KPMG LLP Compu-Max 2552-10

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

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: 11/27/2018 Time: 10:06 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. JOSEPHS REG MED CENTER PLYMOUT (15-0076) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2017 and ending 06/30/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[_] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this cerficication statement to be the legally binding equivalent of my original signature.

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

CFO
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-193,152	82,383			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-193,152	82,383			200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 1915 LAKE AVENUE	P.O. Box: 670		1
2	City: PLYMOUTH	State: IN	ZIP Code: 46563	County: MARSHALL	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ST. JOSEPHS REG MED CENTER PLYMOUT	15-0076	43780	1	07 / 01 / 1996	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2017	To: 06 / 30 / 2018	20
21	Type of control (see instructions)	1		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	89	71	2	5	1,057	46	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (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)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	Y	Y	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	Y	Y	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. Enter in column 4 direct the GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06

Rural Providers				1	2	
105	Does this hospital qualify as a CAH?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.					109

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110

		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.			111

Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N				115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.			N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.			N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1		118
			Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:					118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.			N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.			Y		121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.			N		122

Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	15H034	140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name: SAINT JOSEPH REG MEDICAL CTR	Contractor's Name: WISCONSIN PHYSICIANS SERVICE I Contractor's Number: 08102			141
142	Street: 5215 HOLY CROSS PARKWAY	P.O. Box:			142
143	City: MISHAWAKA	State: IN	ZIP Code: 46545		143
144	Are provider based physicians' costs included in Worksheet A?			Y	144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.			N	N 145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.			N	146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.			N	147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.			N	148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.			N	149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	N	N	160
161	CMHC		N	N	N	161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	9.99			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07 / 01 / 2015	06 / 30 / 2016	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	Y		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/01/2018	Y	11/01/2018	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

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

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: MAUREEN	Last name: DELAHANTY	Title: REIMBURSEMENT MANAGER	41
42	Employer: SAINT JOSEPH HEALTH SYSTEM			42
43	Phone number: 574-335-4652	E-mail Address: DELAHANTYM@SJRMC.COM		43

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	38	13,908			1,663	156	4,054	1
2	HMO and other (see instructions)						694	714		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		38	13,908			1,663	156	4,054	7
8	Intensive Care Unit	31	7	2,562			574		1,196	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						354	523	13
14	Total (see instructions)		45	16,470			2,237	510	5,773	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30							21	24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		45							27
28	Observation Bed Days							412	1,344	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								54	30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							46	69	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					713	63	1,983	1
2	HMO and other (see instructions)					227	310		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		290.78	100.00		713	63	1,983	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		290.78	100.00					27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	17,573,349		17,573,349	604,832.46	29.05	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative		118,513		118,513	615.00	192.70	4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		142,172		142,172	2,979.00	47.72	5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		1,142,827		1,142,827	19,839.30	57.60	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		274,357		274,357	4,398.00	62.38	11
12	Contract management and administrative services		661,086		661,086	9,842.00	67.17	12
13	Contract labor: Physician-Part A - Administrative		509,537		509,537	3,003.00	169.68	13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		3,365,390		3,365,390	94,669.00	35.55	14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		6,077,716		6,077,716			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		289,596		289,596			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative		21,139		21,139			22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		45,593		45,593			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related		916,270		916,270			25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		30,148		30,148	2,512.00	12.00	26
27	Administrative & General		1,628,988		1,628,988	66,227.50	24.60	27
28	Administrative & General under contract (see instructions)		318,047		318,047	1,759.00	180.81	28
29	Maintenance & Repairs							29
30	Operation of Plant		375,809		375,809	14,107.90	26.64	30
31	Laundry & Linen Service							31
32	Housekeeping		383,707		383,707	30,867.50	12.43	32
33	Housekeeping under contract (see instructions)		75,827		75,827	2,080.00	36.46	33
34	Dietary		233,059		233,059	17,105.40	13.62	34
35	Dietary under contract (see instructions)		24,628		24,628	616.00	39.98	35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		445,236		445,236	10,785.10	41.28	38
39	Central Services and Supply							39
40	Pharmacy		602,556		602,556	13,838.20	43.54	40
41	Medical Records & Medical Records Library		209,636		209,636	9,283.90	22.58	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		17,849,679		17,849,679	606,308.46	29.44	1
2	Excluded area salaries (see instructions)		1,142,827		1,142,827	19,839.30	57.60	2
3	Subtotal salarles (line 1 minus line 2)		16,706,852		16,706,852	586,469.16	28.49	3
4	Subtotal other wages & related costs (see instructions)		4,810,370		4,810,370	111,912.00	42.98	4
5	Subtotal wage-related costs (see instructions)		7,015,125		7,015,125		41.99%	5
6	Total (sum of lines 3 through 5)		28,532,347		28,532,347	698,381.16	40.85	6
7	Total overhead cost (see instructions)		4,327,641		4,327,641	169,182.50	25.58	7

HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	756,862	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)	1,412,626	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan	28	6
7	Employee Managed Care Program Administration Fees	119,516	7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,654,267	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan	953,575	9
10	Dental, Hearing and Vision Plan	99,952	10
11	Life Insurance (If employee is owner or beneficiary)	30,788	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	114,679	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	87,334	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	-35,522	16
	TAXES		
17	FICA-Employers Portion Only	1,227,129	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	2,616	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	10,195	23
24	Total Wage Related cost (Sum of lines 1-23)	6,434,045	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.230324	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	7,840,971	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 and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	29,771,717	6
7	Medicaid cost (line 1 times line 6)	6,857,141	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,594,251	402,294	1,996,545	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	367,194	402,294	769,488	21
22	Payments received from patients for amounts previously written off as charity care	40,204	26,833	67,037	22
23	Cost of charity care (line 21 minus line 22)	326,990	375,461	702,451	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	5,542,000	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	108,332	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	166,665	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	5,375,335	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,296,402	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,998,853	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,998,853	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				2,034,393	2,034,393	317,094	2,351,487	1
2	00200	Cap Rel Costs-Mvble Equip				2,102,814	2,102,814		2,102,814	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	30,148	667,486	697,634		697,634		697,634	4
5	00500	Administrative & General	1,628,988	11,457,854	13,086,842	-995,634	12,091,208	-1,841,805	10,249,403	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	375,809	2,264,822	2,640,631	-426,768	2,213,863		2,213,863	7
8	00800	Laundry & Linen Service		151,674	151,674		151,674		151,674	8
9	00900	Housekeeping	383,707	291,130	674,837	-2,854	671,983	-62,500	609,483	9
10	01000	Dietary	233,059	453,221	686,280	-18,005	668,275	-205,649	462,626	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	445,236	160,816	606,052	-96,480	509,572		509,572	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	602,556	1,453,513	2,056,069	-1,419,755	636,314	-2,494	633,820	15
16	01600	Medical Records & Library	209,636	104,801	314,437		314,437		314,437	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	2,445,911	800,221	3,246,132	-830,204	2,415,928		2,415,928	30
31	03100	Intensive Care Unit	913,134	339,444	1,252,578	-7,539	1,245,039	-36,398	1,208,641	31
43	04300	Nursery				344,449	344,449		344,449	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,944,245	3,524,846	5,469,091	-1,152,918	4,316,173	-973,571	3,342,602	50
52	05200	Delivery Room & Labor Room				344,449	344,449		344,449	52
54	05400	Radiology-Diagnostic	1,013,704	627,914	1,641,618	-261,196	1,380,422	-9,978	1,370,444	54
55	05500	Radiology-Therapeutic	445,915	1,092,557	1,538,472	-329,925	1,208,547	-135,299	1,073,248	55
57	05700	CT Scan	94,605	246,412	341,017	-156,130	184,887		184,887	57
59	05900	Cardiac Catheterization	52,869	222,849	275,718	-159,823	115,895		115,895	59
60	06000	Laboratory	1,206,908	2,269,372	3,476,280	-61,781	3,414,499	-2,640	3,411,859	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	477,686	509,247	986,933	-26,471	960,462	-20,385	940,077	65
66	06600	Physical Therapy	823,858	248,958	1,072,816	-83,790	989,026	-20	989,006	66
66.01	06601	PHYSICAL THERAPY - LIFEPLEX	617,617	337,194	954,811	-177,645	777,166		777,166	66.01
66.02	06602	PHYSICAL THERAPY - CULVER MILITARY								66.02
71	07100	Medical Supplies Charged to Patients		-97,042	-97,042	97,042				71
72	07200	Impl. Dev. Charged to Patients				789,552	789,552		789,552	72
73	07300	Drugs Charged to Patients				1,363,144	1,363,144		1,363,144	73
76.97	07697	CARDIAC REHABILITATION	58,826	53,150	111,976	-31,461	80,515		80,515	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				60,645	60,645		60,645	76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT & INFUSION CTR	1,411	289	1,700		1,700		1,700	90.01
90.02	09002	ATHLETIC TRAINERS	231,992	59,380	291,372		291,372	-152,576	138,796	90.02
90.03	09003	SAINT JOSEPH HEALTH CENTER	439,701	287,085	726,786	-128,819	597,967	-82,699	515,268	90.03
90.04	09004	WOUND CARE	212,139	790,747	1,002,886	-152,926	849,960		849,960	90.04
91	09100	Emergency	1,540,862	1,838,914	3,379,776	-616,364	2,763,412	-38,535	2,724,877	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	16,430,522	30,156,854	46,587,376		46,587,376	-3,247,455	43,339,921	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices								192
192.01	19201	FOUNDATION ADMINISTATION								192.01
192.02	19202	HOSPITALIST	1,063,621	789,416	1,853,037		1,853,037		1,853,037	192.02
192.03	19203	INTENSIVIST		1,276,867	1,276,867		1,276,867		1,276,867	192.03
194	07950	PLYMOUTH MOB-4		152,360	152,360		152,360		152,360	194
194.01	07951	COMMUNITY OUTREACH & PARTNERSHIP	79,206	21,448	100,654		100,654		100,654	194.01
200		TOTAL (sum of lines 118-199)	17,573,349	32,396,945	49,970,294		49,970,294	-3,247,455	46,722,839	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	NEGATIVE BALANCES	A	Medical Supplies Charged to P	71		97,042	1
500	Total reclassifications					97,042	500
	Code Letter - A						
1	IMPLANTABLE DEVICES	B	Impl. Dev. Charged to Patient	72		789,552	1
2	IMPLANTABLE DEVICES	B					2
500	Total reclassifications					789,552	500
	Code Letter - B						
1	DRUGS	C	Drugs Charged to Patients	73		1,363,144	1
500	Total reclassifications					1,363,144	500
	Code Letter - C						
1	INTEREST EXPENSE	E	Cap Rel Costs-Bldg & Fixt	1		274,293	1
500	Total reclassifications					274,293	500
	Code Letter - E						
1	DEPRECIATION	F	Cap Rel Costs-Bldg & Fixt	1		1,760,100	1
2	DEPRECIATION	F	Cap Rel Costs-Mvble Equip	2		2,102,814	2
3	DEPRECIATION	F					3
4	DEPRECIATION	F					4
5	DEPRECIATION	F					5
6	DEPRECIATION	F					6
7	DEPRECIATION	F					7
8	DEPRECIATION	F					8
9	DEPRECIATION	F					9
10	DEPRECIATION	F					10
11	DEPRECIATION	F					11
12	DEPRECIATION	F					12
13	DEPRECIATION	F					13
14	DEPRECIATION	F					14
15	DEPRECIATION	F					15
16	DEPRECIATION	F					16
17	DEPRECIATION	F					17
18	DEPRECIATION	F					18
19	DEPRECIATION	F					19
20	DEPRECIATION	F					20
21	DEPRECIATION	F					21
500	Total reclassifications					3,862,914	500
	Code Letter - F						
1	OB/NURSERY/LABOR ROOM	G	Nursery	43	273,113	71,336	1
2	OB/NURSERY/LABOR ROOM	G	Delivery Room & Labor Room	52	273,113	71,336	2
500	Total reclassifications				546,226	142,672	500
	Code Letter - G						
1	HYPERBARIC OXYGEN THERAPY	H	HYPERBARIC OXYGEN THERAPY	76.98	59,474	1,171	1
500	Total reclassifications				59,474	1,171	500
	Code Letter - H						
	GRAND TOTAL (Increases)				605,700	6,530,788	

