

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

WORKSHEET S  
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. [X] ELECTRONICALLY FILED COST REPORT DATE: 11-22-2013 TIME: 10:17\_\_\_\_  
 2. [X] MANUALLY SUBMITTED COST REPORT  
 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT  
 4. [F] MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. JOSEPH'S REG MED CENTER PLYMOUTH (15-0076) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2012 AND ENDING 06/30/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) \_\_\_\_\_  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)  
 \_\_\_\_\_  
 TITLE  
 \_\_\_\_\_  
 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL						1
2 SUBPROVIDER - IPF		-118,187	139,589	11,004	114	2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF						5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC						10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		-118,187	139,589	11,004	114	200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1915 LAKE AVENUE  
 2 CITY: PLYMOUTH

STATE: IN

P.O.BOX: 670  
 ZIP CODE: 46563

COUNTY: MARSHALL

1  
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)				
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	ST. JOSEPH'S REG MED CENTER PL	15-0076	46563	1	07/01/1966	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2012			TO: 06/30/2013					20
21	TYPE OF CONTROL									21

INPATIENT PPS INFORMATION

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID UNPAID DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID UNPAID DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2) (PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.							1 2 Y N 22
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.							3 N 23
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	1,314						24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2			26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				2			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)							1 2 Y Y 39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TEACHING HOSPITALS

56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	2	3	56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	Y			60
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. )(SEE INSTRUCTIONS)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY) ADDED AS A RESULT OF SECTION 5503. (SEE INSTRUCTIONS)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)				61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
			UNWEIGHTED IME	UNWEIGHTED DIRECT GME	
	PROGRAM NAME 1	PROGRAM CODE 2	FTE COUNT 3	FTE COUNT 4	
					61.10
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
					61.20
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

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

	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
64 ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

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

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

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

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

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4). (SEE INSTRUCTIONS)

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

INPATIENT PSYCHIATRIC FACILITY PPS

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

INPATIENT REHABILITATION FACILITY PPS

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

LONG TERM CARE HOSPITAL PPS

80 IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	80
---	--	---	----

TEFRA PROVIDERS

85 IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	85
86 DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.		N	86

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

		V	XIX	
<b>TITLE V AND XIX INPATIENT SERVICES</b>				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	1	2	
		N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
<b>RURAL PROVIDERS</b>				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	109
<b>MISCELLANEOUS COST REPORTING INFORMATION</b>				
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-18 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 13,000 PAID LOSSES: 54,900 SELF INSURANCE: 87,000			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	Y	Y	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121
<b>TRANSPLANT CENTER INFORMATION</b>				
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

ALL PROVIDERS

140 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1,  
 CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS  
 ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER. 1  
Y 15H034 140

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

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

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

	TITLE XVIII		TITLE	TITLE
	PART A	PART B	V	XIX
FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)	1	2	3	4
155 HOSPITAL	N	N		N 155
156 SUBPROVIDER - IPF	N	N		156
157 SUBPROVIDER - IRF	N	N		157
158 SUBPROVIDER - (OTHER)	N	N		158
159 SNF	N	N		159
160 HHA	N	N		160
161 CMHC		N		161
161.10 CORF				161.10

MULTICAMPUS

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

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

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

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

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO. Y 167  
 168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'),  
 ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 168  
 169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH  
 (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 1.00 169  
 170 IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE  
 FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS) 07/01/2012 06/30/2013 170

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
<b>PROVIDER ORGANIZATION AND OPERATION</b>					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	1 N	2	1	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	1 N	2	3 2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	Y		3	
<b>FINANCIAL DATA AND REPORTS</b>					
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	1 Y	2 A	3 4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
<b>APPROVED EDUCATIONAL ACTIVITIES</b>					
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?		1 N	2 6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		Y/N	Y 12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
<b>BED COMPLEMENT</b>					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
<b>PS&amp;R REPORT DATA</b>					
		<b>PART A</b>		<b>PART B</b>	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	1 Y	2 09/30/2013	3 Y	4 09/30/2013
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

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





HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	14,294,936	14,294,936	543,336.00	26.31	1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A ADMINISTRATIVE						4
4.01	PHYSICIAN-PART A - TEACHING						4.01
5	PHYSICIAN-PART B						5
6	NON-PHYSICIAN-PART B		152,597	152,597	3,400.00	44.88	6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44					9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		342,476	342,476	3,579.00	95.69	10
	OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)		142,481	142,481	1,375.00	103.62	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES		115,216	115,216	1,913.00	60.23	12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		200,909	216,959	1,689.00	128.45	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		3,730,727	3,730,727	74,436.00	50.12	14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						16
	WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)		4,450,462	4,450,462			17
18	WAGE-RELATED COSTS (OTHER)		24,712	24,712			18
19	EXCLUDED AREAS		133,458	133,458			19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A - ADMINISTRATIVE						22
22.01	PHYSICIAN PART A - TEACHING						22.01
23	PHYSICIAN PART B						23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
	OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS DEPARTMENT		122,390	122,390	3,485.00	35.12	26
27	ADMINISTRATIVE & GENERAL		1,568,141	1,568,141	62,179.00	25.22	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		24,695	24,695	73.00	338.29	28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT		360,907	360,907	14,637.00	24.66	30
31	LAUNDRY & LINEN SERVICE		29,715	29,715	2,123.00	14.00	31
32	HOUSEKEEPING		392,720	392,720	32,912.00	11.93	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		223,330	223,330	16,949.00	13.18	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)		109,451	109,451	2,080.00	52.62	35
36	CAFETERIA						36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		457,635	457,635	12,321.00	37.14	38
39	CENTRAL SERVICES AND SUPPLY						39
40	PHARMACY		432,851	432,851	11,265.00	38.42	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		292,193	292,193	14,894.00	19.62	41
42	SOCIAL SERVICE						42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	14,276,485		14,276,485	542,089.00	26.34	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	342,476		342,476	3,579.00	95.69	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	13,934,009		13,934,009	538,510.00	25.88	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	4,189,333	16,050	4,205,383	79,413.00	52.96	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	4,475,174		4,475,174		32.12%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	22,598,516	16,050	22,614,566	617,923.00	36.60	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	4,014,028		4,014,028	172,918.00	23.21	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
 PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	1,176,923 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)	1,682,762 8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	160,849 10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	53,377 11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	38,453 13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	63,379 15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	999,547 17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	596 19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	19,106 23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	4,194,992 24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	5,606 25

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL  
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
11/22/2013 10:17

