SCAN	14,205,829			930,995		3,371,098		57
59	CARDIAC CATHETERIZATION	1,063,833			63,134		394,065		59
60	LABORATORY	25,070,658			1,956,859		1,204,004		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	5,887,907			859,719		1,304,369		65
66	PHYSICAL THERAPY	4,210,941			299,454				66
72	IMPL. DEV. CHARGED TO PATIENTS	2,143,127			718,713		116,108		72
73	DRUGS CHARGED TO PATIENTS	9,777,134			1,907,002		2,121,988		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,032,270					802,368		76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION CTR								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	168,169							90.03
90.04	WOUND CARE	1,506,616					455,685		90.04
91	EMERGENCY	12,702,462	0.001464	0.001464	826,400	1,210	2,320,028	3,397	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,188,561			157,322		334,065		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	125,077,399			9,858,690	1,210	21,589,603	3,397	200

Compu-1	Max 2552-10									
KF	PMG LLP		Compu	-MAX						
	SEPH'S REG MED CENTER PLYMOUT er CCN: 15-0076	LYMOUT In Lieu of Form CMS-2552-10			Period : From: 07/01/2013 To: 06/30/2014			Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10		
								-		
APPOR	TIONMENT OF MEDICAL AND OTHER HEALTH	SERVICE COS	rs		COMPONENT	CCN: 15-0076		WORKSH PART		
APPL	CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR									
			PR	OGRAM CHA	ARGES		PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM- BURSED SERVICES (see inst.)	COST REIM- BURSED SUBJECT TO DED. & COINS. (see inst.)	SUBJECT TO DED	PPS SERVICES (see inst.)	COST REIM- BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM- BURSED NOT SUBJECT TO DED. & COINS. (see inst.)		
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7		
50	ANCILLARY SERVICE COST CENTERS	0.00(010	4 100 020			0.45.005				
50 52	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0.226218 0.548870	4,189,929			947,837			50 52	
52 54	RADIOLOGY-DIAGNOSTIC	0.198842	2,324,152			462,139			54	
55	RADIOLOGY-THERAPEUTIC	0.198842	2,524,152			458,343			55	
57	CT SCAN	0.030822	3,371,098			103,904			57	
59	CARDIAC CATHETERIZATION	0.884308	394,065			348,475			59	
60	LABORATORY	0.182758	1,204,004			220,041			60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		-,,						62.30	
65	RESPIRATORY THERAPY	0.225612	1,304,369			294,281			65	
66	PHYSICAL THERAPY	0.462290							66	
72	IMPL. DEV. CHARGED TO PATIENTS	0.369357	116,108			42,885			72	
73	DRUGS CHARGED TO PATIENTS	0.307011	2,121,988		40,504	651,474		12,435		
76.97	CARDIAC REHABILITATION								76.97	
76.98	HYPERBARIC OXYGEN THERAPY	0.302414	802,368			242,647			76.98	
76.99	LITHOTRIPSY								76.99	
00.01	OUTPATIENT SERVICE COST CENTERS								00.01	
90.01 90.02	OUTPATIENT TREATMENT & INFUSION CTR ATHLETIC TRAINERS								90.01 90.02	
90.02	ATHLETIC TRAINERS SAINT JOSEPH HEALTH CENTER	2.946821					+ +		90.02	
90.03	WOUND CARE	0.626193	455.685			285,347			90.03	
90.04	EMERGENCY	0.248524	2,320,028			576,583			90.04	
91	OBSERVATION BEDS (NON-DISTINCT PART)	0.407689	334.065			136,195			91	
12	OTHER REIMBURSABLE COST CENTERS	0.+07089	557,005			150,195			12	
200	SUBTOTAL (see instructions)		21,589,603		40,504	4,770,151		12,435	200	
			21,000,000		.0,504	.,, , 0,101		12,400		
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201	

KPMG LLP	C ΩMPU-MAX	K	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

CHECK	[]	TITLE	v			[X.	x]	PPS
APPLICABLE	[]	TITLE	XVIII,	PART	Α	Ľ]	TEFRA
BOXES:	[XX]	TITLE	XIX					

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST- MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	553,544		553,544	4,907	112.81	890	100,401	30
31	INTENSIVE CARE UNIT	100,024		100,024	1.074	93.13	108	10.058	31
32	CORONARY CARE UNIT				/				32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	6,871		6,871	606	11.34	158	1,792	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	660,439		660,439	6,587		1,156	112,251	200

KPMG LLP	Compu-Ma	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0076

WORKSHEET D PART II

CHECK	[] Т	ITLE	v			[X:	x]	HOSPITAL	Γ	1	SUB	(OTHER)	[XX	1	PPS
APPLICABLE	[] Т	ITLE	XVIII,	PART	Α	Ľ]	IPF					[1	TEFRA
BOXES:	[XX] T	ITLE	XIX			[]	IRF							

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	465,333	24,468,293	0.019018	937,588	17,831	50
52	DELIVERY ROOM & LABOR ROOM	7,135	1,245,851	0.005727	654,943	3,751	52
54	RADIOLOGY-DIAGNOSTIC	423,927	12,183,994	0.034794	83,719	2,913	54
55	RADIOLOGY-THERAPEUTIC	227,065	7,221,754	0.031442			55
57	CT SCAN	66,630	14,205,829	0.004690	160,665	754	57
59	CARDIAC CATHETERIZATION	422,879	1,063,833	0.397505	16,586	6,593	59
60	LABORATORY	212,660	25,070,658	0.008482	369,702	3,136	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	118,257	5,887,907	0.020085	111,420	2,238	65
66	PHYSICAL THERAPY	116,401	4,210,941	0.027643	21,509	595	66
72	IMPL. DEV. CHARGED TO PATIENTS	7,347	2,143,127	0.003428	50,512	173	72
73	DRUGS CHARGED TO PATIENTS	91,419	9,777,134	0.009350	445,084	4,162	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	12,124	1,032,270	0.011745			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION CTR						90.01
90.02	ATHLETIC TRAINERS	1,784					90.02
90.03	SAINT JOSEPH HEALTH CENTER	11,402	168,169	0.067801			90.03
90.04	WOUND CARE	60,552	1,506,616	0.040191			90.04
91	EMERGENCY	180,723	12,702,462	0.014227	128,282	1,825	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	102,316	2,188,561	0.046750			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	2,527,954	125,077,399		2,980,010	43,971	200

KPMG LLP	Compu-May	K	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

CHECK [] TITLE V [XX] PPS APPLICABLE [] TITLE XVIII, PART A [] TEFRA BOXES: [XX] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST- MENT AMOUNT (see instruct- ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
	(General Routine Care)						
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

CHECK [] TITLE V [XX] PPS APPLICABLE [] TITLE XVIII, PART A [] TEFRA BOXES: [XX] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	4,907		890		30
31	INTENSIVE CARE UNIT	1,074		108		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	606		158		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	6,587		1,156		200

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA OTHER PASS THROUGH COSTS	RY SERVICE	COMPONENT CCN: 15-0076	WORKSHEET D PART IV

CHECK	Γ]	TITLE	v		[X:	K]	HOSPITAL	Γ]	SUB (OTHER)	[1	ICF/MR	[X2	K]	PPS
APPLICABLE	Γ]	TITLE	XVIII,	PART A	Γ	1	IPF	Γ]	SNF				[1	TEFRA
BOXES:	[2	[X2	TITLE	XIX		Γ	1	IRF	Γ]	NF						

		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	EMERGENCY			18,594		18,594	18,594	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			18,594		18,594	18,594	200

KPMG LLP	Comput	-Max	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILI OTHER PASS THROUGH COSTS	ARY SERVICE	COMPONENT CCN: 15	-0076 WORKSHEET D PART IV

CHECK	[] TITLE V	[XX] HOSPITAL	[] SUB (OTHER) [] ICF/MR	[XX] PPS
APPLICABLE	[] TITLE XVIII, PART A	[] IPF	[] SNF	[] TEFRA
BOXES:	[XX] TITLE XIX	[] IRF	[] NF	

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT- IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS- THROUGH COSTS (col. 8 x col. 10)	OUTPAT- IENT PROGRAM CHARGES	OUTPAT- IENT PROGRAM PASS- THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	24,468,293			937,588				50
52	DELIVERY ROOM & LABOR ROOM	1,245,851			654,943				52
54	RADIOLOGY-DIAGNOSTIC	12,183,994			83,719				54
55	RADIOLOGY-THERAPEUTIC	7,221,754							55
57	CT SCAN	14,205,829			160,665				57
59	CARDIAC CATHETERIZATION	1,063,833			16,586				59
60	LABORATORY	25,070,658			369,702				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	5,887,907			111,420				65
66	PHYSICAL THERAPY	4,210,941			21,509				66
72	IMPL. DEV. CHARGED TO PATIENTS	2,143,127			50,512				72
73	DRUGS CHARGED TO PATIENTS	9,777,134			445,084				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,032,270							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION CTR								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	168,169							90.03
90.04	WOUND CARE	1,506,616							90.04
91	EMERGENCY	12,702,462	0.001464	0.001464	128,282	188			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,188,561							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	125,077,399			2,980,010	188			200