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

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	NEGATIVE BALANCES	A	Administrative & General	5		97,042		1
500	Total reclassifications					97,042		500
	Code letter - A							
1	IMPLANTABLE DEVICES	B	Operating Room	50		777,206		1
2	IMPLANTABLE DEVICES	B	Cardiac Catheterization	59		12,346		2
500	Total reclassifications					789,552		500
	Code letter - B							
1	DRUGS	C	Pharmacy	15		1,363,144		1
500	Total reclassifications					1,363,144		500
	Code letter - C							
1	INTEREST EXPENSE	E	Administrative & General	5		274,293	11	1
500	Total reclassifications					274,293		500
	Code letter - E							
1	DEPRECIATION	F	Administrative & General	5		624,299	9	1
2	DEPRECIATION	F	Operation of Plant	7		426,768	9	2
3	DEPRECIATION	F	Housekeeping	9		2,854		3
4	DEPRECIATION	F	Dietary	10		18,005		4
5	DEPRECIATION	F	Nursing Administration	13		96,480		5
6	DEPRECIATION	F	Pharmacy	15		56,611		6
7	DEPRECIATION	F	Adults & Pediatrics	30		141,306		7
8	DEPRECIATION	F	Intensive Care Unit	31		7,539		8
9	DEPRECIATION	F	Operating Room	50		375,712		9
10	DEPRECIATION	F	Radiology-Diagnostic	54		261,196		10
11	DEPRECIATION	F	Radiology-Therapeutic	55		329,925		11
12	DEPRECIATION	F	CT Scan	57		156,130		12
13	DEPRECIATION	F	Cardiac Catheterization	59		147,477		13
14	DEPRECIATION	F	Laboratory	60		61,781		14
15	DEPRECIATION	F	Respiratory Therapy	65		26,471		15
16	DEPRECIATION	F	Physical Therapy	66		83,790		16
17	DEPRECIATION	F	PHYSICAL THERAPY - LIFEPLEX	66.01		177,645		17
18	DEPRECIATION	F	CARDIAC REHABILITATION	76.97		31,461		18
19	DEPRECIATION	F	SAINT JOSEPH HEALTH CENTER	90.03		128,819		19
20	DEPRECIATION	F	WOUND CARE	90.04		92,281		20
21	DEPRECIATION	F	Emergency	91		616,364		21
500	Total reclassifications					3,862,914		500
	Code letter - F							
1	OB/NURSERY/LABOR ROOM	G	Adults & Pediatrics	30	546,226	142,672		1
2	OB/NURSERY/LABOR ROOM	G						2
500	Total reclassifications				546,226	142,672		500
	Code letter - G							
1	HYPERBARIC OXYGEN THERAPY	H	WOUND CARE	90.04	59,474	1,171		1
500	Total reclassifications				59,474	1,171		500
	Code letter - H							
	GRAND TOTAL (Decreases)				605,700	6,530,788		

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

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	477,930					477,930		1
2	Land Improvements								2
3	Buildings and Fixtures	44,115,991	777,644		777,644	3,167	44,890,468	14,348,425	3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	26,227,692	1,000,821		1,000,821	226,832	27,001,681	10,460,087	6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	70,821,613	1,778,465		1,778,465	229,999	72,370,079	24,808,512	8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	70,821,613	1,778,465		1,778,465	229,999	72,370,079	24,808,512	10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)								3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi				0.000000					1
2	Cap Rel Costs-Mvble Equ				0.000000					2
3	Total (sum of lines 1-2)				0.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	2,351,487						2,351,487	1
2	Cap Rel Costs-Mvble Equip	2,102,814						2,102,814	2
3	Total (sum of lines 1-2)	4,454,301						4,454,301	3

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

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-274,293	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,063,130				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	1,165,517				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-205,649	Dietary	10		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients	B	-2,494	Pharmacy	15		17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	PROVIDER TAX EXPENSE	A					33
33.01	OTHER REVENUE	B	-78,337	Administrative & General	5		33.01
33.03	OTHER REVENUE	B	-62,500	Housekeeping	9		33.03
33.07	OTHER REVENUE	B	-135,299	Radiology-Therapeutic	55		33.07
33.08	OTHER REVENUE	B	-2,640	Laboratory	60		33.08
33.09	OTHER REVENUE	B	-20,165	Respiratory Therapy	65		33.09
33.10	OTHER REVENUE	B	-147,750	ATHLETIC TRAINERS	90.02		33.10
33.11	OTHER REVENUE	B	-82,699	SAINT JOSEPH HEALTH CENTER	90.03		33.11
33.12	OTHER REVENUE	B	-178	Emergency	91		33.12
33.13	OTHER REVENUE	B	-220	Respiratory Therapy	65		33.13
33.14	OTHER REVENUE	B	-20	Physical Therapy	66		33.14
34	PROVIDER TAX	A	-2,313,888	Administrative & General	5		34
35	DONATIONS	A	-23,710	Administrative & General	5		35
36							36
37							37
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,247,455				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

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

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

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

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	HO NON CAPITAL COSTS	8,705,230	8,361,139	344,091		1
2	5	Administrative & General	WORKERS COMP	52,749	65,779	-13,030		2
3	5	Administrative & General	INSURANCE	147,787	451,841	-304,054		3
3.01	5	Administrative & General	PENSION	359,767	-158,316	518,083		3.01
3.02	5	Administrative & General	RETIREE HEALTH COSTS		-29,040	29,040		3.02
3.03	1	Cap Rel Costs-Bldg & Fixt	HO CAPITAL COSTS	591,387		591,387	9	3.03
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			9,856,920	8,691,403	1,165,517		5

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

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

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

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

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

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

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

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	31	Intensive Care Unit INTENSIVE CARE	77,037		77,037	197,500	428	40,639	2,032	1
2	50	Operating Room OPERATING ROOM	973,571	973,571		246,400				2
3	54	Radiology-Diagnostic RADIOLOGY-DIAGN	24,750		24,750	271,900	113	14,772	739	3
4	55	Radiology-Therapeuti RADIOLOGY-THERA	12,000		12,000	211,500	120	12,202	610	4
5	60	Laboratory LABORATORY	50,000		50,000	260,300	768	96,111	4,806	5
6	90.02	ATHLETIC TRAINERS ATHLETIC TRAINE	15,096		15,096	211,500	101	10,270	514	6
7	91	Emergency EMERGENCY	105,366		105,366	211,500	659	67,009	3,350	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,257,820	973,571	284,249		2,189	241,003	12,051	200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	31	Intensive Care Unit INTENSIVE CARE					40,639	36,398	36,398	1
2	50	Operating Room OPERATING ROOM							973,571	2
3	54	Radiology-Diagnostic RADIOLOGY-DIAGN					14,772	9,978	9,978	3
4	55	Radiology-Therapeuti RADIOLOGY-THERA					12,202			4
5	60	Laboratory LABORATORY					96,111			5
6	90.02	ATHLETIC TRAINERS ATHLETIC TRAINE					10,270	4,826	4,826	6
7	91	Emergency EMERGENCY					67,009	38,357	38,357	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					241,003	89,559	1,063,130	200

