

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**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. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 11/25/2015	Time: 13:47
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> 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 certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)  
  
\_\_\_\_\_  
Title  
  
\_\_\_\_\_  
Date

**PART III - SETTLEMENT SUMMARY**

		TITLE XVIII				TITLE XIX	
		TITLE V	PART A	PART B	HIT		
		1	2	3	4	5	
1	HOSPITAL		-72,089	-8,781	-52,414		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			63,998			10
10.01	HEALTH CLINIC - RHC II						10.01
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-72,089	55,217	-52,414		200

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

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

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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 / 2014	To: 06 / 30 / 2015								20
21	Type of control (see instructions)	1									21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	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 column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	507				351	404	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1						37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning: 07 / 01 / 2014		Ending: 10 / 26 / 2014				38

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

		1	2	3	
<b>Teaching Hospitals</b>					
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
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 osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery 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 received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

**Teaching Hospitals that Claim Residents in Nonprovider Settings**

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				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))
65	1	2	3	4	5
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
67	1	2	3	4	5

**Inpatient Psychiatric Facility 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, indicate which program year began during this cost reporting period. (see instructions)				71

**Inpatient Rehabilitation Facility PPS**

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

**Long Term Care Hospital PPS**

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

**TEFRA Providers**

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

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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 applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

**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	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.				109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

**Miscellaneous Cost Reporting Information**

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	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:	50,867		336,788	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 certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.				134

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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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

		Title XVIII		Title V	Title XIX	
		Part A	Part B			
		1	2	3	4	
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. (see instructions)					166
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.50			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014	06/30/2015		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N		171

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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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		
<b>Provider Organization and Operation</b>					
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	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	
<b>Financial Data and Reports</b>					
		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
<b>Approved Educational Activities</b>				
		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 Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
<b>Bad Debts</b>			
		Y	
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

		Y/N	
<b>Bed Complement</b>			
		Y	
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
<b>PS&amp;R Report Data</b>					
		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	
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	10/28/2015	Y	10/28/2015
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	
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	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

**KPMG LLP Compu-Max 2552-10**

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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 COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)**

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

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

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

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

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

Cost Report Preparer Contact Information			
41	First name: JOHN	Last name: JEFFRIES	Title: DIRECTOR OF FINANCE
42	Employer: HSHS ST JOSEPH'S HOSPITAL		
43	Phone number: 618-526-5312	E-mail Address: JOHN.JEFFRIES@HSHS.ORG	

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				Total All Patients
						Title V	Title XVIII	Title XIX		
		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			1,407	729	3,478	1
2	HMO and other (see instructions)						150	351		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			1,407	729	3,478	7
8	Intensive Care Unit	31	4	1,460			12			14
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						182		1,329
14	Total (see instructions)		49	17,885			1,419	911	4,821	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					5,931		43,985	26
26.01	RHC II	88.01								26.01
27	Total (sum of lines 14-26)		49							27
28	Observation Bed Days								519	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								27	30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)								198	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		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)					454	251	1,396	1
2	HMO and other (see instructions)					47			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)		284.57			454	251	1,396	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		38.06						26
26.01	RHC II								26.01
27	Total (sum of lines 14-26)		322.63						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

**KPMG LLP Compu-Max 2552-10**

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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	
<b>SALARIES</b>							
1	200	17,022,878		17,022,878	671,070.80	25.37	1
2							2
3							3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10		550,891	3,640	554,531	16,672.15	33.26	10
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11		40,860		40,860	1,552.00	26.33	11
12							12
13		368,502		368,502	2,463.00	149.62	13
14		1,815,788		1,815,788	26,814.00	67.72	14
15							15
16							16
<b>WAGE-RELATED COSTS</b>							
17		6,626,818		6,626,818			17
18							18
19		107,402		107,402			19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26		134,011		134,011	2,473.00	54.19	26
27		2,916,296	-1,524	2,914,772	81,228.81	35.88	27
28		2,697		2,697	132.00	20.43	28
29							29
30		480,231		480,231	20,852.00	23.03	30
31		108,684		108,684	9,323.75	11.66	31
32		418,695		418,695	38,800.55	10.79	32
33		139		139	15.00	9.27	33
34		434,962	-357,929	77,033	7,662.00	10.05	34
35							35
36			357,929	357,929	23,407.00	15.29	36
37							37
38		494,685		494,685	13,152.00	37.61	38
39							39
40		329,263		329,263			40
41		410,051		410,051	22,564.35	18.17	41
42		83,791	-3,640	80,151	2,489.75	32.19	42
43							43

**Part III - Hospital Wage Index Summary**

1	Net salaries (see instructions)		17,025,714		17,025,714	671,217.80	25.37	1
2	Excluded area salaries (see instructions)		550,891		554,531	16,672.15	33.26	2
3	Subtotal salaries (line 1 minus line 2)		16,474,823	-3,640	16,471,183	654,545.65	25.16	3
4	Subtotal other wages & related costs (see instructions)		2,225,150		2,225,150	30,829.00	72.18	4
5	Subtotal wage-related costs (see instructions)		6,626,818		6,626,818		40.23%	5
6	Total (sum of lines 3 through 5)		25,326,791	-3,640	25,323,151	685,374.65	36.95	6
7	Total overhead cost (see instructions)		5,813,505	-5,164	5,808,341	222,100.21	26.15	7

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL WAGE RELATED COSTS**

**WORKSHEET S-3  
PART IV**

**Part IV - Wage Related Cost**

**Part A - Core List**

		Amount Reported	
	<b>RETIREMENT COST</b>		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)	1,413,578	3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	<b>HEALTH AND INSURANCE COST</b>		
8	Health Insurance (Purchased or Self Funded)	3,898,042	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	30,572	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	212,453	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	<b>TAXES</b>		
17	FICA-Employers Portion Only	1,152,271	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	-14,070	19
20	State or Federal Unemployment Taxes		20
	<b>OTHER</b>		
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	41,374	23
24	Total Wage Related cost (Sum of lines 1-23)	6,734,220	24

**Part B - Other Than Core Related Cost**

25	OTHER WAGE RELATED COSTs (SPECIFY)	47,089	25
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**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	Supporting Exhibit for Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)**

**EXHIBIT 3**

<b>STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD</b>			
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
<b>STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)</b>			
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**

<b>STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD</b>			
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	<b>DEPOSIT DATE(S)</b>	<b>CONTRIBUTION(S)</b> 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
<b>STEP 4: TOTAL PENSION COST FOR WAGE INDEX</b>			
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**HOSPITAL CONTRACT LABOR AND BENEFIT COST**

**WORKSHEET S-3  
PART V**

**Part V - Contract Labor and Benefit Cost**

**Hospital and Hospital-Based Component Identification:**

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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA**

**WORKSHEET S-5**

**RENAL DIALYSIS STATISTICS**

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

**ESRD PPS**

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

**TRANSPLANT INFORMATION**

11	Number of patients on transplant list			11
12	Number of patients transplanted during the cost reporting period			12

**EPOETIN**

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider			13
14	Epoetin amount from Worksheet A for home dialysis program			14
15	Number of EPO units furnished relating to the renal dialysis department			15
16	Number of EPO units furnished relating to the home dialysis department			16

**ARANESP**

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider			17
18	ARANESP amount from Worksheet A for home dialysis program			18
19	Number of ARANESP units furnished relating to the renal dialysis department			19
20	Number of ARANESP units furnished relating to the home dialysis department			20

**PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))**

21	MCP	INITIAL METHOD	
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Erythropoiesis-Stimulating Agents (ESA) Statistics:		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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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:  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 the Homeless (Section 340(d), PHS)			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	Other (specify)			9

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.	1 N	2	10
----	--	--------	---	----

Facility hours of operations (1)

	Type Operation	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		from	to	from	to	from	to	from	to	from	to	from	to			
11	Clinic	0730	1830	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 subscripsts 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.