Compu-1	Max 2552-10								
KF	PMG LLP		Compu	I-MAX					
		In Lieu of			Period :		Run Date: 03/12	3/2015	
ST IC	SEPH'S REG MED CENTER PLYMOUT	CMS-255			From: 07/01/201	,	Run Time: 10:2		
		CN15-253	52-10			>			
Provid	er CCN: 15-0076				Го: 06/30/2014		Version: 2014.1	0	
APPOF	ATIONMENT OF MEDICAL AND OTHER HEALTH	SERVICE COS	rs		COMPONEN	T CCN: 15-0076		WORKSI PAR	
CHECI		[XX] HOSE	-] SUB (C	THER)		IG BED SNF		
BOXE	ICABLE [] TITLE XVIII, PART B S: [XX] TITLE XIX - O/P	[] IPF [] IRF	-] SNF] NF		[] SWIN [] ICF/	IG BED NF 'MR		
			PF	ROGRAM CH			PROGRAM COST		
		COST TO CHARGE RATIO	PPS REIM- BURSED	COST REIM- BURSED	I NOT	PPS	COST REIM- BURSED	COST REIM- BURSED NOT	
		(from Wkst C,	SERVICES (see	SUBJECT TO DED	SUBJECT	SERVICES (see	SUBJECT TO DED.	SUBJECT TO DED.	
		Part I,	inst.)	& COINS	· & COINS.	inst.)	& COINS.	& COINS.	
		col. 9)		(see	(see		(see	(see	
				inst.)	inst.)		inst.)	inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								_
50	OPERATING ROOM	0.226218							50
52	DELIVERY ROOM & LABOR ROOM	0.548870							52
54 55	RADIOLOGY-DIAGNOSTIC RADIOLOGY-THERAPEUTIC	0.198842 0.172846							54
57	CT SCAN	0.030822							57
59	CARDIAC CATHETERIZATION	0.030822							59
60	LABORATORY	0.182758							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	0.162736							62.30
65	RESPIRATORY THERAPY	0.225612							65
66	PHYSICAL THERAPY	0.462290							66
72	IMPL. DEV. CHARGED TO PATIENTS	0.369357							72
73	DRUGS CHARGED TO PATIENTS	0.307011							73
76.97	CARDIAC REHABILITATION	0.507011		1		1			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.302414							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION CTR								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	2.946821							90.03
90.04	WOUND CARE	0.626193							90.04
91	EMERGENCY	0.248524							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.407689							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM								201
-	ONLY CHARGES								
202	NET CHARGES (line 200 - line 201)								202

Compu-Max 2552-10						
KPMG LLP	<u>C</u> ΩMPU-MA	v				
	In Lieu of Form	Period :	Run Date: 03/1			
ST. JOSEPH'S REG MED CENTER PLYMOUT						
Provider CCN: 15-0076	rovider CCN: 15-0076 To: 06/30/2014 Version: 2014.1					
COMPUTATION OF INPATIENT OPERATING COST		COMPONENT CCN: 15-0076		WORKSHEET PART I	Г D-1	
	• • • •	(OTHER) [] ICF				
APPLICABLE [XX] TITLE XVIII, PART A [TEFRA		
BOXES: [] TITLE XIX - I/P [] IRF [] NF		LJ	OTHER		
PART I - ALL PROVIDER COMPONENTS						
	INPATIENT DAYS					
1 INPATIENT DAYS (including private room days and swing-bed				4,907		
2 INPATIENT DAYS (including private room days, excluding swi 3 PRIVATE ROOM DAYS (excluding swing-bed private room da		OM DAVE, DO NOT COMPLETE THE		4,907		
4 SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room day 4		JOM DAYS, DO NOT COMPLETE THIS	S LINE.	4,000	3	
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (includin		MBER 31 OF THE COST REPORTING I	PERIOD	4,000	5	
TOTAL SWING BED SNE TYPE INDATIENT DAYS (including						
6 ver, enter 0 on this line)	-8 F				6	
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including	g private room days) THROUGH DECEM	IBER 31 OF THE COST REPORTING PI	ERIOD		7	
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including	g private room days) AFTER DECEMBE	R 31 OF THE COST REPORTING PERIO	DD (if calendar year,		8	
enter 0 on this line)						
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS AP			OF THE COST	1,693	9	
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE T REPORTING PERIOD (see instructions)	O TITLE XVIII ONLY (including private	e room days) THROUGH DECEMBER 31	OF THE COST		10	
SWING BED SNE TYPE INPATIENT DAVS APPLICABLE T	O TITLE XVIII ONLY (including private	room days) AFTER DECEMBER 31 OF	THE COST		+ - 1	
11 REPORTING PERIOD (if calendar year, enter 0 on this line)			1112 0001		11	
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO	O TITLES V OR XIX ONLY (including p	rivate room days) THROUGH DECEMBE	ER 31 OF THE		12	
COST REPORTING PERIOD					12	
3 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO	O TITLES V OR XIX ONLY (including p	rivate room days) AFTER DECEMBER 3	1 OF THE COST		13	
 ¹³ REPORTING PERIOD (if calendar year, enter 0 on this line) 14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLIC 	TABLE TO THE DROCP AM (avaluding	awing had days)			14	
14 MEDICALL I NECESSAR I PRIVATE ROOM DATS APPLIC 15 TOTAL NURSERY DAYS (Title V or Title XIX only)	ABLE TO THE PROGRAM (excluding	swing-bed days)			14	
16 TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)						
	SWING-BED ADJUSTMENT				16	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPL					17	
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPL					18	
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLIC					19	
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLIC 21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SER 51 OF THE COST REPORTING PE	KIOD	4,827,198	20 21	
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES		OST REPORTING PERIOD (line 5 x line	e 17)	4,027,170	22	
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES					23	
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES	THROUGH DECEMBER 31 OF THE CO	OST 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)	ANNO DED COST			4 007 100	26	
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF	SWING-BED COST TE ROOM DIFFERENTIAL ADJUSTN	ЛЕМТ		4,827,198	27	
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (exc					28	
29 PRIVATE ROOM CHARGES (excluding swing-bed charges)	stand bot and observation bed end			1	29	
30 SEMI-PRIVATE ROOM CHARGES (excluding swing-bed char	ges)				30	
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE					31 32	
	32 AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)					
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (lin		ation a)			33	
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERE 35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTI		cuons)			34 35	
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (lin					36	
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF		OOM COST DIFFERENTIAL (line 27 - lir	ne 36)	4,827,198		
		, , , , , , , , , , , , , , , , , , , ,				

KPMG LLP COMPU-MAX						
	In Lieu of Form	Period :	Run Date: 03/13/2015			
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22			
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10			

COMPUTATION OF INPATIENT OPERATING COST	COMPONENT CCN: 15-0076	WORKSHEET D-1 PART II
CHECK [] TITLE V - I/P [XX APPLICABLE [XX] TITLE XVIII, PART A [BOXES: [] TITLE XIX - I/P [HOSPITAL [] SUB (OTHER) [XX] PPS IPF [] TEFRA IRF [] OTHER	