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	2,351,487	2,351,487					1
2	Cap Rel Costs-Mvble Equip	2,102,814		2,102,814				2
4	Employee Benefits Department	697,634			697,634			4
5	Administrative & General	10,249,403	263,967	236,052	64,780	10,814,202	10,814,202	5
6	Maintenance & Repairs							6
7	Operation of Plant	2,213,863	499,231	446,436	14,945	3,174,475	956,022	7
8	Laundry & Linen Service	151,674	8,939	7,993		168,606	50,777	8
9	Housekeeping	609,483	4,425	3,957	15,259	633,124	190,671	9
10	Dietary	462,626	30,929	27,658	9,268	530,481	159,759	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	509,572			17,706	527,278	158,795	13
14	Central Services & Supply							14
15	Pharmacy	633,820	18,304	16,369	23,962	692,455	208,539	15
16	Medical Records & Library	314,437	37,079	33,158	8,337	393,011	118,359	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,415,928	285,957	255,717	75,545	3,033,147	913,460	30
31	Intensive Care Unit	1,208,641	54,838	49,039	36,313	1,348,831	406,213	31
43	Nursery	344,449			10,861	355,310	107,005	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,342,602	283,923	253,898	77,309	3,957,732	1,191,896	50
52	Delivery Room & Labor Room	344,449			10,861	355,310	107,005	52
54	Radiology-Diagnostic	1,370,444	107,138	95,808	40,312	1,613,702	485,981	54
55	Radiology-Therapeutic	1,073,248	133,481	119,365	17,733	1,343,827	404,706	55
57	CT Scan	184,887	6,179	5,526	3,762	200,354	60,338	57
59	Cardiac Catheterization	115,895	31,313	28,001	2,102	177,311	53,399	59
60	Laboratory	3,411,859	64,101	57,322	47,995	3,581,277	1,078,534	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	940,077	48,923	43,749	18,996	1,051,745	316,742	65
66	Physical Therapy	989,006	86,239	77,119	32,762	1,185,126	356,911	66
66.01	PHYSICAL THERAPY - LIFEPLEX	777,166			24,561	801,727	241,447	66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY							66.02
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	789,552				789,552	237,781	72
73	Drugs Charged to Patients	1,363,144				1,363,144	410,523	73
76.97	CARDIAC REHABILITATION	80,515			2,339	82,854	24,952	76.97
76.98	HYPERBARIC OXYGEN THERAPY	60,645	8,009	7,162	2,365	78,181	23,545	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR	1,700			56	1,756	529	90.01
90.02	ATHLETIC TRAINERS	138,796			9,226	148,022	44,578	90.02
90.03	SAINT JOSEPH HEALTH CENTER	515,268			17,486	532,754	160,444	90.03
90.04	WOUND CARE	849,960	38,098	34,069	6,071	928,198	279,535	90.04
91	Emergency	2,724,877	121,049	108,248	61,275	3,015,449	908,130	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	43,339,921	2,132,122	1,906,646	652,187	42,878,941	9,656,576	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,802	2,506		5,308	1,599	190
192	Physicians' Private Offices		216,563	193,662		410,225	123,543	192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST	1,853,037			42,297	1,895,334	570,797	192.02
192.03	INTENSIVIST	1,276,867				1,276,867	384,540	192.03
194	PLYMOUTH MOB-4	152,360				152,360	45,885	194
194.01	COMMUNITY OUTREACH & PARTNERSHIP	100,654			3,150	103,804	31,262	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	46,722,839	2,351,487	2,102,814	697,634	46,722,839	10,814,202	202

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	PHARMACY	
		7	8	9	10	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	4,130,497						7
8	Laundry & Linen Service	23,245	242,628					8
9	Housekeeping	11,507		835,302				9
10	Dietary	80,434		16,404	787,078			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration					686,073		13
14	Central Services & Supply							14
15	Pharmacy	47,602	2	9,708		20,504	978,810	15
16	Medical Records & Library	96,428		19,666		13,386		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	743,660	12,650	151,665	766,556	104,973		30
31	Intensive Care Unit	142,611	5,799	29,085		39,884		31
43	Nursery		950			12,296		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	738,369	37,137	150,586	8,663	86,411	6,692	50
52	Delivery Room & Labor Room		1,402			12,296		52
54	Radiology-Diagnostic	278,623	21,580	56,823		42,507	52,779	54
55	Radiology-Therapeutic	347,129	10,553	70,795		16,996		55
57	CT Scan	16,070	29,857	3,277		4,223	21,636	57
59	Cardiac Catheterization	81,432	1,010	16,608		2,418	341	59
60	Laboratory	166,700	44,042	33,997		85,968	69	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	127,229	12,741	25,948		23,944	8,810	65
66	Physical Therapy	224,272	6,088	45,739		33,345		66
66.01	PHYSICAL THERAPY - LIFEPLEX		4,278			31,233		66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY							66.02
71	Medical Supplies Charged to Patients		3,075					71
72	Impl. Dev. Charged to Patients		3,177					72
73	Drugs Charged to Patients		19,073				866,355	73
76.97	CARDIAC REHABILITATION		589			2,725		76.97
76.98	HYPERBARIC OXYGEN THERAPY	20,828	5,811	4,248		2,895		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR					170		90.01
90.02	ATHLETIC TRAINERS					16,179		90.02
90.03	SAINT JOSEPH HEALTH CENTER		554			18,597	1,430	90.03
90.04	WOUND CARE	99,076	210	20,206		7,425	18,286	90.04
91	Emergency	314,800	20,022	64,201	11,859	78,577	285	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,560,015	240,600	718,956	787,078	656,952	976,683	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	7,288		1,486				190
192	Physicians' Private Offices	563,194		114,860				192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST		1,342			19,857	32	192.02
192.03	INTENSIVIST		686					192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP					9,264	2,095	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,130,497	242,628	835,302	787,078	686,073	978,810	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		16	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	640,850						16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	33,411	5,759,522		5,759,522			30
31	Intensive Care Unit	15,316	1,987,739		1,987,739			31
43	Nursery	2,508	478,069		478,069			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	98,090	6,275,576		6,275,576			50
52	Delivery Room & Labor Room	3,702	479,715		479,715			52
54	Radiology-Diagnostic	56,999	2,608,994		2,608,994			54
55	Radiology-Therapeutic	27,873	2,221,879		2,221,879			55
57	CT Scan	78,860	414,615		414,615			57
59	Cardiac Catheterization	2,668	335,187		335,187			59
60	Laboratory	116,338	5,106,925		5,106,925			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	33,653	1,600,812		1,600,812			65
66	Physical Therapy	16,079	1,867,560		1,867,560			66
66.01	PHYSICAL THERAPY - LIFEPLEX	11,299	1,089,984		1,089,984			66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY							66.02
71	Medical Supplies Charged to Patients	8,123	11,198		11,198			71
72	Impl. Dev. Charged to Patients	8,390	1,038,900		1,038,900			72
73	Drugs Charged to Patients	50,377	2,709,472		2,709,472			73
76.97	CARDIAC REHABILITATION	1,556	112,676		112,676			76.97
76.98	HYPERBARIC OXYGEN THERAPY	15,349	150,857		150,857			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR		2,455		2,455			90.01
90.02	ATHLETIC TRAINERS		208,779		208,779			90.02
90.03	SAINT JOSEPH HEALTH CENTER	1,463	715,242		715,242			90.03
90.04	WOUND CARE	555	1,353,491		1,353,491			90.04
91	Emergency	52,883	4,466,206		4,466,206			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	635,492	40,995,853		40,995,853			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		15,681		15,681			190
192	Physicians' Private Offices		1,211,822		1,211,822			192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST	3,546	2,490,908		2,490,908			192.02
192.03	INTENSIVIST	1,812	1,663,905		1,663,905			192.03
194	PLYMOUTH MOB-4		198,245		198,245			194
194.01	COMMUNITY OUTREACH & PARTNERSHIP		146,425		146,425			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	640,850	46,722,839		46,722,839			202

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

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		263,967	236,052	500,019	500,019		5
6	Maintenance & Repairs							6
7	Operation of Plant		499,231	446,436	945,667	44,205	989,872	7
8	Laundry & Linen Service		8,939	7,993	16,932	2,348	5,571	8
9	Housekeeping		4,425	3,957	8,382	8,816	2,758	9
10	Dietary		30,929	27,658	58,587	7,387	19,276	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration					7,342		13
14	Central Services & Supply							14
15	Pharmacy		18,304	16,369	34,673	9,642	11,408	15
16	Medical Records & Library		37,079	33,158	70,237	5,473	23,109	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		285,957	255,717	541,674	42,237	178,215	30
31	Intensive Care Unit		54,838	49,039	103,877	18,782	34,177	31
43	Nursery					4,948		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		283,923	253,898	537,821	55,101	176,950	50
52	Delivery Room & Labor Room					4,948		52
54	Radiology-Diagnostic		107,138	95,808	202,946	22,471	66,772	54
55	Radiology-Therapeutic		133,481	119,365	252,846	18,713	83,189	55
57	CT Scan		6,179	5,526	11,705	2,790	3,851	57
59	Cardiac Catheterization		31,313	28,001	59,314	2,469	19,515	59
60	Laboratory		64,101	57,322	121,423	49,869	39,950	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		48,923	43,749	92,672	14,646	30,490	65
66	Physical Therapy		86,239	77,119	163,358	16,503	53,747	66
66.01	PHYSICAL THERAPY - LIFEPLEX					11,164		66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY							66.02
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients					10,995		72
73	Drugs Charged to Patients					18,982		73
76.97	CARDIAC REHABILITATION					1,154		76.97
76.98	HYPERBARIC OXYGEN THERAPY		8,009	7,162	15,171	1,089	4,992	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR					24		90.01
90.02	ATHLETIC TRAINERS					2,061		90.02
90.03	SAINT JOSEPH HEALTH CENTER					7,419		90.03
90.04	WOUND CARE		38,098	34,069	72,167	12,925	23,744	90.04
91	Emergency		121,049	108,248	229,297	41,990	75,442	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		2,132,122	1,906,646	4,038,768	446,493	853,156	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,802	2,506	5,308	74	1,747	190
192	Physicians' Private Offices		216,563	193,662	410,225	5,712	134,969	192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST					26,393		192.02
192.03	INTENSIVIST					17,780		192.03
194	PLYMOUTH MOB-4					2,122		194
194.01	COMMUNITY OUTREACH & PARTNERSHIP					1,445		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,351,487	2,102,814	4,454,301	500,019	989,872	202