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3  
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	142,481	1
2	HOSPITAL	142,481	2
3	SUBPROVIDER - IPF		3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTC		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.277032	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				2,607,104	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				17,839,890	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				4,942,220	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.				2,335,116	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				2,335,116	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	4,109,615	145,211	4,254,826		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	1,138,495	40,228	1,178,723		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	25,544		25,544		22
23	COST OF CHARITY CARE	1,112,951	40,228	1,153,179		23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM				N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			2,294,310		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			95,557		27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			2,198,753		28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			609,125		29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,762,304		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			4,097,420		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100				1,431,345	1
2	00200				1,553,992	2
3	00300					3
4	00400	122,390	-185,808	-63,418	184,626	4
5	00500	1,568,141	11,716,572	13,284,713	-1,202,336	5
6	00600					6
7	00700	360,907	1,440,148	1,801,055	-287,107	7
8	00800	29,715	189,820	219,535		8
9	00900	392,720	241,168	633,888	-211	9
10	01000	223,330	548,496	771,826	-2,808	10
12	01200					12
13	01300	457,635	118,160	575,795		13
14	01400					14
15	01500	432,851	1,509,686	1,942,537	-1,453,351	15
16	01600	292,193	384,745	676,938	-351	16
23	02300				16,050	23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	2,209,811	1,223,431	3,433,242	-1,057,640	30
31	03100	829,648	389,758	1,219,406	-23,306	31
43	04300				430,695	43
ANCILLARY SERVICE COST CENTERS						
50	05000	1,722,403	3,020,724	4,743,127	-775,997	50
52	05200				430,695	52
54	05400	808,015	667,466	1,475,481	-314,278	54
55	05500	266,207	552,201	818,408	-226,954	55
57	05700	61,144	66,698	127,842		57
59	05900	97,247	595,515	692,762	-433,846	59
60	06000	1,051,395	1,947,959	2,999,354	-88,688	60
62.30	06250					62.30
65	06500	431,208	412,454	843,662	-66,323	65
66	06600	849,593	434,030	1,283,623	-52,565	66
72	07200				724,517	72
73	07300				1,406,423	73
74	07400					74
76.97	07697					76.97
76.98	07698				199,909	76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	6,553	1,152	7,705		90.01
90.02	09002	177,866	70,322	248,188		90.02
90.03	09003	206,368	104,296	310,664	-668	90.03
90.04	09004	147,725	737,048	884,773	-346,684	90.04
91	09100	1,207,395	617,451	1,824,846	-45,139	91
92	09200					92
94	09400					94
SPECIAL PURPOSE COST CENTERS						
113	11300					113
118		13,952,460	26,803,492	40,755,952		118
NONREIMBURSABLE COST CENTERS						
190	19000					190
190.01	19001		103,694	103,694		190.01
190.02	19002					190.02
192.02	19201	342,476	419,815	762,291		192.02
200		14,294,936	27,327,001	41,621,937		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	1,431,345	598,241	2,029,586	1
2	00200	CAP REL COSTS-MVBLE EQUIP	1,553,992		1,553,992	2
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	121,208		121,208	4
5	00500	ADMINISTRATIVE & GENERAL	12,082,377	-2,448,366	9,634,011	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	1,513,948		1,513,948	7
8	00800	LAUNDRY & LINEN SERVICE	219,535		219,535	8
9	00900	HOUSEKEEPING	633,677	-62,500	571,177	9
10	01000	DIETARY	769,018	-158,680	610,338	10
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	575,795		575,795	13
14	01400	CENTRAL SERVICES & SUPPLY				14
15	01500	PHARMACY	489,186	-603	488,583	15
16	01600	MEDICAL RECORDS & LIBRARY	676,587		676,587	16
23	02300	PARAMED ED PRGM-(SPECIFY)	16,050	-7,623	8,427	23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	2,375,602	-13,496	2,362,106	30
31	03100	INTENSIVE CARE UNIT	1,196,100	-41,926	1,154,174	31
43	04300	NURSERY	430,695		430,695	43
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	3,967,130	-845,507	3,121,623	50
52	05200	DELIVERY ROOM & LABOR ROOM	430,695		430,695	52
54	05400	RADIOLOGY-DIAGNOSTIC	1,161,203		1,161,203	54
55	05500	RADIOLOGY-THERAPEUTIC	591,454	-93,488	497,966	55
57	05700	CT SCAN	127,842		127,842	57
59	05900	CARDIAC CATHETERIZATION	258,916		258,916	59
60	06000	LABORATORY	2,910,666	-3,379	2,907,287	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	777,339	-12,830	764,509	65
66	06600	PHYSICAL THERAPY	1,231,058	-10,500	1,220,558	66
72	07200	IMPL. DEV. CHARGED TO PATIENTS	724,517		724,517	72
73	07300	DRUGS CHARGED TO PATIENTS	1,406,423		1,406,423	73
74	07400	RENAL DIALYSIS				74
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	199,909		199,909	76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	CLINIC	7,705	-7,186	519	90.01
90.02	09002	ATHLETIC TRAINERS	248,188	-109,500	138,688	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	309,996	-7,137	302,859	90.03
90.04	09004	WOUND CARE	538,089		538,089	90.04
91	09100	EMERGENCY	1,779,707	-25,008	1,754,699	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS						
94	09400	HOME PROGRAM DIALYSIS				94
SPECIAL PURPOSE COST CENTERS						
113	11300	INTEREST EXPENSE				113
118		SUBTOTALS (SUM OF LINES 1-117)	40,755,952	-3,249,488	37,506,464	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
190.01	19001	PLYMOUTH MOB-4	103,694		103,694	190.01
190.02	19002	HOSPITALIST				190.02
192.02	19201	PHYSICIAN PRIVATE OFFICE	762,291		762,291	192.02
200		TOTAL (SUM OF LINES 118-199)	41,621,937	-3,249,488	38,372,449	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----		SALARY	OTHER
		COST CENTER	LINE #		
	1	2	3	4	5
1 BLDG & EQUIP RENT/DEPRECIATION EXP	A	CAP REL COSTS-MVBLE EQUIP	2		1,182 1
2		CAP REL COSTS-BLDG & FIXT	1		739,271 2
3		CAP REL COSTS-MVBLE EQUIP	2		26,679 3
4		CAP REL COSTS-BLDG & FIXT	1		205,838 4
5		CAP REL COSTS-MVBLE EQUIP	2		81,269 5
6		CAP REL COSTS-MVBLE EQUIP	2		211 6
7		CAP REL COSTS-MVBLE EQUIP	2		2,225 7
8		CAP REL COSTS-BLDG & FIXT	1		583 8
9		CAP REL COSTS-MVBLE EQUIP	2		46,928 9
10		CAP REL COSTS-MVBLE EQUIP	2		351 10
11		CAP REL COSTS-MVBLE EQUIP	2		5,541 11
12		CAP REL COSTS-BLDG & FIXT	1		26,341 12
13		CAP REL COSTS-MVBLE EQUIP	2		164,368 13
14		CAP REL COSTS-MVBLE EQUIP	2		14,778 14
15		CAP REL COSTS-MVBLE EQUIP	2		8,528 15
16		CAP REL COSTS-MVBLE EQUIP	2		36,100 16
17		CAP REL COSTS-BLDG & FIXT	1		7,846 17
18		CAP REL COSTS-MVBLE EQUIP	2		85,003 18
19		CAP REL COSTS-BLDG & FIXT	1		8,104 19
20		CAP REL COSTS-MVBLE EQUIP	2		88,700 20
21		CAP REL COSTS-MVBLE EQUIP	2		217,474 21
22		CAP REL COSTS-BLDG & FIXT	1		280 22
23		CAP REL COSTS-MVBLE EQUIP	2		226,674 23
24		CAP REL COSTS-BLDG & FIXT	1		513 24
25		CAP REL COSTS-MVBLE EQUIP	2		355,864 25
26		CAP REL COSTS-BLDG & FIXT	1		707 26
27		CAP REL COSTS-MVBLE EQUIP	2		87,330 27
28		CAP REL COSTS-MVBLE EQUIP	2		13,426 28
29		CAP REL COSTS-MVBLE EQUIP	2		52,897 29
30		CAP REL COSTS-BLDG & FIXT	1		46,460 30
31		CAP REL COSTS-MVBLE EQUIP	2		544 31
32		CAP REL COSTS-BLDG & FIXT	1		5,561 32
33		CAP REL COSTS-MVBLE EQUIP	2		668 33
34		CAP REL COSTS-BLDG & FIXT	1		117,939 34
35		CAP REL COSTS-BLDG & FIXT	1		20,673 35
36		CAP REL COSTS-MVBLE EQUIP	2		8,163 36
37		CAP REL COSTS-MVBLE EQUIP	2		29,089 37
500 TOTAL RECLASSIFICATIONS					2,734,108 500
CODE LETTER - A					
1 PHARMACY DRUG RECLASS	B	DRUGS CHARGED TO PATIENTS	73		1,406,423 1
500 TOTAL RECLASSIFICATIONS					1,406,423 500
CODE LETTER - B					
1 INTEREST EXPENSE RECLASS	C	INTEREST EXPENSE	113		250,578 1
2		CAP REL COSTS-BLDG & FIXT	1		250,578 2
500 TOTAL RECLASSIFICATIONS					501,156 500
CODE LETTER - C					
1 NURSERY-LABOR/DELIVERY RECLASS	D	NURSERY	43	305,203	125,492 1
2		DELIVERY ROOM & LABOR ROOM	52	305,203	125,492 2
500 TOTAL RECLASSIFICATIONS				610,406	250,984 500
CODE LETTER - D					
1 IMPLANT RECLASS	E	IMPL. DEV. CHARGED TO PATIENT	72		647,048 1
2		IMPL. DEV. CHARGED TO PATIENT	72		77,469 2
500 TOTAL RECLASSIFICATIONS					724,517 500
CODE LETTER - E					
1 NEGATIVE WKST A AMOUNT RECLASS	F	EMPLOYEE BENEFITS DEPARTMENT	4		185,808 1
500 TOTAL RECLASSIFICATIONS					185,808 500
CODE LETTER - F					
1 PROPERTY INSURANCE RECLASS	G	CAP REL COSTS-BLDG & FIXT	1		651 1
500 TOTAL RECLASSIFICATIONS					651 500
CODE LETTER - G					

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----			
		COST CENTER	LINE #	SALARY	OTHER
	1	2	3	4	5
1 MEDICAL DIRECTOR RECLASSIFICATIONS	H	PARAMED ED PRGM-(SPECIFY)	23		16,050 1
500 TOTAL RECLASSIFICATIONS					16,050 500
CODE LETTER - H					
1 WOUND CARE TO HYPERBARIC RECLASS	I	HYPERBARIC OXYGEN THERAPY	76.98	58,357	141,552 1
500 TOTAL RECLASSIFICATIONS				58,357	141,552 500
CODE LETTER - I					
1 SHORT TERM DISABILITY TO OTHER EXP	J	EMPLOYEE BENEFITS DEPARTMENT	4		1 1
500 TOTAL RECLASSIFICATIONS					1 500
CODE LETTER - J					
GRAND TOTAL (INCREASES)				668,763	5,961,250

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 BLDG & EQUIP RENT/DEPRECIATION EXP	A	EMPLOYEE BENEFITS DEPARTMENT	4		1,182	9 1
2		ADMINISTRATIVE & GENERAL	5		739,271	9 2
3		ADMINISTRATIVE & GENERAL	5		26,679	10 3
4		OPERATION OF PLANT	7		205,838	9 4
5		OPERATION OF PLANT	7		81,269	9 5
6		HOUSEKEEPING	9		211	9 6
7		DIETARY	10		2,225	10 7
8		DIETARY	10		583	9 8
9		PHARMACY	15		46,928	9 9
10		MEDICAL RECORDS & LIBRARY	16		351	9 10
11		ADULTS & PEDIATRICS	30		5,541	10 11
12		ADULTS & PEDIATRICS	30		26,341	9 12
13		ADULTS & PEDIATRICS	30		164,368	9 13
14		INTENSIVE CARE UNIT	31		14,778	10 14
15		INTENSIVE CARE UNIT	31		8,528	9 15
16		OPERATING ROOM	50		36,100	10 16
17		OPERATING ROOM	50		7,846	9 17
18		OPERATING ROOM	50		85,003	9 18
19		RADIOLOGY-DIAGNOSTIC	54		8,104	9 19
20		RADIOLOGY-DIAGNOSTIC	54		88,700	10 20
21		RADIOLOGY-DIAGNOSTIC	54		217,474	9 21
22		RADIOLOGY-THERAPEUTIC	55		280	9 22
23		RADIOLOGY-THERAPEUTIC	55		226,674	9 23
24		CARDIAC CATHETERIZATION	59		513	9 24
25		CARDIAC CATHETERIZATION	59		355,864	9 25
26		LABORATORY	60		707	9 26
27		LABORATORY	60		87,330	9 27
28		RESPIRATORY THERAPY	65		13,426	10 28
29		RESPIRATORY THERAPY	65		52,897	9 29
30		PHYSICAL THERAPY	66		46,460	10 30
31		PHYSICAL THERAPY	66		544	9 31
32		PHYSICAL THERAPY	66		5,561	9 32
33		SAINT JOSEPH HEALTH CENTER	90.03		668	9 33
34		WOUND CARE	90.04		117,939	10 34
35		WOUND CARE	90.04		20,673	9 35
36		WOUND CARE	90.04		8,163	9 36
37		EMERGENCY	91		29,089	9 37
500 TOTAL RECLASSIFICATIONS					2,734,108	500
CODE LETTER - A						
1 PHARMACY DRUG RECLASS	B	PHARMACY	15		1,406,423	1
500 TOTAL RECLASSIFICATIONS					1,406,423	500
CODE LETTER - B						
1 INTEREST EXPENSE RECLASS	C	ADMINISTRATIVE & GENERAL	5		250,578	11 1
2		INTEREST EXPENSE	113		250,578	11 2
500 TOTAL RECLASSIFICATIONS					501,156	500
CODE LETTER - C						
1 NURSERY-LABOR/DELIVERY RECLASS	D	ADULTS & PEDIATRICS	30	305,203	125,492	1
2		ADULTS & PEDIATRICS	30	305,203	125,492	2
500 TOTAL RECLASSIFICATIONS				610,406	250,984	500
CODE LETTER - D						
1 IMPLANT RECLASS	E	OPERATING ROOM	50		647,048	1
2		CARDIAC CATHETERIZATION	59		77,469	2
500 TOTAL RECLASSIFICATIONS					724,517	500
CODE LETTER - E						
1 NEGATIVE WKST A AMOUNT RECLASS	F	ADMINISTRATIVE & GENERAL	5		185,808	1
500 TOTAL RECLASSIFICATIONS					185,808	500
CODE LETTER - F						
1 PROPERTY INSURANCE RECLASS	G	LABORATORY	60		651	11 1
500 TOTAL RECLASSIFICATIONS					651	500
CODE LETTER - G						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 MEDICAL DIRECTOR RECLASSIFICATIONS	H	EMERGENCY	91		16,050	1
500 TOTAL RECLASSIFICATIONS					16,050	500
1 WOUND CARE TO HYPERBARIC RECLASS	I	WOUND CARE	90.04	58,357	141,552	1
500 TOTAL RECLASSIFICATIONS				58,357	141,552	500
1 SHORT TERM DISABILITY TO OTHER EXP	J	EMPLOYEE BENEFITS DEPARTMENT	4		1	1
500 TOTAL RECLASSIFICATIONS					1	500
CODE LETTER - J						
GRAND TOTAL (DECREASES)				668,763	5,961,250	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	477,930					477,930		1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES	32,873,863	308,598		308,598		33,182,461	9,686,008	3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	21,009,945	1,802,635		1,802,635	425,232	22,387,348	12,086,743	6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	54,361,738	2,111,233		2,111,233	425,232	56,047,739	21,772,751	8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	54,361,738	2,111,233		2,111,233	425,232	56,047,739	21,772,751	10