39 PRC 40 MEI 41 TOT 41 TOT 42 NUI 43 INT 43 INT 44 COT 45 BUF 46 SUF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT		TOTAL INPATIENT COST 1 2,348,316 MENTS	TOTAL INPATIENT DAYS 2 1,074	AVERAGE PER DIEM (col. 1 ÷ col. 2) 3 2,186.51	PROGRAM DAYS 4 487	983.74 1.665,472 PROGRAM COST (col. 3 x col. 4) 5 1,064,830	39 40 41 42 43 44 45 46
40 MEI 41 TOT 41 TOT 42 NUL 43 INT 43 INT 44 COF 45 BUL 46 SUF 47 OTF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	EDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (lin TAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40) JRSERY (Titles V and XIX only) TENSIVE CARE TYPE INPATIENT HOSPITAL UNITS TENSIVE CARE UNIT JRONARY CARE UNIT JRONARY CARE UNIT IRGICAL INTENSIVE CARE UNIT IRGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) JTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (SERVICE)	TOTAL INPATIENT COST 1 2,348,316 	INPATIENT DAYS 2	PER DIEM (col. 1 ÷ col. 2) 3	DAYS 4	1,665,472 PROGRAM COST (col. 3 x col. 4) 5	40 41 42 43 44 45 46
41 TOT 42 NUI 42 NUI 1NT 43 INT 44 COF 45 BUF 46 SUF 47 OTF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	DIAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40) JRSERY (Titles V and XIX only) TENSIVE CARE TYPE INPATIENT HOSPITAL UNITS TENSIVE CARE UNIT DRONARY CARE UNIT JRONARY CARE (SPECIFY) JRONARY CARE (SPECIFY) JRONARY CARE (SPECIFY) JRONARY CARE (SPECIFY) JRONARY CARE (SPECIFY) JRONARY CARE (SPECIFY) JRONARY COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (SPECIES)	TOTAL INPATIENT COST 1 2,348,316 	INPATIENT DAYS 2	PER DIEM (col. 1 ÷ col. 2) 3	DAYS 4	PROGRAM COST (col. 3 x col. 4) 5	41 42 43 44 45 46
42 NUI 1NT 43 INT 44 COI 45 BUI 46 SUF 47 OTF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	JRSERY (Titles V and XIX only) TENSIVE CARE TYPE INPATIENT HOSPITAL UNITS TENSIVE CARE UNIT JRONARY CARE UNIT JRONARY CARE UNIT JRONARY CARE UNIT JRONARY CARE UNIT JROGRAM INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) YTAL PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) YTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (SUM 1000000000000000000000000000000000000	INPATIENT COST 1 2,348,316 MENTS	INPATIENT DAYS 2	PER DIEM (col. 1 ÷ col. 2) 3	DAYS 4	PROGRAM COST (col. 3 x col. 4) 5	42 43 44 45 46
INT 43 INT 43 INT 44 COF 45 BUI 46 SUF 47 OTF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	TENSIVE CARE TYPE INPATIENT HOSPITAL UNITS TENSIVE CARE UNIT JRONARY CARE UNIT JRN INTENSIVE CARE UNIT IRGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) DTAL PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) DTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUST SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	INPATIENT COST 1 2,348,316 MENTS	INPATIENT DAYS 2	PER DIEM (col. 1 ÷ col. 2) 3	DAYS 4	COST (col. 3 x col. 4) 5	43 44 45 46
INT 43 INT 43 INT 44 COF 45 BUI 46 SUF 47 OTF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	TENSIVE CARE TYPE INPATIENT HOSPITAL UNITS TENSIVE CARE UNIT JRONARY CARE UNIT JRN INTENSIVE CARE UNIT IRGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) DTAL PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) DTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUST SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	INPATIENT COST 1 2,348,316 MENTS	INPATIENT DAYS 2	(col. 1 ÷ col. 2) 3	DAYS 4	(col. 3 x col. 4) 5	43 44 45 46
INT 43 INT 43 INT 44 COF 45 BUI 46 SUF 47 OTF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	TENSIVE CARE TYPE INPATIENT HOSPITAL UNITS TENSIVE CARE UNIT JRONARY CARE UNIT JRN INTENSIVE CARE UNIT IRGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) DTAL PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) DTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUST SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	COST 1 2,348,316 	DAYS 2	<u>col. 2)</u> 3	4	col. 4) 5	43 44 45 46
INT 43 INT 43 INT 44 COF 45 BUI 46 SUF 47 OTF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	TENSIVE CARE TYPE INPATIENT HOSPITAL UNITS TENSIVE CARE UNIT JRONARY CARE UNIT JRN INTENSIVE CARE UNIT IRGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) DTAL PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) DTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUST SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	1 2,348,316 	2	3		5	43 44 45 46
INT 43 INT 43 INT 44 COF 45 BUI 46 SUF 47 OTF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	TENSIVE CARE TYPE INPATIENT HOSPITAL UNITS TENSIVE CARE UNIT JRONARY CARE UNIT JRN INTENSIVE CARE UNIT IRGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) DTAL PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) DTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUST SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	2,348,316					43 44 45 46
INT 43 INT 43 INT 44 COF 45 BUI 46 SUF 47 OTF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	TENSIVE CARE TYPE INPATIENT HOSPITAL UNITS TENSIVE CARE UNIT JRONARY CARE UNIT JRN INTENSIVE CARE UNIT IRGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) DTAL PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) DTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUST SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	AENTS	1,074	2,186.51	487	1,064,830	43 44 45 46
43 INT 44 COP 45 BUF 46 SUF 47 OTF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	TENSIVE CARE UNIT JRONARY CARE UNIT JRN INTENSIVE CARE UNIT IRGICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY) OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) JTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUST SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	AENTS	1,074	2,186.51	487	1,064,830	44 45 46
44 COF 45 BUF 46 SUF 47 OTF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	DRONARY CARE UNIT JRN INTENSIVE CARE UNIT JRGICAL INTENSIVE CARE UNIT (HER SPECIAL CARE (SPECIFY) OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) YTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUST SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	AENTS	1,074	2,186.51	487	1,064,830	44 45 46
45 BUF 46 SUF 47 OTF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	JRN INTENSIVE CARE UNIT IRGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) JTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUSTM SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						45 46
46 SUF 47 OTF 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	IRGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) OTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUSTM SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						46
47 OTH 48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	THER SPECIAL CARE (SPECIFY) OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) OTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUSTN SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						
48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) TAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUST SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						47
48 PRC 49 TOT 50 PAS 51 PAS 52 TOT	OGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) TAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUST SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES		· · · · ·				47
49 TOT 50 PAS 51 PAS 52 TOT	TAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) PASS-THROUGH COST ADJUSTM SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES					1	
50 PAS 51 PAS 52 TOT	PASS-THROUGH COST ADJUST SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES					2,377,901	48
50 PAS 51 PAS 52 TOT	PASS-THROUGH COST ADJUST SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES					5,108,203	
51 PAS 52 TOT	SS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						
51 PAS 52 TOT		PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					
	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						50 51
	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)						52
TO?	TAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, N	ONPHYSICIAN .	ANESTHETIST	AND MEDICAL	EDUCATION	4,717,775	
53	COSTS (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COM	PUTATION					-
54 PRC	OGRAM DISCHARGES						54
	RGET AMOUNT PER DISCHARGE						55
56 TAF	TARGET AMOUNT (line 54 x line 55)						56
	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
	BONUS PAYMENT (see instructions)						58
LES	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET						
59 BAS	BASKET						59
60 LES	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
IEI	LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER			WHICH OPERA	TING COSTS		~
61 (line	ne 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMO	UNT (line 56). C	THERWISE EN	TER ZERO (see	instructions)		61
	RELIEF PAYMENT (see instructions)					62	
	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWIN	G BED COST					-
ME	EDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 C		EPORTING PERI	OD (see instruct	ions) (Title		
64	/III only)						64
ME	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII						
65	only)					ĺ	65
	TAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For	CAH, see instruc	tions)			(66
	TLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER			ERIOD (line 12	x line 19)	[]	67
	TLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 C				,		68
						69	

		X	Compu-Max	PMG LLP	KPMG LLP
5	Run Date: 03/13/2015	Period :	In Lieu of Form		
	Run Time: 10:22	From: 07/01/2013	CMS-2552-10	OSEPH'S REG MED CENTER PLYMOUT	ST. JOSEPH'S REG MED
	Version: 2014.10	To: 06/30/2014		der CCN: 15-0076	Provider CCN: 15-0076
	Version: 2014.10	To: 06/30/2014		der CCN: 15-0076	Provider CCN: 15-0076

COMPUTATION OF INPATIENT OPERATING COST		COMPONENT CCN: 15-0076	WORKSHEET D-1 PARTS III & IV
CHECK [] TITLE V - I/P	[XX] HOSPITAL	[] SUB (OTHER) [] ICF/MR	[XX] PPS
APPLICABLE [XX] TITLE XVIII, PART A	[] IPF	[] SNF	[] TEFRA
BOXES: [] TITLE XIX - I/P	[] IRF	[] NF	[] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					907	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					983.74	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					892,252	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV- ATION BED COST (from line89)	OBSERV- ATION BED PASS- THROUGH COST col. 3 x col. 4) (see instr- uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	553,544	4,827,198	0.114672	892,252	102,316	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