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		8	9	10	13	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	24,851						8
9	Housekeeping		19,956					9
10	Dietary		392	85,642				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration				7,342			13
14	Central Services & Supply							14
15	Pharmacy		232		219	56,174		15
16	Medical Records & Library		470		143		99,432	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,291	3,622	83,409	1,123		5,183	30
31	Intensive Care Unit	592	695		427		2,376	31
43	Nursery	97			132		389	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,791	3,598	943	925	384	15,217	50
52	Delivery Room & Labor Room	143			132		574	52
54	Radiology-Diagnostic	2,203	1,358		455	3,029	8,843	54
55	Radiology-Therapeutic	1,077	1,691		182		4,324	55
57	CT Scan	3,048	78		45	1,242	12,234	57
59	Cardiac Catheterization	103	397		26	20	414	59
60	Laboratory	4,581	812		920	4	18,062	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,300	620		256	506	5,221	65
66	Physical Therapy	621	1,093		357		2,495	66
66.01	PHYSICAL THERAPY - LIFEPLEX	437			334		1,753	66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY							66.02
71	Medical Supplies Charged to Patients	314					1,260	71
72	Impl. Dev. Charged to Patients	324					1,302	72
73	Drugs Charged to Patients	1,947				49,720	7,815	73
76.97	CARDIAC REHABILITATION	60			29		241	76.97
76.98	HYPERBARIC OXYGEN THERAPY	593	101		31		2,381	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR				2			90.01
90.02	ATHLETIC TRAINERS				173			90.02
90.03	SAINT JOSEPH HEALTH CENTER	57			199	82	227	90.03
90.04	WOUND CARE	21	483		79	1,049	86	90.04
91	Emergency	2,044	1,534	1,290	841	16	8,204	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	24,644	17,176	85,642	7,030	56,052	98,601	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		36					190
192	Physicians' Private Offices		2,744					192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST	137			213	2	550	192.02
192.03	INTENSIVIST	70					281	192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP				99	120		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,851	19,956	85,642	7,342	56,174	99,432	202

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

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	856,754		856,754				30
31	Intensive Care Unit	160,926		160,926				31
43	Nursery	5,566		5,566				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	794,730		794,730				50
52	Delivery Room & Labor Room	5,797		5,797				52
54	Radiology-Diagnostic	308,077		308,077				54
55	Radiology-Therapeutic	362,022		362,022				55
57	CT Scan	34,993		34,993				57
59	Cardiac Catheterization	82,258		82,258				59
60	Laboratory	235,621		235,621				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	145,711		145,711				65
66	Physical Therapy	238,174		238,174				66
66.01	PHYSICAL THERAPY - LIFEPLEX	13,688		13,688				66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY							66.02
71	Medical Supplies Charged to Patients	1,574		1,574				71
72	Impl. Dev. Charged to Patients	12,621		12,621				72
73	Drugs Charged to Patients	78,464		78,464				73
76.97	CARDIAC REHABILITATION	1,484		1,484				76.97
76.98	HYPERBARIC OXYGEN THERAPY	24,358		24,358				76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR	26		26				90.01
90.02	ATHLETIC TRAINERS	2,234		2,234				90.02
90.03	SAINT JOSEPH HEALTH CENTER	7,984		7,984				90.03
90.04	WOUND CARE	110,554		110,554				90.04
91	Emergency	360,658		360,658				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,844,274		3,844,274				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	7,165		7,165				190
192	Physicians' Private Offices	553,650		553,650				192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST	27,295		27,295				192.02
192.03	INTENSIVIST	18,131		18,131				192.03
194	PLYMOUTH MOB-4	2,122		2,122				194
194.01	COMMUNITY OUTREACH & PARTNERSHIP	1,664		1,664				194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,454,301		4,454,301				202

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	2,008,830						1
2	Cap Rel Costs-Mvble Equip		2,008,830					2
4	Employee Benefits Department			17,543,201				4
5	Administrative & General	225,502	225,502	1,628,988	-10,814,202	35,908,637		5
6	Maintenance & Repairs							6
7	Operation of Plant	426,483	426,483	375,809		3,174,475	1,356,845	7
8	Laundry & Linen Service	7,636	7,636			168,606	7,636	8
9	Housekeeping	3,780	3,780	383,707		633,124	3,780	9
10	Dietary	26,422	26,422	233,059		530,481	26,422	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration			445,236		527,278		13
14	Central Services & Supply							14
15	Pharmacy	15,637	15,637	602,556		692,455	15,637	15
16	Medical Records & Library	31,676	31,676	209,636		393,011	31,676	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	244,288	244,288	1,899,685		3,033,147	244,288	30
31	Intensive Care Unit	46,847	46,847	913,134		1,348,831	46,847	31
43	Nursery			273,113		355,310		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	242,550	242,550	1,944,245		3,957,732	242,550	50
52	Delivery Room & Labor Room			273,113		355,310		52
54	Radiology-Diagnostic	91,526	91,526	1,013,704		1,613,702	91,526	54
55	Radiology-Therapeutic	114,030	114,030	445,915		1,343,827	114,030	55
57	CT Scan	5,279	5,279	94,605		200,354	5,279	57
59	Cardiac Catheterization	26,750	26,750	52,869		177,311	26,750	59
60	Laboratory	54,760	54,760	1,206,908		3,581,277	54,760	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	41,794	41,794	477,686		1,051,745	41,794	65
66	Physical Therapy	73,672	73,672	823,858		1,185,126	73,672	66
66.01	PHYSICAL THERAPY - LIFEPLEX			617,617		801,727		66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY							66.02
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients					789,552		72
73	Drugs Charged to Patients					1,363,144		73
76.97	CARDIAC REHABILITATION			58,826		82,854		76.97
76.98	HYPERBARIC OXYGEN THERAPY	6,842	6,842	59,474		78,181	6,842	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR			1,411		1,756		90.01
90.02	ATHLETIC TRAINERS			231,992		148,022		90.02
90.03	SAINT JOSEPH HEALTH CENTER			439,701		532,754		90.03
90.04	WOUND CARE	32,546	32,546	152,665		928,198	32,546	90.04
91	Emergency	103,410	103,410	1,540,862		3,015,449	103,410	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,821,430	1,821,430	16,400,374	-10,814,202	32,064,739	1,169,445	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,394	2,394			5,308	2,394	190
192	Physicians' Private Offices	185,006	185,006			410,225	185,006	192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST			1,063,621		1,895,334		192.02
192.03	INTENSIVIST					1,276,867		192.03
194	PLYMOUTH MOB-4					152,360		194
194.01	COMMUNITY OUTREACH & PARTNERSHIP			79,206		103,804		194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,351,487	2,102,814	697,634		10,814,202	4,130,497	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.170575	1.046785	0.039767		0.301159	3.044192	203
204	Cost to be allocated (Per Wkst. B, Part II)					500,019	989,872	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.013925	0.729539	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE GROSS REVENUE	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	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	179,445,069						8
9	Housekeeping		1,345,429					9
10	Dietary		26,422	18,716				10
11	Cafeteria				20,604			11
12	Maintenance of Personnel							12
13	Nursing Administration				461	20,143		13
14	Central Services & Supply						179,445,069	14
15	Pharmacy	1,309	15,637		602	602	1,309	15
16	Medical Records & Library		31,676		393	393		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,356,195	244,288	18,228	3,082	3,082	9,356,195	30
31	Intensive Care Unit	4,289,025	46,847		1,171	1,171	4,289,025	31
43	Nursery	702,322			361	361	702,322	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	27,468,408	242,550	206	2,537	2,537	27,468,408	50
52	Delivery Room & Labor Room	1,036,635			361	361	1,036,635	52
54	Radiology-Diagnostic	15,961,719	91,526		1,248	1,248	15,961,719	54
55	Radiology-Therapeutic	7,805,485	114,030		499	499	7,805,485	55
57	CT Scan	22,083,513	5,279		124	124	22,083,513	57
59	Cardiac Catheterization	747,058	26,750		71	71	747,058	59
60	Laboratory	32,562,679	54,760		2,524	2,524	32,562,679	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	9,423,852	41,794		703	703	9,423,852	65
66	Physical Therapy	4,502,722	73,672		979	979	4,502,722	66
66.01	PHYSICAL THERAPY - LIFEPLEX	3,164,056			917	917	3,164,056	66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY							66.02
71	Medical Supplies Charged to Patients	2,274,746					2,274,746	71
72	Impl. Dev. Charged to Patients	2,349,555					2,349,555	72
73	Drugs Charged to Patients	14,107,299					14,107,299	73
76.97	CARDIAC REHABILITATION	435,850			80	80	435,850	76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,298,148	6,842		85	85	4,298,148	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR				5	5		90.01
90.02	ATHLETIC TRAINERS				475	475		90.02
90.03	SAINT JOSEPH HEALTH CENTER	409,680			546	546	409,680	90.03
90.04	WOUND CARE	155,337	32,546		218	218	155,337	90.04
91	Emergency	14,809,041	103,410	282	2,307	2,307	14,809,041	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	177,944,634	1,158,029	18,716	19,749	19,288	177,944,634	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,394					190
192	Physicians' Private Offices		185,006					192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST	992,948			583	583	992,948	192.02
192.03	INTENSIVIST	507,487					507,487	192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP				272	272		194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	242,628	835,302	787,078		686,073		202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.001352	0.620844	42.053751		34.060120		203
204	Cost to be allocated (Per Wkst. B, Part II)	24,851	19,956	85,642		7,342		204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000138	0.014832	4.575871		0.364494		205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE					
		15	16					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	1,540,084						15
16	Medical Records & Library		179,443,760					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		9,356,195					30
31	Intensive Care Unit		4,289,025					31
43	Nursery		702,322					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	10,529	27,468,408					50
52	Delivery Room & Labor Room		1,036,635					52
54	Radiology-Diagnostic	83,044	15,961,719					54
55	Radiology-Therapeutic		7,805,485					55
57	CT Scan	34,042	22,083,513					57
59	Cardiac Catheterization	536	747,058					59
60	Laboratory	109	32,562,679					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	13,862	9,423,852					65
66	Physical Therapy		4,502,722					66
66.01	PHYSICAL THERAPY - LIFEPLEX		3,164,056					66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY							66.02
71	Medical Supplies Charged to Patients		2,274,746					71
72	Impl. Dev. Charged to Patients		2,349,555					72
73	Drugs Charged to Patients	1,363,144	14,107,299					73
76.97	CARDIAC REHABILITATION		435,850					76.97
76.98	HYPERBARIC OXYGEN THERAPY		4,298,148					76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER	2,250	409,680					90.03
90.04	WOUND CARE	28,772	155,337					90.04
91	Emergency	448	14,809,041					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,536,736	177,943,325					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST	51	992,948					192.02
192.03	INTENSIVIST		507,487					192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP	3,297						194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	978,810	640,850					202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.635556	0.003571					203
204	Cost to be allocated (Per Wkst. B, Part II)	56,174	99,432					204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.036475	0.000554					205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	5,759,522		5,759,522		5,759,522	30
31	Intensive Care Unit	1,987,739		1,987,739	36,398	2,024,137	31
43	Nursery	478,069		478,069		478,069	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,275,576		6,275,576		6,275,576	50
52	Delivery Room & Labor Room	479,715		479,715		479,715	52
54	Radiology-Diagnostic	2,608,994		2,608,994	9,978	2,618,972	54
55	Radiology-Therapeutic	2,221,879		2,221,879		2,221,879	55
57	CT Scan	414,615		414,615		414,615	57
59	Cardiac Catheterization	335,187		335,187		335,187	59
60	Laboratory	5,106,925		5,106,925		5,106,925	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,600,812		1,600,812		1,600,812	65
66	Physical Therapy	1,867,560		1,867,560		1,867,560	66
66.01	PHYSICAL THERAPY - LIFEPLEX	1,089,984		1,089,984		1,089,984	66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY						66.02
71	Medical Supplies Charged to Patients	11,198		11,198		11,198	71
72	Impl. Dev. Charged to Patients	1,038,900		1,038,900		1,038,900	72
73	Drugs Charged to Patients	2,709,472		2,709,472		2,709,472	73
76.97	CARDIAC REHABILITATION	112,676		112,676		112,676	76.97
76.98	HYPERBARIC OXYGEN THERAPY	150,857		150,857		150,857	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION CTR	2,455		2,455		2,455	90.01
90.02	ATHLETIC TRAINERS	208,779		208,779	4,826	213,605	90.02
90.03	SAINT JOSEPH HEALTH CENTER	715,242		715,242		715,242	90.03
90.04	WOUND CARE	1,353,491		1,353,491		1,353,491	90.04
91	Emergency	4,466,206		4,466,206	38,357	4,504,563	91
92	Observation Beds (Non-Distinct Part)	1,434,008		1,434,008		1,434,008	92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	42,429,861		42,429,861	89,559	42,519,420	200
201	Less Observation Beds	1,434,008		1,434,008		1,434,008	201
202	Total (line 200 minus line 201)	40,995,853		40,995,853		41,085,412	202