12	Have you received an approval for an exception to the productivity standard?	1 N	2	12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	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 by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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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:  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 1	Date 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 the Homeless (Section 340(d), PHS			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	Other (specify)			9

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.	1 N	2	10
----	--	--------	---	----

Facility hours of operations (1)

	Type Operation	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		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 subscripsts 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.

12	Have you received an approval for an exception to the productivity standard?	1 N	2	12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	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 by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

# KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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## 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)		0.381413	1
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### Medicaid (see instructions for each line)

2	Net revenue from Medicaid		7,706,672	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		15,325,632	6
7	Medicaid cost (line 1 times line 6)		5,845,395	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.			8

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

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

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

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

### Uncompensated care (see instructions for each line)

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

		Uninsured patients	Insured patients	TOTAL (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	1,625,598	383,725	2,009,323	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	620,024	146,358	766,382	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	620,024	146,358	766,382	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)			25
26	Total bad debt expense for the entire hospital complex (see instructions)		2,980,845	26
27	Medicare bad debts for the entire hospital complex (see instructions)		91,056	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		2,889,789	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,102,203	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		1,868,585	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,868,585	31

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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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 ALLOCA- TION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	Cap Rel Costs-Bldg & Fixt		1,165,565	1,165,565	259,068	1,424,633		1,424,633	1
2	00200	Cap Rel Costs-Mvble Equip				1,442,731	1,442,731		1,442,731	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	134,011	6,783,327	6,917,338	-2,966	6,914,372	-1,404,256	5,510,116	4
5.01	00540	COMMUNICATIONS		53,700	53,700	93,993	147,693	-5	147,688	5.01
5.02	00550	INFORMATION SYSTEMS		362,831	362,831	-352,719	10,112	2,747,630	2,757,742	5.02
5.03	00560	PURCHASING	138,935	113,393	252,328		252,328	-5,047	247,281	5.03
5.04	00570	ADMITTING	472,334	21,567	493,901	-79,527	414,374		414,374	5.04
5.05	00580	BUSINESS OFFICE	318,127	753,596	1,071,723	-1,209	1,070,514	-462	1,070,052	5.05
5.06	00590	ADMIN & GENERAL	1,986,900	6,523,813	8,510,713	-39,682	8,471,031	-3,770,495	4,700,536	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	480,231	1,229,253	1,709,484	88,358	1,797,842	-109	1,797,733	7
8	00800	Laundry & Linen Service	108,684	20,129	128,813	-4,116	124,697	-915	123,782	8
9	00900	Housekeeping	418,695	194,585	613,280		613,280		613,280	9
10	01000	Dietary	434,962	218,507	653,469	-587,535	65,934		65,934	10
11	01100	Cafeteria				577,855	577,855	-8,533	569,322	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	494,685	9,861	504,546	-1,055	503,491	-3,319	500,172	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	329,263	1,178,207	1,507,470	-779,299	728,171		728,171	15
16	01600	Medical Records & Library	410,051	104,820	514,871	-21,284	493,587	-23,831	469,756	16
17	01700	Social Service	83,791	10,437	94,228	-4,285	89,943		89,943	17
19	01900	Nonphysician Anesthetists				592,794	592,794	-592,794		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
		<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	03000	Adults & Pediatrics	1,621,741	240,783	1,862,524	-152,259	1,710,265		1,710,265	30
31	03100	Intensive Care Unit	11,062	2,147	13,209	-965	12,244		12,244	31
43	04300	Nursery	247,037	110,607	357,644	-12,726	344,918	-25,298	319,620	43
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	Operating Room	1,578,158	430,332	2,008,490	-221,266	1,787,224	-34,100	1,753,124	50
51	05100	Recovery Room	844	14,920	15,764	-13,305	2,459		2,459	51
52	05200	Delivery Room & Labor Room	528,734	80,695	609,429	-11,875	597,554		597,554	52
53	05300	Anesthesiology	37,861	1,127,949	1,165,810	-626,810	539,000	-424,276	114,724	53
54	05400	Radiology-Diagnostic	1,219,804	656,077	1,875,881	-264,980	1,610,901		1,610,901	54
57	05700	CT Scan	106,212	165,110	271,322	17,971	289,293		289,293	57
58	05800	MRI	79,764	94,634	174,398	11,268	185,666		185,666	58
60	06000	Laboratory	1,115,389	1,657,707	2,773,096	-107,275	2,665,821	-31,890	2,633,931	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	Blood Storing, Processing & Trans.		145,627	145,627		145,627		145,627	63
65	06500	Respiratory Therapy	361,918	205,224	567,142	-35,755	531,387	-28,155	503,232	65
66	06600	Physical Therapy	1,205,278	472,193	1,677,471	-24,501	1,652,970	-77,475	1,575,495	66
69	06900	Electrocardiology	21,054	51,469	72,523	-18,271	54,252	-23,094	31,158	69
70	07000	Electroencephalography	45,660	7,919	53,579	6,680	60,259		60,259	70
71	07100	Medical Supplies Charged to Patients	44,516	945,810	990,326	-347,493	642,833		642,833	71
72	07200	Impl. Dev. Charged to Patients				353,402	353,402		353,402	72
73	07300	Drugs Charged to Patients				764,004	764,004		764,004	73
76.97	07697	CARDIAC REHABILITATION	104,730	19,299	124,029	-838	123,191		123,191	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	08800	Rural Health Clinic	928,935	2,702,241	3,631,176	303,438	3,934,614		3,934,614	88
88.01	08801	RHC II	218,983	110,903	329,886	-329,886				88.01
91	09100	Emergency	866,236	315,100	1,181,336	-13,078	1,168,258	-177,999	990,259	91
91.01	09101	PRIORITY CARE CARLYLE	317,402	299,594	616,996	-23,659	593,337	-180,838	412,499	91.01
91.02	09102	PRIORITY CARE NEW BADEN								91.02
92	09200	Observation Beds (Non-Distinct Part)								92
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
		<b>SPECIAL PURPOSE COST CENTERS</b>								
113	11300	Interest Expense		64,261	64,261		64,261	-64,261		113
118		SUBTOTALS (sum of lines 1-117)	16,471,987	28,664,192	45,136,179	432,943	45,569,122	-4,129,522	41,439,600	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
192	19200	Physicians' Private Offices	547,022	1,868,558	2,415,580	-436,583	1,978,997	-845,793	1,133,204	192
194	07950	LIFELINE	3,869	27,609	31,478	3,640	35,118		35,118	194
194.01	07951	DEVELOPMENT								194.01
200		TOTAL (sum of lines 118-199)	17,022,878	30,560,359	47,583,237		47,583,237	-4,975,315	42,607,922	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	37,792	555,002	1
500	Total reclassifications				37,792	555,002	500
	Code Letter - A						
1	TO RECLASS CAFETERIA COST	B	Cafeteria	11	357,929	219,926	1
500	Total reclassifications				357,929	219,926	500
	Code Letter - B						
1	TO RECLASS MANAGERS SALARY	C	Adults & Pediatrics	30	9,476		1
2	TO RECLASS MANAGERS SALARY	C	Intensive Care Unit	31	726		2
3	TO RECLASS MANAGERS SALARY	C	Nursery	43	12,570		3
4	TO RECLASS MANAGERS SALARY	C	Recovery Room	51	88		4
5	TO RECLASS MANAGERS SALARY	C	Delivery Room & Labor Room	52	29,829		5
6	TO RECLASS MANAGERS SALARY	C	Anesthesiology	53	184		6
7	TO RECLASS MANAGERS SALARY	C	Radiology-Diagnostic	54	35,297		7
8	TO RECLASS MANAGERS SALARY	C	CT Scan	57	18,395		8
9	TO RECLASS MANAGERS SALARY	C	MRI	58	11,988		9
10	TO RECLASS MANAGERS SALARY	C	Physical Therapy	66	1,524		10
11	TO RECLASS MANAGERS SALARY	C	Electrocardiology	69	3,124		11
12	TO RECLASS MANAGERS SALARY	C	Electroencephalography	70	7,518		12
13	TO RECLASS MANAGER SALARY	C	Medical Supplies Charged to P	71	10,452		13
14	TO RECLASS MANAGERS SALARY	C	CARDIAC REHABILITATION	76.97	15,643		14
15	TO RECLASS MANAGERS SALARY	C	PRIORITY CARE CARLYLE	91.01	16,967		15
16	TO RECLASS MANAGERS SALARY	C					16
17	TO RECLASS MANAGERS SALARY	C					17
500	Total reclassifications				173,781		500
	Code Letter - C						
1	RECLASS SOCIAL SERV SLRY TO LIFELIN	D	LIFELINE	194	3,640		1
500	Total reclassifications				3,640		500
	Code Letter - D						
1	RECLASS CCRH GERMANTOWN TO CCRH BRE	F	Rural Health Clinic	88	218,983	110,903	1
500	Total reclassifications				218,983	110,903	500
	Code Letter - F						
1	RECLASS PLANT SALO PANT OPS	G					1
500	Total reclassifications						500
	Code Letter - G						
1	RECLASS PLANT EXP TO PANT OPS	H	Operation of Plant	7		105,062	1
2	RECLAS PLNT EXP TO PLANT OPS	H					2
3	RECLASS	H					3
4							4
500	Total reclassifications					105,062	500
	Code Letter - H						
1	RECLASS TELEPNE EXP TO TELEPHONE EX	I	COMMUNICATIONS	5.01		18,392	1
2	RECLASS TELEPHONE EXP TO TLPN EXP	I					2
3							3
4							4
500	Total reclassifications					18,392	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						
1	DEPRECIATION EXPENSE	L	Cap Rel Costs-Bldg & Fixt	1		1,424,633	1
2			Cap Rel Costs-Mvble Equip	2		1,442,731	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13