Image: Construction Construction Period I: CMS-2552-10 Period I: Prom: 070/2013 Run Date: 03/13/2015 COMPUTATION OF INPATIENT OPERATING COST CMS-2552-10 Prom: 070/2013 Run Time: 10-22 COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-0076 WORKSHEET D-I Part 1 CRECK [] TITLE V - 1/P [X] HOSPITAL [] SUB (OTHER) []] ICP/MR [X] PPS ROXES: CRECK [] TITLE XVIII, PART A [] IPP [] JNP [] JNP [] JCP/MR [X] PPS ROXES: FATI LAL PROVIDER CONTONENTS INPATIENT DATS [] OTHER [] OTHER 1 INPATIENT DATS Exclusion of the state o	Compu-Max 2552-10						
ST. JOSEPHTS REG MED CENTER PLYMOUT CMS-2552-10 From: 07/01/2013 Run Time: 10-22 Provider CCN: 15-0076 COMPONENT CCN: 15-0076 Version: 2014.10 COMPUTATION OF INFATIENT OPERATING COST COMPONENT CCN: 15-0076 WORKSHEET D-1 CRECK [] ITTLE XVIII, PART A I IPP [] SUB [] ICF/MR [XX] PPS APPLICABLE [] ITTLE XVIII, PART A I IPP [] SUB [] ICF/MR [XX] PPS APPLICABLE [] ITTLE XVIII, PART A [] IPP [] SUB [] IPPRATE [] OTHER APPLICABLE [] ITTLE XVIII, PART A [] IPP [] SUB [] IPPRATE [] OTHER [] IPPRATE [] OTHER [] IPPRATE [] OTHER [] IPPRATE [] IPPRATE [] IPPRATE [] IPPRATE IPPRATE [] IPPRATE IPPP	KPMG LLP	Compu-N	1AX				
Provider CCN: 15-0076 To: 06/30/2014 Version: 2014.10 COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-0076 WORKSHEET D-J PART I CRECK [] TITLE V - 1/P [XX] HOSPITAL [] SUDE (OTHER) [] ICF/MR [XX] PPS APPLICABLE [] TITLE VIII, PART A [] IPF] SUSP [] ICF/MR [XX] PPS PART I - ALL PROVIDER COMPONENTS [] INF [] NP [] OTHER 4.907 1 1 INATENT DAYS (incidenting private room days, accolding sewhord) 4.907 1 4.907 1 1 INATENT DAYS (incidenting revise conditions, secondating sewhord) 4.907 1 4.907 1 1 INATENT DAYS (incidenting revise conditions, secondating sewhord) 4.907 2 3 1 INATENT DAYS (incidenting revise conditions, secondating sewhord) 4.907 1 4.907 1 1 INATENT DAYS (incidenting revise conditions, secondating average of an one one one one one one one one one on		In Lieu of Form	Period :	Run Date: 03/1	3/2015		
COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-0073 WORKNIEET D1 CRECK [] ITTLE V - 1/P [XX] HOSPITAL SUB (OTHER) [] ICP/MR [XX] PPS APPLICABLE [] ITTLE XVIII, PART A [] IPP [] SNP [] IPPRATE APPLICABLE [] ITTLE XVIII, PART A [] IPP [] SNP [] IPPRATE PART I - ALL PROVIDER COMPRENTS INPATIENT DAYS [] OTHER 4907 [] 2 INVATIENT DAYS (including private nom days, including visite ond days, cicluding visite-bod and visite ond days, including visite nom days, including visite nom days, including visite ond days) including visite ond days, including visite ond	ST. JOSEPH'S REG MED CENTER PLYMOUT						
CHECK [] ITTLE VILL XILL SUB (OTHER) [] ICF/MR [X] PPS APPLICABLE [] ITTLE XVILI, PART A [] IPP [] SNP [] ICF/MR [X] PPS APPLICABLE [] ITTLE XVILI, PART A [] IPP [] SNP [] ICF/MR ICF/							
CHECK [] ITTLE VILL XILL SUB (OTHER) [] ICF/MR [X] PPS APPLICABLE [] ITTLE XVILI, PART A [] IPP [] SNP [] ICF/MR [X] PPS APPLICABLE [] ITTLE XVILI, PART A [] IPP [] SNP [] ICF/MR ICF/					-		
APPLICABLE I I I I I TEFRA BOXESS: [XX] I<	COMPUTATION OF INPATIENT OPERATING COST		COMPONENT CCN: 15-007	6		Г D-1	
INPATIENT DAYS (Including private room days and swing bed days excluding swing, bed and swing, bed days excluding swing, bed private room days) 44.907 2 1 IPRIVATE ROOM DAYS (sccluding swing, bed private room days) FOUL ALSWING, BED SNF-TYFE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 6 1 TOTAL, SWING, BED SNF-TYFE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 7 1 TOTAL, SWING, BED SNF-TYFE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 7 1 TOTAL, SWING, BED SNF-TYFE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 8 9 INPATIENT DAYS INCLUDING PERIVATE ROOM DAYS APPLICABLE TO THE ROGEAM (excluding swing-bed and newborn days) 890 9 9 SWING-BED SNF-TYFE INPATIENT DAYS APPLICABLE TO THE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST 10 1 SWING-BED SNF-TYFE INPATIENT DAYS APPLICABLE TO THE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST 11 1 SWING-BED SNF-TYFE INPATIENT DAYS APPLICABLE	APPLICABLE [] TITLE XVIII, PART A [] IPF [] SN	IF	[]	TEFRA		
2 INPATIENT DAYS (including private noom days, excluding swing-bed and newborn days) 4,407 2 3 SRU-PRIVATE ROOM DAYS (sectiding swing-bed private noom days) 4,400 4 4 STOLAL SWING-BED SNF-TYPE INPATIENT DAYS (including private noom days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 5 7 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private noom days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 6 7 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private noom days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 7 8 rent on this line) 8 7 107AL SWING-BED SNF-TYPE INPATIENT DAYS (including private noom days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 7 8 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private noom days) AFTER DECEMBER 31 OF THE COST 8 9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THLE XVIII ONLY (including private noom days) THROUGH DECEMBER 31 OF THE COST 10 11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO THLE SVIII ONLY (including private noom days) THROUGH DECEMBER 31 OF THE COST 10 12 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO THLE SVIII ONLY (including private noom days) THROUGH DECEMBER 31 OF THE COST 11 13 REPORTING PERIOD 11 12	PART I - ALL PROVIDER COMPONENTS	INPATIENT DAYS					
3 PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE. 3 4 SEMP.FRVATE ROOM DAYS (excluding swing-bed private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 5 6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 6 7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 7 8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 8 9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days) 890 9 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO THE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST 8 10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST 11 11 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including surga-bed days) 11 12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST 12 13 REPORTING PERIOD 11 12 14 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE	1 INPATIENT DAYS (including private room days and swing-bed				4,907	1	
4 SRIM-PRIVATE ROOM DAYS (excluding swing-bed private room days) 44.000 4.0000 4.0000					4,907		
5 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 5 707AL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 7 707AL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 7 8 707AL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 8 9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-hed and newborn days) 890 9 9 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO THE PROGRAM (excluding private room days) THROUGH DECEMBER 31 OF THE COST 800 9 10 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO THE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST 10 11 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO THE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST 11 12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO THE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST 12 13 REPORTING PERIOD 11 12 14 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO THE XVIII ONLY (including swing-bed days) 11 14			E ROOM DAYS, DO NOT COMPLETE TH	IS LINE.	4.000		
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25SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)2526TOTAL SWING-BED COST (see instructions)2627GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST4,827,198PRIVATE ROOM DIFFERENTIAL ADJUSTMENT28GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)2829PRIVATE ROOM CHARGES (excluding swing-bed charges)2930SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)3031GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)3132AVERAGE PRIVATE ROOM CHARGES (excluding swing-bed charges)3133AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)3234AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 4)3334AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)3434AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 34 x line 31)3535AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)3536PRIVATE ROOM COST DIFFERENTIAL (line 3x line 35)36							
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST 4,827,198 27 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges) 28 29 PRIVATE ROOM CHARGES (excluding swing-bed charges) 29 30 SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges) 30 31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28) 31 32 AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3) 31 33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4) 32 34 AVERAGE PER DIEM PRIVATE ROOM COAR DIFFERENTIAL (line 32 minus line 33) (see instructions) 34 35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 line 31) 35 36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35) 36						25	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges) 28 29 PRIVATE ROOM CHARGES (excluding swing-bed charges) 29 30 SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges) 30 31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28) 31 32 AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3) 31 33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4) 32 34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions) 33 35 AVERAGE PER DIEM PRIVATE ROOM CONST DIFFERENTIAL (line 3x line 31) 35 36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3x line 35) 36							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges) 28 29 PRIVATE ROOM CHARGES (excluding swing-bed charges) 29 30 SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges) 30 31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28) 31 32 AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3) 32 33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4) 33 34 AVERAGE SEMI-PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions) 34 35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 k line 31) 35 36 PRIVATE ROOM COST DIFFERENTIAL ADUSTMENT (line 3 x line 35) 36			(1/17) & #TO & 1/17)		4,827,198	27	
29PRIVATE ROOM CHARGES (excluding swing-bed charges)2930SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)3031GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)3132AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)3233AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)3334AVERAGE PER DIEM RIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)3435AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)3536PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)36						28	
30SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)3031GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)3132AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)3233AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)3334AVERAGE PER DIEM RIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)3435AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)3536PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)36		aroung swing-oca and observation bec	((mu 200)				
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 line 31) 35 36 PRIVATE ROOM COST DIFFERENTIAL ADUSTMENT (line 3 x line 35) 36	30 SEMI-PRIVATE ROOM CHARGES (excluding swing-bed char					30	
33AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)3334AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)3435AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)3536PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)36							
34AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)3435AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)3536PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)36							
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			structions)				
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35) 36			suucuons)				
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36) 4,827,198 37							
	37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF	SWING-BED COST AND PRIVATE	ROOM COST DIFFERENTIAL (line 27 - 1	ine 36)	4,827,198	37	

KPMG LLP COMPU-MAX						
	In Lieu of Form	Period :	Run Date: 03/13/2015			
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22			
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10			

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

CHECK	[] TITLE V - I/P	[XX] HOSPITAL [] SUB (OTHER)	[XX] PPS
APPLICABLE	[] TITLE XVIII, PART A	[] IPF	[] TEFRA
BOXES:	[XX] TITLE XIX - I/P	[] IRF	[] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS	THROUGH CO	ST ADJUSTME	NTS		1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					983.74	
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					875,529	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (lin	ne 14 x line 35)					40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					875,529	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)	679,067	606	1,120.57	158	177,050	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS			,			
43	INTENSIVE CARE UNIT	2,348,316	1.074	2,186.51	108	236,143	43
44	CORONARY CARE UNIT	//-		,			44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					897,888	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)						49
	PASS-THROUGH COST ADJUST	MENTS				, ,	-
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES		D, sum of Parts I	and III)		112,251	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D. sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					156,410	52
53	TOTAL PROGRAM EACLODABLE COST (suit) of times 50 and 51) TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					2,030,200	
	TARGET AMOUNT AND LIMIT COM	PUTATION					
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 AM	OUNT (line 56 m	inus line 53)				57
58	BONUS PAYMENT (see instructions)	JUNI (IIIe Juli	inus inic 55)				58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD END	ING 1996, UPDA	TED AND COM	POUNDED BY 1	THE MARKET		59
60	BASKET						60
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATI				TING COSTS		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AM						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWI						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF 7 only)	THE COST REPO	RTING PERIOD	(see instructions) (Title XVIII		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For	CAH, see instruc	tions)				66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER			PERIOD (line 12	x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 (68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68			、 · · · · ·	/		69