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	7,030,303		7,030,303				30
31	Intensive Care Unit	4,289,026		4,289,026				31
43	Nursery	702,322		702,322				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,455,160	21,013,248	27,468,408	0.228465	0.228465	0.228465	50
52	Delivery Room & Labor Room	991,956	44,679	1,036,635	0.462762	0.462762	0.462762	52
54	Radiology-Diagnostic	1,651,336	14,310,383	15,961,719	0.163453	0.163453	0.164078	54
55	Radiology-Therapeutic	3,135	7,802,350	7,805,485	0.284656	0.284656	0.284656	55
57	CT Scan	2,538,493	19,545,020	22,083,513	0.018775	0.018775	0.018775	57
59	Cardiac Catheterization	77,138	669,920	747,058	0.448676	0.448676	0.448676	59
60	Laboratory	5,220,705	27,341,974	32,562,679	0.156834	0.156834	0.156834	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,306,459	7,117,393	9,423,852	0.169868	0.169868	0.169868	65
66	Physical Therapy	696,943	3,805,779	4,502,722	0.414762	0.414762	0.414762	66
66.01	PHYSICAL THERAPY - LIFEPLEX	373	3,163,683	3,164,056	0.344489	0.344489	0.344489	66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY		48,628	48,628				66.02
71	Medical Supplies Charged to Patients	713,718	1,561,028	2,274,746	0.004923	0.004923	0.004923	71
72	Impl. Dev. Charged to Patients	1,773,212	576,343	2,349,555	0.442169	0.442169	0.442169	72
73	Drugs Charged to Patients	4,761,562	9,345,736	14,107,298	0.192062	0.192062	0.192062	73
76.97	CARDIAC REHABILITATION		435,850	435,850	0.258520	0.258520	0.258520	76.97
76.98	HYPERBARIC OXYGEN THERAPY	16,008	2,133,066	2,149,074	0.070196	0.070196	0.070196	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER	11,380	398,300	409,680	1.745855	1.745855	1.745855	90.03
90.04	WOUND CARE	12,269	2,292,142	2,304,411	0.587348	0.587348	0.587348	90.04
91	Emergency	2,129,184	12,679,858	14,809,042	0.301586	0.301586	0.304177	91
92	Observation Beds (Non-Distinct Part)	482,404	1,843,489	2,325,893	0.616541	0.616541	0.616541	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	41,863,086	136,128,869	177,991,955				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	41,863,086	136,128,869	177,991,955				202

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
43	Nursery						43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
52	Delivery Room & Labor Room						52
54	Radiology-Diagnostic						54
55	Radiology-Therapeutic						55
57	CT Scan						57
59	Cardiac Catheterization						59
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
66.01	PHYSICAL THERAPY - LIFEPLEX						66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY						66.02
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION CTR						90.01
90.02	ATHLETIC TRAINERS						90.02
90.03	SAINT JOSEPH HEALTH CENTER						90.03
90.04	WOUND CARE						90.04
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)						200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)						202

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	7,030,303		7,030,303				30
31	Intensive Care Unit	4,289,026		4,289,026				31
43	Nursery	702,322		702,322				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,455,160	21,013,248	27,468,408				50
52	Delivery Room & Labor Room	991,956	44,679	1,036,635				52
54	Radiology-Diagnostic	1,651,336	14,310,383	15,961,719				54
55	Radiology-Therapeutic	3,135	7,802,350	7,805,485				55
57	CT Scan	2,538,493	19,545,020	22,083,513				57
59	Cardiac Catheterization	77,138	669,920	747,058				59
60	Laboratory	5,220,705	27,341,974	32,562,679				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,306,459	7,117,393	9,423,852				65
66	Physical Therapy	696,943	3,805,779	4,502,722				66
66.01	PHYSICAL THERAPY - LIFEPLEX	373	3,163,683	3,164,056				66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY		48,628	48,628				66.02
71	Medical Supplies Charged to Patients	713,718	1,561,028	2,274,746				71
72	Impl. Dev. Charged to Patients	1,773,212	576,343	2,349,555				72
73	Drugs Charged to Patients	4,761,562	9,345,736	14,107,298				73
76.97	CARDIAC REHABILITATION		435,850	435,850				76.97
76.98	HYPERBARIC OXYGEN THERAPY	16,008	2,133,066	2,149,074				76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER	11,380	398,300	409,680				90.03
90.04	WOUND CARE	12,269	2,292,142	2,304,411				90.04
91	Emergency	2,129,184	12,679,858	14,809,042				91
92	Observation Beds (Non-Distinct Part)	482,404	1,843,489	2,325,893				92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	41,863,086	136,128,869	177,991,955				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	41,863,086	136,128,869	177,991,955				202

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	5,759,522		5,759,522		5,759,522	30
31	Intensive Care Unit	1,987,739		1,987,739	36,398	2,024,137	31
43	Nursery	478,069		478,069		478,069	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,275,576		6,275,576		6,275,576	50
52	Delivery Room & Labor Room	479,715		479,715		479,715	52
54	Radiology-Diagnostic	2,608,994		2,608,994	9,978	2,618,972	54
55	Radiology-Therapeutic	2,221,879		2,221,879		2,221,879	55
57	CT Scan	414,615		414,615		414,615	57
59	Cardiac Catheterization	335,187		335,187		335,187	59
60	Laboratory	5,106,925		5,106,925		5,106,925	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,600,812		1,600,812		1,600,812	65
66	Physical Therapy	1,867,560		1,867,560		1,867,560	66
66.01	PHYSICAL THERAPY - LIFEPLEX	1,089,984		1,089,984		1,089,984	66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY						66.02
71	Medical Supplies Charged to Patients	11,198		11,198		11,198	71
72	Impl. Dev. Charged to Patients	1,038,900		1,038,900		1,038,900	72
73	Drugs Charged to Patients	2,709,472		2,709,472		2,709,472	73
76.97	CARDIAC REHABILITATION	112,676		112,676		112,676	76.97
76.98	HYPERBARIC OXYGEN THERAPY	150,857		150,857		150,857	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION CTR	2,455		2,455		2,455	90.01
90.02	ATHLETIC TRAINERS	208,779		208,779	4,826	213,605	90.02
90.03	SAINT JOSEPH HEALTH CENTER	715,242		715,242		715,242	90.03
90.04	WOUND CARE	1,353,491		1,353,491		1,353,491	90.04
91	Emergency	4,466,206		4,466,206	38,357	4,504,563	91
92	Observation Beds (Non-Distinct Part)	1,434,008		1,434,008		1,434,008	92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	42,429,861		42,429,861	89,559	42,519,420	200
201	Less Observation Beds	1,434,008		1,434,008		1,434,008	201
202	Total (line 200 minus line 201)	40,995,853		40,995,853	89,559	41,085,412	202

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	7,030,303		7,030,303				30
31	Intensive Care Unit	4,289,026		4,289,026				31
43	Nursery	702,322		702,322				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,455,160	21,013,248	27,468,408	0.228465	0.228465	0.228465	50
52	Delivery Room & Labor Room	991,956	44,679	1,036,635	0.462762	0.462762	0.462762	52
54	Radiology-Diagnostic	1,651,336	14,310,383	15,961,719	0.163453	0.163453	0.164078	54
55	Radiology-Therapeutic	3,135	7,802,350	7,805,485	0.284656	0.284656	0.284656	55
57	CT Scan	2,538,493	19,545,020	22,083,513	0.018775	0.018775	0.018775	57
59	Cardiac Catheterization	77,138	669,920	747,058	0.448676	0.448676	0.448676	59
60	Laboratory	5,220,705	27,341,974	32,562,679	0.156834	0.156834	0.156834	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,306,459	7,117,393	9,423,852	0.169868	0.169868	0.169868	65
66	Physical Therapy	696,943	3,805,779	4,502,722	0.414762	0.414762	0.414762	66
66.01	PHYSICAL THERAPY - LIFEPLEX	373	3,163,683	3,164,056	0.344489	0.344489	0.344489	66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY		48,628	48,628				66.02
71	Medical Supplies Charged to Patients	713,718	1,561,028	2,274,746	0.004923	0.004923	0.004923	71
72	Impl. Dev. Charged to Patients	1,773,212	576,343	2,349,555	0.442169	0.442169	0.442169	72
73	Drugs Charged to Patients	4,761,562	9,345,736	14,107,298	0.192062	0.192062	0.192062	73
76.97	CARDIAC REHABILITATION		435,850	435,850	0.258520	0.258520	0.258520	76.97
76.98	HYPERBARIC OXYGEN THERAPY	16,008	2,133,066	2,149,074	0.070196	0.070196	0.070196	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER	11,380	398,300	409,680	1.745855	1.745855	1.745855	90.03
90.04	WOUND CARE	12,269	2,292,142	2,304,411	0.587348	0.587348	0.587348	90.04
91	Emergency	2,129,184	12,679,858	14,809,042	0.301586	0.301586	0.304177	91
92	Observation Beds (Non-Distinct Part)	482,404	1,843,489	2,325,893	0.616541	0.616541	0.616541	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	41,863,086	136,128,869	177,991,955				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	41,863,086	136,128,869	177,991,955				202