**KPMG LLP Compu-Max 2552-10**

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY		OTHER
		1	2	3	4	5	
14						14	
15						15	
16						16	
17						17	
18						18	
19						19	
20						20	
21						21	
22						22	
23						23	
24						24	
25						25	
26						26	
27						27	
28						28	
29						29	
30						30	
31						31	
32						32	
33						33	
34						34	
35						35	
500	Total reclassifications					2,867,364	500
	Code Letter - L						
1	PROPERTY TAXES	M	Rural Health Clinic	88		22,443	1
500	Total reclassifications					22,443	500
	Code Letter - M						
1	PHARMACY	N	Drugs Charged to Patients	73		764,004	1
500	Total reclassifications					764,004	500
	Code Letter - N						
	<b>GRAND TOTAL (Increases)</b>					<b>867,726</b>	<b>5,016,498</b>

(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	37,792	555,002	1	
500	Total reclassifications				37,792	555,002	500	
	Code letter - A							
1	TO RECLASS CAFETERIA COST	B	Dietary	10	357,929	219,926	1	
500	Total reclassifications				357,929	219,926	500	
	Code letter - B							
1	TO RECLASS MANAGERS SALARY	C	ADMIN & GENERAL	5.06	1,524		1	
2	TO RECLASS MANAGERS SALARY	C					2	
3	TO RECLASS MANAGERS SALARY	C					3	
4	TO RECLASS MANAGERS SALARY	C	Adults & Pediatrics	30	43,126		4	
5	TO RECLASS MANAGERS SALARY	C	Operating Room	50	20,201		5	
6	TO RECLASS MANAGERS SALARY	C	Radiology-Diagnostic	54	82,647		6	
7	TO RECLASS MANAGERS SALARY	C	Respiratory Therapy	65	26,283		7	
8	TO RECLASS MANAGERS SALARY	C					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 MANAGERS 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				173,781		500	
	Code letter - C							
1	RECLASS SOCIAL SERV SLRY TO LIFELIN	D	Social Service	17	3,640		1	
500	Total reclassifications				3,640		500	
	Code letter - D							
1	RECLASS CCRH GERMANTOWN TO CCRH BRE	F	RHC II	88.01	218,983	110,903	1	
500	Total reclassifications				218,983	110,903	500	
	Code letter - F							
1	RECLASS PLANT SALO PANT OPS	G					1	
500	Total reclassifications						500	
	Code letter - G							
1	RECLASS PLANT EXP TO PANT OPS	H	PRIORITY CARE CARLYLE	91.01		18,512	1	
2	RECLAS PLNT EXP TO PLANT OPS	H	Rural Health Clinic	88		9,315	2	
3	RECLASS	H	Physicians' Private Offices	192		75,372	3	
4			Laboratory	60		1,863	4	
500	Total reclassifications					105,062	500	
	Code letter - H							
1	RECLASS TELEPNE EXP TO TELEPHONE EX	I	Physical Therapy	66		329	1	
2	RECLASS TELEPHONE EXP TO TLPHN EXP	I	Rural Health Clinic	88		12,947	2	
3			Physicians' Private Offices	192		4,800	3	
4			PRIORITY CARE CARLYLE	91.01		316	4	
500	Total reclassifications					18,392	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							
1	DEPRECIATION EXPENSE	L	Cap Rel Costs-Bldg & Fixt	1		1,165,565	9	
2			Employee Benefits Department	4		2,966	9	
3			INFORMATION SYSTEMS	5.02		352,719	3	
4			ADMITTING	5.04		3,926	4	
5			BUSINESS OFFICE	5.05		1,209	5	
6			ADMIN & GENERAL	5.06		38,158	6	
7			Operation of Plant	7		16,704	7	
8			Laundry & Linen Service	8		4,116	8	
9			Dietary	10		9,680	9	
10			Nursing Administration	13		1,055	10	
11			Medical Records & Library	16		21,284	11	

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref. 10	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
12			Social Service	17		645	12	
13			Adults & Pediatrics	30		118,609	13	
14			Intensive Care Unit	31		1,691	14	
15			Nursery	43		25,296	15	
16			Operating Room	50		201,065	16	
17			Recovery Room	51		13,393	17	
18			Delivery Room & Labor Room	52		41,704	18	
19			Anesthesiology	53		34,200	19	
20			Radiology-Diagnostic	54		217,630	20	
21			CT Scan	57		424	21	
22			MRI	58		720	22	
23			Laboratory	60		105,412	23	
24			Respiratory Therapy	65		9,472	24	
25			Physical Therapy	66		25,696	25	
26			Electrocardiology	69		21,395	26	
27			Electroencephalography	70		838	27	
28			Medical Supplies Charged to P	71		4,543	28	
29			Pharmacy	15		15,295	29	
30			CARDIAC REHABILITATION	76.97		16,481	30	
31			Rural Health Clinic	88		26,629	31	
32			Emergency	91		13,078	32	
33			PRIORITY CARE CARLYLE	91.01		21,798	33	
34							34	
35			Physicians' Private Offices	192		333,968	35	
500	Total reclassifications					2,867,364	500	
	Code letter - L							
1	PROPERTY TAXES	M	Physicians' Private Offices	192		22,443	1	
500	Total reclassifications					22,443	500	
	Code letter - M							
1	PHARMACY	N	Pharmacy	15		764,004	1	
500	Total reclassifications					764,004	500	
	Code letter - N							
	GRAND TOTAL (Decreases)				867,726	5,016,498		