KPMG LLP	Compu-N	ЛАХ	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST		WORKSHEET D-1 PARTS III & IV	
CHECK [] TITLE V - I/P	[XX] HOSPITAL [] SUB (OTHE	R) []ICF/MR	[XX] PPS
APPLICABLE [] TITLE XVIII, PART	A [] IPF [] SNF		[] TEFRA
BOXES: [XX] TITLE XIX - I/P	[] IRF [] NF		[] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)	OTAL OBSERVATION BED DAYS (see instructions)					
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					907	87 88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV- ATION BED COST (from line89)	OBSERV- ATION BED PASS- THROUGH COST col. 3 x col. 4) (see instr- uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0076

WORKSHEET D-3

CHECK	[] TITLE V	[XX] HOSPITAL [] SUB (OTHER	R) [] SWING BED SNF [XX] PPS	
APPLICABLE	[XX] TITLE XVIII, PART A	[] IPF [] SNF	[] SWING BED NF [] TEFRA	
BOXES:	[] TITLE XIX	[] IRF [] NF	[] ICF/MR [] OTHER	

				INPATIENT	
		RATIO OF	INPATIENT	PROGRAM	
		COST TO	PROGRAM	COSTS	
		CHARGES	CHARGES	(col. 1 x	
				col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		2,092,672		30
31	INTENSIVE CARE UNIT		1,325,245		31
	ANCILLARY SERVICE COST CENTERS		í í í		
50	OPERATING ROOM	0.226218	2,061,792	466,414	50
52	DELIVERY ROOM & LABOR ROOM	0.548870			52
54	RADIOLOGY-DIAGNOSTIC	0.198842	67,146	13,351	54
55	RADIOLOGY-THERAPEUTIC	0.172846	10,154	1,755	55
57	CT SCAN	0.030822	930,995	28,695	57
59	CARDIAC CATHETERIZATION	0.884308	63,134	55,830	59
60	LABORATORY	0.182758	1,956,859	357,632	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.225612	859,719	193,963	65
66	PHYSICAL THERAPY	0.462290	299,454	138,435	66
72	IMPL. DEV. CHARGED TO PATIENTS	0.369357	718,713	265,462	72
73	DRUGS CHARGED TO PATIENTS	0.307011	1,907,002	585,471	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.302414			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT & INFUSION CTR				90.01
90.02	ATHLETIC TRAINERS				90.02
90.03	SAINT JOSEPH HEALTH CENTER	2.946821			90.03
90.04	WOUND CARE	0.626193			90.04
91	EMERGENCY	0.250187	826,400	206,755	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.407689	157,322	64,138	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		9,858,690	2,377,901	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		9,858,690		202

KPING LLP COMPU-MAX				
	In Lieu of Form	Period :	Run Date: 03/13/2015	
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22	
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	r	COMPONENT CCN: 15-0076	WORKSHEET D-3	

CHECK	[] TITLE V	[XX] HOSPITAL [] SUB (OTHER)	[] SWING BED SNF [XX] PPS
APPLICABLE	[] TITLE XVIII, PART A	[] IPF [] SNF	[] SWING BED NF [] TEFRA
BOXES:	[XX] TITLE XIX	[] IRF [] NF	[] ICF/MR [] OTHER

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		732,899		30
31	INTENSIVE CARE UNIT		173,092		31
43	NURSERY		399,151		43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.226218	937,588	212,099	50
52	DELIVERY ROOM & LABOR ROOM	0.548870	654,943	359,479	52
54	RADIOLOGY-DIAGNOSTIC	0.198842	83,719	16,647	54
55	RADIOLOGY-THERAPEUTIC	0.172846	,	,	55
57	CT SCAN	0.030822	160,665	4,952	57
59	CARDIAC CATHETERIZATION	0.884308	16,586	14,667	59
60	LABORATORY	0.182758	369,702	67,566	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		,	,	62.30
65	RESPIRATORY THERAPY	0.225612	111.420	25,138	65
66	PHYSICAL THERAPY	0.462290	21,509	9,943	66
72	IMPL. DEV. CHARGED TO PATIENTS	0.369357	50.512	18,657	72
73	DRUGS CHARGED TO PATIENTS	0.307011	445.084	136,646	73
76.97	CARDIAC REHABILITATION		- /		76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.302414			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT & INFUSION CTR				90.01
90.02	ATHLETIC TRAINERS				90.02
90.03	SAINT JOSEPH HEALTH CENTER	2.946821			90.03
90.04	WOUND CARE	0.626193			90.04
91	EMERGENCY	0.250187	128.282	32.094	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.407689			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		2,980,010	897,888	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)		_,,,010		200
202	NET CHARGES (line 200 minus line 201)		2,980,010		202

KPMG LLP	C ΩMPU-MAX	K	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E PART A

CHECK [XX] HOSPITAL

APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	1	1.01	1.02	1
	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO				
1.01	OCTOBER 1, 2013 (see instructions)	1,102,722			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER	2 114 (22			1.02
1.02	OCTOBER 1, 2013 (see instructions)	3,114,622			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	8,440			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	1,382,029			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see	42.52			4
-	instructions)	42.52			
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST				5
	REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions) FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN				
6	ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR				-
7	\$412.105(f)(1)(iv)(B)(1)				7
	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR				-
7.01	\$412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC				
	PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv)				
8	AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE				8
	50069, AUGUST 1, 2002				
0.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503				0.01
8.01	OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
0.00	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED				8.02
8.02	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				10
	RECORDS				
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				14
	SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17 18	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE ADJUSTED ROLLING AVERAGE FTE COUNT				17
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				18
20	PRIOR YEAR RESIDENT TO BED RATIO (me to divided by me 4)				20
20	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				20
22	IME PAYMENT ADJUSTMENT (see instructions)				22
22	INDITAL MERCY ADJOSTINEAU (SECONDARIAN)				
	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42				
23	SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24				25
25	(see instructions)				
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)	2.4900			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.2035			31
32	SUM OF LINES 30 AND 31	2.6935			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0806			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	151,639 PRIOR TO	ON OR AFTER		54
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	ON OR AFTER OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE ADJUSTMENT TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)	OCTOBER I	OCTOBER I		35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		467.097		35.02
	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		349,363		35.02
35.03			577,505		
35.03 36		349 363			30
35.03 36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03) ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES	349,363			36
	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	349,363			40

KPMG LLP	Compu-Max		
	CMS-2552-10	From: 07/01/2013	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E PART A

CHECK [XX] HOSPITAL

APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
41.01	TOTAL ESRD MEDICARE COVERED AND PAID DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684				41.01
41.01	AND 685 (see instructions)				41.01
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see				43
43	instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41.01 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41.01)				46
47	SUBTOTAL (see instructions)	4,726,786			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)	4,726,786			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	335,297			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wst 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)	1.210			58
59	TOTAL (sum of amounts on lines 49 through 58)	5.063.293			59
60	PRIMARY PAYER PAYMENTS	19,741			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	5,043,552			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	590,112			62
63	CONSURANCE BILLED TO PROGRAM BENEFICIARES	3,344			63
64	ALLOWABLE BAD DEBTS (see instructions)	49,576			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	32,224			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	32,224			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	4,482,320			67
	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see	4,402,520			
68	instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.96	LOW VOLUME ADJUSTMENT FOR FEDERAL FISCAL YEAR (2013)	93.856			70.96
70.90	LOW VOLUME ADJUSTMENT FOR FEDERAL FISCAL YEAR (2013)	316.849			70.90
71	AMOUNT DUE PROVIDER (see instructions)	4.893.025			70.97
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	97.861			71.01
72	INTERIM PAYMENTS	4,793,979			71.01
72	TENTATIVE SETTLEMENT (for contractor use only)	4,195,919			73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	1,185			74
/4		1,185			14
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	360,609			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

KPMG LLP	Compu-May	K	
	Supporting Exhibit for Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