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY **WORKSHEET C PART II**

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	6,275,576	794,730	5,480,846		50
52	Delivery Room & Labor Room	479,715	5,797	473,918		52
54	Radiology-Diagnostic	2,608,994	308,077	2,300,917		54
55	Radiology-Therapeutic	2,221,879	362,022	1,859,857		55
57	CT Scan	414,615	34,993	379,622		57
59	Cardiac Catheterization	335,187	82,258	252,929		59
60	Laboratory	5,106,925	235,621	4,871,304		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	1,600,812	145,711	1,455,101		65
66	Physical Therapy	1,867,560	238,174	1,629,386		66
66.01	PHYSICAL THERAPY - LIFEPLEX	1,089,984	13,688	1,076,296		66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY					66.02
71	Medical Supplies Charged to Patients	11,198	1,574	9,624		71
72	Impl. Dev. Charged to Patients	1,038,900	12,621	1,026,279		72
73	Drugs Charged to Patients	2,709,472	78,464	2,631,008		73
76.97	CARDIAC REHABILITATION	112,676	1,484	111,192		76.97
76.98	HYPERBARIC OXYGEN THERAPY	150,857	24,358	126,499		76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90.01	OUTPATIENT TREATMENT & INFUSION CTR	2,455	26	2,429		90.01
90.02	ATHLETIC TRAINERS	208,779	2,234	206,545		90.02
90.03	SAINT JOSEPH HEALTH CENTER	715,242	7,984	707,258		90.03
90.04	WOUND CARE	1,353,491	110,554	1,242,937		90.04
91	Emergency	4,466,206	360,658	4,105,548		91
92	Observation Beds (Non-Distinct Part)	1,434,008	213,314	1,220,694		92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal	34,204,531	3,034,342	31,170,189		200
201	Less Observation Beds	1,434,008	213,314	1,220,694		201
202	Total	32,770,523	2,821,028	29,949,495		202

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY **WORKSHEET C PART II**

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		6,275,576	27,468,408	0.228465	50
52	Delivery Room & Labor Room		479,715	1,036,635	0.462762	52
54	Radiology-Diagnostic		2,608,994	15,961,719	0.163453	54
55	Radiology-Therapeutic		2,221,879	7,805,485	0.284656	55
57	CT Scan		414,615	22,083,513	0.018775	57
59	Cardiac Catheterization		335,187	747,058	0.448676	59
60	Laboratory		5,106,925	32,562,679	0.156834	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		1,600,812	9,423,852	0.169868	65
66	Physical Therapy		1,867,560	4,502,722	0.414762	66
66.01	PHYSICAL THERAPY - LIFEPLEX		1,089,984	3,164,056	0.344489	66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY			48,628		66.02
71	Medical Supplies Charged to Patients		11,198	2,274,746	0.004923	71
72	Impl. Dev. Charged to Patients		1,038,900	2,349,555	0.442169	72
73	Drugs Charged to Patients		2,709,472	14,107,298	0.192062	73
76.97	CARDIAC REHABILITATION		112,676	435,850	0.258520	76.97
76.98	HYPERBARIC OXYGEN THERAPY		150,857	2,149,074	0.070196	76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90.01	OUTPATIENT TREATMENT & INFUSION CTR		2,455			90.01
90.02	ATHLETIC TRAINERS		208,779			90.02
90.03	SAINT JOSEPH HEALTH CENTER		715,242	409,680	1.745855	90.03
90.04	WOUND CARE		1,353,491	2,304,411	0.587348	90.04
91	Emergency		4,466,206	14,809,042	0.301586	91
92	Observation Beds (Non-Distinct Part)		1,434,008	2,325,893	0.616541	92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal		34,204,531	165,970,304		200
201	Less Observation Beds		1,434,008	2,325,893		201
202	Total		32,770,523	163,644,411		202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	856,754		856,754	5,398	158.72	1,663	263,951	30
31	Intensive Care Unit	160,926		160,926	1,196	134.55	574	77,232	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	5,566		5,566	523	10.64			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,023,246		1,023,246	7,117		2,237	341,183	200

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	794,730	27,468,408	0.028933	2,485,841	71,923	50
52	Delivery Room & Labor Room	5,797	1,036,635	0.005592			52
54	Radiology-Diagnostic	308,077	15,961,719	0.019301	766,673	14,798	54
55	Radiology-Therapeutic	362,022	7,805,485	0.046380			55
57	CT Scan	34,993	22,083,513	0.001585	1,075,623	1,705	57
59	Cardiac Catheterization	82,258	747,058	0.110109	31,641	3,484	59
60	Laboratory	235,621	32,562,679	0.007236	2,331,891	16,874	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	145,711	9,423,852	0.015462	1,137,293	17,585	65
66	Physical Therapy	238,174	4,502,722	0.052896	423,745	22,414	66
66.01	PHYSICAL THERAPY - LIFEPLEX	13,688	3,164,056	0.004326			66.01
66.02	PHYSICAL THERAPY - CULVER MILIT						66.02
71	Medical Supplies Charged to Pat	1,574	2,274,746	0.000692	309,282	214	71
72	Impl. Dev. Charged to Patients	12,621	2,349,555	0.005372	953,075	5,120	72
73	Drugs Charged to Patients	78,464	14,107,298	0.005562	1,954,835	10,873	73
76.97	CARDIAC REHABILITATION	1,484	435,850	0.003405			76.97
76.98	HYPERBARIC OXYGEN THERAPY	24,358	2,149,074	0.011334	5,336	60	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION	26					90.01
90.02	ATHLETIC TRAINERS	2,234					90.02
90.03	SAINT JOSEPH HEALTH CENTER	7,984	409,680	0.019488			90.03
90.04	WOUND CARE	110,554	2,304,411	0.047975	10,837	520	90.04
91	Emergency	360,658	14,809,042	0.024354	948,001	23,088	91
92	Observation Beds (Non-Distinct	213,314	2,325,893	0.091713	244,485	22,422	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,034,342	165,921,676		12,678,558	211,080	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	5,398		1,663		30
31	Intensive Care Unit	1,196		574		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	523				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	7,117		2,237		200

(A) Worksheet A line numbers

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

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
52	Delivery Room & Labor Room									52
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
57	CT Scan									57
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
66.01	PHYSICAL THERAPY - LIFEPLEX									66.01
66.02	PHYSICAL THERAPY - CULVER MILIT									66.02
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90.01	OUTPATIENT TREATMENT & INFUSION									90.01
90.02	ATHLETIC TRAINERS									90.02
90.03	SAINT JOSEPH HEALTH CENTER									90.03
90.04	WOUND CARE									90.04
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	27,468,408			2,485,841		5,324,521		50
52	Delivery Room & Labor Room	1,036,635							52
54	Radiology-Diagnostic	15,961,719			766,673		3,017,854		54
55	Radiology-Therapeutic	7,805,485					3,055,978		55
57	CT Scan	22,083,513			1,075,623		5,369,389		57
59	Cardiac Catheterization	747,058			31,641		273,807		59
60	Laboratory	32,562,679			2,331,891		2,350,594		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,423,852			1,137,293		2,037,902		65
66	Physical Therapy	4,502,722			423,745		24,284		66
66.01	PHYSICAL THERAPY - LIFEPLEX	3,164,056					10,191		66.01
66.02	PHYSICAL THERAPY - CULVER MILIT								66.02
71	Medical Supplies Charged to Pat	2,274,746			309,282		360,556		71
72	Impl. Dev. Charged to Patients	2,349,555			953,075		125,219		72
73	Drugs Charged to Patients	14,107,298			1,954,835		2,057,458		73
76.97	CARDIAC REHABILITATION	435,850					260		76.97
76.98	HYPERBARIC OXYGEN THERAPY	2,149,074			5,336		375,521		76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	409,680							90.03
90.04	WOUND CARE	2,304,411			10,837		925,301		90.04
91	Emergency	14,809,042			948,001		2,279,042		91
92	Observation Beds (Non-Distinct	2,325,893			244,485		477,074		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	165,921,676			12,678,558		28,064,951		200

(A) Worksheet A line numbers

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.228465	5,324,521			1,216,467			50
52	Delivery Room & Labor Room	0.462762							52
54	Radiology-Diagnostic	0.163453	3,017,854			493,277			54
55	Radiology-Therapeutic	0.284656	3,055,978			869,902			55
57	CT Scan	0.018775	5,369,389			100,810			57
59	Cardiac Catheterization	0.448676	273,807			122,851			59
60	Laboratory	0.156834	2,350,594			368,653			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.169868	2,037,902			346,174			65
66	Physical Therapy	0.414762	24,284			10,072			66
66.01	PHYSICAL THERAPY - LIFEPLEX	0.344489	10,191			3,511			66.01
66.02	PHYSICAL THERAPY - CULVER MILIT								66.02
71	Medical Supplies Charged to Pat	0.004923	360,556	159		1,775	1		71
72	Impl. Dev. Charged to Patients	0.442169	125,219			55,368			72
73	Drugs Charged to Patients	0.192062	2,057,458		22,028	395,159		4,231	73
76.97	CARDIAC REHABILITATION	0.258520	260			67			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.070196	375,521			26,360			76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	1.745855							90.03
90.04	WOUND CARE	0.587348	925,301			543,474			90.04
91	Emergency	0.301586	2,279,042			687,327			91
92	Observation Beds (Non-Distinct	0.616541	477,074			294,136			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		28,064,951	159	22,028	5,535,383	1	4,231	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		28,064,951	159	22,028	5,535,383	1	4,231	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	856,754		856,754	5,398	158.72	156	24,760	30
31	Intensive Care Unit	160,926		160,926	1,196	134.55			31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	5,566		5,566	523	10.64	354	3,767	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,023,246		1,023,246	7,117		510	28,527	200