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

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

----- COMPUTATION OF RATIOS ----- ALLOCATION OF OTHER CAPITAL -----

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

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

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14)
1 CAP REL COSTS-BLDG & FIXT	1,864,836	164,399	351				2,029,586
2 CAP REL COSTS-MVBLE EQUIP	1,366,543	187,449					1,553,992
3 TOTAL	3,231,379	351,848	351				3,583,578

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-250,878	CAP REL COSTS-BLDG & FIXT	1	11 1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2 3
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					4
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					5
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					6
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					7
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					8
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					9
9 PARKING LOT (CHAPTER 21)					10
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-941,214			11
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					12
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	567,986			13
13 LAUNDRY AND LINEN SERVICE					14
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-158,680	DIETARY	10	15
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					16
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					17
17 SALE OF DRUGS TO OTHER THAN PATIENTS					18
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					19
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					20
20 VENDING MACHINES					21
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					22
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					23
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	24
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	25
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	26
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	27
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	28
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	29
29 PHYSICIANS' ASSISTANT					30
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	31
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	32
32 CAH HIT ADJ FOR DEPRECIATION AND					33
33 LOBBYING EXPENSES	A	-2,135	ADMINISTRATIVE & GENERAL	5	34
34 DONATIONS	A	-45,535	ADMINISTRATIVE & GENERAL	5	35
35 ENTERTAINMENT EXP	A	-11,630	ADMINISTRATIVE & GENERAL	5	36
36 PROPERTY TAX EXPENSE	A	-651	LABORATORY	60	37
37					38
38 OTHER REVENUE ADJ	B	-22,773	ADMINISTRATIVE & GENERAL	5	39
39 OTHER REVENUE ADJ	B	-62,500	HOUSEKEEPING	9	40
40 OTHER REVENUE ADJ	B	-603	PHARMACY	15	41
41 OTHER REVENUE ADJ	B	-2,000	ADULTS & PEDIATRICS	30	42
42 OTHER REVENUE ADJ	B	-93,488	RADIOLOGY-THERAPEUTIC	55	43
43 OTHER REVENUE ADJ	B	-2,728	LABORATORY	60	44
44 OTHER REVENUE ADJ	B	-12,830	RESPIRATORY THERAPY	65	45
45 OTHER REVENUE ADJ	B	-10,500	PHYSICAL THERAPY	66	46
46 OTHER REVENUE ADJ	B	-7,186	CLINIC	90.01	47
47 OTHER REVENUE ADJ	B	-109,500	ATHLETIC TRAINERS	90.02	48
48 OTHER REVENUE ADJ	B	-7,137	SAINT JOSEPH HEALTH CENTER	90.03	49
49 OTHER REVENUE ADJ	B	-241	EMERGENCY	91	49.04
49.04 MEDICAID PROV BED TAX ADJ	A	-2,077,400	ADMINISTRATIVE & GENERAL	5	49.05
49.05 LOBBYING ADJ FROM HOME OFC	A	2,135	ADMINISTRATIVE & GENERAL	5	50
50 TOTAL (SUM OF LINES 1 THRU 49)		-3,249,488			
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

LINE NO. 1	COST CENTER 2	EXPENSE ITEMS 3	AMOUNT OF ALLOWABLE COST 4	AMOUNT (INCL IN WKST A, COL. 5) 5	NET ADJ- USTMENTS (COL. 4-5) 6	WKST A-7 REF 7	
1	5	ADMINISTRATIVE & GENERAL	HO NON CAPITAL COSTS	6,401,402	7,461,045	-1,059,643	1
2							2
3	5	ADMINISTRATIVE & GENERAL	WORKERS COMP	48,996	63,821	-14,825	3
3.02	5	ADMINISTRATIVE & GENERAL	MALPRACTICE INSURANCE	347,851	426,063	-78,212	4.02
3.04	5	ADMINISTRATIVE & GENERAL	PENSION	1,543,969	913,921	630,048	4.04
3.05	5	ADMINISTRATIVE & GENERAL	RETIREE HEALTH COSTS	8,426	-233,073	241,499	4.05
3.06	1	CAP REL COSTS-BLDG & FIXT	HO CAPITAL COSTS	849,119		849,119	9 4.06
4							4
5		TOTALS (SUM OF LINES 1-4)		9,199,763	8,631,777	567,986	5
		TRANSFER COL. 6, LINE 5 TO					
		WKST A-8, COL. 2, LINE 12.					

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

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

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

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT		
LINE NO.	1	2	3	4	5	6	7	8	9		
1	60	LABORATORY	DR A	54,164		54,164	142,500	832	57,000	2,850	1
2	91	EMERGENCY	DR B	59,867	2,267	57,600	208,000	384	38,400	1,920	2
3	23	PARAMED ED PRGM-(SPECIFY	DR C	16,050		16,050	142,500	123	8,427	421	3
4	91	EMERGENCY	DR D	4,000		4,000	208,000	7	700	35	4
5	50	OPERATING ROOM	DR E	845,507	845,507		142,500				5
6	30	ADULTS & PEDIATRICS	DR F	22,458		22,458	142,500	160	10,962	548	6
7	31	INTENSIVE CARE UNIT	DR G	48,914		48,914	142,500	102	6,988	349	7
8	5	ADMINISTRATIVE & GENERAL	DR H	14,074	300	13,774	142,500	61	4,179	209	8
200		TOTAL		1,065,034	848,074	216,960		1,669	126,656	6,332	200