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

**KPMG LLP Compu-Max 2552-10**

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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**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	1,495,337					1,495,337		1
2	Land Improvements	3,834,614					3,834,614		2
3	Buildings and Fixtures	32,328,887	385,808		385,808		32,714,695		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	22,729,747					22,729,747		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	60,388,585	385,808		385,808		60,774,393		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	60,388,585	385,808		385,808		60,774,393		10

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

SUMMARY OF CAPITAL									
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,165,565						1,165,565	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	1,165,565						1,165,565	3

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

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

**PART III - RECONCILIATION OF CAPITAL COST CENTERS**

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

SUMMARY OF CAPITAL									
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,424,633						1,424,633	1
2	Cap Rel Costs-Mvble Equip	1,442,731						1,442,731	2
3	Total (sum of lines 1-2)	2,867,364						2,867,364	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**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.
				COST CENTER	LINE#	
		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)					4
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)	B	-462	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	-946,986			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	606,230			12
13	Laundry and linen service					13
14	Cafeteria - employees and guests	B	-8,533	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	-23,831	Medical Records & Library	16	18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines					20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare 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	-592,794	Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation					32
33						33
34	MISCELLANEOUS INCOME	B	-5	COMMUNICATIONS	5.01	34
35	MISCELLANEOUS INCOME	B	-5,047	PURCHASING	5.03	35
36						36
36.01	MISCELLANEOUS INCOME	B	-182,054	ADMIN & GENERAL	5.06	36.01
36.02	MISCELLANEOUS INCOME	B	-3,319	Nursing Administration	13	36.02
36.05	MISC INCOME	B	-54,485	Physical Therapy	66	36.05
36.06	MISC INCOME	B	-915	Laundry & Linen Service	8	36.06
36.07	MISC INCOME	B	-2,053	Nursery	43	36.07
36.08	MISC INCOME	B	-5,000	ADMIN & GENERAL	5.06	36.08
36.09	MISC INCOME	B	-109	Operation of Plant	7	36.09
37						37
38	NON-ALLOW INTEREST	A	-64,261	Interest Expense	113	38
39	MEDICAID TAX	A	-1,184,699	ADMIN & GENERAL	5.06	39
40						40
41						41
42	NON-ALLOW LOBBYING COST	A	-19,836	ADMIN & GENERAL	5.06	42
43	ADVERTISING COST	A	-277,094	ADMIN & GENERAL	5.06	43
44	MEDICAL GROUP EXPENSE	A	-845,793	Physicians' Private Offices	192	44
45	EMPLOYEE SELF INSURANCE	A	-1,362,250	Employee Benefits Department	4	45
46	NON-ALLOW MEDICARE EXPENSE	A	-2,019	ADMIN & GENERAL	5.06	46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-4,975,315			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

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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	

(3) Additional adjustments may be made on lines 33 thru 49 and subscripsts 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 Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.
	1	2	3	4	5	6	7
1	5.06	ADMIN & GENERAL	CONTRACTED SERVICES HSHS	932,468	3,031,862	-2,099,394	1
2	5.02	INFORMATION SYSTEMS	CONTRACTED SERVICES HSHS	2,747,630		2,747,630	2
3	4	Employee Benefits Department	HEALTH & DENTAL PREMIUMS	3,283,384	3,325,390	-42,006	3
4	88	Rural Health Clinic	RURAL HEALTH CLINIC SERV	1,827,913	1,827,913		4
4.01	4	Employee Benefits Department	RELATED PARTY SERVICES	26,937	26,937		4.01
4.02	5.03	PURCHASING	RELATED PARTY SERVICES	356	356		4.02
4.03	5.05	BUSINESS OFFICE	RELATED PARTY SERVICES	635,595	635,595		4.03
4.04	10	Dietary	RELATED PARTY SERVICES	167	167		4.04
4.05	13	Nursing Administration	RELATED PARTY SERVICES	1,700	1,700		4.05
4.06	16	Medical Records & Library	RELATED PARTY SERVICES	247	247		4.06
4.07	17	Social Service	RELATED PARTY SERVICES	233	233		4.07
4.08	54	Radiology-Diagnostic	RELATED PARTY SERVICES	2,323	2,323		4.08
4.09	60	Laboratory	RELATED PARTY SERVICES	35,954	35,954		4.09
4.10	66	Physical Therapy	RELATED PARTY SERVICES	45,847	45,847		4.10
4.11	73	Drugs Charged to Patients	RELATED PARTY SERVICES	72,230	72,230		4.11
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			9,612,984	9,006,754	606,230	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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		Type of Business	
				Name	Percentage of Ownership		
	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	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	5.06	ADMIN & GENERAL VARIOUS	1,305		1,305	171,400	11	906	45	1
2	43	Nursery VARIOUS	33,381		33,381	171,400	123	10,136	507	2
3	50	Operating Room VARIOUS	34,100	34,100		204,100				3
4	53	Anesthesiology VARIOUS	449,492	415,492	34,000	171,400	306	25,216	1,261	4
5										5
6	60	Laboratory VARIOUS	110,192		110,192	219,500	742	78,302	3,915	6
7	65	Respiratory Therapy VARIOUS	77,350		77,350	171,400	597	49,195	2,460	7
8	66	Physical Therapy VARIOUS	64,274		64,274	171,400	501	41,284	2,064	8
9	69	Electrocardiology VARIOUS	23,094	23,094		171,400				9
10	91	Emergency VARIOUS	193,079	145,079	48,000	171,400	183	15,080	754	10
11	91.01	PRIORITY CARE CARLYL VARIOUS	180,838	180,838		171,400				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,167,105	798,603	368,502		2,463	220,119	11,006	200

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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5.06	ADMIN & GENERAL VARIOUS					906	399	399	1
2	43	Nursery VARIOUS					10,136	23,245	23,245	2
3	50	Operating Room VARIOUS							34,100	3
4	53	Anesthesiology VARIOUS					25,216	8,784	424,276	4
5										5
6	60	Laboratory VARIOUS					78,302	31,890	31,890	6
7	65	Respiratory Therapy VARIOUS					49,195	28,155	28,155	7
8	66	Physical Therapy VARIOUS					41,284	22,990	22,990	8
9	69	Electrocardiology VARIOUS							23,094	9
10	91	Emergency VARIOUS					15,080	32,920	177,999	10
11	91.01	PRIORITY CARE CARLYL VARIOUS							180,838	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					220,119	148,383	946,986	200