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	794,730	27,468,408	0.028933	1,211,967	35,066	50
52	Delivery Room & Labor Room	5,797	1,036,635	0.005592			52
54	Radiology-Diagnostic	308,077	15,961,719	0.019301	207,339	4,002	54
55	Radiology-Therapeutic	362,022	7,805,485	0.046380	2,352	109	55
57	CT Scan	34,993	22,083,513	0.001585	324,770	515	57
59	Cardiac Catheterization	82,258	747,058	0.110109	7,984	879	59
60	Laboratory	235,621	32,562,679	0.007236	655,666	4,744	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	145,711	9,423,852	0.015462			65
66	Physical Therapy	238,174	4,502,722	0.052896	34,943	1,848	66
66.01	PHYSICAL THERAPY - LIFEPLEX	13,688	3,164,056	0.004326			66.01
66.02	PHYSICAL THERAPY - CULVER MILIT						66.02
71	Medical Supplies Charged to Pat	1,574	2,274,746	0.000692			71
72	Impl. Dev. Charged to Patients	12,621	2,349,555	0.005372			72
73	Drugs Charged to Patients	78,464	14,107,298	0.005562			73
76.97	CARDIAC REHABILITATION	1,484	435,850	0.003405			76.97
76.98	HYPERBARIC OXYGEN THERAPY	24,358	2,149,074	0.011334			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT & INFUSION	26					90.01
90.02	ATHLETIC TRAINERS	2,234					90.02
90.03	SAINT JOSEPH HEALTH CENTER	7,984	409,680	0.019488			90.03
90.04	WOUND CARE	110,554	2,304,411	0.047975			90.04
91	Emergency	360,658	14,809,042	0.024354	348,866	8,496	91
92	Observation Beds (Non-Distinct	213,314	2,325,893	0.091713			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,034,342	165,921,676		2,793,887	55,659	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	5,398		156		30
31	Intensive Care Unit	1,196				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	523		354		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	7,117		510		200

(A) Worksheet A line numbers

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

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
52	Delivery Room & Labor Room									52
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
57	CT Scan									57
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
66.01	PHYSICAL THERAPY - LIFEPLEX									66.01
66.02	PHYSICAL THERAPY - CULVER MILIT									66.02
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90.01	OUTPATIENT TREATMENT & INFUSION									90.01
90.02	ATHLETIC TRAINERS									90.02
90.03	SAINT JOSEPH HEALTH CENTER									90.03
90.04	WOUND CARE									90.04
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8) 7	Ratio of Cost to Charges (col. 5÷ col. 7) 8	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7) 9	Inpatient Program Charges 10	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11	Outpatient Program Charges 12	Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	27,468,408			1,211,967				50
52	Delivery Room & Labor Room	1,036,635							52
54	Radiology-Diagnostic	15,961,719			207,339				54
55	Radiology-Therapeutic	7,805,485			2,352				55
57	CT Scan	22,083,513			324,770				57
59	Cardiac Catheterization	747,058			7,984				59
60	Laboratory	32,562,679			655,666				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,423,852							65
66	Physical Therapy	4,502,722			34,943				66
66.01	PHYSICAL THERAPY - LIFEPLEX	3,164,056							66.01
66.02	PHYSICAL THERAPY - CULVER MILIT								66.02
71	Medical Supplies Charged to Pat	2,274,746							71
72	Impl. Dev. Charged to Patients	2,349,555							72
73	Drugs Charged to Patients	14,107,298							73
76.97	CARDIAC REHABILITATION	435,850							76.97
76.98	HYPERBARIC OXYGEN THERAPY	2,149,074							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	409,680							90.03
90.04	WOUND CARE	2,304,411							90.04
91	Emergency	14,809,042			348,866				91
92	Observation Beds (Non-Distinct	2,325,893							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	165,921,676			2,793,887				200

(A) Worksheet A line numbers

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.228465							50
52	Delivery Room & Labor Room	0.462762							52
54	Radiology-Diagnostic	0.163453							54
55	Radiology-Therapeutic	0.284656							55
57	CT Scan	0.018775							57
59	Cardiac Catheterization	0.448676							59
60	Laboratory	0.156834							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.169868							65
66	Physical Therapy	0.414762							66
66.01	PHYSICAL THERAPY - LIFEPLEX	0.344489							66.01
66.02	PHYSICAL THERAPY - CULVER MILIT								66.02
71	Medical Supplies Charged to Pat	0.004923							71
72	Impl. Dev. Charged to Patients	0.442169							72
73	Drugs Charged to Patients	0.192062							73
76.97	CARDIAC REHABILITATION	0.258520							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.070196							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT & INFUSION								90.01
90.02	ATHLETIC TRAINERS								90.02
90.03	SAINT JOSEPH HEALTH CENTER	1.745855							90.03
90.04	WOUND CARE	0.587348							90.04
91	Emergency	0.301586							91
92	Observation Beds (Non-Distinct	0.616541							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,398	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,398	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	4,054	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,663	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	5,759,522	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,759,522	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,759,522	37

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,066.97	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,774,371	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)					1,774,371	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	2,024,137	1,196	1,692.42	574	971,449	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,707,005	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					5,452,825	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	341,183	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	211,080	51
52	Total Program excludable cost (sum of lines 50 and 51)	552,263	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	4,900,562	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0076** **WORKSHEET D-1**
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,344	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,066.97	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,434,008	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	856,754	5,759,522	0.148754	1,434,008	213,314	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,398	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,398	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	4,054	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	156	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	523	15
16	Nursery days (title V or XIX only)	354	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)	5,759,522	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,759,522	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,759,522	37

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,066.97	38
39	Program general inpatient routine service cost (line 9 x line 38)					166,447	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)					166,447	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)	478,069	523	914.09	354	323,588	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	2,024,137	1,196	1,692.42			43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					544,703	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,034,738	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	28,527	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	55,659	51
52	Total Program excludable cost (sum of lines 50 and 51)	84,186	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	950,552	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0076** **WORKSHEET D-1**
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,344	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

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

Check Applicable Boxes:

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

(A)	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		2,641,869		30
31	Intensive Care Unit		2,010,716		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.228465	2,485,841	567,928	50
52	Delivery Room & Labor Room	0.462762			52
54	Radiology-Diagnostic	0.164078	766,673	125,794	54
55	Radiology-Therapeutic	0.284656			55
57	CT Scan	0.018775	1,075,623	20,195	57
59	Cardiac Catheterization	0.448676	31,641	14,197	59
60	Laboratory	0.156834	2,331,891	365,720	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.169868	1,137,293	193,190	65
66	Physical Therapy	0.414762	423,745	175,753	66
66.01	PHYSICAL THERAPY - LIFEPLEX	0.344489			66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY				66.02
71	Medical Supplies Charged to Patients	0.004923	309,282	1,523	71
72	Impl. Dev. Charged to Patients	0.442169	953,075	421,420	72
73	Drugs Charged to Patients	0.192062	1,954,835	375,450	73
76.97	CARDIAC REHABILITATION	0.258520			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.070196	5,336	375	76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT & INFUSION CTR				90.01
90.02	ATHLETIC TRAINERS				90.02
90.03	SAINT JOSEPH HEALTH CENTER	1.745855			90.03
90.04	WOUND CARE	0.587348	10,837	6,365	90.04
91	Emergency	0.304177	948,001	288,360	91
92	Observation Beds (Non-Distinct Part)	0.616541	244,485	150,735	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		12,678,558	2,707,005	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		12,678,558		202

(A) Worksheet A line numbers

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

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

Check Applicable Boxes:

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		2,195,345		30
31	Intensive Care Unit		543,392		31
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.228465	1,211,967	276,892	50
52	Delivery Room & Labor Room	0.462762			52
54	Radiology-Diagnostic	0.164078	207,339	34,020	54
55	Radiology-Therapeutic	0.284656	2,352	670	55
57	CT Scan	0.018775	324,770	6,098	57
59	Cardiac Catheterization	0.448676	7,984	3,582	59
60	Laboratory	0.156834	655,666	102,831	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.169868			65
66	Physical Therapy	0.414762	34,943	14,493	66
66.01	PHYSICAL THERAPY - LIFEPLEX	0.344489			66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY				66.02
71	Medical Supplies Charged to Patients	0.004923			71
72	Impl. Dev. Charged to Patients	0.442169			72
73	Drugs Charged to Patients	0.192062			73
76.97	CARDIAC REHABILITATION	0.258520			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.070196			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT & INFUSION CTR				90.01
90.02	ATHLETIC TRAINERS				90.02
90.03	SAINT JOSEPH HEALTH CENTER	1.745855			90.03
90.04	WOUND CARE	0.587348			90.04
91	Emergency	0.304177	348,866	106,117	91
92	Observation Beds (Non-Distinct Part)	0.616541			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,793,887	544,703	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,793,887		202