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
 11/22/2013 10:17

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
10	11	12	13	14	15	16	17	18	
1	60 LABORATORY					57,000			1
2	91 EMERGENCY					38,400	19,200	21,467	2
3	23 PARAMED ED PRGM-(SPECIFY					8,427	7,623	7,623	3
4	91 EMERGENCY					700	3,300	3,300	4
5	50 OPERATING ROOM							845,507	5
6	30 ADULTS & PEDIATRICS					10,962	11,496	11,496	6
7	31 INTENSIVE CARE UNIT					6,988	41,926	41,926	7
8	5 ADMINISTRATIVE & GENERAL					4,179	9,595	9,895	8
200	TOTAL					126,656	93,140	941,214	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	2,029,586	2,029,586				1
2 CAP REL COSTS-MVBLE EQUIP	1,553,992		1,553,992			2
4 EMPLOYEE BENEFITS DEPARTMENT	121,208		1,323	122,531		4
5 ADMINISTRATIVE & GENERAL	9,634,011	229,079	28,640	13,558	9,905,288	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,513,948	433,250	90,938	3,120	2,041,256	7
8 LAUNDRY & LINEN SERVICE	219,535	7,757		257	227,549	8
9 HOUSEKEEPING	571,177	3,840	236	3,395	578,648	9
10 DIETARY	610,338	26,841	652	1,931	639,762	10
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	575,795			3,957	579,752	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	488,583	15,885	52,511	3,742	560,721	15
16 MEDICAL RECORDS & LIBRARY	676,587	32,179	393	2,526	711,685	16
23 PARAMED ED PRGM-(SPECIFY)	8,427				8,427	23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,362,106	248,164	183,924	13,828	2,808,022	30
31 INTENSIVE CARE UNIT	1,154,174	47,590	9,543	7,173	1,218,480	31
43 NURSERY	430,695			2,639	433,334	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,121,623	246,398	91,760	14,887	3,474,668	50
52 DELIVERY ROOM & LABOR ROOM	430,695			2,639	433,334	52
54 RADIOLOGY-DIAGNOSTIC	1,161,203	92,978	243,349	6,986	1,504,516	54
55 RADIOLOGY-THERAPEUTIC	497,966	115,839	253,643	2,302	869,750	55
57 CT SCAN	127,842	5,363		529	133,734	57
59 CARDIAC CATHETERIZATION	258,916	27,174	398,204	841	685,135	59
60 LABORATORY	2,907,287	55,628	93,257	9,090	3,065,262	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	764,509	42,457	59,191	3,728	869,885	65
66 PHYSICAL THERAPY	1,220,558	74,841	891	7,346	1,303,636	66
72 IMPL. DEV. CHARGED TO PATIENTS	724,517				724,517	72
73 DRUGS CHARGED TO PATIENTS	1,406,423				1,406,423	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	199,909	6,950		505	207,364	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC	519			57	576	90.01
90.02 ATHLETIC TRAINERS	138,688			1,538	140,226	90.02
90.03 SAINT JOSEPH HEALTH CENTER	302,859		747	1,784	305,390	90.03
90.04 WOUND CARE	538,089	33,062	8,570	773	580,494	90.04
91 EMERGENCY	1,754,699	93,938	32,550	10,439	1,891,626	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	37,506,464	1,839,213	1,550,322	119,570	37,309,460	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,432			2,432	190
190.01 PLYMOUTH MOB-4	103,694	187,941	3,670		295,305	190.01
190.02 HOSPITALIST						190.02
192.02 PHYSICIAN PRIVATE OFFICE	762,291			2,961	765,252	192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	38,372,449	2,029,586	1,553,992	122,531	38,372,449	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY + LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	9,905,288					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	710,265	2,751,521				7
8 LAUNDRY & LINEN SERVICE	79,177	15,610	322,336			8
9 HOUSEKEEPING	201,343	7,728		787,719		9
10 DIETARY	222,608	54,017		15,596	931,983	10
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	201,728					13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	195,106	31,967		9,230		15
16 MEDICAL RECORDS & LIBRARY	247,634	64,758		18,698		16
23 PARAMED ED PRGM-(SPECIFY)	2,932					23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	977,065	499,415	22,084	144,197	736,736	30
31 INTENSIVE CARE UNIT	423,976	95,772	8,308	27,653	157,783	31
43 NURSERY	150,781					43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,209,027	495,860	64,629	143,172	13,680	50
52 DELIVERY ROOM & LABOR ROOM	150,781		3,023		11,866	52
54 RADIOLOGY-DIAGNOSTIC	523,504	187,113	30,975	54,026		54
55 RADIOLOGY-THERAPEUTIC	302,634	233,119	10,499	67,309		55
57 CT SCAN	46,533	10,793	35,557	3,116		57
59 CARDIAC CATHETERIZATION	238,396	54,686	4,639	15,790		59
60 LABORATORY	1,066,573	111,948	57,455	32,323		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	302,681	85,442	16,329	24,670		65
66 PHYSICAL THERAPY	453,607	150,613	10,163	43,487		66
72 IMPL. DEV. CHARGED TO PATIENTS	252,099		7,125			72
73 DRUGS CHARGED TO PATIENTS	489,372		23,241			73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	72,153	13,987	3,520	4,039		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC	200					90.01
90.02 ATHLETIC TRAINERS	48,792					90.02
90.03 SAINT JOSEPH HEALTH CENTER	106,262		491			90.03
90.04 WOUND CARE	201,986	66,535	2,304	19,211		90.04
91 EMERGENCY	658,201	189,045	21,994	54,584	11,918	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
94 OTHER REIMBURSABLE COST CENTERS						94
HOME PROGRAM DIALYSIS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	9,535,416	2,368,408	322,336	677,101	931,983	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	846	4,894		1,413		190
190.01 PLYMOUTH MOB-4	102,753	378,219		109,205		190.01
190.02 HOSPITALIST						190.02
192.02 PHYSICIAN PRIVATE OFFICE	266,273					192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	9,905,288	2,751,521	322,336	787,719	931,983	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	PARAMED EDUCATION 23	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	781,480					13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		797,024				15
16 MEDICAL RECORDS & LIBRARY			1,042,775			16
23 PARAMED ED PRGM-(SPECIFY)				11,359		23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	242,789	8,799	71,444		5,510,551	30
31 INTENSIVE CARE UNIT	83,459		26,877		2,042,308	31
43 NURSERY	37,936				622,051	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	212,441	568	209,066		5,823,111	50
52 DELIVERY ROOM & LABOR ROOM	37,936		9,780		646,720	52
54 RADIOLOGY-DIAGNOSTIC		44,146	100,208		2,444,488	54
55 RADIOLOGY-THERAPEUTIC			33,964		1,517,275	55
57 CT SCAN		15,498	115,030		360,261	57
59 CARDIAC CATHETERIZATION		742	15,008		1,014,396	59
60 LABORATORY			185,872		4,519,433	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			52,827		1,351,834	65
66 PHYSICAL THERAPY		476	32,880		1,994,862	66
72 IMPL. DEV. CHARGED TO PATIENTS			23,050		1,006,791	72
73 DRUGS CHARGED TO PATIENTS		711,512	75,185		2,705,733	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY			11,388		312,451	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC					776	90.01
90.02 ATHLETIC TRAINERS					189,018	90.02
90.03 SAINT JOSEPH HEALTH CENTER		9,736	1,589		423,468	90.03
90.04 WOUND CARE	22,762	5,245	7,454		905,991	90.04
91 EMERGENCY	144,157	302	71,153	11,359	3,054,339	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
94 OTHER REIMBURSABLE COST CENTERS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	781,480	797,024	1,042,775	11,359	36,445,857	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					9,585	190
190.01 PLYMOUTH MOB-4					885,482	190.01
190.02 HOSPITALIST						190.02
192.02 PHYSICIAN PRIVATE OFFICE					1,031,525	192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	781,480	797,024	1,042,775	11,359	38,372,449	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	I&R COST & POST STEP-		TOTAL	
	DOWN ADJS	25		
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
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS		5,510,551		30
31 INTENSIVE CARE UNIT		2,042,308		31
43 NURSERY		622,051		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM		5,823,111		50
52 DELIVERY ROOM & LABOR ROOM		646,720		52
54 RADIOLOGY-DIAGNOSTIC		2,444,488		54
55 RADIOLOGY-THERAPEUTIC		1,517,275		55
57 CT SCAN		360,261		57
59 CARDIAC CATHETERIZATION		1,014,396		59
60 LABORATORY		4,519,433		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY		1,351,834		65
66 PHYSICAL THERAPY		1,994,862		66
72 IMPL. DEV. CHARGED TO PATIENTS		1,006,791		72
73 DRUGS CHARGED TO PATIENTS		2,705,733		73
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY		312,451		76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90.01 CLINIC		776		90.01
90.02 ATHLETIC TRAINERS		189,018		90.02
90.03 SAINT JOSEPH HEALTH CENTER		423,468		90.03
90.04 WOUND CARE		905,991		90.04
91 EMERGENCY		3,054,339		91
92 OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
SPECIAL PURPOSE COST CENTERS				
113 INTEREST EXPENSE				113
118 SUBTOTALS (SUM OF LINES 1-117)		36,445,857		118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		9,585		190
190.01 PLYMOUTH MOB-4		885,482		190.01
190.02 HOSPITALIST				190.02
192.02 PHYSICIAN PRIVATE OFFICE		1,031,525		192.02
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)		38,372,449		202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS	BLDGS & FIXTURES	MOVABLE EQUIPMENT		BENEFITS DEPARTMENT	
	0	1	2	2A	4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT			1,323	1,323	1,323	4
5 ADMINISTRATIVE & GENERAL		229,079	28,640	257,719	146	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		433,250	90,938	524,188	34	7
8 LAUNDRY & LINEN SERVICE		7,757		7,757	3	8
9 HOUSEKEEPING		3,840	236	4,076	37	9
10 DIETARY		26,841	652	27,493	21	10
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					43	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		15,885	52,511	68,396	40	15
16 MEDICAL RECORDS & LIBRARY		32,179	393	32,572	27	16
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		248,164	183,924	432,088	149	30
31 INTENSIVE CARE UNIT		47,590	9,543	57,133	77	31
43 NURSERY					28	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		246,398	91,760	338,158	164	50
52 DELIVERY ROOM & LABOR ROOM					28	52
54 RADIOLOGY-DIAGNOSTIC		92,978	243,349	336,327	75	54
55 RADIOLOGY-THERAPEUTIC		115,839	253,643	369,482	25	55
57 CT SCAN		5,363		5,363	6	57
59 CARDIAC CATHETERIZATION		27,174	398,204	425,378	9	59
60 LABORATORY		55,628	93,257	148,885	98	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		42,457	59,191	101,648	40	65
66 PHYSICAL THERAPY		74,841	891	75,732	79	66
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY		6,950		6,950	5	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC					1	90.01
90.02 ATHLETIC TRAINERS					17	90.02
90.03 SAINT JOSEPH HEALTH CENTER			747	747	19	90.03
90.04 WOUND CARE		33,062	8,570	41,632	8	90.04
91 EMERGENCY		93,938	32,550	126,488	112	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		1,839,213	1,550,322	3,389,535	1,291	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,432		2,432		190
190.01 PLYMOUTH MOB-4		187,941	3,670	191,611		190.01
190.02 HOSPITALIST						190.02
192.02 PHYSICIAN PRIVATE OFFICE					32	192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		2,029,586	1,553,992	3,583,578	1,323	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY + LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	257,865					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	18,490	542,712				7
8 LAUNDRY & LINEN SERVICE	2,061	3,079	12,900			8
9 HOUSEKEEPING	5,241	1,524		10,878		9
10 DIETARY	5,795	10,654		215	44,178	10
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	5,251					13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	5,079	6,305		127		15
16 MEDICAL RECORDS & LIBRARY	6,446	12,773		258		16
23 PARAMED ED PRGM-(SPECIFY)	76					23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	25,435	98,507	883	1,991	34,924	30
31 INTENSIVE CARE UNIT	11,037	18,890	332	382	7,479	31
43 NURSERY	3,925					43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	31,487	97,804	2,591	1,977	648	50
52 DELIVERY ROOM & LABOR ROOM	3,925		121		562	52
54 RADIOLOGY-DIAGNOSTIC	13,628	36,906	1,239	746		54
55 RADIOLOGY-THERAPEUTIC	7,878	45,980	420	930		55
57 CT SCAN	1,211	2,129	1,422	43		57
59 CARDIAC CATHETERIZATION	6,206	10,786	186	218		59
60 LABORATORY	27,765	22,081	2,298	446		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	7,879	16,853	653	341		65
66 PHYSICAL THERAPY	11,808	29,707	407	601		66
72 IMPL. DEV. CHARGED TO PATIENTS	6,563		285			72
73 DRUGS CHARGED TO PATIENTS	12,739		930			73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	1,878	2,759	141	56		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC	5					90.01
90.02 ATHLETIC TRAINERS	1,270					90.02
90.03 SAINT JOSEPH HEALTH CENTER	2,766		20			90.03
90.04 WOUND CARE	5,258	13,123	92	265		90.04
91 EMERGENCY	17,134	37,287	880	754	565	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	248,236	467,147	12,900	9,350	44,178	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	22	965		20		190
190.01 PLYMOUTH MOB-4	2,675	74,600		1,508		190.01
190.02 HOSPITALIST						190.02
192.02 PHYSICIAN PRIVATE OFFICE	6,932					192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	257,865	542,712	12,900	10,878	44,178	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	PARAMED EDUCATION 23	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	5,294					13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		79,947				15
16 MEDICAL RECORDS & LIBRARY			52,076			16
23 PARAMED ED PRGM-(SPECIFY)				76		23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,645	883	3,569		600,074	30
31 INTENSIVE CARE UNIT	565		1,343		97,238	31
43 NURSERY	257				4,210	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,439	57	10,422		484,747	50
52 DELIVERY ROOM & LABOR ROOM	257		489		5,382	52