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NON-PATIENT TELEPHONES	DATA PROCESSING	
		0	1	2	4	5.01	5.02	
<b>GENERAL SERVICE COST CENTERS</b>								
1	Cap Rel Costs-Bldg & Fixt	1,424,633	1,424,633					1
2	Cap Rel Costs-Mvble Equip	1,442,731		1,442,731				2
4	Employee Benefits Department	5,510,116	3,636		5,513,752			4
5.01	COMMUNICATIONS	147,688	2,264		24,682	174,634		5.01
5.02	INFORMATION SYSTEMS	2,757,742	15,654	354,429		9,470	3,137,295	5.02
5.03	PURCHASING	247,281	41,657		45,359	1,393		5.03
5.04	ADMITTING	414,374	10,436	3,944	129,523	1,393		5.04
5.05	BUSINESS OFFICE	1,070,052	10,886		103,860	8,077	3,137,295	5.05
5.06	ADMIN & GENERAL	4,700,536	306,625	41,491	648,164	13,926		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	1,797,733	77,915	16,779	156,782	7,242		7
8	Laundry & Linen Service	123,782	21,772	4,135	35,482	279		8
9	Housekeeping	613,280	8,948		136,693	1,671		9
10	Dietary	65,934	25,408	9,662	25,149	3,342		10
11	Cafeteria	569,322	15,589		116,854			11
12	Maintenance of Personnel							12
13	Nursing Administration	500,172	7,127	1,060	161,501	1,393		13
14	Central Services & Supply							14
15	Pharmacy	728,171			107,495			15
16	Medical Records & Library	469,756	9,921	21,380	133,871	10,305		16
17	Social Service	89,943	1,437	648	26,167	2,785		17
19	Nonphysician Anesthetists				12,338			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
<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	Adults & Pediatrics	1,710,265	92,844	119,143	518,469	17,268		30
31	Intensive Care Unit	12,244	15,168	1,699	3,848	1,671		31
43	Nursery	319,620	5,980	25,410	84,755			43
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	1,753,124	80,855	199,208	508,631	10,862		50
51	Recovery Room	2,459	5,980	13,453	304			51
52	Delivery Room & Labor Room	597,554	16,235	41,892	182,356			52
53	Anesthesiology	114,724	4,021	34,354	83	557		53
54	Radiology-Diagnostic	1,610,901	46,266	218,610	382,775	6,685		54
57	CT Scan	289,293	3,135	426	40,681			57
58	MRI	185,666	2,235	723	29,955			58
60	Laboratory	2,633,931	30,902	108,433	364,144	5,292		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	145,627						63
65	Respiratory Therapy	503,232	9,442	9,515	109,576	2,507		65
66	Physical Therapy	1,575,495	117,533	25,812	393,988	9,191		66
69	Electrocardiology	31,158		21,224	7,893			69
70	Electroencephalography	60,259	5,080	842	17,361			70
71	Medical Supplies Charged to Patients	642,833	6,387	4,563	17,946			71
72	Impl. Dev. Charged to Patients	353,402						72
73	Drugs Charged to Patients	764,004	5,849	15,364		1,393		73
76.97	CARDIAC REHABILITATION	123,191	11,888	16,555	39,299	1,114		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic	3,934,614	101,836	51,710	374,764	25,346		88
88.01	RHC II							88.01
91	Emergency	990,259	45,170	12,384	282,803	5,013		91
91.01	PRIORITY CARE CARLYLE	412,499	14,239	27,606	109,162			91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct Part)							92
<b>OTHER REIMBURSABLE COST CENTERS</b>								
<b>SPECIAL PURPOSE COST CENTERS</b>								
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	41,439,600	1,180,320	1,402,454	5,332,713	148,175	3,137,295	118
<b>NONREIMBURSABLE COST CENTERS</b>								
192	Physicians' Private Offices	1,133,204	244,313	40,277	178,588	26,459		192
194	LIFELINE	35,118			2,451			194
194.01	DEVELOPMENT							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	42,607,922	1,424,633	1,442,731	5,513,752	174,634	3,137,295	202

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING AND STORES 5.03	ADMITTING 5.04	CASHIERING ACCTS REC & COLL 5.05	SUBTOTAL (cols.0-4) 4A	OPERATION OF PLANT 5.06	7	
<b>GENERAL SERVICE COST CENTERS</b>								
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	335,690						5.03
5.04	ADMITTING	837	560,507					5.04
5.05	BUSINESS OFFICE	380		4,330,550				5.05
5.06	ADMIN & GENERAL	2,278			5,713,020	5,713,020		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	3,082			2,059,533	318,910	2,378,443	7
8	Laundry & Linen Service	936			186,386	28,861	54,192	8
9	Housekeeping	1,202			761,794	117,961	22,273	9
10	Dietary	172			129,667	20,078	63,242	10
11	Cafeteria				701,765	108,666	38,802	11
12	Maintenance of Personnel							12
13	Nursing Administration	260			671,513	103,981	17,739	13
14	Central Services & Supply							14
15	Pharmacy				835,666	129,400		15
16	Medical Records & Library	386			645,619	99,972	24,694	16
17	Social Service	172			121,152	18,760	3,577	17
19	Nonphysician Anesthetists				12,338	1,910		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
<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	Adults & Pediatrics	6,565	21,765	168,166	2,654,485	411,036	231,094	30
31	Intensive Care Unit	35	165	1,275	36,105	5,591	37,754	31
43	Nursery	3,742	5,840	45,122	490,469	75,947	14,885	43
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	9,021	56,370	435,548	3,053,619	472,841	201,252	50
51	Recovery Room	117	4,185	32,336	58,834	9,110	14,885	51
52	Delivery Room & Labor Room	3,387	11,369	87,845	940,638	145,654	40,409	52
53	Anesthesiology	2,360	11,301	87,316	254,716	39,442	10,007	53
54	Radiology-Diagnostic	12,636	62,960	486,461	2,827,294	437,795	115,158	54
57	CT Scan	3,412	61,395	474,367	872,709	135,135	7,804	57
58	MRI	533	24,650	190,456	434,218	67,237	5,564	58
60	Laboratory	58,160	124,789	963,966	4,289,617	664,230	76,917	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	11,151	3,651	28,212	188,641	29,210		63
65	Respiratory Therapy	8,516	7,309	56,470	706,567	109,409	23,501	65
66	Physical Therapy	7,987	23,327	180,236	2,333,569	361,344	292,548	66
69	Electrocardiology	329	7,992	61,752	130,348	20,184		69
70	Electroencephalography	383	3,530	27,276	114,731	17,766	12,645	70
71	Medical Supplies Charged to Patients	72,051	18,712	144,577	907,069	140,456	15,896	71
72	Impl. Dev. Charged to Patients		3,120	24,106	380,628	58,939		72
73	Drugs Charged to Patients	81,489	27,428	211,925	1,107,452	171,485	14,560	73
76.97	CARDIAC REHABILITATION	177	1,260	9,737	203,221	31,468	29,589	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic	32,307	34,350	265,407	4,820,334	746,401	253,475	88
88.01	RHC II							88.01
91	Emergency	4,307	39,466	304,936	1,684,338	260,813	112,431	91
91.01	PRIORITY CARE CARLYLE	5,130	5,573	43,058	617,267	95,581	35,442	91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct Part)							92
<b>OTHER REIMBURSABLE COST CENTERS</b>								
<b>SPECIAL PURPOSE COST CENTERS</b>								
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	333,500	560,507	4,330,550	40,945,322	5,455,573	1,770,335	118
<b>NONREIMBURSABLE COST CENTERS</b>								
192	Physicians' Private Offices	2,190			1,625,031	251,630	608,108	192
194	LIFELINE				37,569	5,817		194
194.0	DEVELOPMENT							194.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	335,690	560,507	4,330,550	42,607,922	5,713,020	2,378,443	202

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
		8	9	10	11	13	15	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	269,439						8
9	Housekeeping	18,310	920,338					9
10	Dietary	1,048	4,090	218,125				10
11	Cafeteria	1,234	31,534		882,001			11
12	Maintenance of Personnel							12
13	Nursing Administration		8,825		23,642	825,700		13
14	Central Services & Supply							14
15	Pharmacy						965,066	15
16	Medical Records & Library		9,363		40,587			16
17	Social Service		2,906		4,489			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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	80,897	383,136	218,125	112,972	250,745		30
31	Intensive Care Unit	389	3,444		561	1,640		31
43	Nursery	2,412	12,969		13,542	41,825		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	63,885			94,567	198,600		50
51	Recovery Room				37	205		51
52	Delivery Room & Labor Room	20,506	25,668		33,817	91,919		52
53	Anesthesiology				75	273		53
54	Radiology-Diagnostic	25,445	71,031		67,222		87,332	54
57	CT Scan				6,621		26,930	57
58	MRI				4,264			58
60	Laboratory	123	56,664		77,247			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.							63
65	Respiratory Therapy	1,156	12,323		25,175			65
66	Physical Therapy	15,045	110,690		85,851			66
69	Electrocardiology				1,496			69
70	Electroencephalography				3,629			70
71	Medical Supplies Charged to Patients				6,509			71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		7,318		16,497		572,350	73
76.97	CARDIAC REHABILITATION		7,803		7,669	11,686		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic		67,157		122,472	46,267	276,891	88
88.01	RHC II							88.01
91	Emergency	22,111	97,291		48,855	141,057		91
91.01	PRIORITY CARE CARLYLE				34,340	36,494		91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	252,561	912,212	218,125	832,136	820,711	963,503	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices	16,878	8,126		49,528	4,989	1,563	192
194	LIFELINE				337			194
194.0	DEVELOPMENT							194.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	269,439	920,338	218,125	882,001	825,700	965,066	202