(A) Worksheet A line numbers

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,130,324			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,694,743			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	2,123			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	1,509,545			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	41.38			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0348			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2154			31
32	Sum of lines 30 and 31	0.2502			32
33	Allowable disproportionate share percentage (see instructions)	0.0986			33
34	Disproportionate share adjustment (see instructions)	118,939			34
		Prior to		**On or after**	
	Uncompensated Care Adjustment	**October 1 (1.00)**	**(1.01)**	**October 1 (2.00)**	
35	Total uncompensated care amount (see instructions)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000052088	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	240,030		352,464	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	60,501		263,624	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	324,125			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	5,270,254			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	5,270,254			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	391,154			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	5,661,408			59
60	Primary payer payments	5,861			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	5,655,547			61
62	Deductibles billed to program beneficiaries	690,680			62
63	Coinsurance billed to program beneficiaries				63
64	Allowable bad debts (see instructions)	34,213			64
65	Adjusted reimbursable bad debts (see instructions)	22,238			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,524			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,987,105			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	11,376			70.93
70.94	HRR adjustment amount (see instructions)	-10,603			70.94
70.96	Low volume adjustment for federal fiscal year (2017)	168,126			70.96
70.97	Low volume adjustment for federal fiscal year (2018)	451,136			70.97
70.98	Low volume adjustment for federal fiscal year (OTHER ADJ (NO DESC ENTERED))				70.98
70.99	HAC adjustment amount (see instructions)	62,814			70.99
71	Amount due provider (see instructions)	5,544,326			71
71.01	Sequestration adjustment (see instructions)	110,887			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	5,626,591			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-193,152			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	53,410			75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
	HSP Bonus Payment Amount	**Prior to 10/1**	**On or After 10/1**		
100	HSP bonus amount (see instructions)				100
	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97) **EXHIBIT 4**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Pre/Post Entitlement	Prior to October 1		On or After October 1		Total (col. 2 through 4)	
		1	2	3	3.01	4	4.01	5	
1	DRG Amounts Other Than Outlier Payments								1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1,130,324		1,130,324				1,130,324	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	3,694,743				3,694,743		3,694,743	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1								1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1								1.04
2	Outlier payments for discharges	2,123		2,123				2,123	2
2.01	Outlier payment for discharges for Model 4 BPCI								2.01
3	Operating outlier reconciliation								3
4	Managed Care Simulated Payments	1,509,545		362,457		1,147,088		1,509,545	4
	Indirect Medical Education Adjustment								
5	Amount from Worksheet E Part A, line 21								5
6	IME payment adjustment								6
6.01	IME payment adjustment for managed care								6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7	IME payment adjustment factor								7
8	IME add-on adjustment amount								8
8.01	IME payment adjustment add-on for managed care								8.01
9	Total IME payment (sum of lines 6 and 8)								9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)								9.01
	Disproportionate Share Adjustment								
10	Allowable disproportionate share percentage	0.0986	0.0986	0.0986	0.0986	0.0986	0.0986		10
11	Disproportionate share adjustment	118,939		27,863		91,076		118,939	11
11.01	Uncompensated care payments	324,125		60,501		263,624		324,125	11.01
	Additional payment for high percentage of ESRD beneficiary discharges								
12	Total ESRD additional payment								12
13	Subtotal	5,270,254		1,220,811		4,049,443		5,270,254	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)								14
15	Total payment for inpatient operating costs SCH and MDH only	5,270,254		1,220,811		4,049,443		5,270,254	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	391,154		92,301		298,853		391,154	16
17	Special add-on payments for new technologies								17
17.01	DO NOT USE THIS LINE								17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG								17.02
18	Capital outlier reconciliation adjustment amount								18
19	**SUBTOTAL**			1,313,112		4,348,296		5,661,408	19
20	Capital DRG other than outlier	390,243		91,679		298,564		390,243	20
20.01	Model 4 BPCI Capital DRG other than outlier								20.01
21	Capital DRG outlier payments	911		622		289		911	21
21.01	Model 4 BPCI Capital DRG outlier payments								21.01
22	Indirect medical education percentage								22
23	Indirect medical education adjustment								23
24	Allowable disproportionate share percentage								24
25	Disproportionate share adjustment								25
26	Total prospective capital payments	391,154		92,301		298,853		391,154	26
27	**Low volume adjustment factor**			0.128036		0.103750			27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.96)(prior to 10/1)			168,126				168,126	28
29	Low Volume Adjustment (transfer amount to Worksheet E, Part A, line 70.97)(on/after 10/1)					451,136		451,136	29

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCLUATION **EXHIBIT 5**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to October 1		On or After October 1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1,130,324	1,130,324				1,130,324	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	3,694,743			3,694,743		3,694,743	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1							1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1							1.04
2	Outlier payments for discharges	2,123	2,123				2,123	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	1,509,545	362,457		1,147,088		1,509,545	4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E Part A, line 21							5
6	IME payment adjustment							6
6.01	IME payment adjustment for managed care							6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor							7
8	IME add-on adjustment amount							8
8.01	IME payment adjustment add-on for managed care							8.01
9	Total IME payment (sum of lines 6 and 8)							9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)							9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage	0.0986	0.0986	0.0986	0.0986	0.0986		10
11	Disproportionate share adjustment	118,939	27,863		91,076		118,939	11
11.01	Uncompensated care payments	324,125	60,501		263,624		324,125	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	5,270,254	1,220,811		4,049,443		5,270,254	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)							14
15	Total payment for inpatient operating costs SCH and MDH only	5,270,254	1,220,811		4,049,443		5,270,254	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	391,154	92,301		298,853		391,154	16
17	Special add-on payments for new technologies							17
17.01	DO NOT USE THIS LINE							17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG							17.02
18	Capital outlier reconciliation adjustment amount							18
19	**SUBTOTAL**		1,313,112		4,348,296		5,661,408	19
20	Capital DRG other than outlier	390,243	91,679		298,564		390,243	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	911	622		289		911	21
21.01	Model 4 BPCI Capital DRG outlier payments							21.01
22	Indirect medical education percentage							22
23	Indirect medical education adjustment							23
24	Allowable disproportionate share percentage							24
25	Disproportionate share adjustment							25
26	Total prospective capital payments	391,154	92,301		298,853		391,154	26
27								27
28	Low volume adjustment prior to October 1	168,126	168,126				168,126	28
29	Low volume adjustment on or after October 1	451,136			451,136		451,136	29
30	HVBP payment adjustment	11,376			11,376		11,376	30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-10,603	-9,495		-1,108		-10,603	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment		14,717		48,097		62,814	32

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

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

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	4,232			1
2	Medical and other services reimbursed under OPPS (see instructions)	5,535,383			2
3	OPPS payments	4,802,882			3
4	Outlier payment (see instructions)	3,677			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	4,232			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	22,187			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	22,187			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	22,187			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	17,955			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	4,232			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	4,806,559			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	32			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	999,219			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,811,540			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	3,811,540			30
31	Primary payer payments	2,007			31
32	Subtotal (line 30 minus line 31)	3,809,533			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	132,452			34
35	Adjusted reimbursable bad debts (see instructions)	86,094			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	89,800			36
37	Subtotal (see instructions)	3,895,627			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	3,895,627			40
40.01	Sequestration adjustment (see instructions)	77,913			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	3,735,331			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	82,383			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				5,599,691		3,735,331	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	01/26/2018	26,900			3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		26,900			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				5,626,591		3,735,331	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01				82,383	6.01
	based on the cost report (1)		.02		-193,152			6.02
7	Total Medicare program liability (see instructions)				5,433,439		3,817,714	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-0076** **WORKSHEET E-3 PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	2,793,887		9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	2,793,887		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	2,793,887		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,793,887		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	-96,829				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	7,441,397				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	1,018,734				7
8	Prepaid expenses					8
9	Other current assets	46,954				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	8,410,256				11
	FIXED ASSETS					
12	Land	477,930				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	44,486,499				15
16	Accumulated depreciation	-28,854,001				16
17	Leasehold improvements	403,970				17
18	Accumulated depreciation	-350,982				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	26,895,033				23
24	Accumulated depreciation	-18,412,054				24
25	Minor equipment depreciable	106,648				25
26	Accumulated depreciation	-96,705				26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	24,656,338				30
	OTHER ASSETS					
31	Investments	332,117				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	31,314,316				34
35	Total other assets (sum of lines 31-34)	31,646,433				35
36	Total assets (sum of lines 11, 30 and 35)	64,713,027				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	713,966				37
38	Salaries, wages and fees payable	1,536,035				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	6,214,995				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	8,464,996				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)					50
51	Total liabilities (sum of lines 45 and 50)	8,464,996				51
	CAPITAL ACCOUNTS					
52	General fund balance	56,248,031				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	56,248,031				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	64,713,027				60

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		69,306,070			1
2	Net income (loss) (from Worksheet G-3, line 29)		7,385,848			2
3	Total (sum of line 1 and line 2)		76,691,918			3
4	Additions (credit adjustments) (specify)					4
5	TOTAL UNREST EQ TRANSFERS EXT	-20,589,992				5
6	NA REL FROM REST FOR CAP ACQ	146,101				6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		-20,443,891			10
11	Subtotal (line 3 plus line 10)		56,248,027			11
12	Deductions (debit adjustments) (specify)					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)		56,248,027			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	TOTAL UNREST EQ TRANSFERS EXT					5
6	NA REL FROM REST FOR CAP ACQ					6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

ST. JOSEPHS REG MED CENTER PLYMOUT Provider CCN: 15-0076	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 10:06 Version: 2018.04 (08/29/2018)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	7,732,624		7,732,624	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	7,732,624		7,732,624	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	4,289,026		4,289,026	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	4,289,026		4,289,026	16
17	Total inpatient routine care services (sum of lines 10 and 16)	12,021,650		12,021,650	17
18	Ancillary services	27,221,165	121,049,187	148,270,352	18
19	Outpatient services	2,619,229	15,080,722	17,699,951	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PHARMACY	-72,246	73,554	1,308	27
27.02	INTERN-RESIDENT SERVICE (NOT APPVD.	572,555	420,393	992,948	27.02
27.03	INTENSIVIST	468,727	38,760	507,487	27.03
27.99	REVENUE ADJUSTMENTS	393,702	2,891,299	3,285,001	27.99
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	43,224,782	139,553,915	182,778,697	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		49,970,294	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		49,970,294	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	182,778,697	1
2	Less contractual allowances and discounts on patients' accounts	129,895,168	2
3	Net patient revenues (line 1 minus line 2)	52,883,529	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	49,970,294	4
5	Net income from service to patients (line 3 minus line 4)	2,913,235	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER REVENUES)	4,472,613	24
25	Total other income (sum of lines 6-24)	4,472,613	25
26	Total (line 5 plus line 25)	7,385,848	26
29	Net income (or loss) for the period (line 26 minus line 28)	7,385,848	29

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

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	390,243	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	911	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	14.72	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)	391,154	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
66.01	PHYSICAL THERAPY - LIFEPLEX							66.01
66.02	PHYSICAL THERAPY - CULVER MILITARY							66.02
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT & INFUSION CTR							90.01
90.02	ATHLETIC TRAINERS							90.02
90.03	SAINT JOSEPH HEALTH CENTER							90.03
90.04	WOUND CARE							90.04
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.01	FOUNDATION ADMINISTATION							192.01
192.02	HOSPITALIST							192.02
192.03	INTENSIVIST							192.03
194	PLYMOUTH MOB-4							194
194.01	COMMUNITY OUTREACH & PARTNERSHIP							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202