54 RADIOLOGY-DIAGNOSTIC		4,428	5,007		398,356	54
55 RADIOLOGY-THERAPEUTIC			1,697		426,412	55
57 CT SCAN		1,555	5,747		17,476	57
59 CARDIAC CATHETERIZATION		74	750		443,607	59
60 LABORATORY			9,287		210,860	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			2,639		130,053	65
66 PHYSICAL THERAPY		48	1,643		120,025	66
72 IMPL. DEV. CHARGED TO PATIENTS			1,152		8,000	72
73 DRUGS CHARGED TO PATIENTS		71,369	3,756		88,794	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY			569		12,358	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC					6	90.01
90.02 ATHLETIC TRAINERS					1,287	90.02
90.03 SAINT JOSEPH HEALTH CENTER		977	79		4,608	90.03
90.04 WOUND CARE	154	526	372		61,430	90.04
91 EMERGENCY	977	30	3,555		187,782	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	5,294	79,947	52,076		3,302,705	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					3,439	190
190.01 PLYMOUTH MOB-4					270,394	190.01
190.02 HOSPITALIST						190.02
192.02 PHYSICIAN PRIVATE OFFICE					6,964	192.02
200 CROSS FOOT ADJUSTMENTS				76	76	200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	5,294	79,947	52,076	76	3,583,578	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	I&R COST & POST STEP-		TOTAL	
	DOWN ADJS	25		
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
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS		600,074		30
31 INTENSIVE CARE UNIT		97,238		31
43 NURSERY		4,210		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM		484,747		50
52 DELIVERY ROOM & LABOR ROOM		5,382		52
54 RADIOLOGY-DIAGNOSTIC		398,356		54
55 RADIOLOGY-THERAPEUTIC		426,412		55
57 CT SCAN		17,476		57
59 CARDIAC CATHETERIZATION		443,607		59
60 LABORATORY		210,860		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY		130,053		65
66 PHYSICAL THERAPY		120,025		66
72 IMPL. DEV. CHARGED TO PATIENTS		8,000		72
73 DRUGS CHARGED TO PATIENTS		88,794		73
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY		12,358		76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90.01 CLINIC		6		90.01
90.02 ATHLETIC TRAINERS		1,287		90.02
90.03 SAINT JOSEPH HEALTH CENTER		4,608		90.03
90.04 WOUND CARE		61,430		90.04
91 EMERGENCY		187,782		91
92 OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
SPECIAL PURPOSE COST CENTERS				
113 INTEREST EXPENSE				113
118 SUBTOTALS (SUM OF LINES 1-117)		3,302,705		118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,439		190
190.01 PLYMOUTH MOB-4		270,394		190.01
190.02 HOSPITALIST				190.02
192.02 PHYSICIAN PRIVATE OFFICE		6,964		192.02
200 CROSS FOOT ADJUSTMENTS		76		200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)		3,583,578		202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON-CILIATION 5A	ADMINISTRATIVE & GENERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	158,563					1
2 CAP REL COSTS-MVBLE EQUIP		1,388,760				2
4 EMPLOYEE BENEFITS DEPARTMENT		1,182	14,172,546			4
5 ADMINISTRATIVE & GENERAL	17,897	25,595	1,568,141	-9,905,288	28,467,161	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	33,848	81,269	360,907		2,041,256	7
8 LAUNDRY & LINEN SERVICE	606		29,715		227,549	8
9 HOUSEKEEPING	300	211	392,720		578,648	9
10 DIETARY	2,097	583	223,330		639,762	10
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION			457,635		579,752	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	1,241	46,928	432,851		560,721	15
16 MEDICAL RECORDS & LIBRARY	2,514	351	292,193		711,685	16
23 PARAMED ED PRGM-(SPECIFY)					8,427	23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	19,388	164,368	1,599,405		2,808,022	30
31 INTENSIVE CARE UNIT	3,718	8,528	829,648		1,218,480	31
43 NURSERY			305,203		433,334	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	19,250	82,003	1,722,403		3,474,668	50
52 DELIVERY ROOM & LABOR ROOM			305,203		433,334	52
54 RADIOLOGY-DIAGNOSTIC	7,264	217,474	808,015		1,504,516	54
55 RADIOLOGY-THERAPEUTIC	9,050	226,674	266,207		869,750	55
57 CT SCAN	419		61,144		133,734	57
59 CARDIAC CATHETERIZATION	2,123	355,864	97,247		685,135	59
60 LABORATORY	4,346	83,341	1,051,395		3,065,262	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,317	52,897	431,208		869,885	65
66 PHYSICAL THERAPY	5,847	796	849,593		1,303,636	66
72 IMPL. DEV. CHARGED TO PATIENTS					724,517	72
73 DRUGS CHARGED TO PATIENTS					1,406,423	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	543		58,357		207,364	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC			6,553		576	90.01
90.02 ATHLETIC TRAINERS			177,866		140,226	90.02
90.03 SAINT JOSEPH HEALTH CENTER		668	206,368		305,390	90.03
90.04 WOUND CARE	2,583	7,659	89,368		580,494	90.04
91 EMERGENCY	7,339	29,089	1,207,395		1,891,626	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	143,690	1,385,480	13,830,070	-9,905,288	27,404,172	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	190				2,432	190
190.01 PLYMOUTH MOB-4	14,683	3,280			295,305	190.01
190.02 HOSPITALIST						190.02
192.02 PHYSICIAN PRIVATE OFFICE			342,476		765,252	192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,029,586	1,553,992	122,531		9,905,288	202
203 UNIT COST MULT-WS B PT I	12.799871	1.118978	0.008646		0.347955	203
204 COST TO BE ALLOC PER B PT II			1,323		257,865	204
205 UNIT COST MULT-WS B PT II			0.000093		0.009058	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	NURSING	
	OF PLANT	+ LINEN	KEEPING		ADMINIS-	TRATION
	SQUARE	SERVICE	SQUARE	MEALS	DIRECT	
	FEET	GROSS	FEET	SERVED	NRSNG	HRS
	7	REVENUE	9	10	13	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	106,818					7
8 LAUNDRY & LINEN SERVICE	606	131,558,063				8
9 HOUSEKEEPING	300		105,912			9
10 DIETARY	2,097		2,097	17,986		10
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					103	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	1,241		1,241			15
16 MEDICAL RECORDS & LIBRARY	2,514		2,514			16
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	19,388	9,013,824	19,388	14,218	32	30
31 INTENSIVE CARE UNIT	3,718	3,390,990	3,718	3,045	11	31
43 NURSERY					5	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	19,250	26,371,528	19,250	264	28	50
52 DELIVERY ROOM & LABOR ROOM		1,233,940		229	5	52
54 RADIOLOGY-DIAGNOSTIC	7,264	12,643,005	7,264			54
55 RADIOLOGY-THERAPEUTIC	9,050	4,285,144	9,050			55
57 CT SCAN	419	14,513,020	419			57
59 CARDIAC CATHETERIZATION	2,123	1,893,544	2,123			59
60 LABORATORY	4,346	23,450,885	4,346			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,317	6,664,977	3,317			65
66 PHYSICAL THERAPY	5,847	4,148,329	5,847			66
72 IMPL. DEV. CHARGED TO PATIENTS		2,908,146				72
73 DRUGS CHARGED TO PATIENTS		9,485,921				73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	543	1,436,733	543			76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC						90.01
90.02 ATHLETIC TRAINERS						90.02
90.03 SAINT JOSEPH HEALTH CENTER		200,505				90.03
90.04 WOUND CARE	2,583	940,412	2,583		3	90.04
91 EMERGENCY	7,339	8,977,160	7,339	230	19	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
94 OTHER REIMBURSABLE COST CENTERS						94
118 SUBTOTALS (SUM OF LINES 1-117)	91,945	131,558,063	91,039	17,986	103	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	190		190			190
190.01 PLYMOUTH MOB-4	14,683		14,683			190.01
190.02 HOSPITALIST						190.02
192.02 PHYSICIAN PRIVATE OFFICE						192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,751,521	322,336	787,719	931,983	781,480	202
203 UNIT COST MULT-WS B PT I	25.758964	0.002450	7.437486	51.817136	7,587.184466	203
204 COST TO BE ALLOC PER B PT II	542,712	12,900	10,878	44,178	5,294	204
205 UNIT COST MULT-WS B PT II	5.080717	0.000098	0.102708	2.456244	51.398058	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION	
	COSTED REQUIS. 15	GROSS REVENUE 16	ASSIGNED TIME 23	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS DEPARTMENT				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY	1,575,449			15
16 MEDICAL RECORDS & LIBRARY		131,558,063		16
23 PARAMED ED PRGM-(SPECIFY)			100	23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	17,392	9,013,824		30
31 INTENSIVE CARE UNIT		3,390,990		31
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	1,123	26,371,528		50
52 DELIVERY ROOM & LABOR ROOM		1,233,940		52
54 RADIOLOGY-DIAGNOSTIC	87,261	12,643,005		54
55 RADIOLOGY-THERAPEUTIC		4,285,144		55
57 CT SCAN	30,634	14,513,020		57
59 CARDIAC CATHETERIZATION	1,467	1,893,544		59
60 LABORATORY		23,450,885		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY		6,664,977		65
66 PHYSICAL THERAPY	940	4,148,329		66
72 IMPL. DEV. CHARGED TO PATIENTS		2,908,146		72
73 DRUGS CHARGED TO PATIENTS	1,406,423	9,485,921		73
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY		1,436,733		76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90.01 CLINIC				90.01
90.02 ATHLETIC TRAINERS				90.02
90.03 SAINT JOSEPH HEALTH CENTER	19,244	200,505		90.03
90.04 WOUND CARE	10,368	940,412		90.04
91 EMERGENCY	597	8,977,160	100	91
92 OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	1,575,449	131,558,063	100	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
190.01 PLYMOUTH MOB-4				190.01
190.02 HOSPITALIST				190.02
192.02 PHYSICIAN PRIVATE OFFICE				192.02
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 COST TO BE ALLOC PER B PT I	797,024	1,042,775	11,359	202
203 UNIT COST MULT-WS B PT I	0.505903	0.007926	113.590000	203
204 COST TO BE ALLOC PER B PT II	79,947	52,076	76	204
205 UNIT COST MULT-WS B PT II	0.050746	0.000396	0.760000	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,510,551		5,510,551	11,496	5,522,047	30
31 INTENSIVE CARE UNIT	2,042,308		2,042,308	41,926	2,084,234	31
43 NURSERY	622,051		622,051		622,051	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	5,823,111		5,823,111		5,823,111	50
52 DELIVERY ROOM & LABOR ROOM	646,720		646,720		646,720	52
54 RADIOLOGY-DIAGNOSTIC	2,444,488		2,444,488		2,444,488	54
55 RADIOLOGY-THERAPEUTIC	1,517,275		1,517,275		1,517,275	55
57 CT SCAN	360,261		360,261		360,261	57
59 CARDIAC CATHETERIZATION	1,014,396		1,014,396		1,014,396	59
60 LABORATORY	4,519,433		4,519,433		4,519,433	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	1,351,834		1,351,834		1,351,834	65
66 PHYSICAL THERAPY	1,994,862		1,994,862		1,994,862	66
72 IMPL. DEV. CHARGED TO PATIE	1,006,791		1,006,791		1,006,791	72
73 DRUGS CHARGED TO PATIENTS	2,705,733		2,705,733		2,705,733	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	312,451		312,451		312,451	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC	776		776		776	90.01
90.02 ATHLETIC TRAINERS	189,018		189,018		189,018	90.02
90.03 SAINT JOSEPH HEALTH CENTER	423,468		423,468		423,468	90.03
90.04 WOUND CARE	905,991		905,991		905,991	90.04
91 EMERGENCY	3,054,339		3,054,339	22,500	3,076,839	91
92 OBSERVATION BEDS (NON-DISTI OTHER REIMBURSABLE COST CENTERS	1,214,390		1,214,390		1,214,390	92
94 HOME PROGRAM DIALYSIS						94
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	37,660,247		37,660,247	75,922	37,736,169	200
201 LESS OBSERVATION BEDS	1,214,390		1,214,390		1,214,390	201
202 TOTAL (SEE INSTRUCTIONS)	36,445,857		36,445,857		36,521,779	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	7,488,849		7,488,849			30
31 INTENSIVE CARE UNIT	3,390,990		3,390,990			31
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	7,457,350	18,914,178	26,371,528	0.220811	0.220811	0.220811 50
52 DELIVERY ROOM & LABOR ROOM	1,170,311	63,629	1,233,940	0.524110	0.524110	0.524110 52
54 RADIOLOGY-DIAGNOSTIC	1,691,145	10,951,860	12,643,005	0.193347	0.193347	0.193347 54
55 RADIOLOGY-THERAPEUTIC	12,744	4,272,400	4,285,144	0.354078	0.354078	0.354078 55
57 CT SCAN	2,388,366	12,124,654	14,513,020	0.024823	0.024823	0.024823 57
59 CARDIAC CATHETERIZATION	550,355	1,343,189	1,893,544	0.535713	0.535713	0.535713 59
60 LABORATORY	4,331,335	19,119,550	23,450,885	0.192719	0.192719	0.192719 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	2,240,295	4,424,682	6,664,977	0.202827	0.202827	0.202827 65
66 PHYSICAL THERAPY	671,075	3,477,254	4,148,329	0.480883	0.480883	0.480883 66
72 IMPL. DEV. CHARGED TO PATIE	2,227,598	680,548	2,908,146	0.346197	0.346197	0.346197 72
73 DRUGS CHARGED TO PATIENTS	4,571,477	4,914,444	9,485,921	0.285237	0.285237	0.285237 73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	38,430	1,398,303	1,436,733	0.217473	0.217473	0.217473 76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC						90.01
90.02 ATHLETIC TRAINERS						90.02
90.03 SAINT JOSEPH HEALTH CENTER		200,505	200,505	2.112007	2.112007	2.112007 90.03
90.04 WOUND CARE	11,628	928,784	940,412	0.963398	0.963398	0.963398 90.04
91 EMERGENCY	1,419,674	7,557,486	8,977,160	0.340234	0.340234	0.342741 91
92 OBSERVATION BEDS (NON-DISTI OTHER REIMBURSABLE COST CENTERS	81,537	1,443,438	1,524,975	0.796334	0.796334	0.796334 92
94 HOME PROGRAM DIALYSIS						94
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	39,743,159	91,814,904	131,558,063			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	39,743,159	91,814,904	131,558,063			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL. 1 MINUS COL. 2)	(COL. 1 MINUS COL. 2)	(COL. 3 ÷ COL. 4)	PGM DAYS	(COL. 5 x COL. 6)	
	1	2	3	5	6	7	
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	600,074		600,074	6,507	92.22	2,295	211,645 30
31 INTENSIVE CARE UNIT	97,238		97,238	1,276	76.21	681	51,899 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	4,210		4,210	731	5.76		43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	701,522		701,522	8,514		2,976	263,544 200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