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	17	19	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	820,235						16
17	Social Service		150,884					17
19	Nonphysician Anesthetists			14,248				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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	198,424	142,095		4,683,009		4,683,009	30
31	Intensive Care Unit	2,922	293		88,699		88,699	31
43	Nursery	39,685			691,734		691,734	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	17,773		14,248	4,116,785		4,116,785	50
51	Recovery Room	1,217			84,288		84,288	51
52	Delivery Room & Labor Room	730			1,299,341		1,299,341	52
53	Anesthesiology	8,278			312,791		312,791	53
54	Radiology-Diagnostic	121,246			3,752,523		3,752,523	54
57	CT Scan	94,952			1,144,151		1,144,151	57
58	MRI	37,981			549,264		549,264	58
60	Laboratory	171,887			5,336,685		5,336,685	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
63	Blood Storing, Processing & Trans.	487			218,338		218,338	63
65	Respiratory Therapy	1,461			879,592		879,592	65
66	Physical Therapy	11,199			3,210,246		3,210,246	66
69	Electrocardiology	11,930			163,958		163,958	69
70	Electroencephalography	974			149,745		149,745	70
71	Medical Supplies Charged to Patients	4,139			1,074,069		1,074,069	71
72	Impl. Dev. Charged to Patients				439,567		439,567	72
73	Drugs Charged to Patients	5,356			1,895,018		1,895,018	73
76.97	CARDIAC REHABILITATION	243			291,679		291,679	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	8,034			6,341,031		6,341,031	88
88.01	RHC II							88.01
91	Emergency	79,126	8,496		2,454,518		2,454,518	91
91.01	PRIORITY CARE CARLYLE	2,191			821,315		821,315	91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	820,235	150,884	14,248	39,998,346		39,998,346	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices				2,565,853		2,565,853	192
194	LIFELINE				43,723		43,723	194
194.0	DEVELOPMENT							194.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	820,235	150,884	14,248	42,607,922		42,607,922	202

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**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	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		3,636		3,636	3,636		4
5.01	COMMUNICATIONS		2,264		2,264	16	2,280	5.01
5.02	INFORMATION SYSTEMS	811,602	15,654	354,429	1,181,685		124	5.02
5.03	PURCHASING		41,657		41,657	30	18	5.03
5.04	ADMITTING		10,436	3,944	14,380	85	18	5.04
5.05	BUSINESS OFFICE	2,436	10,886		13,322	68	105	5.05
5.06	ADMIN & GENERAL	22,421	306,625	41,491	370,537	433	182	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	5,100	77,915	16,779	99,794	103	95	7
8	Laundry & Linen Service		21,772	4,135	25,907	23	4	8
9	Housekeeping		8,948		8,948	90	22	9
10	Dietary		25,408	9,662	35,070	17	44	10
11	Cafeteria		15,589		15,589	77		11
12	Maintenance of Personnel							12
13	Nursing Administration		7,127	1,060	8,187	106	18	13
14	Central Services & Supply							14
15	Pharmacy					71		15
16	Medical Records & Library		9,921	21,380	31,301	88	135	16
17	Social Service		1,437	648	2,085	17	36	17
19	Nonphysician Anesthetists					8		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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	661	92,844	119,143	212,648	341	225	30
31	Intensive Care Unit		15,168	1,699	16,867	3	22	31
43	Nursery		5,980	25,410	31,390	56		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room		80,855	199,208	280,063	335	142	50
51	Recovery Room		5,980	13,453	19,433			51
52	Delivery Room & Labor Room		16,235	41,892	58,127	120		52
53	Anesthesiology		4,021	34,354	38,375		7	53
54	Radiology-Diagnostic		46,266	218,610	264,876	252	87	54
57	CT Scan		3,135	426	3,561	27		57
58	MRI		2,235	723	2,958	20		58
60	Laboratory	102,097	30,902	108,433	241,432	240	69	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.							63
65	Respiratory Therapy		9,442	9,515	18,957	72	33	65
66	Physical Therapy		117,533	25,812	143,345	259	120	66
69	Electrocardiology			21,224	21,224	5		69
70	Electroencephalography	720	5,080	842	6,642	11		70
71	Medical Supplies Charged to Patients		6,387	4,563	10,950	12		71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		5,849	15,364	21,213		18	73
76.97	CARDIAC REHABILITATION		11,888	16,555	28,443	26	15	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	384	101,836	51,710	153,930	247	331	88
88.01	RHC II							88.01
91	Emergency	26,928	45,170	12,384	84,482	186	65	91
91.01	PRIORITY CARE CARLYLE		14,239	27,606	41,845	72		91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	972,349	1,180,320	1,402,454	3,555,123	3,516	1,935	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices		244,313	40,277	284,590	118	345	192
194	LIFELINE					2		194
194.0	DEVELOPMENT							194.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	972,349	1,424,633	1,442,731	3,839,713	3,636	2,280	202

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DATA PRO-CESSING 5.02	PURCHASING RECEIVING AND STORES 5.03	ADMITTING 5.04	CASHIERING ACCTS REC & COLL 5.05	OPERATION OF PLANT 5.06	7	
<b>GENERAL SERVICE COST CENTERS</b>								
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	1,181,809						5.02
5.03	PURCHASING		41,705					5.03
5.04	ADMITTING		104	14,587				5.04
5.05	BUSINESS OFFICE	1,181,809	47		1,195,351			5.05
5.06	ADMIN & GENERAL		283			371,435		5.06
6	Maintenance & Repairs							6
7	Operation of Plant		383			20,733	121,108	7
8	Laundry & Linen Service		116			1,876	2,759	8
9	Housekeeping		149			7,669	1,134	9
10	Dietary		21			1,305	3,220	10
11	Cafeteria					7,065	1,976	11
12	Maintenance of Personnel							12
13	Nursing Administration		32			6,760	903	13
14	Central Services & Supply							14
15	Pharmacy					8,413		15
16	Medical Records & Library		48			6,499	1,257	16
17	Social Service		21			1,220	182	17
19	Nonphysician Anesthetists					124		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
<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	Adults & Pediatrics		816	568	46,419	26,723	11,767	30
31	Intensive Care Unit		4	4	352	363	1,922	31
43	Nursery		465	152	12,455	4,938	758	43
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room		1,121	1,472	120,224	30,741	10,248	50
51	Recovery Room		15	109	8,926	592	758	51
52	Delivery Room & Labor Room		421	297	24,248	9,469	2,058	52
53	Anesthesiology		293	295	24,102	2,564	510	53
54	Radiology-Diagnostic		1,570	1,644	134,278	28,462	5,864	54
57	CT Scan		424	1,603	130,939	8,786	397	57
58	MRI		66	644	52,571	4,371	283	58
60	Laboratory		7,225	3,210	266,076	43,184	3,917	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		1,385	95	7,787	1,899		63
65	Respiratory Therapy		1,058	191	15,587	7,113	1,197	65
66	Physical Therapy		992	609	49,750	23,492	14,896	66
69	Electrocardiology		41	209	17,045	1,312		69
70	Electroencephalography		48	92	7,529	1,155	644	70
71	Medical Supplies Charged to Patients		8,951	489	39,908	9,131	809	71
72	Impl. Dev. Charged to Patients			81	6,654	3,832		72
73	Drugs Charged to Patients		10,126	716	58,497	11,149	741	73
76.97	CARDIAC REHABILITATION		22	33	2,688	2,046	1,507	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic		4,014	897	73,260	48,542	12,907	88
88.01	RHC II							88.01
91	Emergency		535	1,031	84,171	16,956	5,725	91
91.01	PRIORITY CARE CARLYLE		637	146	11,885	6,214	1,805	91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct Part)							92
<b>OTHER REIMBURSABLE COST CENTERS</b>								
<b>SPECIAL PURPOSE COST CENTERS</b>								
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,181,809	41,433	14,587	1,195,351	354,698	90,144	118
<b>NONREIMBURSABLE COST CENTERS</b>								
192	Physicians' Private Offices		272			16,359	30,964	192
194	LIFELINE					378		194
194.0	DEVELOPMENT							194.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,181,809	41,705	14,587	1,195,351	371,435	121,108	202

