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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S PARTS I, II & III**

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. [X] ELECTRONICALLY FILED COST REPORT DATE: 11/26/2014 TIME: 08:33 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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. JOSEPH'S HOSPITAL (14-0145) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 07/01/2013 AND ENDING 06/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		88,942	-170,597	-103,312		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			71,957			10
10.01	HEALTH CLINIC - RHC II						10.01
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		88,942	-98,640	-103,312		200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A
VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS

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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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 9515 HOLY CROSS LANE	P.O. Box:		1
2	City: BREESE	State: IL	ZIP Code: 62230	County: CLINTON	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. JOSEPH'S HOSPITAL	14-0145	41180	1	07/01/1966	N	P	O	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	RHC-BREESE	14-8503	41180		01/01/2009	N	O	N	15
15.01	Hospital-Based Health Clinic - RHC II	RHC-GERMANTOWN	14-8502	41180		01/01/2009	N	O	N	15.01
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2013	To: 06 / 30 / 2014	20
21	Type of control (see instructions)	1		21

Inpatient PPS Information		1	2	
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)	N	Y	22.01
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.	1	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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	584				7	493	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	1		37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning: 07 / 01 / 2013	Ending: 06 / 30 / 2014	38

	1	2	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	Y	Y	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		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 paymetn exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, 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 and enter in column 4 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 and enter in column 4 direct 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 Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

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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 non-provider 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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
	Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 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 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						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 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86

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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 appilcable column.				N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.					95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.					97
Rural Providers				1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elinination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		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
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'		N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.			N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.			Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2		118
			Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:		55,384	308,750	309,439	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.			N	Y	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.			Y		121
Transplant Center Information						
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.			N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.					134

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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	148005	140

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

141	Name: HOSPITAL SISTERS HEALTH SYSTE	Contractor's Name: NGS	Contractor's Number: 00131	141
142	Street: 4936 LAVERNA ROAD	P.O. Box:		142
143	City: SPRINGFIELD	State: IL	ZIP Code: 62794	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	N		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no 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	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.		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
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.75		169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2013	09/30/2013	170

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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 ON 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.		N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?		N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.		N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.		N		11
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.			Y	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)	N		N		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)	Y	10/30/2014	Y	10/30/2014	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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

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

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35

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

COST REORT PREPARER INFORMATION				
41	FIRST NAME: JOHN	LAST NAME: JEFFRIES	TITLE: DIRECTOR OF FINANCE	41
42	EMPLOYER: HSHS ST JOSEPH'S HOSPITAL			42
43	PHONE NUMBER: 618-526-5312	E-MAIL ADDRESS: PATRICK,SZAJKOVICS@SRINC.ORG		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA 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	45	16,425			1,292	584	3,013	1
2	HMO AND OTHER (see instructions)						64	7		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)		45	16,425			1,292	584	3,013	7
8	INTENSIVE CARE UNIT	31	4	1,460			9		12	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						431	1,077	13
14	TOTAL (see instructions)		49	17,885			1,301	1,015	4,102	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					4,071		32,248	26
26.01	RHC II	88.01								26.01
27	TOTAL (sum of lines 14-26)		49							27
28	OBSERVATION BED DAYS								541	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)								78	30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)							62	156	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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)					433	302	1,302	1
2	HMO AND OTHER (see instructions)								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)		282.71			433	302	1,302	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		29.20						26
26.01	RHC II								26.01
27	TOTAL (sum of lines 14-26)		311.91						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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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	15,531,855		15,531,855	652,999.00	23.79	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		194,928	12,764	207,692	16,146.27	12.86	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		76,770		76,770	2,169.82	35.38	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		355,750		355,750	3,244.00	109.66	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		1,978,925		1,978,925	28,647.00	69.08	14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)		5,996,615		5,996,615			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		81,274		81,274			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		129,413		129,413	4,180.00	30.96	26
27	ADMINISTRATIVE & GENERAL		2,259,290	-99,422	2,159,868	90,502.83	23.87	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		460,283	1,868	462,151	18,759.40	24.64	30
31	LAUNDRY & LINEN SERVICE		102,815	15,863	118,678	9,015.75	13.16	31
32	HOUSEKEEPING		425,272	63,636	488,908	36,351.71	13.45	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		432,001	-328,345	103,656	7,437.00	13.94	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			328,345	328,345	22,719.00	14.45	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		549,578		549,578	12,931.05	42.50	38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		638,738		638,738	32,788.48	19.48	41
42	SOCIAL SERVICE		80,915	-2,998	77,917	2,303.25	33.83	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		15,531,855		15,531,855	652,999.00	23.79	1
2	EXCLUDED AREA SALARIES (see instructions)		194,928	12,764	207,692	16,146.27	12.86	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		15,336,927	-12,764	15,324,163	636,852.73	24.06	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		2,411,445		2,411,445	34,060.82	70.80	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		5,996,615		5,996,615		39.13%	5

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

6	TOTAL (sum of lines 3 through 5)		23,744,987	-12,764	23,732,223	670,913.55	35.37	6
7	TOTAL OVERHEAD COST (see instructions)		5,078,305	-21,053	5,057,252	236,988.47	21.34	7

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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		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	1,292,322	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	3,471,067	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)		11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	27,750	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	161,189	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	111,472	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	-24,109	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	34,698	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	5,074,389	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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

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

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

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE			9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5			10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)			12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2			15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
14.01	HOSPITAL-BASED HEALTH CLINIC - RHC II			14.01
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA **COMPONENT CCN: 14-8503** **WORKSHEET S-8**

CHECK APPLICABLE BOX: **[XX] RHC [ ] FQHC**

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 9401 HOLY CROSS	1
2	CITY: BREESE STATE: IL ZIP CODE: 62230 COUNTY: CLINTON	2
3	FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN	3

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD	DATE	
		1	2	
4	COMMUNITY HEALTH CENTER (Section 330(d), PHS Act)			4
5	MIGRANT HEALTH CENTER (Section 329(d), PHS Act)			5
6	HEALTH SERVICES FOR HOMELESS (Section 340(d), PHS Act)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8
9	OTHER (SPECIFY)			9

		1	2	
10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	N		10

FACILITY HOURS OF OPERATIONS(1)

		SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	TYPE OPERATION	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	CLINIC			0730	1830	0730	1830	0730	1830	0730	1730	0730	1700	0800	1130	11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (both type and hours of operation). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

		1	2	
12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	N		12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?	N		13
14	PROVIDER NAME: CCN NUMBER:			14

		Y/N	V	XVIII	XIX	TOTAL VISITS	
		1	2	3	4	5	
15	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (see instructions)	N					15

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HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA **COMPONENT CCN: 14-8502** **WORKSHEET S-8**

CHECK APPLICABLE BOX: **[XX] RHC [ ] FQHC**

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 205 MUNSTER ST.	1
2	CITY: GERMANTOWN STATE: IL ZIP CODE: 62245 COUNTY: CLINTON	2
3	FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN	3

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD	DATE	
		1	2	
4	COMMUNITY HEALTH CENTER (Section 330(d), PHS Act)			4
5	MIGRANT HEALTH CENTER (Section 329(d), PHS Act)			5
6	HEALTH SERVICES FOR HOMELESS (Section 340(d), PHS Act)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8
9	OTHER (SPECIFY)			9

		1	2	
10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	N		10

FACILITY HOURS OF OPERATIONS(1)

		SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	TYPE OPERATION	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	CLINIC			0830	1700	0800	1700	0800	1700	0800	1700					11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (both type and hours of operation). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

		1	2	
12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	N		12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?	N		13
14	PROVIDER NAME: CCN NUMBER:			14

		Y/N	V	XVIII	XIX	TOTAL VISITS	
		1	2	3	4	5	
15	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (see instructions)	N					15

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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)	0.398828	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	2,711,270	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	11,478,567	6
7	MEDICAID COST (line 1 times line 6)	4,577,974	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.	1,866,704	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	1,866,704	19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	1,861,843	439,490	2,301,333	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	742,555	175,281	917,836	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	742,555	175,281	917,836	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	1,491,267	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	103,567	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	1,387,700	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	553,454	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	1,471,290	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	3,337,994	31

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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		1,530,007	1,530,007		1,530,007		1,530,007	1
2	00200	CAP REL COSTS-MVBLE EQUIP		1,475,627	1,475,627		1,475,627		1,475,627	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	129,413	6,117,706	6,247,119		6,247,119	-1,194,599	5,052,520	4
5.01	00540	COMMUNICATIONS		67,336	67,336	91,354	158,690		158,690	5.01
5.02	00550	INFORMATION SYSTEMS		364,056	364,056		364,056	2,571,118	2,935,174	5.02
5.03	00560	PURCHASING	146,311	58,281	204,592	-79,500	125,092	-7,823	117,269	5.03
5.04	00570	ADMITTING	444,899	15,033	459,932	-75,601	384,331		384,331	5.04
5.05	00580	BUSINESS OFFICE	261,563	277,723	539,286		539,286	-817	538,469	5.05
5.06	00590	ADMIN & GENERAL	1,406,517	6,107,724	7,514,241	-19,922	7,494,319	-3,491,822	4,002,497	5.06
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	460,283	1,225,649	1,685,932	113,800	1,799,732		1,799,732	7
8	00800	LAUNDRY & LINEN SERVICE	102,815	17,974	120,789	15,863	136,652	-1,219	135,433	8
9	00900	HOUSEKEEPING	425,272	195,179	620,451	63,636	684,087		684,087	9
10	01000	DIETARY	432,001	190,494	622,495	-470,194	152,301	-3,803	148,498	10
11	01100	CAFETERIA				470,194	470,194	-3,348	466,846	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	549,578	8,385	557,963		557,963	-5,951	552,012	13
14	01400	CENTRAL SERVICES & SUPPLY								14
15	01500	PHARMACY								15
16	01600	MEDICAL RECORDS & LIBRARY	638,738	187,209	825,947		825,947	-35,063	790,884	16
17	01700	SOCIAL SERVICE	80,915	8,824	89,739	-2,998	86,741	-300	86,441	17
19	01900	NONPHYSICIAN ANESTHETISTS				600,034	600,034	-600,034		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 SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	1,522,919	113,893	1,636,812	-54,439	1,582,373		1,582,373	30
31	03100	INTENSIVE CARE UNIT	8,646	533	9,179	689	9,868		9,868	31
43	04300	NURSERY	220,227	64,528	284,755	18,110	302,865	-11,469	291,396	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	1,584,119	201,579	1,785,698	-19,989	1,765,709	-23,750	1,741,959	50
51	05100	RECOVERY ROOM	2,082	1,231	3,313	228	3,541		3,541	51
52	05200	DELIVERY ROOM & LABOR ROOM	463,625	54,323	517,948	44,425	562,373		562,373	52
53	05300	ANESTHESIOLOGY	44,592	1,064,162	1,108,754	-600,034	508,720	-419,355	89,365	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,099,165	394,895	1,494,060	-24,764	1,469,296		1,469,296	54
57	05700	CT SCAN	100,801	167,723	268,524	10,012	278,536		278,536	57
58	05800	MRI	80,979	86,341	167,320	6,553	173,873		173,873	58
60	06000	LABORATORY	1,013,608	1,313,341	2,326,949		2,326,949	-31,344	2,295,605	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	BLOOD STORING, PROCESSING & TRANS.		118,157	118,157		118,157		118,157	63
65	06500	RESPIRATORY THERAPY	351,115	178,273	529,388	-26,538	502,850	-22,429	480,421	65
66	06600	PHYSICAL THERAPY	1,079,072	373,427	1,452,499	16,155	1,468,654	-92,955	1,375,699	66
69	06900	ELECTROCARDIOLOGY	18,785	45,584	64,369	2,847	67,216	-33,003	34,213	69
70	07000	ELECTROENCEPHALOGRAPHY	43,780	3,606	47,386	7,568	54,954		54,954	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,888	1,044,932	1,090,820	-342,427	748,393	-56,290	692,103	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				353,402	353,402		353,402	72
73	07300	DRUGS CHARGED TO PATIENTS	352,948	1,064,243	1,417,191		1,417,191	-2,922	1,414,269	73
76.97	07697	CARDIAC REHABILITATION	101,628	3,102	104,730	16,123	120,853		120,853	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	RURAL HEALTH CLINIC	830,495	2,322,597	3,153,092	167,908	3,321,000		3,321,000	88
88.01	08801	RHC II	117,130	73,417	190,547	-190,547				88.01
91	09100	EMERGENCY	820,414	1,330,567	2,150,981		2,150,981	-1,216,209	934,772	91
91.01	09101	PRIORITY CARE CARLYLE	356,604	520,207	876,811	-23,590	853,221	-441,215	412,006	91.01
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		37,344	37,344		37,344	-37,344		113