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

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	484,747	26,371,528	0.018381	2,304,844	42,365	50
52 DELIVERY ROOM & LABOR ROOM	5,382	1,233,940	0.004362	11,520	50	52
54 RADIOLOGY-DIAGNOSTIC	398,356	12,643,005	0.031508	955,743	30,114	54
55 RADIOLOGY-THERAPEUTIC	426,412	4,285,144	0.099509			55
57 CT SCAN	17,476	14,513,020	0.001204	1,254,247	1,510	57
59 CARDIAC CATHETERIZATION	443,607	1,893,544	0.234273	115,163	26,980	59
60 LABORATORY	210,860	23,450,885	0.008992	2,358,306	21,206	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	130,053	6,664,977	0.019513	1,273,437	24,849	65
66 PHYSICAL THERAPY	120,025	4,148,329	0.028933	416,354	12,046	66
72 IMPL. DEV. CHARGED TO PATIENT	8,000	2,908,146	0.002751	983,220	2,705	72
73 DRUGS CHARGED TO PATIENTS	88,794	9,485,921	0.009361	2,286,742	21,406	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	12,358	1,436,733	0.008601	4,941	42	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC	6					90.01
90.02 ATHLETIC TRAINERS	1,287					90.02
90.03 SAINT JOSEPH HEALTH CENTER	4,608	200,505	0.022982			90.03
90.04 WOUND CARE	61,430	940,412	0.065322	590	39	90.04
91 EMERGENCY	187,782	8,977,160	0.020918	649,404	13,584	91
92 OBSERVATION BEDS (NON-DISTINC	131,967	1,524,975	0.086537	48,076	4,160	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)	2,733,150	120,678,224		12,662,587	201,056	200

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
 11/22/2013 10:17

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
 11/22/2013 10:17

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	6,507		2,295		30
31 INTENSIVE CARE UNIT	1,276		681		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	731				43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	8,514		2,976		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
57 CT SCAN						57
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC						90.01
90.02 ATHLETIC TRAINERS						90.02
90.03 SAINT JOSEPH HEALTH CENTER						90.03
90.04 WOUND CARE						90.04
91 EMERGENCY			11,359		11,359	91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS)						92
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)			11,359		11,359	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ] TITLE V	[XX] HOSPITAL (15-0076)	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA		
BOXES	[ ] TITLE XIX	[ ] IRF	[ ] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	26,371,528		2,304,844		5,042,235	50
52	DELIVERY ROOM & LABOR ROOM	1,233,940		11,520			52
54	RADIOLOGY-DIAGNOSTIC	12,643,005		955,743		2,406,670	54
55	RADIOLOGY-THERAPEUTIC	4,285,144				1,745,812	55
57	CT SCAN	14,513,020		1,254,247		3,386,005	57
59	CARDIAC CATHETERIZATION	1,893,544		115,163		366,067	59
60	LABORATORY	23,450,885		2,358,306		693,622	60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	6,664,977		1,273,437		1,389,924	65
66	PHYSICAL THERAPY	4,148,329		416,354		1,091	66
72	IMPL. DEV. CHARGED TO PATIEN	2,908,146		983,220		307,687	72
73	DRUGS CHARGED TO PATIENTS	9,485,921		2,286,742		1,690,734	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,436,733		4,941		810,457	76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	CLINIC						90.01
90.02	ATHLETIC TRAINERS						90.02
90.03	SAINT JOSEPH HEALTH CENTER	200,505					90.03
90.04	WOUND CARE	940,412		590		476,955	90.04
91	EMERGENCY	8,977,160	0.001265	649,404	821	1,441,286	91
92	OBSERVATION BEDS (NON-DISTIN	1,524,975		48,076		191,841	92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	120,678,224		12,662,587	821	19,950,386	1,823 200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES SUBJECT TO DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.220811	5,042,235			1,113,381		50
52 DELIVERY ROOM & LABOR ROOM	0.524110						52
54 RADIOLOGY-DIAGNOSTIC	0.193347	2,406,670			465,322		54
55 RADIOLOGY-THERAPEUTIC	0.354078	1,745,812			618,154		55
57 CT SCAN	0.024823	3,386,005			84,051		57
59 CARDIAC CATHETERIZATION	0.535713	366,067			196,107		59
60 LABORATORY	0.192719	693,622			133,674		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.202827	1,389,924			281,914		65
66 PHYSICAL THERAPY	0.480883	1,091			525		66
72 IMPL. DEV. CHARGED TO PATIENTS	0.346197	307,687			106,520		72
73 DRUGS CHARGED TO PATIENTS	0.285237	1,690,734		42,916	482,260		73
74 RENAL DIALYSIS						12,241	74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.217473	810,457			176,253		76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90.01 CLINIC							90.01
90.02 ATHLETIC TRAINERS							90.02
90.03 SAINT JOSEPH HEALTH CENTER	2.112007						90.03
90.04 WOUND CARE	0.963398	476,955			459,497		90.04
91 EMERGENCY	0.340234	1,441,286			490,375		91
92 OBSERVATION BEDS (NON-DISTINCT)	0.796334	191,841			152,770		92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)		19,950,386		42,916	4,760,803		200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		19,950,386		42,916	4,760,803		202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL. 1 MINUS COL. 2)	(COL. 1 MINUS COL. 2)	(COL. 3 ÷ COL. 4)	PGM DAYS	(COL. 5 x COL. 6)	
	1	2	3	5	6	7	
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	600,074		600,074	6,507	92.22	763	70,364 30
31 INTENSIVE CARE UNIT	97,238		97,238	1,276	76.21	64	4,877 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	4,210		4,210	731	5.76	487	2,805 43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	701,522		701,522	8,514		1,314	78,046 200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

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

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	484,747	26,371,528	0.018381	1,082,736	19,902	50
52 DELIVERY ROOM & LABOR ROOM	5,382	1,233,940	0.004362	600,219	2,618	52
54 RADIOLOGY-DIAGNOSTIC	398,356	12,643,005	0.031508	88,161	2,778	54
55 RADIOLOGY-THERAPEUTIC	426,412	4,285,144	0.099509	3,808	379	55
57 CT SCAN	17,476	14,513,020	0.001204	130,729	157	57
59 CARDIAC CATHETERIZATION	443,607	1,893,544	0.234273	41,144	9,639	59
60 LABORATORY	210,860	23,450,885	0.008992	342,793	3,082	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	130,053	6,664,977	0.019513	100,838	1,968	65
66 PHYSICAL THERAPY	120,025	4,148,329	0.028933	17,724	513	66
72 IMPL. DEV. CHARGED TO PATIENT	8,000	2,908,146	0.002751			72
73 DRUGS CHARGED TO PATIENTS	88,794	9,485,921	0.009361	503,040	4,709	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	12,358	1,436,733	0.008601			76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 CLINIC	6					90.01
90.02 ATHLETIC TRAINERS	1,287					90.02
90.03 SAINT JOSEPH HEALTH CENTER	4,608	200,505	0.022982			90.03
90.04 WOUND CARE	61,430	940,412	0.065322			90.04
91 EMERGENCY	187,782	8,977,160	0.020918	90,242	1,888	91
92 OBSERVATION BEDS (NON-DISTINC	131,967	1,524,975	0.086537			92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)	2,733,150	120,678,224		3,001,434	47,633	200

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL  
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
11/22/2013 10:17

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

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

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
 11/22/2013 10:17

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	6,507		763		30
31 INTENSIVE CARE UNIT	1,276		64		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	731		487		43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	8,514		1,314		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM							50
52 DELIVERY ROOM & LABOR ROOM							52
54 RADIOLOGY-DIAGNOSTIC							54
55 RADIOLOGY-THERAPEUTIC							55
57 CT SCAN							57
59 CARDIAC CATHETERIZATION							59
60 LABORATORY							60
62.30 BLOOD CLOTTING FOR HEMOPHILIA							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY							66
72 IMPL. DEV. CHARGED TO PATIENT							72
73 DRUGS CHARGED TO PATIENTS							73
74 RENAL DIALYSIS							74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90.01 CLINIC							90.01
90.02 ATHLETIC TRAINERS							90.02
90.03 SAINT JOSEPH HEALTH CENTER							90.03
90.04 WOUND CARE							90.04
91 EMERGENCY			11,359		11,359	11,359	91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS							92
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)			11,359		11,359	11,359	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	26,371,528			1,082,736			50
52 DELIVERY ROOM & LABOR ROOM	1,233,940			600,219			52
54 RADIOLOGY-DIAGNOSTIC	12,643,005			88,161			54
55 RADIOLOGY-THERAPEUTIC	4,285,144			3,808			55
57 CT SCAN	14,513,020			130,729			57
59 CARDIAC CATHETERIZATION	1,893,544			41,144			59
60 LABORATORY	23,450,885			342,793			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	6,664,977			100,838			65
66 PHYSICAL THERAPY	4,148,329			17,724			66
72 IMPL. DEV. CHARGED TO PATIEN	2,908,146						72
73 DRUGS CHARGED TO PATIENTS	9,485,921			503,040			73
74 RENAL DIALYSIS							74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY	1,436,733						76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90.01 CLINIC							90.01
90.02 ATHLETIC TRAINERS							90.02
90.03 SAINT JOSEPH HEALTH CENTER	200,505						90.03
90.04 WOUND CARE	940,412						90.04
91 EMERGENCY	8,977,160	0.001265	0.001265	90,242	114		91
92 OBSERVATION BEDS (NON-DISTIN	1,524,975						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	120,678,224			3,001,434	114		200



WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	6,507	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,507	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,076	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,295	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,522,047	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,522,047	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,522,047	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 848.63 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,947,606 39  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,947,606 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	2,084,234	1,276	1,633.41	681	1,112,352	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					2,960,742	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					6,020,700	49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 263,544 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 201,877 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 465,421 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 5,555,279 53