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

EXHIBIT 4

		AMOUNTS FROM E PART A	PRIOR TO 10/1/2010 OR AFTER 3/31/2015 PRE/POST ENTITLE- MENT	10/01/2012 through 09/30/2013	201	10/01/2013 through 09/30/2014	4.01	(COLUMNS 2 THROUGH 4) TOTAL	
1	DRG Amounts Other Than Outlier Payments	1	2	3	3.01	4	4.01	5	1
1	DRG Amounts Other Than Outlier Payments								1
1.01	for Discharges prior to 10/1/2013	1,102,722		1,102,722				1,102,722	1.01
1.02	DRG Amounts Other Than Outlier Payments for Discharges on/after 10/1/2013	3,114,622				3,114,622		3,114,622	1.02
1.03	DRG for Federal Specific Operating Payment for Model 4 BPCI								1.03
2	Outlier Payments for Discharges	8,440				8,440		8,440	2
2.01	Outlier Payment for Discharges for Model 4 BPCI								2.01
3	Operating Outlier Reconciliation								3
4	Managed Care Simulated Payments INDIRECT MEDICAL EDUCATION	1,382,029		395,337		986,692		1,382,029	4
5	ADJUSTMENT Amount from Worksheet E Part A, Line 21								5
5	IME Payment Adjustment								6
0	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422								0
7	Amount from Worksheet E Part A, Line 27								7
8	IME Add-on Adjustment								8
9	Total IME Payment								9
	DISPROPORTIONATE SHARE								
10	ADJUSTMENT	0.000 (0.000.6	0.000.6	0.0006	0.0007	0.000.6		10
10 11	Allowable Disproportionate Share Percentage Disproportionate Share Adjustment	0.0806	0.0806	0.0806 88,879	0.0806	0.0806 62,760	0.0806	151,639	10 11
11.01	Uncompensated Care Payments	349,363		00,0/9		349,363		349,363	
11.01	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES	547,505				547,505		547,505	11.01
12	Total ESRD Additional Payment								12
13	Subtotal	4,726,786		1,191,601		3,535,185		4,726,786	13
14	Hospital Specific Payments								14
15	Total Payment for Inpatient Operating Costs - E Part A Line 49	4,726,786		1,191,601		3,535,185		4,726,786	15
16	Payment for Inpatient Program Capital	335,297		87,216		248,081		335,297	16
17	Special Add-on Payments for New Technologies								17
18	Capital Outlier Reconciliatino Adjustment Amount								18
19	Subtotal			1,278,817		3,783,266		5,062,083	19
	CAPITAL PAYMENTS								
20	Capital DRG Other Than Outlier	334,342		87,216		247,126		334,342	
20.01	Model 4 BPCI Capital DRG Other Than Outlier Capital DRG Outlier Payments	955				955		955	20.01 21
21.01	Model 4 BPCI Capital DRG Outlier Payments	755				955		933	21.01
22	Indirect Medical Education Percentage								22
23	Indirect Medical Education Adjustment								23
24	Allowable Disproportionate Share Percentage								24
25	Disproportionate Share Adjustment								25
26	Total Prospective Capital Payments	335,297		87,216		248,081		335,297	26
27	LOW VOLUME ADJUSTMENT Low Volume Adjustment Factor			0.073393		0.083750			27
27	Low Volume Adjustment			93.856		0.063730		93,856	
29	Low Volume Adjustment			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		316,849		316,849	

KPMG LLP	Compu-	-Max	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10
Plovider CCN. 13-0076		10: 00/30/2014	Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT	COMPONENT CCN: 15-0076	WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL [] IPF [] IRF [] SUB (OTHER) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	12,435	1.01	1.02	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	4,766,754			2
3	PPS PAYMENTS	4.214.622			3
4	OUTLIER PAYMENT (see instructions)	27,599			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)	0.906			5
6	LINE 2 TIMES LINE 5	4,318,679			6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6	0.9823			7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200	3,397			9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	12,435			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	40,504			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)	,			13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	40,504			14
	CUSTOMARY CHARGES				
	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR				
15	SERVICES ON A CHARGE BASIS				15
	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR				
16	SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR				16
	413.13(e)				
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1,000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)	40,504			18
	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see				
19	instructions)	28,069			19
	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see				
20	instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	12,435			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	4,245,618			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
25	DEDUCTIBLES AND COINSURANCE (see instructions)	36,170			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	931,365			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	3,290,518			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	3,290,518			30
31	PRIMARY PAYER PAYMENTS	1,066			31
32	SUBTOTAL (line 30 minus line 31)	3,289,452			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	108,608			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	70,595			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)	3,360,047			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	-26			38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	3,360,073			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	67,201			40.01
41	INTERIM PAYMENTS	3,289,499			41
42	TENTATIVE SETTLEMENT (for contractor use only)	.,=**,.**			42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	3.373			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION	2,070			
					44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse instructions)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (see instructions)		93
94	TOTAL (sum of lines 91 and 93)		94

KPMG LLP	Con	λρυ-Max	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLY	MOUT CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-0076

WORKSHEET E-1 PART I

CHECK	[XX]	HOSPITAL	[]	SUB (OTHER)
APPLICABLE	[]	IPF	[1	SNF
BOXES:	[]	IRF	Γ]	SWING BED SNF

				INPAT PAR		PAR	T B	
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				4,660,194		3,236,874	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO) BE					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	01/20/2015	133,785	01/20/2015	11,825	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06 3.07
			.07			01/02/2014	40.800	3.07
-			.08			01/02/2014	40,800	3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		133,785		52,625	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99)				4,793,979		3,289,499	4
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				,,		-,,	
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.10					5.09
			.10					5.10
<u> </u>			.50					5.50 5.51
		PROVIDER	.51					5.52
		TO	.52					5.53
		PROGRAM	.54					5.54
		Stand	.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01					6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	NAME OF CONTRACTOR			CONTRACTOR NU	JMBER	NPR DATE (Month	/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1 PART II

> 1,767 2,180 696 5,074

134,464,506

4,166,094

4

5

6

7

8 9

10

[XX] HOSPITAL [] CAH CHECK

APPLICABLE BOX:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEAL	TH 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	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I,	
/	LINE 168	

LINE 168 CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions) 8

8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	621,047	
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	12,421	
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	608,626	

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	608,626	32

KPMG LLP	<u>C</u> ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10
CALCULATION OF REIMBURSEMENT SETTLEMENT		COMPONENT CCN: 15-0076	WORKSHEET E-3 PART VII

CHECK	[] TITLE V	[XX] HOSPITAL	[] NF	[XX] PPS
	[XX] TITLE XIX	[] SUB (OTHER)	[] ICF/MR	[] TEFRA
BOXES:		[] SNF		[] OTHER

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

	COMPUTATION OF NET COST OF COVERED SERVICES	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
1				1
1	INPATIENT HOSPITAL SNF/NF SERVICES			-
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES	2,980,010		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)	2,980,010		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE			14
14	BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	2,980,010		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	2,980,010		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	188		26
27	SUBTOTAL (sum of lines 22 through 26)	188		27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21	188		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)	188		31
32	DEDUCTIBLES	- 50		32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	188		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)	100		37
38	SUBTOTAL (line 36 ± line 37)	188		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)	100		39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)	188		40
41	INTERIM PAYMENTS	100		41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)	188		42
43	DROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	100		43

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

WORKSHEET G

BALANCE SHEET

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	43,819,000				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	8,709,000				4
5	OTHER RECEIVABLES	1,390,000				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-1,435,000				6
7	INVENTORY	912,000				7
8	PREPAID EXPENSES	285,000				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	53,680,000				11
	FIXED ASSETS					
12	LAND					12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	18,709,000				15
16	ACCUMULATED DEPRECIATION					16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT					23
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)	18,709,000				30
	OTHER ASSETS					
31	INVESTMENTS	193,000				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	27,000				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	220,000				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	72,609,000				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,833,000				37
38	SALARIES, WAGES & FEES PAYABLE	1,504,000				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	123,000				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	612,000				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	4,072,000				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	6,265,000				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	217,000				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	6,482,000				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	10,554,000				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	62,055,000				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT,					58
50	AND EXPANSION	(2.055.000				
59	TOTAL FUND BALANCES (sum of lines 52-58)	62,055,000				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	72,609,000				60

KPMG LLP	C ΩMPU-MAX	X	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERA	L FUND	SPECIFIC PU	RPOSE FUND	
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		59,347,954			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		2,707,047			2
3	TOTAL (sun of line 1 and line 2)		62,055,001			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		62,055,001			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)		62,055,001			19

		ENDOW	MENT FUND	PLAN	T FUND	
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					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)					19

KPMG LLP	Compu-May	K	
	In Lieu of Form	Period :	Run Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2 PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	34,770,000		34,770,000	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	34,770,000		34,770,000	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	34,770,000		34,770,000	17
18	ANCILLARY SERVICES		99,840,000	99,840,000	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER PATIENT REVENUES		154,000	154,000	27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	34,770,000	99,994,000	134,764,000	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		42,986,953	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		42,986,953	43

KPMG LLP	Compu	-Max		
	In Lieu of Form	Period :	Run Date: 03/13/2015	
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013	Run Time: 10:22	
Provider CCN: 15-0076		To: 06/30/2014	Version: 2014.10	

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	134,764,000	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	90,336,000	2
3	NET PATIENT REVENUES (line 1 minus line 2)	44,428,000	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	42,986,953	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	1,441,047	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO 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 REVENUE)	1,222,000	24
24.01	OTHER (RESTRICTED ASSETS RELEASED)	44,000	24.01
25	TOTAL OTHER INCOME (sum of lines 6-24)	1,266,000	25
26	TOTAL (line 5 plus line 25)	2,707,047	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	2,707,047	29