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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	
118		SUBTOTALS (sum of lines 1-117)	15,336,927	28,425,212	43,762,139	68,358	43,830,497	-5,161,946	38,668,551	118
		NONREIMBURSABLE COST CENTERS								
192	19200	PHYSICIANS' PRIVATE OFFICES	192,012	770,909	962,921	-69,488	893,433	-426,101	467,332	192
194	07950	LIFELINE	2,916	26,702	29,618	1,130	30,748		30,748	194
194.01	07951	DEVELOPMENT								194.01
200		TOTAL (sum of lines 118-199)	15,531,855	29,222,823	44,754,678		44,754,678	-5,588,047	39,166,631	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS NON-PHYSICIAN ANESTHETISTIS	A	NONPHYSICIAN ANESTHETISTS	19	62,314	537,720	1
500	TOTAL RECLASSIFICATIONS				62,314	537,720	500
	CODE LETTER - A						
1	TO RECLASS CAFETERIA COST	B	CAFETERIA	11	328,345	141,849	1
500	TOTAL RECLASSIFICATIONS				328,345	141,849	500
	CODE LETTER - B						
1	TO RECLASS MANAGERS SALARY	C	ADULTS & PEDIATRICS	30	8,786		1
2	TO RECLASS MANAGERS SALARY	C	LAUNDRY & LINEN SERVICE	8	15,863		2
3	TO RECLASS MANAGERS SALARY	C	HOUSEKEEPING	9	63,636		3
4	TO RECLASS MANAGERS SALARY	C	INTENSIVE CARE UNIT	31	689		4
5	TO RECLASS MANAGERS SALARY	C	NURSERY	43	18,110		5
6	TO RECLASS MANAGERS SALARY	C	RECOVERY ROOM	51	228		6
7	TO RECLASS MANAGERS SALARY	C	DELIVERY ROOM & LABOR ROOM	52	44,425		7
8	TO RECLASS MANAGERS SALARY	C	RADIOLOGY-DIAGNOSTIC	54	20,694		8
9	TO RECLASS MANAGERS SALARY	C	CT SCAN	57	10,012		9
10	TO RECLASS MANAGERS SALARY	C	MRI	58	6,553		10
11	TO RECLASS MANAGERS SALARY	C	PHYSICAL THERAPY	66	61,170		11
12	TO RECLASS MANAGERS SALARY	C	ELECTROCARDIOLOGY	69	2,847		12
13	TO RECLASS MANAGER SALARY	C	ELECTROENCEPHALOGRAPHY	70	7,568		13
14	TO RECLASS MANAGERS SALARY	C	MEDICAL SUPPLIES CHARGED TO P	71	10,975		14
15	TO RECLASS MANAGERS SALARY	C	CARDIAC REHABILITATION	76.97	16,123		15
16	TO RECLASS MANAGERS SALARY	C	PHYSICIANS' PRIVATE OFFICES	192	11,634		16
17	TO RECLASS MANAGERS SALARY	C					17
500	TOTAL RECLASSIFICATIONS				299,313		500
	CODE LETTER - C						
1	RECLASS SOCIAL SERV SLRY TO LIFELIN	D	LIFELINE	194	2,998		1
500	TOTAL RECLASSIFICATIONS				2,998		500
	CODE LETTER - D						
1	RECLASS CCRH GERMANTOWN TO CCRH BRE	F	RURAL HEALTH CLINIC	88	117,130	73,417	1
500	TOTAL RECLASSIFICATIONS				117,130	73,417	500
	CODE LETTER - F						
1	RECLASS PLANT SALO PANT OPS	G	OPERATION OF PLANT	7	1,868		1
500	TOTAL RECLASSIFICATIONS				1,868		500
	CODE LETTER - G						
1	RECLASS PLANT EXP TO PANT OPS	H	OPERATION OF PLANT	7		111,932	1
2	RECLAS PLNT EXP TO PLANT OPS	H					2
3	RECLASS	H					3
500	TOTAL RECLASSIFICATIONS					111,932	500
	CODE LETTER - H						
1	RECLASS TELEPNE EXP TO TELEPHONE EX	I	COMMUNICATIONS	5.01		15,753	1
2	RECLASS TELPHONE EXP TO TLPHN EXP	I					2
3							3
500	TOTAL RECLASSIFICATIONS					15,753	500
	CODE LETTER - I						
1	RECLASS SWTCHBRD SAL TO FROM ADMT	J	COMMUNICATIONS	5.01	75,601		1
500	TOTAL RECLASSIFICATIONS				75,601		500
	CODE LETTER - J						
1	IMPLANTABLE DEVICES CHARGED TO PATI	K	IMPL. DEV. CHARGED TO PATIENT	72		353,402	1
500	TOTAL RECLASSIFICATIONS					353,402	500
	CODE LETTER - K						
	GRAND TOTAL (INCREASES)				887,569	1,234,073	

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

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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	RECLASS NON-PHYSICIAN ANESTHETISTIS	A	ANESTHESIOLOGY	53	62,314	537,720		1
500	TOTAL RECLASSIFICATIONS				62,314	537,720		500
	CODE LETTER - A							
1	TO RECLASS CAFETERIA COST	B	DIETARY	10	328,345	141,849		1
500	TOTAL RECLASSIFICATIONS				328,345	141,849		500
	CODE LETTER - B							
1	TO RECLASS MANAGERS SALARY	C	PURCHASING	5.03	79,500			1
2	TO RECLASS MANAGERS SALARY	C						2
3	TO RECLASS MANAGERS SALARY	C	ADMIN & GENERAL	5.06	19,922			3
4	TO RECLASS MANAGERS SALARY	C	ADULTS & PEDIATRICS	30	63,225			4
5	TO RECLASS MANAGERS SALARY	C	OPERATING ROOM	50	19,989			5
6	TO RECLASS MANAGERS SALARY	C	RADIOLOGY-DIAGNOSTIC	54	45,458			6
7	TO RECLASS MANAGERS SALARY	C	RESPIRATORY THERAPY	65	26,538			7
8	TO RECLASS MANAGERS SALARY	C	PHYSICAL THERAPY	66	44,681			8
9	TO RECLASS MANAGERS SALARY	C						9
10	TO RECLASS MANAGERS SALARY	C						10
11	TO RECLASS MANAGERS SALARY	C						11
12	TO RECLASS MANAGERS SALARY	C						12
13	TO RECLASS MANAGER SALARY	C						13
14	TO RECLASS MANAGERS SALARY	C						14
15	TO RECLASS MANAGERS SALARY	C						15
16	TO RECLASS MANAGERS SALARY	C						16
17	TO RECLASS MANAGERS SALARY	C						17
500	TOTAL RECLASSIFICATIONS				299,313			500
	CODE LETTER - C							
1	RECLASS SOCIAL SERV SLRY TO LIFELIN	D	SOCIAL SERVICE	17	2,998			1
500	TOTAL RECLASSIFICATIONS				2,998			500
	CODE LETTER - D							
1	RECLASS CCRH GERMANTOWN TO CCRH BRE	F	RHC II	88.01	117,130	73,417		1
500	TOTAL RECLASSIFICATIONS				117,130	73,417		500
	CODE LETTER - F							
1	RECLASS PLANT SALO PANT OPS	G	LIFELINE	194	1,868			1
500	TOTAL RECLASSIFICATIONS				1,868			500
	CODE LETTER - G							
1	RECLASS PLANT EXP TO PANT OPS	H	PRIORITY CARE CARLYLE	91.01		23,590		1
2	RECLAS PLNT EXP TO PLANT OPS	H	RURAL HEALTH CLINIC	88		8,725		2
3	RECLASS	H	PHYSICIANS' PRIVATE OFFICES	192		79,617		3
500	TOTAL RECLASSIFICATIONS					111,932		500
	CODE LETTER - H							
1	RECLASS TELEPNE EXP TO TELEPHONE EX	I	PHYSICAL THERAPY	66		334		1
2	RECLASS TELPHONE EXP TO TLPHN EXP	I	RURAL HEALTH CLINIC	88		13,914		2
3			PHYSICIANS' PRIVATE OFFICES	192		1,505		3
500	TOTAL RECLASSIFICATIONS					15,753		500
	CODE LETTER - I							
1	RECLASS SWTCHBRD SAL TO FROM ADMT	J	ADMITTING	5.04	75,601			1
500	TOTAL RECLASSIFICATIONS				75,601			500
	CODE LETTER - J							
1	IMPLANTABLE DEVICES CHARGED TO PATI	K	MEDICAL SUPPLIES CHARGED TO P	71		353,402		1
500	TOTAL RECLASSIFICATIONS					353,402		500
	CODE LETTER - K							
	GRAND TOTAL (DECREASES)				887,569	1,234,073		

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

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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 RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	1,454,337	41,000		41,000		1,495,337		1
2	LAND IMPROVEMENTS	3,808,828	25,786		25,786		3,834,614		2
3	BUILDINGS AND FIXTURES	31,431,984	896,903		896,903		32,328,887		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	22,146,405	583,342		583,342		22,729,747		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	58,841,554	1,547,031		1,547,031		60,388,585		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	58,841,554	1,547,031		1,547,031		60,388,585		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	1,530,007						1,530,007	1
2	CAP REL COSTS-MVBLE EQUIP	1,475,627						1,475,627	2
3	TOTAL (sum of lines 1-2)	3,005,634						3,005,634	3

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	1,530,007						1,530,007	1
2	CAP REL COSTS-MVBLE EQUIP	1,475,627						1,475,627	2
3	TOTAL (sum of lines 1-2)	3,005,634						3,005,634	3

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

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)	B	-5,517	PURCHASING	5.03		4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)	B	-2,922	DRUGS CHARGED TO PATIENTS	73		5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)	B	-817	BUSINESS OFFICE	5.05		7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,219,586				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)	B	-2,306	PURCHASING	5.03		11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	1,104,792				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-3,348	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-35,063	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES	B	-3,803	DIETARY	10		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE 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	A	-600,034	NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	REBATES & REFUNDS	B	-56,290	MEDICAL SUPPLIES CHARGED TO PATIENTS	71		33
34							34
35							35
36	MISCELLANEOUS INCOME	B	-18,000	INFORMATION SYSTEMS	5.02		36
36.01	MISCELLANEOUS INCOME	B	-84,176	ADMIN & GENERAL	5.06		36.01
36.02	MISCELLANEOUS INCOME	B	-5,951	NURSING ADMINISTRATION	13		36.02
36.03	MISCELLANEOUS INCOME	B	-26,355	EMPLOYEE BENEFITS DEPARTMENT	4		36.03
36.05	MISC INCOME	B	-74,119	PHYSICAL THERAPY	66		36.05
36.06	MISC INCOME	B	-1,219	LAUNDRY & LINEN SERVICE	8		36.06
36.07	MISC INCOME	B	-1,339	NURSERY	43		36.07
36.08	MISC INCOME	B	-1,000	ADMIN & GENERAL	5.06		36.08
37							37
38	NON-ALLOW INTEREST	A	-37,344	INTEREST EXPENSE	113		38
39	MEDICAID TAX	A	-1,646,027	ADMIN & GENERAL	5.06		39
40	PHYSICIAN RECRUITMENT	A	-35,002	ADMIN & GENERAL	5.06		40
41							41
42	NON-ALLOW LOBBYING COST	A	-19,836	ADMIN & GENERAL	5.06		42
43	ADVERTISING COST	A	-260,989	ADMIN & GENERAL	5.06		43
44	MEDICAL GROUP EXPENSE	A	-426,101	PHYSICIANS' PRIVATE OFFICES	192		44
45	EMPLOYEE SELF INSURANCE	A	-1,122,593	EMPLOYEE BENEFITS DEPARTMENT	4		45
46	NON-ALLOW MEDICARE EXPENSE	A	-2,802	ADMIN & GENERAL	5.06		46
47	GRANT REVENUE LIFELINE	B	-300	SOCIAL SERVICE	17		47
48							48
49							49