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
		8	9	10	11	13	15	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	30,685						8
9	Housekeeping	2,085	20,097					9
10	Dietary	119	89	39,885				10
11	Cafeteria	141	689		25,537			11
12	Maintenance of Personnel							12
13	Nursing Administration		193		685	16,884		13
14	Central Services & Supply							14
15	Pharmacy						8,484	15
16	Medical Records & Library		204		1,175			16
17	Social Service		63		130			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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	9,213	8,368	39,885	3,271	5,127		30
31	Intensive Care Unit	44	75		16	34		31
43	Nursery	275	283		392	855		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	7,276			2,738	4,061		50
51	Recovery Room				1	4		51
52	Delivery Room & Labor Room	2,335	561		979	1,880		52
53	Anesthesiology				2	6		53
54	Radiology-Diagnostic	2,898	1,551		1,946		768	54
57	CT Scan				192		237	57
58	MRI				123			58
60	Laboratory	14	1,237		2,237			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.							63
65	Respiratory Therapy	132	269		729			65
66	Physical Therapy	1,713	2,417		2,486			66
69	Electrocardiology				43			69
70	Electroencephalography				105			70
71	Medical Supplies Charged to Patients				188			71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		160		478		5,031	73
76.97	CARDIAC REHABILITATION		170		222	239		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic		1,466		3,546	946	2,434	88
88.01	RHC II							88.01
91	Emergency	2,518	2,125		1,415	2,884		91
91.01	PRIORITY CARE CARLYLE				994	746		91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	28,763	19,920	39,885	24,093	16,782	8,470	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices	1,922	177		1,434	102	14	192
194	LIFELINE				10			194
194.0	DEVELOPMENT							194.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	30,685	20,097	39,885	25,537	16,884	8,484	202

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	17	19	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	40,707						16
17	Social Service		3,754					17
19	Nonphysician Anesthetists			132				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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	9,850	3,536		378,757		378,757	30
31	Intensive Care Unit	145	7		19,858		19,858	31
43	Nursery	1,969			53,988		53,988	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	882			459,303		459,303	50
51	Recovery Room	60			29,898		29,898	51
52	Delivery Room & Labor Room	36			100,531		100,531	52
53	Anesthesiology	411			66,565		66,565	53
54	Radiology-Diagnostic	6,017			450,213		450,213	54
57	CT Scan	4,712			150,878		150,878	57
58	MRI	1,885			62,921		62,921	58
60	Laboratory	8,530			577,371		577,371	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
63	Blood Storing, Processing & Trans.	24			11,190		11,190	63
65	Respiratory Therapy	72			45,410		45,410	65
66	Physical Therapy	556			240,635		240,635	66
69	Electrocardiology	592			40,471		40,471	69
70	Electroencephalography	48			16,274		16,274	70
71	Medical Supplies Charged to Patients	205			70,643		70,643	71
72	Impl. Dev. Charged to Patients				10,567		10,567	72
73	Drugs Charged to Patients	266			108,395		108,395	73
76.97	CARDIAC REHABILITATION	12			35,423		35,423	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	399			302,919		302,919	88
88.01	RHC II							88.01
91	Emergency	3,927	211		206,231		206,231	91
91.01	PRIORITY CARE CARLYLE	109			64,453		64,453	91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	40,707	3,754		3,502,894		3,502,894	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices				336,297		336,297	192
194	LIFELINE				390		390	194
194.0	DEVELOPMENT							194.0
1								1
200	Cross Foot Adjustments			132	132		132	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	40,707	3,754	132	3,839,713		3,839,713	202

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**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 PROCESSING TIME SPENT	PURCHASING RECEIVING AND STORES SUPPLY EXP	
		1	2	4	5.01	5.02	5.03	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	196,301						1
2	Cap Rel Costs-Mvble Equip		1,436,264					2
4	Employee Benefits Department	501		16,888,867				4
5.01	COMMUNICATIONS	312		75,601	627			5.01
5.02	INFORMATION SYSTEMS	2,157	352,843		34	10,000		5.02
5.03	PURCHASING	5,740		138,935	5		4,383,912	5.03
5.04	ADMITTING	1,438	3,926	396,733	5		10,932	5.04
5.05	BUSINESS OFFICE	1,500		318,127	29	10,000	4,958	5.05
5.06	ADMIN & GENERAL	42,250	41,305	1,985,376	50		29,746	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	10,736	16,704	480,231	26		40,253	7
8	Laundry & Linen Service	3,000	4,116	108,684	1		12,230	8
9	Housekeeping	1,233		418,695	6		15,693	9
10	Dietary	3,501	9,619	77,033	12		2,245	10
11	Cafeteria	2,148		357,929				11
12	Maintenance of Personnel							12
13	Nursing Administration	982	1,055	494,685	5		3,389	13
14	Central Services & Supply							14
15	Pharmacy			329,263				15
16	Medical Records & Library	1,367	21,284	410,051	37		5,035	16
17	Social Service	198	645	80,151	10		2,249	17
19	Nonphysician Anesthetists			37,792				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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	12,793	118,609	1,588,091	62		85,735	30
31	Intensive Care Unit	2,090	1,691	11,788	6		455	31
43	Nursery	824	25,296	259,607			48,872	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	11,141	198,315	1,557,957	39		117,814	50
51	Recovery Room	824	13,393	932			1,527	51
52	Delivery Room & Labor Room	2,237	41,704	558,563			44,232	52
53	Anesthesiology	554	34,200	253	2		30,819	53
54	Radiology-Diagnostic	6,375	217,630	1,172,454	24		165,020	54
57	CT Scan	432	424	124,607			44,564	57
58	MRI	308	720	91,752			6,955	58
60	Laboratory	4,258	107,947	1,115,389	19		759,534	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
63	Blood Storing, Processing & Trans.						145,627	63
65	Respiratory Therapy	1,301	9,472	335,635	9		111,214	65
66	Physical Therapy	16,195	25,696	1,206,802	33		104,312	66
69	Electrocardiology		21,129	24,178			4,300	69
70	Electroencephalography	700	838	53,178			5,006	70
71	Medical Supplies Charged to Patients	880	4,543	54,968			940,948	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	806	15,295		5		1,064,174	73
76.97	CARDIAC REHABILITATION	1,638	16,481	120,373	4		2,311	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	14,032	51,478	1,147,918	91		421,917	88
88.01	RHC II							88.01
91	Emergency	6,224	12,328	866,236	18		56,252	91
91.01	PRIORITY CARE CARLYLE	1,962	27,482	334,369			66,990	91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	162,637	1,396,168	16,334,336	532	10,000	4,355,308	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices	33,664	40,096	547,022	95		28,604	192
194	LIFELINE			7,509				194
194.0	DEVELOPMENT							194.0
1								1
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,424,633	1,442,731	5,513,752	174,634	3,137,295	335,690	202
203	Unit Cost Multiplier (Wkst. B, Part I)	7.257390	1.004503	0.326473	278.523126	313.729500	0.076573	203
204	Cost to be allocated (Per Wkst. B, Part II)			3,636	2,280	1,181,809	41,705	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000215	3.636364	118.180900	0.009513	205