	PMG LLP	Compu-N		D D (02/1	2/2015		
		In Lieu of Form	Period :	Run Date: 03/13/2015 Run Time: 10:22			
	JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10	From: 07/01/2013				
rov	vider CCN: 15-0076		To: 06/30/2014	Version: 2014.10			
CAL	CULATION OF CAPITAL PAYMENT		COMPONENT CCN: 15-00	76	WORKSHI	ЕЕТ	
	<i></i>						
	CK [] TITLE V	[XX] HOSPITAL	[XX] PPS	-			
	LICABLE [XX] TITLE XVIII, PART A ES: [] TITLE XIX	[] SUB (OTHER)	[] COST METHO	D			
AR	T I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT						
	CAPITAL DRG OTHER THAN OUTLIER				334,342	1	
01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER				,	1.	
	CAPITAL DRG OUTLIER PAYMENTS				955	-	
01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS					2	
	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DA NUMBER OF INTERNS & RESIDENTS (see instructions)	AYS IN THE COST REPORTING PE	RIOD (see instructions)		13.90	1	
	INDIRECT MEDICAL EDUCATION PERCENTAGE (see in	astructions)				4	
	INDIRECT MEDICAL EDUCATION PERCENTAGE (see in INDIRECT MEDICAL EDUCATION ADJUSTMENT (multip		1)			$\frac{1}{e}$	
	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO M			ctions)			
	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTA			(inoms)		1	
	SUM OF LINES 7 AND 8	· · ·				9	
)	ALLOWABLE DISPROPORTIONATE SHARE PERCENTA					1	
	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 time TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line				335,297		
	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line	es 1, 1.01, 2, 2.01, 6 and 11)			335,297	1	
	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see in	es 1, 1.01, 2, 2.01, 6 and 11)			335,297	1	
AR	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see in PROGRAM INPATIENT ANCILLARY CAPITAL COST (see)	tes instructions)			335,297	1	
AR	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see in PROGRAM INPATIENT ANCILLARY CAPITAL COST (see in TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 pl)	tes instructions)			335,297	1	
AR	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see in PROGRAM INPATIENT ANCILLARY CAPITAL COST (see in TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 pl) CAPITAL COST PAYMENT FACTOR (see instructions)	is 1, 1.01, 2, 2.01, 6 and 11) instructions) is instructions) us line 2)			335,297		
AR	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see in PROGRAM INPATIENT ANCILLARY CAPITAL COST (see in TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 pl) CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 time)	is 1, 1.01, 2, 2.01, 6 and 11) instructions) is instructions) us line 2)			335,297		
AR	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see in PROGRAM INPATIENT ANCILLARY CAPITAL COST (see in TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 pl CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times)	istructions) instructions) instructions) istructions istructions) istructions i			335,297		
	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see in PROGRAM INPATIENT ANCILLARY CAPITAL COST (see in TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 pl) CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 time)	is 1, 1.01, 2, 2.01, 6 and 11) Instructions) ise instructions) Isus line 2) Image line 4)	Instructions)		335,297		
AR 1 2	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see ir PROGRAM INPATIENT ANCILLARY CAPITAL COST (see ir TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 pi CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 the second se	es 1, 1.01, 2, 2.01, 6 and 11) Instructions) Se instructions) Instructions) Instructions) Instructions Instructions Instructions Instructions Instructions Instructions Instructions Instructions Instruc	Istructions)		335,297		
AR 1 2 3 4	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see ir PROGRAM INPATIENT ANCILLARY CAPITAL COST (see TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 pl CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 tin T III - COMPUTATION OF EXCEPTION PAYMENTS PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAOR NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minn APPLICABLE EXCEPTION PERCENTAGE (see instructions)	es 1, 1.01, 2, 2.01, 6 and 11) structions) se instructions) us line 2) mes line 4) structions (see in use line 2) structure 2) structu	nstructions)		335,297		
AR 1 2 3 4 5	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see ir PROGRAM INPATIENT ANCILLARY CAPITAL COST (see TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 pl CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 til T III - COMPUTATION OF EXCEPTION PAYMENTS PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (line 1 minn APPLICABLE EXCEPTION PERCENTAGE (see instructions) CAPITAL COST FOR COMPARISON TO PAYMENTS (line	ss 1, 1.01, 2, 2.01, 6 and 11) instructions) se instructions) lus line 2) mes line 4) DINARY CIRCUMSTANCES (see in us line 2) i) 3 x line 4)	structions)		335,297		
AR 1 2 3 4 5 5	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line TI - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see in PROGRAM INPATIENT ANCILLARY CAPITAL COST (see in TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 pi) CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 tin) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 tin) TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 min) PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (line 1 min) APPLICABLE EXCEPTION PERCENTAGE (see instructions) CAPITAL COST FOR COMPARISON TO PAYMENTS (line) PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY C	ss 1, 1.01, 2, 2.01, 6 and 11) istructions) se instructions) us line 2) mes line 4) 2 2DINARY CIRCUMSTANCES (see in us line 2) 3 3 x line 4) IRCUMSTANCES (see instructions)			335,297		
AR 1 2 3 4 5 5 7	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see in PROGRAM INPATIENT ANCILLARY CAPITAL COST (see in OTAL INPATIENT PROGRAM CAPITAL COST (ine 1 p) CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 time) PROGRAM INPATIENT PROGRAM CAPITAL COST (line 3 time) TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 time) PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROCRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (see instructions) PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY C PADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVE	es 1, 1.01, 2, 2.01, 6 and 11) Instructions) Se instructions) It line 2) Mess line 4) State 2 State 4) Instructions State 4) Instructions Instruct			335,297		
AR 1 2 3 4 5 6 7 8	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line TI - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see in PROGRAM INPATIENT ANCILLARY CAPITAL COST (see in TOTAL INPATIENT PROGRAM CAPITAL COST (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 pl CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 time) PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (line 1 minint APPLICABLE EXCEPTION PERCENTAGE (see instructions) CAPITAL COST FOR COMPARISON TO PAYMENTS (line 2 minint PROCENTAGE ADJUSTMENT FOR EXTRAORDINARY COMPARISON TO CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)	es 1, 1.01, 2, 2.01, 6 and 11) Instructions) See instructions) Us line 2) The set of t			335,297		
AR 1 2 3 4 5 6 7 8 9	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see ir PROGRAM INPATIENT ANCILLARY CAPITAL COST (see TOTAL INPATIENT PROGRAM CAPITAL COST (line 1) CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 tin T III - COMPUTATION OF EXCEPTION PAYMENTS PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (line 1 min APPLICABLE EXCEPTION PERCENTAGE (see instructions) CAPITAL COST FOR COMPARISON TO PAYMENTS (line PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY C ADJUSTMENT TO CAPITAL MINIUM PAYMENT LEVEL (CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7) CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 1	ss 1, 1.01, 2, 2.01, 6 and 11) istructions) ise instructions) ius line 2) mes line 4) DINARY CIRCUMSTANCES (see in s) 3 x line 4) IRCUMSTANCES (see instructions) 2L FOR EXTRAORDINARY CIRCU 1 12 as applicable)	MSTANCES (line 2 x line 6)		335,297		
AR 1 2 3 4 5 6 7 8 9 0	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line TI - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see in PROGRAM INPATIENT ANCILLARY CAPITAL COST (see in TOTAL INPATIENT PROGRAM CAPITAL COST (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 pi) CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 tin) TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 min) PROGRAM INPATIENT CAPITAL COSTS (see instructions) CAPITAL COST FOR COMPARISON OF ANALY C ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVE CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7) CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 1 CURRENT YEAR COMPARISON OF CAPITAL MINIMUM	the set of	MSTANCES (line 2 x line 6) PAYMENTS (line 8 less line 9)	L, Part III, line 14)	335,297		
AR 1 2 3 4 5 6 7 8 9 0 1	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see ir PROGRAM INPATIENT ANCILLARY CAPITAL COST (see TOTAL INPATIENT PROGRAM CAPITAL COST (line 1) CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 tin T III - COMPUTATION OF EXCEPTION PAYMENTS PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (line 1 min APPLICABLE EXCEPTION PERCENTAGE (see instructions) CAPITAL COST FOR COMPARISON TO PAYMENTS (line PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY C ADJUSTMENT TO CAPITAL MINIUM PAYMENT LEVEL (CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7) CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 1	es 1, 1.01, 2, 2.01, 6 and 11) hstructions) ee instructions) lus line 2) mes line 4) eDINARY CIRCUMSTANCES (see in us line 2) e) e) e) e) e) e) e) e) e) e	MSTANCES (line 2 x line 6) PAYMENTS (line 8 less line 9) L PAYMENT (from prior year Worksheet l	L, Part III, line 14)	335,297		
AR 1 2 3 4 5 6 7 8 9 0 1 2	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see ir PROGRAM INPATIENT ROUTINE CAPITAL COST (see ir TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 p CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 tin T III - COMPUTATION OF EXCEPTION PAYMENTS PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (line 1 mint APPLICABLE EXCEPTION PERCENTAGE (see instructions) CAPITAL COST FOR COMPARISON TO PAYMENTS (line PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY C ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL (APITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7) CURRENT YEAR COMPARISON OF CAPITAL MINIMUM CARTAL MINIMUM PAYMENT LEVEL (line 5 plus line 7) CURRENT YEAR COMPARISON OF CAPITAL MINIMUM NET COMPARISON OF CAPITAL MINIMUM PAYMENT L (CURRENT YEAR EXCEPTION PAYMENT (if line 12 is pos	ss 1, 1.01, 2, 2.01, 6 and 11) istructions) ise instructions) ius line 2) mes line 4) DINARY CIRCUMSTANCES (see in as line 2) i) 3 x line 4) IRCUMSTANCES (see instructions) EL FOR EXTRAORDINARY CIRCU 12 as applicable) IPAYMENT LEVEL TO CAPITAL 1 PAYMENT LEVEL 1 PAYMENT LEVEL 1 PAYMENT LEVEL 1 PAYMENT LEVEL 1 PAYMENT LEV	MSTANCES (line 2 x line 6) PAYMENTS (line 8 less line 9) L PAYMENT (from prior year Worksheet 1 line 10 plus line 11)		335,297		
AR 1 2 3 4 5 6 7 8 9 0 1 2 3	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see ir PROGRAM INPATIENT ROUTINE CAPITAL COST (see in TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 pi CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 ti T III - COMPUTATION OF EXCEPTION PAYMENTS PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (ine 1 mini APPLICABLE EXCEPTION PERCENTAGE (see instructions) CAPITAL COST FOR COMPARISON TO PAYMENTS (ine PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY C ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVL CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7) CURRENT YEAR COMPARISON OF CAPITAL MINIMUM NET COMPARISON OF CAPITAL MINIMUM NET COMPARISON OF CAPITAL MINIMUM	ss 1, 1.01, 2, 2.01, 6 and 11) istructions) ise instructions) ius line 2) mes line 4) DINARY CIRCUMSTANCES (see in as line 2) i) 3 x line 4) IRCUMSTANCES (see instructions) EL FOR EXTRAORDINARY CIRCU 12 as applicable) IPAYMENT LEVEL TO CAPITAL 1 PAYMENT LEVEL 1 PAYMENT LEVEL 1 PAYMENT LEVEL 1 PAYMENT LEVEL 1 PAYMENT LEV	MSTANCES (line 2 x line 6) PAYMENTS (line 8 less line 9) L PAYMENT (from prior year Worksheet 1 line 10 plus line 11)		335,297		
AR 1 2 3 4 5 6 7 8 9 0 1 2 3 4 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 8 9 0 1 2 3 4 5 6 7 8 8 9 0 1 2 3 4 5 6 7 8 8 9 0 1 2 3 4 5 6 7 8 8 9 0 1 2 3 4 5 6 7 8 8 9 0 1 2 3 4 5 6 7 8 8 9 0 1 2 3 4 8 8 9 0 1 2 3 4 8 8 9 0 1 2 3 4 8 8 9 0 1 2 3 4 1 2 3 1 2 1 1 2 3 4 1 2 2 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line TI - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see in PROGRAM INPATIENT ANCILLARY CAPITAL COST (see in OTAL INPATIENT PROGRAM CAPITAL COST (line 1 p) CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 tin TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 tin TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 tin TOTAL INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROCRAM INPATIENT CAPITAL COSTS (see instructions) CAPITAL COST FOR COMPARISON TO PAYMENTS (line 1 CAPITAL COST FOR CO	ss 1, 1.01, 2, 2.01, 6 and 11) istructions) se instructions) lus line 2) mes line 4) c) c) c) c) c) c) c) c) c) c	MSTANCES (line 2 x line 6) PAYMENTS (line 8 less line 9) L PAYMENT (from prior year Worksheet 1 line 10 plus line 11)		335,297		
	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of line T II - PAYMENT UNDER REASONABLE COST PROGRAM INPATIENT ROUTINE CAPITAL COST (see ir PROGRAM INPATIENT ROUTINE CAPITAL COST (see in TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 pi CAPITAL COST PAYMENT FACTOR (see instructions) TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 ti T III - COMPUTATION OF EXCEPTION PAYMENTS PROGRAM INPATIENT CAPITAL COSTS (see instructions) PROGRAM INPATIENT CAPITAL COSTS (ine 1 mini APPLICABLE EXCEPTION PERCENTAGE (see instructions) CAPITAL COST FOR COMPARISON TO PAYMENTS (ine PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY C ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVL CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7) CURRENT YEAR COMPARISON OF CAPITAL MINIMUM NET COMPARISON OF CAPITAL MINIMUM NET COMPARISON OF CAPITAL MINIMUM	ss 1, 1.01, 2, 2.01, 6 and 11) istructions) se instructions) us line 2) mes line 4) D DINARY CIRCUMSTANCES (see instructions) is 3 x line 4) IRCUMSTANCES (see instructions) EL FOR EXTRAORDINARY CIRCU 12 as applicable) 1 PAYMENT LEVEL TO CAPITAL 1 PAYMENT LEVEL OVER CAPITAL LEVEL TO CAPITAL PAYMENTS (itive, enter the amount on this line) PAYMENT LEVEL OVER CAPITAL EVEL TO CAPITAL PAYMENTS (itive, enter the amount on this line) PAYMENT LEVEL OVER CAPITAL	MSTANCES (line 2 x line 6) PAYMENTS (line 8 less line 9) L PAYMENT (from prior year Worksheet 1 line 10 plus line 11)		335,297		