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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	
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-5,588,047				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5.06	ADMIN & GENERAL	CONTRACTED SERVICES HSHS	1,102,738	2,541,413	-1,438,675		1
2	5.02	INFORMATION SYSTEMS	CONTRACTED SERVICES HSHS	2,589,118		2,589,118		2
3	4	EMPLOYEE BENEFITS DEPARTMENT	HEALTH & DENTAL PREMIUMS	3,381,323	3,426,974	-45,651		3
4	88	RURAL HEALTH CLINIC	RURAL HEALTH CLINIC SERV	1,918,473	1,918,473			4
4.02	4	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY SVS-SEB	5,262	5,262			4.02
4.03	5.02	INFORMATION SYSTEMS	RELATED PARTY SVS-SEB-SID	345,420	345,420			4.03
4.04	5.06	ADMIN & GENERAL	RELATED PARTY SVS-SID	367,048	367,048			4.04
4.05	4	EMPLOYEE BENEFITS DEPARTMENT	RELATED SVS-SJH	8,098	8,098			4.05
4.11	66	PHYSICAL THERAPY	RELATED PARTY SJH	22,709	22,709			4.11
4.14	5.05	BUSINESS OFFICE	RELATED PARTY SVS-SEB	126,837	126,837			4.14
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			9,867,026	8,762,234	1,104,792		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	B		100.00	HOSPITAL SISTERS HRALTH SYSTEM		CORPORATE OFFICE	6
7	G			HSHS MEDICAL GROUP		PHYSICIAN OFFICES	7
8	G			ST. ELIZABETH BELLEVILLE		SISTER HOSPITAL	8
9	G			ST. JOHN'S HOSPITAL		SISTER HOSPITAL	9
10							10

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

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

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN / PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	5.06	ADMIN & GENERAL VARIOUS	6,199		6,199	171,400	35	2,884	144	1
2	43	NURSERY VARIOUS	20,266		20,266	171,400	123	10,136	507	2
3	50	OPERATING ROOM VARIOUS	23,750	23,750		204,100				3
4	53	ANESTHESIOLOGY VARIOUS	442,263	408,263	34,000	171,400	278	22,908	1,145	4
5	54	RADIOLOGY-DIAGNOSTIC VARIOUS	6,000		6,000	171,400	734	60,484	3,024	5
6	60	LABORATORY VARIOUS	109,541		109,541	219,500	741	78,197	3,910	6
7	65	RESPIRATORY THERAPY VARIOUS	71,624		71,624	171,400	597	49,195	2,460	7
8	66	PHYSICAL THERAPY VARIOUS	60,120		60,120	171,400	501	41,284	2,064	8
9	69	ELECTROCARDIOLOGY VARIOUS	33,003	33,003		171,400				9
10	91	EMERGENCY VARIOUS	1,235,574	1,187,574	48,000	171,400	235	19,365	968	10
11	91.01	PRIORITY CARE CARLYL VARIOUS	441,215	441,215		171,400				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,449,555	2,093,805	355,750		3,244	284,453	14,222	200

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATIO N	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRAC T-ICE INSURANC E	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW - ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	5.06	ADMIN & GENERAL VARIOUS					2,884	3,315	3,315	1
2	43	NURSERY VARIOUS					10,136	10,130	10,130	2
3	50	OPERATING ROOM VARIOUS							23,750	3
4	53	ANESTHESIOLOGY VARIOUS					22,908	11,092	419,355	4
5	54	RADIOLOGY-DIAGNOSTIC VARIOUS					60,484			5
6	60	LABORATORY VARIOUS					78,197	31,344	31,344	6
7	65	RESPIRATORY THERAPY VARIOUS					49,195	22,429	22,429	7
8	66	PHYSICAL THERAPY VARIOUS					41,284	18,836	18,836	8
9	69	ELECTROCARDIOLOGY VARIOUS							33,003	9
10	91	EMERGENCY VARIOUS					19,365	28,635	1,216,209	10
11	91.01	PRIORITY CARE CARLYL VARIOUS							441,215	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					284,453	125,781	2,219,586	200

KPMG LLP

COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NON-PATIENT TELEPHONES	DATA PRO-CESSING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,530,007	1,530,007					1
2	CAP REL COSTS-MVBLE EQUIP	1,475,627		1,475,627				2
4	EMPLOYEE BENEFITS DEPARTMENT	5,052,520	3,751	2,856	5,059,127			4
5.01	COMMUNICATIONS	158,690	2,336		24,832	185,858		5.01
5.02	INFORMATION SYSTEMS	2,935,174	16,147	313,457		10,078	3,274,856	5.02
5.03	PURCHASING	117,269	42,970		21,945	1,482		5.03
5.04	ADMITTING	384,331	10,765	6,223	121,301	1,482		5.04
5.05	BUSINESS OFFICE	538,469	11,229	1,994	85,914	8,596	3,274,856	5.05
5.06	ADMIN & GENERAL	4,002,497	315,776	29,448	455,445	14,821		5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,799,732	81,800	8,909	151,800	7,707		7
8	LAUNDRY & LINEN SERVICE	135,433	22,458	6,212	38,981	296		8
9	HOUSEKEEPING	684,087	9,230	864	160,588	1,779		9
10	DIETARY	148,498	26,209	11,293	24,923	3,557		10
11	CAFETERIA	466,846	16,080		116,973			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	552,012	7,217	1,060	180,516	1,482		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	790,884	12,936	19,273	209,802	10,968		16
17	SOCIAL SERVICE	86,441	1,482	648	25,593	2,964		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	1,582,373	175,069	121,859	482,341	18,378		30
31	INTENSIVE CARE UNIT	9,868	15,646	1,700	3,066	1,779		31
43	NURSERY	291,396	6,169	29,255	78,285			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,741,959	83,402	189,747	513,752	11,561		50
51	RECOVERY ROOM	3,541	6,633	13,461	759			51
52	DELIVERY ROOM & LABOR ROOM	562,373	16,746	32,124	166,876			52
53	ANESTHESIOLOGY	89,365	4,147	30,989	14,647	593		53
54	RADIOLOGY-DIAGNOSTIC	1,469,296	44,078	215,837	352,901	7,114		54
57	CT SCAN	278,536	3,234	426	36,398			57
58	MRI	173,873	2,306	125,724	28,751			58
60	LABORATORY	2,295,605	29,929	79,396	332,933	5,632		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	118,157						63
65	RESPIRATORY THERAPY	480,421	9,739	9,148	106,612	2,668		65
66	PHYSICAL THERAPY	1,375,699	112,343	31,517	359,851	9,782		66
69	ELECTROCARDIOLOGY	34,213		7,270	7,105			69
70	ELECTROENCEPHALOGRAPHY	54,954	5,240	8,517	16,866			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	692,103	6,588	4,743	18,677			71
72	IMPL. DEV. CHARGED TO PATIENTS	353,402						72
73	DRUGS CHARGED TO PATIENTS	1,414,269	6,034	20,839	115,930	1,482		73
76.97	CARDIAC REHABILITATION	120,853	12,262	16,012	38,677	1,186		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	3,321,000	79,869	29,578	317,707	26,975		88
88.01	RHC II							88.01
91	EMERGENCY	934,772	46,593	13,483	269,476	5,336		91
91.01	PRIORITY CARE CARLYLE	412,006	13,340	35,679	120,953			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	38,668,551	1,259,753	1,419,541	5,001,176	157,698	3,274,856	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	467,332	270,254	56,086	56,622	28,160		192
194	LIFELINE	30,748			1,329			194
194.01	DEVELOPMENT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201

KPMG LLP COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NON-PATIENT TELEPHONES	DATA PRO-CESSING	
		0	1	2	4	5.01	5.02	
202	TOTAL (sum of lines 118-201)	39,166,631	1,530,007	1,475,627	5,059,127	185,858	3,274,856	202

KPMG LLP

COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING ACCTS REC & COLL	SUBTOTAL (cols.0-4)		OPERATION OF PLANT	
		5.03	5.04	5.05	4A	5.06	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING	183,666						5.03
5.04	ADMITTING	573	524,675					5.04
5.05	BUSINESS OFFICE	909		3,921,967				5.05
5.06	ADMIN & GENERAL	1,283			4,819,270	4,819,270		5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	3,352			2,053,300	288,099	2,341,399	7
8	LAUNDRY & LINEN SERVICE	605			203,985	28,621	50,308	8
9	HOUSEKEEPING	773			857,321	120,291	20,677	9
10	DIETARY	72			214,552	30,104	58,709	10
11	CAFETERIA	72			599,971	84,182	36,020	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	101			742,388	104,164	16,166	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	292			1,044,155	146,505	28,977	16
17	SOCIAL SERVICE	31			117,159	16,439	3,320	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	3,710	19,951	149,139	2,552,820	358,186	392,167	30
31	INTENSIVE CARE UNIT	15	137	1,025	33,236	4,663	35,048	31
43	NURSERY	1,875	4,982	37,238	449,200	63,027	13,818	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,380	62,085	464,102	3,071,988	431,031	186,827	50
51	RECOVERY ROOM	57	4,766	35,628	64,845	9,098	14,858	51
52	DELIVERY ROOM & LABOR ROOM	1,689	11,100	82,973	873,881	122,614	37,513	52
53	ANESTHESIOLOGY	1,352	12,553	93,839	247,485	34,725	9,290	53
54	RADIOLOGY-DIAGNOSTIC	7,265	66,924	500,278	2,663,693	373,743	98,738	54
57	CT SCAN	1,492	58,135	434,574	812,795	114,043	7,244	57
58	MRI	303	21,740	162,511	515,208	72,289	5,165	58
60	LABORATORY	29,902	120,703	902,177	3,796,277	532,648	67,044	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	5,351	3,068	22,935	149,511	20,978		63
65	RESPIRATORY THERAPY	4,515	12,151	90,834	716,088	100,474	21,817	65
66	PHYSICAL THERAPY	2,833	22,333	166,943	2,081,301	292,027	251,657	66
69	ELECTROCARDIOLOGY	232	8,048	60,158	117,026	16,420		69
70	ELECTROENCEPHALOGRAPHY	131	3,401	25,427	114,536	16,071	11,739	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,350	11,195	83,683	864,339	121,275	14,757	71
72	IMPL. DEV. CHARGED TO PATIENTS		4,200	31,396	388,998	54,580		72
73	DRUGS CHARGED TO PATIENTS	43,570	27,320	204,222	1,833,666	257,282	13,516	73
76.97	CARDIAC REHABILITATION	126	1,795	13,418	204,329	28,669	27,468	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	13,541			3,788,670	531,588	178,912	88
88.01	RHC II							88.01
91	EMERGENCY	2,443	39,077	292,111	1,603,291	224,958	104,372	91
91.01	PRIORITY CARE CARLYLE	2,046	9,011	67,356	660,391	92,659	29,883	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	183,241	524,675	3,921,967	38,255,675	4,691,453	1,736,010	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	425			878,879	123,316	605,389	192
194	LIFELINE				32,077	4,501		194
194.01	DEVELOPMENT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	183,666	524,675	3,921,967	39,166,631	4,819,270	2,341,399	202