TARGET AMOUNT AND LIMIT COMPUTATION  
 54 PROGRAM DISCHARGES 54  
 55 TARGET AMOUNT PER DISCHARGE 55  
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57  
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58  
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59  
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60  
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61  
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62  
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 1,431 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 848.63 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 1,214,390 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	600,074	5,522,047	0.108669	1,214,390	131,967	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	6,507	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,507	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,076	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	763	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	731	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	487	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,522,047	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,522,047	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,522,047	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 848.63 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 647,505 39  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 647,505 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)	622,051	731	850.96	487	414,418 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	2,084,234	1,276	1,633.41	64	104,538 43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					866,796 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,033,257 49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 78,046 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 47,747 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 125,793 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 1,907,464 53

TARGET AMOUNT AND LIMIT COMPUTATION  
 54 PROGRAM DISCHARGES 54  
 55 TARGET AMOUNT PER DISCHARGE 55  
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57  
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58  
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59  
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60  
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61  
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62  
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 1,431 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		2,579,480			30
31 INTENSIVE CARE UNIT		1,692,013			31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.220811	2,304,844	508,935		50
52 DELIVERY ROOM & LABOR ROOM	0.524110	11,520	6,038		52
54 RADIOLOGY-DIAGNOSTIC	0.193347	955,743	184,790		54
55 RADIOLOGY-THERAPEUTIC	0.354078				55
57 CT SCAN	0.024823	1,254,247	31,134		57
59 CARDIAC CATHETERIZATION	0.535713	115,163	61,694		59
60 LABORATORY	0.192719	2,358,306	454,490		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.202827	1,273,437	258,287		65
66 PHYSICAL THERAPY	0.480883	416,354	200,218		66
72 IMPL. DEV. CHARGED TO PATIENTS	0.346197	983,220	340,388		72
73 DRUGS CHARGED TO PATIENTS	0.285237	2,286,742	652,263		73
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.217473	4,941	1,075		76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90.01 CLINIC					90.01
90.02 ATHLETIC TRAINERS					90.02
90.03 SAINT JOSEPH HEALTH CENTER	2.112007				90.03
90.04 WOUND CARE	0.963398	590	568		90.04
91 EMERGENCY	0.342741	649,404	222,577		91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.796334	48,076	38,285		92
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		12,662,587	2,960,742		200
201 LESS BPP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		12,662,587			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		1,450,110			30
31 INTENSIVE CARE UNIT		175,975			31
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.220811	1,082,736	239,080		50
52 DELIVERY ROOM & LABOR ROOM	0.524110	600,219	314,581		52
54 RADIOLOGY-DIAGNOSTIC	0.193347	88,161	17,046		54
55 RADIOLOGY-THERAPEUTIC	0.354078	3,808	1,348		55
57 CT SCAN	0.024823	130,729	3,245		57
59 CARDIAC CATHETERIZATION	0.535713	41,144	22,041		59
60 LABORATORY	0.192719	342,793	66,063		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.202827	100,838	20,453		65
66 PHYSICAL THERAPY	0.480883	17,724	8,523		66
72 IMPL. DEV. CHARGED TO PATIENTS	0.346197				72
73 DRUGS CHARGED TO PATIENTS	0.285237	503,040	143,486		73
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.217473				76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90.01 CLINIC					90.01
90.02 ATHLETIC TRAINERS					90.02
90.03 SAINT JOSEPH HEALTH CENTER	2.112007				90.03
90.04 WOUND CARE	0.963398				90.04
91 EMERGENCY	0.342741	90,242	30,930		91
92 OBSERVATION BEDS (NON-DISTINCT)	0.796334				92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		3,001,434	866,796		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		3,001,434			202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	5,577,718	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	4,487	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS	1,898,183	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	41.08	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0336	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (SEE INSTRUCTIONS)	0.1855	31
32	SUM OF LINES 30 AND 31	0.2191	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0729	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	406,616	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	5,988,821	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)	5,988,821	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	443,444	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)	821	58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	6,433,086	59
60	PRIMARY PAYER PAYMENTS	12,098	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	6,420,988	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	726,784	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	12,098	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	22,068	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	15,448	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	5,697,554	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	-33,523	70
70.96	LOW VOLUME ADJUSTMENT FOR FISCAL YEAR (2012)	92,162	70.96
70.97	LOW VOLUME ADJUSTMENT FOR FISCAL YEAR (2013)	363,859	70.97
71	AMOUNT DUE PROVIDER (SEE INSTRUCTIONS)	6,120,052	71
71.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	30,600	71.01
72	INTERIM PAYMENTS	6,207,639	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS LINES 71.01, 72 AND 73)	-118,187	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	343,381	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96



ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

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

INPATIENT  
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		6,207,639		3,215,386	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01	NONE		NONE	3.01
	.02				3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.51				3.51
	PROVIDER .52				3.52
	TO .53				3.53
	PROGRAM .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		6,207,639		3,215,386	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE	5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50	NONE		NONE	5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01			156,448	6.01
	TO .02				
	PROVIDER .01				
	PROVIDER .02				
	TO .02	-87,587			6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		6,120,052		3,371,834	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL  
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
11/22/2013 10:17

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	2,111	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,976	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	975	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	6,352	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	131,558,063	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	4,254,826	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	1,409,275	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	28,186	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)	1,381,089	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,370,085	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	11,004	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES			
8			8
9			9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	38,240,049			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	8,591,301			4
5	OTHER RECEIVABLES	1,841,275			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,134,909			6
7	INVENTORY	1,077,086			7
8	PREPAID EXPENSES	261,192			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	48,875,994			11
FIXED ASSETS					
12	LAND	477,930			12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	33,182,460			15
16	ACCUMULATED DEPRECIATION	-23,101,580			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	21,802,087			23
24	ACCUMULATED DEPRECIATION	-16,691,944			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE	585,263			29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	16,254,216			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	210,073			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	210,073			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	65,340,283			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,665,781			37
38	SALARIES, WAGES & FEES PAYABLE	1,315,048			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	119,880			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	324,187			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	3,424,896			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	6,385,388			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	258,234			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	6,643,622			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	10,068,518			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	55,271,765			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	55,271,765			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	65,340,283			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		44,394,030							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		10,877,735							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		55,271,765							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)		55,271,765							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)		55,271,765							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	8,732,057		8,732,057	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	8,732,057		8,732,057	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	8,732,057		8,732,057	18
19 ANCILLARY SERVICES	31,955,183	91,814,904	123,770,087	19
20 OUTPATIENT SERVICES				20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	40,687,240	91,814,904	132,502,144	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		41,621,937	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		41,621,937	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	132,502,144	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	84,661,162	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	47,840,982	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	41,621,937	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	6,219,045	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER OPERATING REVENUE)	1,777,227	24
24.01	OTHER (NON OPERATING INVESTMENT EARNINGS)	2,856,505	24.01
24.02	OTHER (NON OPERATING DERIVATIVES)	-45,188	24.02
24.03	OTHER (OTHER NON OPERATING NET)	-3,005	24.03
24.04	OTHER (NET ASSETS RELEASED)	73,151	24.04
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	4,658,690	25
26	TOTAL (LINE 5 PLUS LINE 25)	10,877,735	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	10,877,735	29

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

COMPONENT NO: -

WORKSHEET I-1

CHECK APPLICABLE BOX:                     RENAL DIALYSIS DEPARTMENT                     HOME PROGRAM DIALYSIS

	TOTAL COSTS	BASIS	STATISTICS	FTES PER 2080 HOURS	
	1	2	3	4	
1 REGISTERED NURSES		HOURS OF SERVICE			1
2 LICENSED PRACTICAL NURSES		HOURS OF SERVICE			2
3 NURSES AIDES		HOURS OF SERVICE			3
4 TECHNICIANS		HOURS OF SERVICE			4
5 SOCIAL WORKERS		HOURS OF SERVICE			5
6 DIETICIANS		HOURS OF SERVICE			6
7 PHYSICIANS		ACCUMULATED COST			7
8 NON-PATIENT CARE SALARY		ACCUMULATED COST			8
9 SUBTOTAL (SUM OF LINES 1-8)					9
10 EMPLOYEE BENEFITS		SALARY			10
11 CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET			11
12 CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME			12
13 MACHINES COSTS & REPAIRS		PERCENTAGE OF TIME			13
14 SUPPLIES		REQUISITIONS			14
15 DRUGS		REQUISITIONS			15
16 OTHER		ACCUMULATED COST			16
17 SUBTOTAL (SUM OF LINES 9-16)					17
18 CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET			18
19 CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME			19
20 EMPLOYEE BENEFITS DEPARTMENT		SALARY			20
21 ADMINISTRATIVE AND GENERAL		ACCUMULATED COST			21
22 MAINT./REPAIRS-OPERATION-HOUSEKEEPING		SQUARE FEET			22
23 MEDICAL EDUCATION PROGRAM COSTS					23
24 CENTRAL SERVICES & SUPPLIES		REQUISITIONS			24
25 PHARMACY		REQUISITIONS			25
26 OTHER ALLOCATED COSTS		ACCUMULATED COST			26
27 SUBTOTAL (SUM OF LINES 17-26)					27
28 LABORATORY		CHARGES			28
29 RESPIRATORY THERAPY		CHARGES			29
30 OTHER ANCILLARY (SPECIFY)		CHARGES			30
30.97 CARDIAC REHABILITATION		CHARGES			30.97
30.98 HYPERBARIC OXYGEN THERAPY		CHARGES			30.98
30.99 LITHOTRIPSY		CHARGES			30.99
31 TOTAL COSTS (SUM OF LINES 27-30)					31

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL  
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
11/22/2013 10:17

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES

COMPONENT NO: -

WORKSHEET I-2

CHECK APPLICABLE BOX: [ XX ] RENAL DIALYSIS DEPARTMENT

[ ] HOME PROGRAM DIALYSIS

	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE	SALARY	EMPLOYEE	
	BUILDING	EQUIPMENT	RNs	OTHER	BENEFITS	DRUGS
	1	2	3	4	5	6
1	TOTAL RENAL DEPT COSTS					1
	MAINTENANCE					
2	HEMODIALYSIS					2
3	INTERMITTENT PERITONEAL					3
	TRAINING					
4	HEMODIALYSIS					4
5	INTERMITTENT PERITONEAL					5
6	CAPD					6
7	CCPD					7
	HOME					
8	HEMODIALYSIS					8
9	INTERMITTENT PERITONEAL					9
10	CAPD					10
11	CCPD					11
	OTHER BILLABLE SERVICES					
12	INPATIENT DIALYSIS					12
13	METHOD II HOME PATIENT					13
14	EPO (INCL IN RENAL DEPT)					14
15	ARANESP (INCL IN RENAL DEPT)					15
16	OTHER					16
17	TOTAL (SUM OF LINES 2-16)					17
18	MEDICAL EDUC PGM COSTS					18
19	TOTAL RENAL COSTS (LINES 17+18)					19

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES

COMPONENT NO: -

WORKSHEET I-2  
 (CONTINUED)

CHECK APPLICABLE BOX:                     RENAL DIALYSIS DEPARTMENT                     HOME PROGRAM DIALYSIS

	MEDICAL SUPPLIES 7	ROUTINE ANCILLARY SERVICES 8	SUBTOTAL (SUM OF COLS.1-8) 9	OVERHEAD 10	TOTAL (COL. 9 + COL.10) 11	
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL  
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
11/22/2013 10:17