KPMG LLP	Compu-N		
	In Lieu of Form	Period : Ru	n Date: 03/13/2015
ST. JOSEPH'S REG MED CENTER PLYMOUT	CMS-2552-10		n Time: 10:22
Provider CCN: 15-0076		To: 06/30/2014 Ver	rsion: 2014.10
CALCULATION OF CAPITAL PAYMENT		COMPONENT CCN: 15-0076	WORKSHEET L
CHECK [] TITLE V	[XX] HOSPITAL	[XX] PPS	
APPLICABLE [] TITLE XVIII, PART A	[] SUB (OTHER)	[] COST METHOD	
BOXES: [XX] TITLE XIX			
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1 CAPITAL DRG OTHER THAN OUTLIER			1
1.01 MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTL	IER		1.01
2 CAPITAL DRG OUTLIER PAYMENTS			2
2.01 MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENT			2.01
 TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF NUMBER OF INTERNS & RESIDENTS (see instruction) 		ERIOD (see instructions)	3 4
5 INDIRECT MEDICAL EDUCATION PERCENTAGE (5
6 INDIRECT MEDICAL EDUCATION ADJUSTMENT (1		.01)	6
7 PERCENTAGE OF SSI RECIPIENT PATIENT DAYS T			7
8 PERCENTAGE OF MEDICAID PATIENT DAYS TO T	OTAL DAYS (see instructions)		8
9 SUM OF LINES 7 AND 8			9
10 ALLOWABLE DISPROPORTIONATE SHARE PERCE			10
11 DISPROPORTIONATE SHARE ADJUSTMENT (line 10 12 TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of the second se			11
	51 miles 1, 1.01, 2, 2.01, 0 and 11)		
PART II - PAYMENT UNDER REASONABLE COST			
1 PROGRAM INPATIENT ROUTINE CAPITAL COST (1
2 PROGRAM INPATIENT ANCILLARY CAPITAL COS			2
3 TOTAL INPATIENT PROGRAM CAPITAL COST (lin 4 CAPITAL COST PAYMENT FACTOR (see instructions			3 4
5 TOTAL INPATIENT PROGRAM CAPITAL COST (lin			5
PART III - COMPUTATION OF EXCEPTION PAYMENTS			
PROGRAM INPATIENT CAPITAL COSTS (see instruc PROGRAM INPATIENT CAPITAL COSTS FOR EXTR		in stars stiens)	1
3 NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTR		instructions)	
4 APPLICABLE EXCEPTION PERCENTAGE (see instruct			4
5 CAPITAL COST FOR COMPARISON TO PAYMENTS			5
6 PERCENTAGE ADJUSTMENT FOR EXTRAORDINAL	RY CIRCUMSTANCES (see instructions)		6
7 ADJUSTMENT TO CAPITAL MINIMUM PAYMENT	LEVEL FOR EXTRAORDINARY CIRCU	UMSTANCES (line 2 x line 6)	7
8 CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus li			8
9 CURRENT YEAR CAPITAL PAYMENTS (from Part I,			9
10 CURRENT YEAR COMPARISON OF CAPITAL MINI 11 CARRYOVER OF ACCUMULATED CAPITAL MININ			10 H line 14)
11 CARRYOVER OF ACCUMULATED CAPITAL MINIM 12 NET COMPARISON OF CAPITAL MINIMUM PAYMI			II, line 14) 11 12
12 NET COMPARISON OF CAPITAL MINIMUM PAYM 13 CURRENT YEAR EXCEPTION PAYMENT (if line 12 i		(line to plus line 11)	12
CAPPYOVER OF ACCUMULATED CAPITAL MININ		AL PAYMENT FOR THE FOLLOWING PERIOD	(if line 12 is
			14
negative, enter the amount on this line)			
 negative, enter the amount on this line) CURRENT YEAR ALLOWABLE OPERATING AND CONTRACT OF CONTRACT. 	CAPITAL PAYMENT (see instructions)		15
	S (see instructions)		15 16 17

KPMG LLP	C ΩMPU-MAX	X	
ST. JOSEPH'S REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/13/2015 Run Time: 10:22 Version: 2014.10

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1 PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL (cols.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26		
	GENERAL SERVICE COST CENTERS	0	2/1	21	25	20		
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							30
31	INTENSIVE CARE UNIT							31
43	NURSERY							43
50	ANCILLARY SERVICE COST CENTERS							50
50 52	OPERATING ROOM DELIVERY ROOM & LABOR ROOM							50 52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
112	SPECIAL PURPOSE COST CENTERS							112
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)							118
100	NONREIMBURSABLE COST CENTERS							100
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES							190
192								192
192.01	FOUNDATION ADMINISTATION						+	192.01
192.02 194	HOSPITALIST PLYMOUTH MOB-4			+			+	192.02 194
200	CROSS FOOT ADJUSTMENTS							200
200	NEGATIVE COST CENTER			-				200
201	TOTAL (sum of lines 118-201)							201
202	1017L (Sull Of Illes 110-201)			1	1		1	202