KPMG LLP

COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING							5.03
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	ADMIN & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	282,914						8
9	HOUSEKEEPING	21,278	1,019,567					9
10	DIETARY	1,126	4,531	309,022				10
11	CAFETERIA	1,325	34,933		756,431			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		9,777		21,140	893,635		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		10,373		53,565		1,283,575	16
17	SOCIAL SERVICE		3,219		3,773			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	84,928	424,446	309,022	95,607	264,583	310,511	30
31	INTENSIVE CARE UNIT	259	3,815		442	1,824	4,572	31
43	NURSERY	2,901	14,367		11,760	48,540	62,102	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	68,041			85,921	232,878	27,813	50
51	RECOVERY ROOM				136	561	1,905	51
52	DELIVERY ROOM & LABOR ROOM	19,695	28,436		28,958	95,676	1,143	52
53	ANESTHESIOLOGY						12,954	53
54	RADIOLOGY-DIAGNOSTIC	26,945	78,690		60,056		189,736	54
57	CT SCAN				5,778		148,588	57
58	MRI				3,841		59,435	58
60	LABORATORY	86	62,773		69,675		268,983	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.						762	63
65	RESPIRATORY THERAPY	1,349	13,651		22,738		2,286	65
66	PHYSICAL THERAPY	14,175	122,625		72,156		17,526	66
69	ELECTROCARDIOLOGY				1,224		18,669	69
70	ELECTROENCEPHALOGRAPHY				3,263		1,524	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				6,016		6,477	71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS		8,107		13,323		8,382	73
76.97	CARDIAC REHABILITATION		8,644		6,967	13,608	381	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		74,397		100,364	39,281	12,573	88
88.01	RHC II							88.01
91	EMERGENCY	23,336	107,781		41,669	154,457	123,824	91
91.01	PRIORITY CARE CARLYLE				21,684	31,986	3,429	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	265,444	1,010,565	309,022	730,056	883,394	1,283,575	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	17,470	9,002		26,103	10,241		192
194	LIFELINE				272			194
194.01	DEVELOPMENT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	282,914	1,019,567	309,022	756,431	893,635	1,283,575	202

KPMG LLP

COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		17	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
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING							5.03
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	ADMIN & GENERAL							5.06
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	143,910						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	139,605	4,931,875		4,931,875			30
31	INTENSIVE CARE UNIT		83,859		83,859			31
43	NURSERY		665,715		665,715			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		4,104,499		4,104,499			50
51	RECOVERY ROOM		91,403		91,403			51
52	DELIVERY ROOM & LABOR ROOM		1,207,916		1,207,916			52
53	ANESTHESIOLOGY		304,454		304,454			53
54	RADIOLOGY-DIAGNOSTIC		3,491,601		3,491,601			54
57	CT SCAN		1,088,448		1,088,448			57
58	MRI		655,938		655,938			58
60	LABORATORY		4,797,486		4,797,486			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		171,251		171,251			63
65	RESPIRATORY THERAPY		878,403		878,403			65
66	PHYSICAL THERAPY		2,851,467		2,851,467			66
69	ELECTROCARDIOLOGY		153,339		153,339			69
70	ELECTROENCEPHALOGRAPHY		147,133		147,133			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,012,864		1,012,864			71
72	IMPL. DEV. CHARGED TO PATIENTS		443,578		443,578			72
73	DRUGS CHARGED TO PATIENTS		2,134,276		2,134,276			73
76.97	CARDIAC REHABILITATION		290,066		290,066			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		4,725,785		4,725,785			88
88.01	RHC II							88.01
91	EMERGENCY	4,305	2,387,993		2,387,993			91
91.01	PRIORITY CARE CARLYLE		840,032		840,032			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	143,910	37,459,381		37,459,381			118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		1,670,400		1,670,400			192
194	LIFELINE		36,850		36,850			194
194.01	DEVELOPMENT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	143,910	39,166,631		39,166,631			202

KPMG LLP

COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NON-PATIENT TELEPHONES	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		3,751	2,856	6,607	6,607		4
5.01	COMMUNICATIONS		2,336		2,336	32	2,368	5.01
5.02	INFORMATION SYSTEMS	720,500	16,147	313,457	1,050,104		128	5.02
5.03	PURCHASING		42,970		42,970	29	19	5.03
5.04	ADMITTING		10,765	6,223	16,988	158	19	5.04
5.05	BUSINESS OFFICE	2,436	11,229	1,994	15,659	112	110	5.05
5.06	ADMIN & GENERAL	11,739	315,776	29,448	356,963	595	189	5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	4,675	81,800	8,909	95,384	198	98	7
8	LAUNDRY & LINEN SERVICE		22,458	6,212	28,670	51	4	8
9	HOUSEKEEPING		9,230	864	10,094	210	23	9
10	DIETARY		26,209	11,293	37,502	33	45	10
11	CAFETERIA		16,080		16,080	153		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		7,217	1,060	8,277	236	19	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		12,936	19,273	32,209	274	140	16
17	SOCIAL SERVICE		1,482	648	2,130	33	38	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	1,091	175,069	121,859	298,019	630	234	30
31	INTENSIVE CARE UNIT		15,646	1,700	17,346	4	23	31
43	NURSERY		6,169	29,255	35,424	102		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,500	83,402	189,747	274,649	670	147	50
51	RECOVERY ROOM		6,633	13,461	20,094	1		51
52	DELIVERY ROOM & LABOR ROOM		16,746	32,124	48,870	218		52
53	ANESTHESIOLOGY		4,147	30,989	35,136	19	8	53
54	RADIOLOGY-DIAGNOSTIC		44,078	215,837	259,915	461	91	54
57	CT SCAN		3,234	426	3,660	48		57
58	MRI		2,306	125,724	128,030	38		58
60	LABORATORY	57,345	29,929	79,396	166,670	435	72	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY		9,739	9,148	18,887	139	34	65
66	PHYSICAL THERAPY		112,343	31,517	143,860	470	125	66
69	ELECTROCARDIOLOGY			7,270	7,270	9		69
70	ELECTROENCEPHALOGRAPHY	720	5,240	8,517	14,477	22		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	200	6,588	4,743	11,531	24		71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS		6,034	20,839	26,873	151	19	73
76.97	CARDIAC REHABILITATION		12,262	16,012	28,274	51	15	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	645	79,869	29,578	110,092	415	344	88
88.01	RHC II							88.01
91	EMERGENCY	2,244	46,593	13,483	62,320	352	68	91
91.01	PRIORITY CARE CARLYLE		13,340	35,679	49,019	158		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	803,095	1,259,753	1,419,541	3,482,389	6,531	2,012	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		270,254	56,086	326,340	74	356	192
194	LIFELINE					2		194
194.01	DEVELOPMENT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NON-PATIENT TELEPHONES	
		0	1	2	2A	4	5.01	
202	TOTAL (sum of lines 118-201)	803,095	1,530,007	1,475,627	3,808,729	6,607	2,368	202

KPMG LLP

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DATA PRO-CESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING ACCTS REC & COLL		OPERATION OF PLANT	
		5.02	5.03	5.04	5.05	5.06	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS	1,050,232						5.02
5.03	PURCHASING		43,018					5.03
5.04	ADMITTING		134	17,299				5.04
5.05	BUSINESS OFFICE	1,050,232	213		1,066,326			5.05
5.06	ADMIN & GENERAL		301			358,048		5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		785			21,404	117,869	7
8	LAUNDRY & LINEN SERVICE		142			2,126	2,533	8
9	HOUSEKEEPING		181			8,937	1,041	9
10	DIETARY		17			2,236	2,956	10
11	CAFETERIA		17			6,254	1,813	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		24			7,739	814	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		69			10,884	1,459	16
17	SOCIAL SERVICE		7			1,221	167	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		869	657	40,548	26,611	19,742	30
31	INTENSIVE CARE UNIT		3	5	279	346	1,764	31
43	NURSERY		439	164	10,124	4,682	696	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		1,260	2,045	126,181	32,022	9,405	50
51	RECOVERY ROOM		13	157	9,687	676	748	51
52	DELIVERY ROOM & LABOR ROOM		396	366	22,559	9,109	1,888	52
53	ANESTHESIOLOGY		317	413	25,513	2,580	468	53
54	RADIOLOGY-DIAGNOSTIC		1,702	2,204	136,017	27,766	4,971	54
57	CT SCAN		350	1,915	118,153	8,473	365	57
58	MRI		71	716	44,184	5,371	260	58
60	LABORATORY		7,004	3,993	245,298	39,584	3,375	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		1,253	101	6,236	1,559		63
65	RESPIRATORY THERAPY		1,058	400	24,696	7,465	1,098	65
66	PHYSICAL THERAPY		664	736	45,389	21,695	12,669	66
69	ELECTROCARDIOLOGY		54	265	16,356	1,220		69
70	ELECTROENCEPHALOGRAPHY		31	112	6,913	1,194	591	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		11,086	369	22,752	9,010	743	71
72	IMPL. DEV. CHARGED TO PATIENTS			138	8,536	4,055		72
73	DRUGS CHARGED TO PATIENTS		10,205	900	55,524	19,114	680	73
76.97	CARDIAC REHABILITATION		30	59	3,648	2,130	1,383	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		3,172			39,493	9,007	88
88.01	RHC II							88.01
91	EMERGENCY		572	1,287	79,420	16,713	5,254	91
91.01	PRIORITY CARE CARLYLE		479	297	18,313	6,884	1,504	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,050,232	42,918	17,299	1,066,326	348,553	87,394	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		100			9,161	30,475	192
194	LIFELINE					334		194
194.01	DEVELOPMENT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,050,232	43,018	17,299	1,066,326	358,048	117,869	202

KPMG LLP

COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING							5.03
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	ADMIN & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	33,526						8
9	HOUSEKEEPING	2,521	23,007					9
10	DIETARY	133	102	43,024				10
11	CAFETERIA	157	788		25,262			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		221		706	18,036		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		234		1,789		47,058	16
17	SOCIAL SERVICE		73		126			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	10,065	9,578	43,024	3,193	5,339	11,383	30
31	INTENSIVE CARE UNIT	31	86		15	37	168	31
43	NURSERY	344	324		393	980	2,277	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	8,063			2,869	4,700	1,020	50
51	RECOVERY ROOM				5	11	70	51
52	DELIVERY ROOM & LABOR ROOM	2,334	642		967	1,931	42	52
53	ANESTHESIOLOGY						475	53
54	RADIOLOGY-DIAGNOSTIC	3,193	1,776		2,006		6,956	54
57	CT SCAN				193		5,447	57
58	MRI				128		2,179	58
60	LABORATORY	10	1,416		2,327		9,861	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.						28	63
65	RESPIRATORY THERAPY	160	308		759		84	65
66	PHYSICAL THERAPY	1,680	2,767		2,410		643	66
69	ELECTROCARDIOLOGY				41		684	69
70	ELECTROENCEPHALOGRAPHY				109		56	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				201		237	71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS		183		445		307	73
76.97	CARDIAC REHABILITATION		195		233	275	14	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		1,679		3,350	793	461	88
88.01	RHC II							88.01
91	EMERGENCY	2,765	2,432		1,392	3,117	4,540	91
91.01	PRIORITY CARE CARLYLE				724	646	126	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	31,456	22,804	43,024	24,381	17,829	47,058	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	2,070	203		872	207		192
194	LIFELINE				9			194
194.01	DEVELOPMENT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	33,526	23,007	43,024	25,262	18,036	47,058	202