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION -  
STATISTICAL BASIS

COMPONENT NO: -

WORKSHEET I-3

CHECK APPLICABLE BOX:                     [ XX ] RENAL DIALYSIS DEPARTMENT                     [ ] HOME PROGRAM DIALYSIS

	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY		EMPLOYEE
	BUILDING	EQUIPMENT	RNs	OTHER	BENEFITS
	(SQUARE	(% OF	(HOURS)	(HOURS)	DEPARTMENT
	FEET)	TIME)			(SALARY)
	1	2	3	4	5
1	TOTAL RENAL DEPT COSTS				1
	MAINTENANCE				
2	HEMODIALYSIS				2
3	INTERMITTENT PERITONEAL				3
	TRAINING				
4	HEMODIALYSIS				4
5	INTERMITTENT PERITONEAL				5
6	CAPD				6
7	CCPD				7
	HOME				
8	HEMODIALYSIS				8
9	INTERMITTENT PERITONEAL				9
10	CAPD				10
11	CCPD				11
	OTHER BILLABLE SERVICES				
12	INPT DIAL TRTMTS				
13	METHOD II HOME PATIENT				13
14	EPO				14
15	ARANESP				15
16	OTHER				16
17	TOTAL STATISTICAL BASIS				17
18	UNIT COST MULTIPLIER				18
	(LINE 1 ÷ LINE 17)				

PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL  
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
11/22/2013 10:17

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION -  
STATISTICAL BASIS

COMPONENT NO: -

WORKSHEET I-3  
(CONTINUED)

CHECK APPLICABLE BOX:                     [ XX ] RENAL DIALYSIS DEPARTMENT                     [   ] HOME PROGRAM DIALYSIS

	DRUGS (REQUIST.)	MEDICAL SUPPLIES (REQUIST.)	ROUTINE ANCILLARY SERVICES (CHARGES)	SUBTOTAL	OVERHEAD (ACCUM. COST)	
	6	7	8	9	10	
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18

(LINE 1 ÷ LINE 17)



PROVIDER CCN: 15-0076 ST. JOSEPH'S REG MED CENTER PL  
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
11/22/2013 10:17

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

COMPONENT NO: -

WORKSHEET I-4  
(CONTINUED)

CHECK APPLICABLE BOX:                     RENAL DIALYSIS DEPARTMENT                     HOME PROGRAM DIALYSIS

	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	AVERAGE PAYMENT RATE (COL. 6 ÷ COL. 4)	AVERAGE PAYMENT RATE (COL. 6.01 ÷ COL. 4.01)	AVERAGE PAYMENT RATE (COL. 6.02 ÷ COL. 4.02)	
1 MAINTENANCE - HEMODIALYSIS							1
2 MAINTENANCE - PERITONEAL DIALYSIS							2
3 TRAINING - HEMODIALYSIS							3
4 TRAINING - PERITONEAL DIALYSIS							4
5 TRAINING - CAPD							5
6 TRAINING - CCPD							6
7 HOME PROGRAM - HEMODIALYSIS							7
8 HOME PROGRAM - PERITONEAL DIALYSIS							8
9 HOME PROGRAM - CAPD							9
10 HOME PROGRAM - CCPD							10
11 TOTALS (SUM OF LINES 1-8, COLS. 1 & 4) (SUM OF LINES 1-10, COLS. 2, 5 & 6)	6	6.01	6.02	7	7.01	7.02	11
12 TOTAL TREATMENTS (SUM OF LINES 1-8 PLUS (SUM OF LINES 9 AND 10 TIMES 3))							12

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

COMPONENT NO: -

WORKSHEET I-5

DESCRIPTION		1	2	
1	TOTAL EXPENSES RELATED TO CARE OF PROGRAM BENEFICIARIES (SEE INSTRUCTIONS)			1
2	TOTAL PAYMENT DUE (FROM I-4, COL. 6, LINE 11)(SEE INSTRUCTIONS)			2
2.01	TOTAL PAYMENT DUE (FROM I-4, COL. 6.01, LINE 11)(SEE INSTRUCTIONS)			2.01
2.02	TOTAL PAYMENT DUE (FROM I-4, COL. 6.02, LINE 11)(SEE INSTRUCTIONS)			2.02
2.03	TOTAL PAYMENT DUE (SEE INSTRUCTIONS)			2.03
2.04	OUTLIER PAYMENTS			2.04
3	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3
3.01	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.01
3.02	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.02
3.03	TOTAL DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.03
4	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4
4.01	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.01
4.02	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.02
4.03	TOTAL COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.03
5	BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE, NET OF BAD DEBT RECOVERIES			5
5.01	TRANSITION PERIOD 1 (75-25%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2011 BUT BEFORE 1/1/2012			5.01
5.02	TRANSITION PERIOD 2 (50-50%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2012 BUT BEFORE 1/1/2013			5.02
5.03	TRANSITION PERIOD 3 (25-75%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2013 BUT BEFORE 1/1/2014			5.03
5.04	100% PPS BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2014			5.04
5.05	TOTAL BAD DEBTS (SUM OF LINE 5 THROUGH LINE 5.04)			5.05
6	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			6
7	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			7
8	NET DEDUCTIBLES AND COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			8
9	PROGRAM PAYMENT (SEE INSTRUCTIONS)			9
10	UNRECOVERED FROM MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			10
11	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) (TRANSFER TO WKST E, PART B, LINE 33)			11

PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE RATE PERCENTAGE

12	TOTAL ALLOWABLE EXPENSES (SEE INSTRUCTIONS)	12
13	TOTAL COMPOSITE COSTS (FROM WKST I-4, COL. 2, LINE 11)	13
14	FACILITY SPECIFIC COMPOSITE COST PERCENTAGE (LINE 13 DIVIDED BY LINE 12)	14

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	442,778	1
2	CAPITAL DRG OUTLIER PAYMENTS	666	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	17.40	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (SEE INSTRUCTIONS)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	443,444	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 5 PLUS LINE 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (FROM PART I, LINE 12 AS APPLICABLE)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 8 LESS LINE 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)		17

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT	1
2	CAPITAL DRG OTHER THAN OUTLIER	2
3	CAPITAL DRG OUTLIER PAYMENTS	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (SEE INSTRUCTIONS)	8
9	SUM OF LINES 7 AND 8	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)	1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	2
3	NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)	3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)	4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)	5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)	7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 5 PLUS LINE 7)	8
9	CURRENT YEAR CAPITAL PAYMENTS (FROM PART I, LINE 12 AS APPLICABLE)	9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 8 LESS LINE 9)	10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)	11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)	12
13	CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)	13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)	14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)	15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)	16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)	17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
52 DELIVERY ROOM & LABOR ROOM					52
54 RADIOLOGY-DIAGNOSTIC					54
55 RADIOLOGY-THERAPEUTIC					55
57 CT SCAN					57
59 CARDIAC CATHETERIZATION					59
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
72 IMPL. DEV. CHARGED TO PATIENTS					72
73 DRUGS CHARGED TO PATIENTS					73
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90.01 CLINIC					90.01
90.02 ATHLETIC TRAINERS					90.02
90.03 SAINT JOSEPH HEALTH CENTER					90.03
90.04 WOUND CARE					90.04
91 EMERGENCY					91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)					92
94 HOME PROGRAM DIALYSIS					94
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
190.01 PLYMOUTH MOB-4					190.01
190.02 HOSPITALIST					190.02
192.02 PHYSICIAN PRIVATE OFFICE					192.02
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

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

EXHIBIT 3

STEP 1: Determine the 3-Year Averaging Period			
1	Wage index fiscal year ending date	09/30/2016	1
2	Provider's cost reporting period used for wage index year on Line 1 (FYB in Col 1, FYE in Col 2)	07/01/2012	06/30/2013 2
3	Midpoint of provider's cost reporting period shown on Line 2, adjusted to first of month	01/01/2013	3
4	Date beginning the 3-year averaging period (subtract 18 months from midpoint shown on Line 3)	07/01/2011	4
5	Date ending the 3-year averaging period (add 18 months to midpoint shown on Line 3)	07/01/2014	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	07/01/2011	9
10	Ending date of averaging period from Line 5	07/01/2014	10
11	Enter provider contributions made during averaging period on Lines 9 & 10		11
11.01		06/30/2012	867,643 11.01
11.02		06/30/2013	867,643 11.02
11.03		06/30/2014	867,643 11.03
12	Total calendar months included in averaging period (36 unless Step 2 completed)	36	12
13	Total contributions made during averaging period	2,602,929	13
14	Average monthly contribution (Line 13 divided by Line 12)	72,304	14
15	Number of months in provider cost reporting period on Line 2	12	15
16	Average pension contributions (Line 14 times Line 15)	867,648	16
STEP 4: Total Pension Cost for Wage Index			
17	Annual prefunding installment (SEE INSTRUCTIONS)	309,275	17
18	Reportable prefunding installment ((Line 17 times Line 15) divided by 12)	309,275	18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	1,176,923	19

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

EXHIBIT 4

	Amounts From E Part A (1)	Prior to 10/1/2010 or after 9/30/2013 Pre/Post Entitlement (2)	10/01/2011 through 09/30/2012 (3)	(3.01)	10/01/2012 through 09/30/2013 (4)	(4.01)	(Columns 2 through 4) TOTAL (5)	
1	DRG Amounts Other than Outlier Payments	5,577,718	1,277,830		4,299,888		5,577,718	1
2	Outlier payments for discharges	4,487	644		3,843		4,487	2
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	1,898,183	488,218		1,409,965		1,898,183	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT								
5	Amount from Worksheet E Part A, Line 21							5
6	IME payment adjustment							6
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422								
7	Amount from Worksheet E Part A, Line 27							7
8	IME add-on adjustment							8
9	Total IME payment							9
DISPROPORTIONATE SHARE ADJUSTMENT								
10	Allowable disproportionate share percentage	0.0729	0.0729	0.0729	0.0729	0.0729	0.0729	10
11	Disproportionate share adjustment	406,616		93,154		313,462	406,616	11
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES								
12	Total ESRD additional payment							12
13	Subtotal	5,988,821		1,371,628		4,617,193	5,988,821	13
14	Hospital specific payments							14
15	Total payment for inpatient operating costs - E Part A Line 49	5,988,821		1,371,628		4,617,193	5,988,821	15
16	Payment for inpatient program capital	443,444		102,963		340,481	443,444	16
17	Special add-on payments for new technologies							17
18	Capital outlier reconciliation adjustment amount							18
19	SUBTOTAL			1,474,591		4,957,674	6,432,265	19
CAPITAL PAYMENTS								
20	Capital DRG other than outlier	442,778		102,693		340,085	442,778	20
21	Capital DRG outlier payments	666		270		396	666	21
22	Indirect medical education percentage							22
23	Indirect medical education adjustment							23
24	Allowable disproportionate share percentage							24
25	Disproportionate share adjustment							25
26	Total prospective capital payments	443,444		102,963		340,481	443,444	26
LOW VOLUME ADJUSTMENT								
27	Low volume adjustment factor			0.062500		0.073393		27
28	Low Volume Adjustment			92,162			92,162	28
29	Low Volume Adjustment					363,859	363,859	29