KPMG LLP

COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		17	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
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING							5.03
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	ADMIN & GENERAL							5.06
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	3,795						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	3,681	473,573		473,573			30
31	INTENSIVE CARE UNIT		20,107		20,107			31
43	NURSERY		55,949		55,949			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		463,031		463,031			50
51	RECOVERY ROOM		31,462		31,462			51
52	DELIVERY ROOM & LABOR ROOM		89,322		89,322			52
53	ANESTHESIOLOGY		64,929		64,929			53
54	RADIOLOGY-DIAGNOSTIC		447,058		447,058			54
57	CT SCAN		138,604		138,604			57
58	MRI		180,977		180,977			58
60	LABORATORY		480,045		480,045			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		9,177		9,177			63
65	RESPIRATORY THERAPY		55,088		55,088			65
66	PHYSICAL THERAPY		233,108		233,108			66
69	ELECTROCARDIOLOGY		25,899		25,899			69
70	ELECTROENCEPHALOGRAPHY		23,505		23,505			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		55,953		55,953			71
72	IMPL. DEV. CHARGED TO PATIENTS		12,729		12,729			72
73	DRUGS CHARGED TO PATIENTS		114,401		114,401			73
76.97	CARDIAC REHABILITATION		36,307		36,307			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		168,806		168,806			88
88.01	RHC II							88.01
91	EMERGENCY	114	180,346		180,346			91
91.01	PRIORITY CARE CARLYLE		78,150		78,150			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	3,795	3,438,526		3,438,526			118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		369,858		369,858			192
194	LIFELINE		345		345			194
194.01	DEVELOPMENT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	3,795	3,808,729		3,808,729			202

KPMG LLP

COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON-PATIENT TELEPHONES PHONES	DATA PRO-CESSING TIME SPENT	PURCHASING RECEIVING AND STORES SUPPLY EXP	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	204,381						1
2	CAP REL COSTS-MVBLE EQUIP		1,468,161					2
4	EMPLOYEE BENEFITS DEPARTMENT	501	2,842	15,402,442				4
5.01	COMMUNICATIONS	312		75,601	627			5.01
5.02	INFORMATION SYSTEMS	2,157	311,870		34	10,000		5.02
5.03	PURCHASING	5,740		66,811	5		4,055,784	5.03
5.04	ADMITTING	1,438	6,192	369,298	5		12,662	5.04
5.05	BUSINESS OFFICE	1,500	1,984	261,563	29	10,000	20,065	5.05
5.06	ADMIN & GENERAL	42,182	29,299	1,386,595	50		28,332	5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	10,927	8,864	462,151	26		74,019	7
8	LAUNDRY & LINEN SERVICE	3,000	6,181	118,678	1		13,362	8
9	HOUSEKEEPING	1,233	860	488,908	6		17,077	9
10	DIETARY	3,501	11,236	75,878	12		1,599	10
11	CAFETERIA	2,148		356,123			1,597	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	964	1,055	549,578	5		2,234	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	1,728	19,175	638,738	37		6,459	16
17	SOCIAL SERVICE	198	645	77,917	10		690	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	23,386	121,242	1,468,480	62		81,934	30
31	INTENSIVE CARE UNIT	2,090	1,691	9,335	6		325	31
43	NURSERY	824	29,107	238,337			41,403	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,141	188,787	1,564,130	39		118,813	50
51	RECOVERY ROOM	886	13,393	2,310			1,269	51
52	DELIVERY ROOM & LABOR ROOM	2,237	31,961	508,050			37,301	52
53	ANESTHESIOLOGY	554	30,832	44,592	2		29,856	53
54	RADIOLOGY-DIAGNOSTIC	5,888	214,745	1,074,401	24		160,439	54
57	CT SCAN	432	424	110,813			32,951	57
58	MRI	308	125,088	87,532			6,701	58
60	LABORATORY	3,998	78,994	1,013,608	19		660,310	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.						118,157	63
65	RESPIRATORY THERAPY	1,301	9,102	324,577	9		99,709	65
66	PHYSICAL THERAPY	15,007	31,358	1,095,561	33		62,558	66
69	ELECTROCARDIOLOGY		7,233	21,632			5,126	69
70	ELECTROENCEPHALOGRAPHY	700	8,474	51,348			2,886	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	880	4,719	56,863			1,045,497	71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS	806	20,734	352,948	5		962,119	73
76.97	CARDIAC REHABILITATION	1,638	15,931	117,751	4		2,788	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	10,669	29,428	967,253	91		299,025	88
88.01	RHC II							88.01
91	EMERGENCY	6,224	13,415	820,414	18		53,957	91
91.01	PRIORITY CARE CARLYLE	1,782	35,498	368,238			45,174	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	168,280	1,412,359	15,226,012	532	10,000	4,046,394	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	36,101	55,802	172,384	95		9,390	192
194	LIFELINE			4,046				194
194.01	DEVELOPMENT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON-PATIENT TELEPHONES PHONES	DATA PRO-CESSING TIME SPENT	PURCHASING RECEIVING AND STORES SUPPLY EXP	
		1	2	4	5.01	5.02	5.03	
202	COST TO BE ALLOC PER B PT I	1,530,007	1,475,627	5,059,127	185,858	3,274,856	183,666	202
203	UNIT COST MULT-WS B PT I	7.486053	1.005085	0.328463	296.424242	327.485600	0.045285	203
204	COST TO BE ALLOC PER B PT II			6,607	2,368	1,050,232	43,018	204
205	UNIT COST MULT-WS B PT II			0.000429	3.776715	105.023200	0.010607	205

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

	COST CENTER DESCRIPTIONS	ADMITTING GROSS REVENUE	CASHIERING ACCTS REC & COLL GROSS REVENUE	RECON-CILIATION	ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		5.04	5.05	5A.06	5.06	7	8	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING							5.03
5.04	ADMITTING	93,923,669						5.04
5.05	BUSINESS OFFICE		93,923,669					5.05
5.06	ADMIN & GENERAL			-4,819,270	34,347,361			5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT				2,053,300	139,624		7
8	LAUNDRY & LINEN SERVICE				203,985	3,000	276,411	8
9	HOUSEKEEPING				857,321	1,233	20,789	9
10	DIETARY				214,552	3,501	1,100	10
11	CAFETERIA				599,971	2,148	1,295	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION				742,388	964		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY				1,044,155	1,728		16
17	SOCIAL SERVICE				117,159	198		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	3,571,592	3,571,592		2,552,820	23,386	82,976	30
31	INTENSIVE CARE UNIT	24,535	24,535		33,236	2,090	253	31
43	NURSERY	891,784	891,784		449,200	824	2,834	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,114,358	11,114,358		3,071,988	11,141	66,477	50
51	RECOVERY ROOM	853,212	853,212		64,845	886		51
52	DELIVERY ROOM & LABOR ROOM	1,987,055	1,987,055		873,881	2,237	19,242	52
53	ANESTHESIOLOGY	2,247,257	2,247,257		247,485	554		53
54	RADIOLOGY-DIAGNOSTIC	11,980,693	11,980,693		2,663,693	5,888	26,326	54
57	CT SCAN	10,407,205	10,407,205		812,795	432		57
58	MRI	3,891,829	3,891,829		515,208	308		58
60	LABORATORY	21,605,503	21,605,503		3,796,277	3,998	84	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	549,247	549,247		149,511			63
65	RESPIRATORY THERAPY	2,175,308	2,175,308		716,088	1,301	1,318	65
66	PHYSICAL THERAPY	3,997,973	3,997,973		2,081,301	15,007	13,849	66
69	ELECTROCARDIOLOGY	1,440,671	1,440,671		117,026			69
70	ELECTROENCEPHALOGRAPHY	608,928	608,928		114,536	700		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,004,044	2,004,044		864,339	880		71
72	IMPL. DEV. CHARGED TO PATIENTS	751,876	751,876		388,998			72
73	DRUGS CHARGED TO PATIENTS	4,890,714	4,890,714		1,833,666	806		73
76.97	CARDIAC REHABILITATION	321,342	321,342		204,329	1,638		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC				3,788,670	10,669		88
88.01	RHC II							88.01
91	EMERGENCY	6,995,492	6,995,492		1,603,291	6,224	22,800	91
91.01	PRIORITY CARE CARLYLE	1,613,051	1,613,051		660,391	1,782		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	93,923,669	93,923,669	-4,819,270	33,436,405	103,523	259,343	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES				878,879	36,101	17,068	192
194	LIFELINE				32,077			194
194.01	DEVELOPMENT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	524,675	3,921,967		4,819,270	2,341,399	282,914	202

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	ADMITTING GROSS REVENUE	CASHIERING ACCTS REC & COLL GROSS REVENUE	RECON-CILIATION	ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		5.04	5.05	5A.06	5.06	7	8	
203	UNIT COST MULT-WS B PT I	0.005586	0.041757		0.140310	16.769316	1.023527	203
204	COST TO BE ALLOC PER B PT II	17,299	1,066,326		358,048	117,869	33,526	204
205	UNIT COST MULT-WS B PT II	0.000184	0.011353		0.010424	0.844189	0.121290	205

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA FTE'S	NURSING ADMINIS-TRATION DIRECT NRSING HRS	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	
		9	10	11	13	16	17	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING							5.03
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	ADMIN & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	17,103						9
10	DIETARY	76	17,327					10
11	CAFETERIA	586		22,256				11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	164		622	6,370			13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	174		1,576		3,369		16
17	SOCIAL SERVICE	54		111			468	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	7,120	17,327	2,813	1,886	815	454	30
31	INTENSIVE CARE UNIT	64		13	13	12		31
43	NURSERY	241		346	346	163		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			2,528	1,660	73		50
51	RECOVERY ROOM			4	4	5		51
52	DELIVERY ROOM & LABOR ROOM	477		852	682	3		52
53	ANESTHESIOLOGY					34		53
54	RADIOLOGY-DIAGNOSTIC	1,320		1,767		498		54
57	CT SCAN			170		390		57
58	MRI			113		156		58
60	LABORATORY	1,053		2,050		706		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.					2		63
65	RESPIRATORY THERAPY	229		669		6		65
66	PHYSICAL THERAPY	2,057		2,123		46		66
69	ELECTROCARDIOLOGY			36		49		69
70	ELECTROENCEPHALOGRAPHY			96		4		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			177		17		71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS	136		392		22		73
76.97	CARDIAC REHABILITATION	145		205	97	1		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	1,248		2,953	280	33		88
88.01	RHC II							88.01
91	EMERGENCY	1,808		1,226	1,101	325	14	91
91.01	PRIORITY CARE CARLYLE			638	228	9		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	16,952	17,327	21,480	6,297	3,369	468	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	151		768	73			192
194	LIFELINE			8				194
194.01	DEVELOPMENT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,019,567	309,022	756,431	893,635	1,283,575	143,910	202

KPMG LLP COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA FTE'S	NURSING ADMINIS-TRATION DIRECT NRSING HRS	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	
		9	10	11	13	16	17	
203	UNIT COST MULT-WS B PT I	59.613343	17.834709	33.987734	140.288069	380.995844	307.500000	203
204	COST TO BE ALLOC PER B PT II	23,007	43,024	25,262	18,036	47,058	3,795	204
205	UNIT COST MULT-WS B PT II	1.345203	2.483061	1.135065	2.831397	13.967943	8.108974	205

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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

	COST CENTER DESCRIPTIONS							
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING							5.03
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	ADMIN & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
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							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
91	EMERGENCY							91
91.01	PRIORITY CARE CARLYLE							91.01
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							
192	PHYSICIANS' PRIVATE OFFICES							192
194	LIFELINE							194
194.01	DEVELOPMENT							194.01
200	CROSS FOOT ADJUSTMENTS							200

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

	COST CENTER DESCRIPTIONS							
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I							202
203	UNIT COST MULT-WS B PT I							203
204	COST TO BE ALLOC PER B PT II							204
205	UNIT COST MULT-WS B PT II							205

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	4,931,875		4,931,875		4,931,875	30
31	INTENSIVE CARE UNIT	83,859		83,859		83,859	31
43	NURSERY	665,715		665,715	10,130	675,845	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	4,104,499		4,104,499		4,104,499	50
51	RECOVERY ROOM	91,403		91,403		91,403	51
52	DELIVERY ROOM & LABOR ROOM	1,207,916		1,207,916		1,207,916	52
53	ANESTHESIOLOGY	304,454		304,454	11,092	315,546	53
54	RADIOLOGY-DIAGNOSTIC	3,491,601		3,491,601		3,491,601	54
57	CT SCAN	1,088,448		1,088,448		1,088,448	57
58	MRI	655,938		655,938		655,938	58
60	LABORATORY	4,797,486		4,797,486	31,344	4,828,830	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	171,251		171,251		171,251	63
65	RESPIRATORY THERAPY	878,403		878,403	22,429	900,832	65
66	PHYSICAL THERAPY	2,851,467		2,851,467	18,836	2,870,303	66
69	ELECTROCARDIOLOGY	153,339		153,339		153,339	69
70	ELECTROENCEPHALOGRAPHY	147,133		147,133		147,133	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,012,864		1,012,864		1,012,864	71
72	IMPL. DEV. CHARGED TO PATIENTS	443,578		443,578		443,578	72
73	DRUGS CHARGED TO PATIENTS	2,134,276		2,134,276		2,134,276	73
76.97	CARDIAC REHABILITATION	290,066		290,066		290,066	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	4,725,785		4,725,785		4,725,785	88
88.01	RHC II						88.01
91	EMERGENCY	2,387,993		2,387,993	28,635	2,416,628	91
91.01	PRIORITY CARE CARLYLE	840,032		840,032		840,032	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	750,746		750,746		750,746	92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	38,210,127		38,210,127	122,466	38,332,593	200
201	LESS OBSERVATION BEDS	750,746		750,746		750,746	201
202	TOTAL (SEE INSTRUCTIONS)	37,459,381		37,459,381		37,581,847	202

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	3,035,105		3,035,105				30
31	INTENSIVE CARE UNIT	24,535		24,535				31
43	NURSERY	891,784		891,784				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,466,946	9,647,412	11,114,358	0.369297	0.369297	0.369297	50
51	RECOVERY ROOM	143,331	709,881	853,212	0.107128	0.107128	0.107128	51
52	DELIVERY ROOM & LABOR ROOM	1,593,888	393,167	1,987,055	0.607893	0.607893	0.607893	52
53	ANESTHESIOLOGY	347,843	1,899,414	2,247,257	0.135478	0.135478	0.140414	53
54	RADIOLOGY-DIAGNOSTIC	700,868	11,279,825	11,980,693	0.291436	0.291436	0.291436	54
57	CT SCAN	1,170,700	9,236,505	10,407,205	0.104586	0.104586	0.104586	57
58	MRI	35,809	3,856,020	3,891,829	0.168542	0.168542	0.168542	58
60	LABORATORY	2,315,422	19,290,081	21,605,503	0.222049	0.222049	0.223500	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	207,520	341,727	549,247	0.311792	0.311792	0.311792	63
65	RESPIRATORY THERAPY	1,496,369	678,939	2,175,308	0.403806	0.403806	0.414117	65
66	PHYSICAL THERAPY	85,437	3,912,536	3,997,973	0.713228	0.713228	0.717940	66
69	ELECTROCARDIOLOGY	93,510	1,347,161	1,440,671	0.106436	0.106436	0.106436	69
70	ELECTROENCEPHALOGRAPHY	542	608,386	608,928	0.241626	0.241626	0.241626	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	557,185	1,446,859	2,004,044	0.505410	0.505410	0.505410	71
72	IMPL. DEV. CHARGED TO PATIENTS	364,655	387,221	751,876	0.589962	0.589962	0.589962	72
73	DRUGS CHARGED TO PATIENTS	1,549,257	3,341,457	4,890,714	0.436394	0.436394	0.436394	73
76.97	CARDIAC REHABILITATION		321,342	321,342	0.902671	0.902671	0.902671	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
91	EMERGENCY	770,833	6,224,659	6,995,492	0.341362	0.341362	0.345455	91
91.01	PRIORITY CARE CARLYLE	8,739	1,604,312	1,613,051	0.520772	0.520772	0.520772	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	75,208	461,279	536,487	1.399374	1.399374	1.399374	92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	16,935,486	76,988,183	93,923,669				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	16,935,486	76,988,183	93,923,669				202

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	473,573		473,573	3,554	133.25	1,292	172,159	30
31	INTENSIVE CARE UNIT	20,107		20,107	12	1,675.58	9	15,080	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	55,949		55,949	1,077	51.95			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	549,629		549,629	4,643		1,301	187,239	200

(A) Worksheet A line numbers

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COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0145** **WORKSHEET D PART II**

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

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	463,031	11,114,358	0.041661	488,367	20,346	50
51	RECOVERY ROOM	31,462	853,212	0.036875	62,884	2,319	51
52	DELIVERY ROOM & LABOR ROOM	89,322	1,987,055	0.044952			52
53	ANESTHESIOLOGY	64,929	2,247,257	0.028893	115,352	3,333	53
54	RADIOLOGY-DIAGNOSTIC	447,058	11,980,693	0.037315	420,682	15,698	54
57	CT SCAN	138,604	10,407,205	0.013318	677,364	9,021	57
58	MRI	180,977	3,891,829	0.046502	19,785	920	58
60	LABORATORY	480,045	21,605,503	0.022219	1,240,958	27,573	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	9,177	549,247	0.016708	76,680	1,281	63
65	RESPIRATORY THERAPY	55,088	2,175,308	0.025324	1,106,380	28,018	65
66	PHYSICAL THERAPY	233,108	3,997,973	0.058307	66,863	3,899	66
69	ELECTROCARDIOLOGY	25,899	1,440,671	0.017977	73,245	1,317	69
70	ELECTROENCEPHALOGRAPHY	23,505	608,928	0.038601	542	21	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,953	2,004,044	0.027920	207,770	5,801	71
72	IMPL. DEV. CHARGED TO PATIENTS	12,729	751,876	0.016930	268,819	4,551	72
73	DRUGS CHARGED TO PATIENTS	114,401	4,890,714	0.023391	721,137	16,868	73
76.97	CARDIAC REHABILITATION	36,307	321,342	0.112986			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	168,806					88
88.01	RHC II						88.01
91	EMERGENCY	180,346	6,995,492	0.025780	495,663	12,778	91
91.01	PRIORITY CARE CARLYLE	78,150	1,613,051	0.048449	3,727	181	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	72,089	536,487	0.134372	33,746	4,535	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	2,960,986	89,972,245		6,079,964	158,460	200

(A) Worksheet A line numbers

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (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

KPMG LLP COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	3,554		1,292		30
31	INTENSIVE CARE UNIT	12		9		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	1,077				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	4,643		1,301		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0145** | **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/MR | [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
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							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
91	EMERGENCY							91
91.01	PRIORITY CARE CARLYLE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0145** | **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/MR | [XX] PPS [ ] TEFRA

		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	11,114,358			488,367		3,256,474		50
51	RECOVERY ROOM	853,212			62,884		214,192		51
52	DELIVERY ROOM & LABOR ROOM	1,987,055							52
53	ANESTHESIOLOGY	2,247,257			115,352		498,455		53
54	RADIOLOGY-DIAGNOSTIC	11,980,693			420,682		3,735,649		54
57	CT SCAN	10,407,205			677,364		3,635,397		57
58	MRI	3,891,829			19,785		1,144,892		58
60	LABORATORY	21,605,503			1,240,958		1,677,041		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	549,247			76,680		112,895		63
65	RESPIRATORY THERAPY	2,175,308			1,106,380		266,720		65
66	PHYSICAL THERAPY	3,997,973			66,863		1,259,758		66
69	ELECTROCARDIOLOGY	1,440,671			73,245		698,894		69
70	ELECTROENCEPHALOGRAPHY	608,928			542		308,593		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,004,044			207,770		327,229		71
72	IMPL. DEV. CHARGED TO PATIENTS	751,876			268,819		214,526		72
73	DRUGS CHARGED TO PATIENTS	4,890,714			721,137		1,244,808		73
76.97	CARDIAC REHABILITATION	321,342					177,287		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
91	EMERGENCY	6,995,492			495,663		1,944,926		91
91.01	PRIORITY CARE CARLYLE	1,613,051			3,727		72,385		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	536,487			33,746		230,371		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	89,972,245			6,079,964		21,020,492		200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0145** **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/MR

			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	0.369297	3,256,474			1,202,606			50
51	RECOVERY ROOM	0.107128	214,192			22,946			51
52	DELIVERY ROOM & LABOR ROOM	0.607893							52
53	ANESTHESIOLOGY	0.135478	498,455			67,530			53
54	RADIOLOGY-DIAGNOSTIC	0.291436	3,735,649			1,088,703			54
57	CT SCAN	0.104586	3,635,397			380,212			57
58	MRI	0.168542	1,144,892			192,962			58
60	LABORATORY	0.222049	1,677,041			372,385			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.311792	112,895			35,200			63
65	RESPIRATORY THERAPY	0.403806	266,720	19,976		107,703	8,066		65
66	PHYSICAL THERAPY	0.713228	1,259,758			898,495			66
69	ELECTROCARDIOLOGY	0.106436	698,894			74,387			69
70	ELECTROENCEPHALOGRAPHY	0.241626	308,593			74,564			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.505410	327,229	2,034		165,385	1,028		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.589962	214,526			126,562			72
73	DRUGS CHARGED TO PATIENTS	0.436394	1,244,808		20,380	543,227		8,894	73
76.97	CARDIAC REHABILITATION	0.902671	177,287			160,032			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
91	EMERGENCY	0.341362	1,944,926			663,924			91
91.01	PRIORITY CARE CARLYLE	0.520772	72,385			37,696			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.399374	230,371			322,375			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		21,020,492	22,010	20,380	6,536,894	9,094	8,894	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		21,020,492	22,010	20,380	6,536,894	9,094	8,894	202

(A) Worksheet A line numbers

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	473,573		473,573	3,554	133.25	584	77,818	30
31	INTENSIVE CARE UNIT	20,107		20,107	12	1,675.58			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	55,949		55,949	1,077	51.95	431	22,390	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	549,629		549,629	4,643		1,015	100,208	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0145** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] TITLE XVIII, PART A [ ] IPF [XX] TITLE XIX [ ] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26) 1	TOTAL CHARGES (from Wkst. C, Part I, (col. 8) 2	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL COSTS (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	463,031	11,114,358	0.041661			50
51	RECOVERY ROOM	31,462	853,212	0.036875			51
52	DELIVERY ROOM & LABOR ROOM	89,322	1,987,055	0.044952			52
53	ANESTHESIOLOGY	64,929	2,247,257	0.028893			53
54	RADIOLOGY-DIAGNOSTIC	447,058	11,980,693	0.037315			54
57	CT SCAN	138,604	10,407,205	0.013318			57
58	MRI	180,977	3,891,829	0.046502			58
60	LABORATORY	480,045	21,605,503	0.022219			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	9,177	549,247	0.016708			63
65	RESPIRATORY THERAPY	55,088	2,175,308	0.025324			65
66	PHYSICAL THERAPY	233,108	3,997,973	0.058307			66
69	ELECTROCARDIOLOGY	25,899	1,440,671	0.017977			69
70	ELECTROENCEPHALOGRAPHY	23,505	608,928	0.038601			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,953	2,004,044	0.027920			71
72	IMPL. DEV. CHARGED TO PATIENTS	12,729	751,876	0.016930			72
73	DRUGS CHARGED TO PATIENTS	114,401	4,890,714	0.023391			73
76.97	CARDIAC REHABILITATION	36,307	321,342	0.112986			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	168,806					88
88.01	RHC II						88.01
91	EMERGENCY	180,346	6,995,492	0.025780			91
91.01	PRIORITY CARE CARLYLE	78,150	1,613,051	0.048449			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	72,089	536,487	0.134372			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	2,960,986	89,972,245				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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

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

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (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

KPMG LLP COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	3,554		584		30
31	INTENSIVE CARE UNIT	12				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	1,077		431		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	4,643		1,015		200

(A) Worksheet A line numbers

KPMG LLP

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0145** | **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
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							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
91	EMERGENCY							91
91.01	PRIORITY CARE CARLYLE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0145** | **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/MR

		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	11,114,358							50
51	RECOVERY ROOM	853,212							51
52	DELIVERY ROOM & LABOR ROOM	1,987,055							52
53	ANESTHESIOLOGY	2,247,257							53
54	RADIOLOGY-DIAGNOSTIC	11,980,693							54
57	CT SCAN	10,407,205							57
58	MRI	3,891,829							58
60	LABORATORY	21,605,503							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	549,247							63
65	RESPIRATORY THERAPY	2,175,308							65
66	PHYSICAL THERAPY	3,997,973							66
69	ELECTROCARDIOLOGY	1,440,671							69
70	ELECTROENCEPHALOGRAPHY	608,928							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,004,044							71
72	IMPL. DEV. CHARGED TO PATIENTS	751,876							72
73	DRUGS CHARGED TO PATIENTS	4,890,714							73
76.97	CARDIAC REHABILITATION	321,342							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
91	EMERGENCY	6,995,492							91
91.01	PRIORITY CARE CARLYLE	1,613,051							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	536,487							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	89,972,245							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0145** **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/MR

			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	0.369297							50
51	RECOVERY ROOM	0.107128							51
52	DELIVERY ROOM & LABOR ROOM	0.607893							52
53	ANESTHESIOLOGY	0.135478							53
54	RADIOLOGY-DIAGNOSTIC	0.291436							54
57	CT SCAN	0.104586							57
58	MRI	0.168542							58
60	LABORATORY	0.222049							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.311792							63
65	RESPIRATORY THERAPY	0.403806							65
66	PHYSICAL THERAPY	0.713228							66
69	ELECTROCARDIOLOGY	0.106436							69
70	ELECTROENCEPHALOGRAPHY	0.241626							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.505410							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.589962							72
73	DRUGS CHARGED TO PATIENTS	0.436394							73
76.97	CARDIAC REHABILITATION	0.902671							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
91	EMERGENCY	0.341362							91
91.01	PRIORITY CARE CARLYLE	0.520772							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.399374							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

KPMG LLP COMPU-MAX

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0145** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[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)	3,554	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	3,554	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	306	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	2,707	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,292	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,931,875	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	4,931,875	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	2,730,354	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	215,730	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	2,514,624	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	1.806313	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	705.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	928.93	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	4,931,875	37

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0145** **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)					1,387.70	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					1,792,908	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)					1,792,908	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	83,859	12	6,988.25	9	62,894	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 (Worksheet D-3, column 3, line 200)					2,014,125	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					3,869,927	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					187,239	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					158,460	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					345,699	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					3,524,228	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 ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

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COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0145** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					541	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,387.70	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					750,746	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	473,573	4,931,875	0.096023	750,746	72,089	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0145** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	3,554	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	3,554	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	306	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	2,707	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	584	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)	1,077	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	431	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)	4,931,875	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	4,931,875	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	2,730,354	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	215,730	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	2,514,624	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	1.806313	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	705.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	928.93	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	4,931,875	37

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0145** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] PPS [ ] TEFRA [XX] 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)					1,387.70	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					810,417	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)					810,417	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)	665,715	1,077	618.12	431	266,410	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	83,859	12	6,988.25			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 (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					1,076,827	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					100,208	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					100,208	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						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 ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0145** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					541	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 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0145** **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/MR**	**[ ] OTHER**

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		1,168,870		30
31	INTENSIVE CARE UNIT		17,344		31
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.369297	488,367	180,352	50
51	RECOVERY ROOM	0.107128	62,884	6,737	51
52	DELIVERY ROOM & LABOR ROOM	0.607893			52
53	ANESTHESIOLOGY	0.140414	115,352	16,197	53
54	RADIOLOGY-DIAGNOSTIC	0.291436	420,682	122,602	54
57	CT SCAN	0.104586	677,364	70,843	57
58	MRI	0.168542	19,785	3,335	58
60	LABORATORY	0.223500	1,240,958	277,354	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.311792	76,680	23,908	63
65	RESPIRATORY THERAPY	0.414117	1,106,380	458,171	65
66	PHYSICAL THERAPY	0.717940	66,863	48,004	66
69	ELECTROCARDIOLOGY	0.106436	73,245	7,796	69
70	ELECTROENCEPHALOGRAPHY	0.241626	542	131	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.505410	207,770	105,009	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.589962	268,819	158,593	72
73	DRUGS CHARGED TO PATIENTS	0.436394	721,137	314,700	73
76.97	CARDIAC REHABILITATION	0.902671			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
91	EMERGENCY	0.345455	495,663	171,229	91
91.01	PRIORITY CARE CARLYLE	0.520772	3,727	1,941	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.399374	33,746	47,223	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		6,079,964	2,014,125	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		6,079,964		202

(A) Worksheet A line numbers

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0145** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:
[ ] TITLE V **[XX] TITLE XVIII, PART A** **[XX] TITLE XIX**
[XX] HOSPITAL **[ ] IPF** **[ ] IRF**
[ ] SUB (OTHER) **[ ] SNF** **[ ] NF**
[ ] SWING BED SNF **[ ] SWING BED NF** **[ ] ICF/MR**
[ ] PPS **[ ] TEFRA** **[XX] 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				30
31	INTENSIVE CARE UNIT				31
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.369297			50
51	RECOVERY ROOM	0.107128			51
52	DELIVERY ROOM & LABOR ROOM	0.607893			52
53	ANESTHESIOLOGY	0.135478			53
54	RADIOLOGY-DIAGNOSTIC	0.291436			54
57	CT SCAN	0.104586			57
58	MRI	0.168542			58
60	LABORATORY	0.222049			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.311792			63
65	RESPIRATORY THERAPY	0.403806			65
66	PHYSICAL THERAPY	0.713228			66
69	ELECTROCARDIOLOGY	0.106436			69
70	ELECTROENCEPHALOGRAPHY	0.241626			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.505410			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.589962			72
73	DRUGS CHARGED TO PATIENTS	0.436394			73
76.97	CARDIAC REHABILITATION	0.902671			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
91	EMERGENCY	0.341362			91
91.01	PRIORITY CARE CARLYLE	0.520772			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.399374			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

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, 2013 (see instructions)	786,718			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	1,930,137			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	8,099			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	134,561			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	47.52			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) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0046			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.2500			31
32	SUM OF LINES 30 AND 31	0.2546			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1022			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	129,718			34
		PRIOR TO	ON OR AFTER		

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		276,881		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		207,092		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	207,092			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)	433			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
47	SUBTOTAL (see instructions)	3,061,764			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)	3,400,184			48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	3,315,579			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	215,697			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	3,531,276			59
60	PRIMARY PAYER PAYMENTS				60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	3,531,276			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	382,304			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	1,216			63
64	ALLOWABLE BAD DEBTS (see instructions)	52,499			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	34,124			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	34,232			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	3,181,880			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	17,444			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-393			70.94
70.96	LOW VOLUME ADJUSTMENT FOR FEDERAL FISCAL YEAR (2013)	157,168			70.96
70.97	LOW VOLUME ADJUSTMENT FOR FEDERAL FISCAL YEAR (2014)	426,141			70.97
71	AMOUNT DUE PROVIDER (see instructions)	3,782,240			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	75,645			71.01
72	INTERIM PAYMENTS	3,617,653			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	88,942			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	88,497			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2				91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				93

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
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

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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

		AMOUNTS FROM E PART A	PRIOR TO 10/1/2010 OR AFTER 3/31/2015 PRE/POST ENTITLE-MENT	10/01/2012 through 09/30/2013		10/01/2013 through 09/30/2014		(COLUMNS 2 THROUGH 4) TOTAL	
		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 prior to 10/1/2013	786,718		786,718				786,718	1.01
1.02	DRG Amounts Other Than Outlier Payments for Discharges on/after 10/1/2013	1,930,137				1,930,137		1,930,137	1.02
1.03	DRG for Federal Specific Operating Payment for Model 4 BPCI								1.03
2	Outlier Payments for Discharges	8,099				8,099		8,099	2
2.01	Outlier Payment for Discharges for Model 4 BPCI								2.01
3	Operating Outlier Reconciliation								3
4	Managed Care Simulated Payments	134,561		11,905		122,656		134,561	4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT								
5	Amount from Worksheet E Part A, Line 21								5
6	IME Payment Adjustment								6
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422								
7	Amount from Worksheet E Part A, Line 27								7
8	IME Add-on Adjustment								8
9	Total IME Payment								9
	DISPROPORTIONATE SHARE ADJUSTMENT								
10	Allowable Disproportionate Share Percentage	0.1022	0.1022	0.1022	0.1022	0.1022	0.1022		10
11	Disproportionate Share Adjustment	129,718		80,403		49,315		129,718	11
11.01	Uncompensated Care Payments	207,092				207,092		207,092	11.01
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES								
12	Total ESRD Additional Payment								12
13	Subtotal	3,061,764		867,121		2,194,643		3,061,764	13
14	Hospital Specific Payments	3,400,184		980,054		2,420,130		3,400,184	14
15	Total Payment for Inpatient Operating Costs - E Part A Line 49	3,315,579		951,821		2,363,758		3,315,579	15
16	Payment for Inpatient Program Capital	215,697		62,168		153,529		215,697	16
17	Special Add-on Payments for New Technologies								17
18	Capital Outlier Reconciliatino Adjustment Amount								18
19	Subtotal			1,013,989		2,517,287		3,531,276	19
	CAPITAL PAYMENTS								
20	Capital DRG Other Than Outlier	213,557		61,574		151,983		213,557	20
20.01	Model 4 BPCI Capital DRG Other Than Outlier								20.01
21	Capital DRG Outlier Payments	2,140		594		1,546		2,140	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	215,697		62,168		153,529		215,697	26
	LOW VOLUME ADJUSTMENT								
27	Low Volume Adjustment Factor			0.155000		0.169286			27
28	Low Volume Adjustment			157,168				157,168	28
29	Low Volume Adjustment					426,141		426,141	29

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0145** **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)	17,988			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	6,536,894			2
3	PPS PAYMENTS	4,125,240			3
4	OUTLIER PAYMENT (see instructions)	7,550			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)	0.845			5
6	LINE 2 TIMES LINE 5	5,523,675			6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6	0.7482			7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	17,988			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	42,390			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	42,390			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)	42,390			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	24,402			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 (line 11 minus line 20) (for CAH, see instructions)	17,988			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	4,132,790			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	999,271			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	3,151,507			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)	3,151,507			30
31	PRIMARY PAYER PAYMENTS	14			31
32	SUBTOTAL (line 30 minus line 31)	3,151,493			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)	106,307			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	69,100			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	75,816			36
37	SUBTOTAL (see instructions)	3,220,593			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	-14			38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	3,220,607			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	64,412			40.01
41	INTERIM PAYMENTS	3,326,792			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-170,597			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0145** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] IRF [ ] 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				3,599,402		3,318,512	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	03/03/2014	18,251	03/03/2014	8,280	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		18,251		8,280	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)				3,617,653		3,326,792	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		164,587			6.01
	BASED ON THE COST REPORT (1)		.02				-106,185	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				3,782,240		3,220,607	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.

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK APPLICABLE BOX: **[XX] HOSPITAL [ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,302	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,301	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	64	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,025	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	93,923,669	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,301,333	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	704,517	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	14,090	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	690,427	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	793,739	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-103,312	32

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0145** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] NF**	**[ ] PPS**
	[XX] TITLE XIX	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] TEFRA**
		[ ] SNF		**[XX] 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	1,076,827		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	1,076,827		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	1,076,827		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			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)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)	1,076,827		18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)	1,076,827		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 Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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	3,904,436				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	12,505,862				4
5	OTHER RECEIVABLES	79,736				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-4,620,203				6
7	INVENTORY	634,790				7
8	PREPAID EXPENSES	240,415				8
9	OTHER CURRENT ASSETS	2,577,295				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	15,322,331				11
	FIXED ASSETS					
12	LAND					12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	21,220,714				15
16	ACCUMULATED DEPRECIATION					16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT					23
24	ACCUMULATED DEPRECIATION					24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	21,220,714				30
	OTHER ASSETS					
31	INVESTMENTS	102,985,018				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	140,197				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	103,125,215				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	139,668,260				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,011,308				37
38	SALARIES, WAGES & FEES PAYABLE	2,371,512				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	2,577,295				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	5,371,647				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	11,331,762				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE	5,920,249				46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	6,830,566				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	12,750,815				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	24,082,577				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	115,585,683				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

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	
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	115,585,683				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	139,668,260				60

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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		99,174,675			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		16,618,392			2
3	TOTAL (sun of line 1 and line 2)		115,793,067			3
4	ADDITIONS (credit adjustments)					4
5	RESTRICTED GRANT					5
6	CHANGE IN TEMP RESTRICTED ASSET					6
7	DIFF IN ACCRUED PENSION					7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		115,793,067			11
12	DEDUCTIONS (debit adjustments)	207,379				12
13	DIFF ACCRUED BENFT LIAB PENSION					13
14	TRANSFERS					14
15	CHANGE IN TEMP RESTRICTED ASSETS					15
16	ROUNDING	5				16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		207,384			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		115,585,683			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 (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	RESTRICTED GRANT					5
6	CHANGE IN TEMP RESTRICTED ASSET					6
7	DIFF IN ACCRUED PENSION					7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	DIFF ACCRUED BENFT LIAB PENSION					13
14	TRANSFERS					14
15	CHANGE IN TEMP RESTRICTED ASSETS					15
16	ROUNDING					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

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	2,893,377		2,893,377	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)	2,893,377		2,893,377	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	23,781		23,781	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)	23,781		23,781	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	2,917,158		2,917,158	17
18	ANCILLARY SERVICES	15,773,684	84,846,738	100,620,422	18
19	OUTPATIENT SERVICES				19
20	RHC		5,782,289	5,782,289	20
20.01	RHC II				20.01
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	18,690,842	90,629,027	109,319,869	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		44,754,678	29
30	ADD (SPECIFY)	15,680		30
31	BAD DEBT EXPENSE			31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)		15,680	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)		44,770,358	43

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

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	109,319,869	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	59,831,625	2
3	NET PATIENT REVENUES (line 1 minus line 2)	49,488,244	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	44,770,358	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	4,717,886	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	9,878,599	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISCELLANEOUS INCOME)	2,021,907	24
24.01	OTHER (NET ASSETRS RELEASED)		24.01
25	TOTAL OTHER INCOME (sum of lines 6-24)	11,900,506	25
26	TOTAL (line 5 plus line 25)	16,618,392	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	16,618,392	29

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0145** **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	213,557	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	2,140	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)	8.50	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		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 (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	215,697	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

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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
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING							5.03
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	ADMIN & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
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							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
91	EMERGENCY							91
91.01	PRIORITY CARE CARLYLE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
194	LIFELINE							194
194.01	DEVELOPMENT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202

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ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT CCN: 14-8503

WORKSHEET M-1

CHECK APPLICABLE BOX: [XX] RHC I [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	140,956	1,595,466	1,736,422	3,424	1,739,846		1,739,846	1
2	PHYSICIAN ASSISTANT	26,700		26,700		26,700		26,700	2
3	NURSE PRACTITIONER	122,171		122,171	11,403	133,574		133,574	3
4	VISITING NURSE								4
5	OTHER NURSE								5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	220,746	242,022	462,768	40,689	503,457		503,457	9
10	SUBTOTAL (sum of lines 1-9)	510,573	1,837,488	2,348,061	55,516	2,403,577		2,403,577	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT								11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (sum of lines 11-13)								14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		12,701	12,701	2,722	15,423		15,423	15
16	TRANSPORTATION (Health Care Staff)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSIONAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS		3,173	3,173	1,820	4,993		4,993	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (sum of lines 15-20)		15,874	15,874	4,542	20,416		20,416	21
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	510,573	1,853,362	2,363,935	60,058	2,423,993		2,423,993	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY		216,665	216,665	33,824	250,489		250,489	23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS (sum of lines 23-27)		216,665	216,665	33,824	250,489		250,489	28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS	319,922	252,570	572,492	74,026	646,518		646,518	30
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	319,922	252,570	572,492	74,026	646,518		646,518	31
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	830,495	2,322,597	3,153,092	167,908	3,321,000		3,321,000	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-8503** **WORKSHEET M-2**

CHECK APPLICABLE BOX: [XX] RHC I [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
	POSITIONS	1	2	3	4	5	
1	PHYSICIANS	6.50	27,305	4,200	27,300		1
2	PHYSICIAN ASSISTANTS	1.46	4,310	2,100	3,066		2
3	NURSE PRACTITIONERS	0.35	633	2,100	735		3
4	SUBTOTAL (sum of lines 1-3)	8.31	32,248		31,101	32,248	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
7.01	MEDICAL NUTRITION THERAPIST (FQHC only)						7.01
7.02	DIABETES SELF MANAGEMENT TRAINING (FQHC only)						7.02
8	TOTAL FTEs AND VISITS (sum of lines 4-7)	8.31	32,248			32,248	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)	2,423,993	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)	250,489	11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)	2,674,482	12
13	RATIO OF RHC/FQHC SERVICES (line 10 divided by line 12)	0.906341	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)	646,518	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)	1,404,785	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)	2,051,303	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)		17
18	SUBTRACT LINE 17 FROM LINE 16	2,051,303	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (line 13 x line 18)	1,859,180	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (sum of lines 10 and 19)	4,283,173	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-8503** **WORKSHEET M-3**

CHECK APPLICABLE BOXES: **[XX] RHC I** **[ ] FQHC** **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (from Worksheet M-2, line 20)	4,283,173	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	156,139	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	4,127,034	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	32,248	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)		5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	32,248	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	127.98	7

		CALCULATION OF LIMIT (1)			
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	(SEE INSTR.)	
		1	2	3	
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	125.19	125.19		8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	127.98	127.98	127.98	9
	CALCULATION OF SETTLEMENT				
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)	4,367	4,071		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)	558,889	521,007		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (from contractor records)				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (line 9 x line 12)				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (see instructions)				14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (see instructions)				15
16	TOTAL PROGRAM COST (sum of lines 11, 14, and 15, columns 1, 2, and 3)		1,079,896		16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)		1,195,710		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)				16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)				16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)		761,633		16.04
16.05	TOTAL PROGRAM COST (see instructions)		761,633		16.05
17	PRIMARY PAYER PAYMENTS		495		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		127,855		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)		213,571		19
20	NET MEDICARE COST EXCUDING VACCINES (see instructions)		761,138		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		25,002		21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		786,140		22
23	ALLOWABLE BAD DEBTS (see instructions)		390		23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)		343		23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		390		24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				25
26	NET REIMBURSABLE AMOUNT (see instructions)		786,483		26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		15,730		26.01
27	INTERIM PAYMENTS		698,796		27
28	TENTATIVE SETTLEMENT (for contractor use only)				28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		71,957		29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-8503** **WORKSHEET M-4**

CHECK APPLICABLE BOXES: **[XX] RHC I** **[ ] FQHC** **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	2,403,577	2,403,577	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.003886	0.005527	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)	9,340	13,285	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (from your records)	49,942	12,004	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)	59,282	25,289	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	2,423,993	2,423,993	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	2,051,303	2,051,303	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)	0.024456	0.010433	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)	50,167	21,401	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)	109,449	46,690	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)	805	1,145	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)	135.96	40.78	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	111	243	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (line 12 x line 13)	15,092	9,910	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		156,139	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		25,002	16

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-8503

WORKSHEET M-5

CHECK APPLICABLE BOX: [XX] RHC I [ ] FQHC

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				504,105	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	03/03/2014	194,691	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		194,691	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. J-3, line 27)				698,796	
	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		87,687	6.01
	BASED ON THE COST REPORT (1)		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				786,483	

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 you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT CCN: 14-8502

WORKSHEET M-1

CHECK APPLICABLE BOX: [XX] RHC II [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	3,424		3,424	-3,424				1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER	11,403		11,403	-11,403				3
4	VISITING NURSE								4
5	OTHER NURSE								5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	40,689		40,689	-40,689				9
10	SUBTOTAL (sum of lines 1-9)	55,516		55,516	-55,516				10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT								11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (sum of lines 11-13)								14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		2,722	2,722	-2,722				15
16	TRANSPORTATION (Health Care Staff)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSIONAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS		1,820	1,820	-1,820				19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (sum of lines 15-20)		4,542	4,542	-4,542				21
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	55,516	4,542	60,058	-60,058				22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY		33,824	33,824	-33,824				23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS (sum of lines 23-27)		33,824	33,824	-33,824				28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS	61,614	35,051	96,665	-96,665				30
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	61,614	35,051	96,665	-96,665				31
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	117,130	73,417	190,547	-190,547				32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-8502** **WORKSHEET M-2**

CHECK APPLICABLE BOX: [XX] RHC II [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
	POSITIONS	1	2	3	4	5	
1	PHYSICIANS			4,200			1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS			2,100			3
4	SUBTOTAL (sum of lines 1-3)						4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
7.01	MEDICAL NUTRITION THERAPIST (FQHC only)						7.01
7.02	DIABETES SELF MANAGEMENT TRAINING (FQHC only)						7.02
8	TOTAL FTEs AND VISITS (sum of lines 4-7)						8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)		10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)		11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)		12
13	RATIO OF RHC/FQHC SERVICES (line 10 divided by line 12)		13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)		14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)		15
16	TOTAL OVERHEAD (sum of lines 14 and 15)		16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)		17
18	SUBTRACT LINE 17 FROM LINE 16		18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (line 13 x line 18)		19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (sum of lines 10 and 19)		20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-8502** **WORKSHEET M-3**

CHECK APPLICABLE BOXES: **[XX] RHC II** **[ ] FQHC** **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (from Worksheet M-2, line 20)		1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)		2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)		3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)		4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)		5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)		6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)		7

		CALCULATION OF LIMIT (1)			
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	(SEE INSTR.)	
		1	2	3	
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)				9
	CALCULATION OF SETTLEMENT				
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)				10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)				11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (from contractor records)				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (line 9 x line 12)				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (see instructions)				14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (see instructions)				15
16	TOTAL PROGRAM COST (sum of lines 11, 14, and 15, columns 1, 2, and 3)				16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)				16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)				16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)				16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)				16.04
16.05	TOTAL PROGRAM COST (see instructions)				16.05
17	PRIMARY PAYER PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)				18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)				19
20	NET MEDICARE COST EXCUDING VACCINES (see instructions)				20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)				21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)				22
23	ALLOWABLE BAD DEBTS (see instructions)				23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				25
26	NET REIMBURSABLE AMOUNT (see instructions)				26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)				26.01
27	INTERIM PAYMENTS				27
28	TENTATIVE SETTLEMENT (for contractor use only)				28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)				29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

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ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 08:33 Version: 2014.10

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-8502** **WORKSHEET M-4**

CHECK APPLICABLE BOXES: **[XX] RHC II** **[ ] FQHC** **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)			1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000000	0.000000	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)			3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (from your records)			4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)			5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)			6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)			7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)			8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)			9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)			10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)			11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)			12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES			13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (line 12 x line 13)			14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)			15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)			16