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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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	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.04	5.05	5A.06	5.06	6	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	111,715,693						5.04
5.05	BUSINESS OFFICE		111,715,693					5.05
5.06	ADMIN & GENERAL			-5,713,020	36,894,902			5.06
6	Maintenance & Repairs					142,403		6
7	Operation of Plant				2,059,533	10,736	131,667	7
8	Laundry & Linen Service				186,386	3,000	3,000	8
9	Housekeeping				761,794	1,233	1,233	9
10	Dietary				129,667	3,501	3,501	10
11	Cafeteria				701,765	2,148	2,148	11
12	Maintenance of Personnel							12
13	Nursing Administration				671,513	982	982	13
14	Central Services & Supply							14
15	Pharmacy				835,666			15
16	Medical Records & Library				645,619	1,367	1,367	16
17	Social Service				121,152	198	198	17
19	Nonphysician Anesthetists				12,338			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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	4,338,198	4,338,198		2,654,485	12,793	12,793	30
31	Intensive Care Unit	32,887	32,887		36,105	2,090	2,090	31
43	Nursery	1,164,030	1,164,030		490,469	824	824	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	11,235,883	11,235,883		3,053,619	11,141	11,141	50
51	Recovery Room	834,187	834,187		58,834	824	824	51
52	Delivery Room & Labor Room	2,266,150	2,266,150		940,638	2,237	2,237	52
53	Anesthesiology	2,252,497	2,252,497		254,716	554	554	53
54	Radiology-Diagnostic	12,549,307	12,549,307		2,827,294	6,375	6,375	54
57	CT Scan	12,237,316	12,237,316		872,709	432	432	57
58	MRI	4,913,208	4,913,208		434,218	308	308	58
60	Laboratory	24,867,460	24,867,460		4,289,617	4,258	4,258	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
63	Blood Storing, Processing & Trans.	727,791	727,791		188,641			63
65	Respiratory Therapy	1,456,765	1,456,765		706,567	1,301	1,301	65
66	Physical Therapy	4,649,560	4,649,560		2,333,569	16,195	16,195	66
69	Electrocardiology	1,593,023	1,593,023		130,348			69
70	Electroencephalography	703,651	703,651		114,731	700	700	70
71	Medical Supplies Charged to Patients	3,729,674	3,729,674		907,069	880	880	71
72	Impl. Dev. Charged to Patients	621,871	621,871		380,628			72
73	Drugs Charged to Patients	5,467,046	5,467,046		1,107,452	806	806	73
76.97	CARDIAC REHABILITATION	251,190	251,190		203,221	1,638	1,638	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	6,846,737	6,846,737		4,820,334	14,032	14,032	88
88.01	RHC II							88.01
91	Emergency	7,866,485	7,866,485		1,684,338	6,224	6,224	91
91.01	PRIORITY CARE CARLYLE	1,110,777	1,110,777		617,267	1,962	1,962	91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	111,715,693	111,715,693	-5,713,020	35,232,302	108,739	98,003	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices				1,625,031	33,664	33,664	192
194	LIFELINE				37,569			194
194.0	DEVELOPMENT							194.0
1								1
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	560,507	4,330,550		5,713,020		2,378,443	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.005017	0.038764		0.154846		18.064078	203
204	Cost to be allocated (Per Wkst. B, Part II)	14,587	1,195,351		371,435		121,108	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000131	0.010700		0.010067		0.919805	205

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA FTE'S SERVED	NURSING ADMINISTRATION DIRECT NRSING HRS	PHARMACY COSTED REQUIS.	
		8	9	10	11	13	15	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	280,838						8
9	Housekeeping	19,085	17,103					9
10	Dietary	1,092	76	14,618				10
11	Cafeteria	1,286	586		23,578			11
12	Maintenance of Personnel							12
13	Nursing Administration		164		632	12,082		13
14	Central Services & Supply							14
15	Pharmacy						1,288,222	15
16	Medical Records & Library		174		1,085			16
17	Social Service		54		120			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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	84,320	7,120	14,618	3,020	3,669		30
31	Intensive Care Unit	405	64		15	24		31
43	Nursery	2,514	241		362	612		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	66,588			2,528	2,906		50
51	Recovery Room				1	3		51
52	Delivery Room & Labor Room	21,374	477		904	1,345		52
53	Anesthesiology				2	4		53
54	Radiology-Diagnostic	26,521	1,320		1,797		116,576	54
57	CT Scan				177		35,947	57
58	MRI				114			58
60	Laboratory	128	1,053		2,065			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.							63
65	Respiratory Therapy	1,205	229		673			65
66	Physical Therapy	15,682	2,057		2,295			66
69	Electrocardiology				40			69
70	Electroencephalography				97			70
71	Medical Supplies Charged to Patients				174			71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		136		441		764,004	73
76.97	CARDIAC REHABILITATION		145		205	171		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic		1,248		3,274	677	369,609	88
88.01	RHC II							88.01
91	Emergency	23,046	1,808		1,306	2,064		91
91.01	PRIORITY CARE CARLYLE				918	534		91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	263,246	16,952	14,618	22,245	12,009	1,286,136	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices	17,592	151		1,324	73	2,086	192
194	LIFELINE				9			194
194.0	DEVELOPMENT							194.0
1								1
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	269,439	920,338	218,125	882,001	825,700	965,066	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.959411	53.811495	14.921672	37.407795	68.341334	0.749146	203
204	Cost to be allocated (Per Wkst. B, Part II)	30,685	20,097	39,885	25,537	16,884	8,484	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.109262	1.175057	2.728485	1.083086	1.397451	0.006586	205

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME				
	16	17	19				

<b>GENERAL SERVICE COST CENTERS</b>							
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	3,369					16
17	Social Service		515				17
19	Nonphysician Anesthetists			1			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
<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	815	485				30
31	Intensive Care Unit	12	1				31
43	Nursery	163					43
<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	73		1			50
51	Recovery Room	5					51
52	Delivery Room & Labor Room	3					52
53	Anesthesiology	34					53
54	Radiology-Diagnostic	498					54
57	CT Scan	390					57
58	MRI	156					58
60	Laboratory	706					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	2					63
65	Respiratory Therapy	6					65
66	Physical Therapy	46					66
69	Electrocardiology	49					69
70	Electroencephalography	4					70
71	Medical Supplies Charged to Patients	17					71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients	22					73
76.97	CARDIAC REHABILITATION	1					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	33					88
88.01	RHC II						88.01
91	Emergency	325	29				91
91.01	PRIORITY CARE CARLYLE	9					91.01
91.02	PRIORITY CARE NEW BADEN						91.02
92	Observation Beds (Non-Distinct Part)						92
<b>OTHER REIMBURSABLE COST CENTERS</b>							
<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	3,369	515	1			118
<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices						192
194	LIFELINE						194
194.0	DEVELOPMENT						194.0
1							1
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	820,235	150,884	14,248			202
203	Unit Cost Multiplier (Wkst. B, Part I)	243.465420	292.978641	14,248.000000			203

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME				
		16	17	19				
204	Cost to be allocated (Per Wkst. B, Part II)	40,707	3,754	132				204
205	Unit Cost Multiplier (Wkst. B, Part II)	12.082814	7.289320	132.000000				205

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**POST STEPDOWN ADJUSTMENTS**

**WORKSHEET B-2**

		WORKSHEET		
	DESCRIPTION	PART	LINE NO.	AMOUNT
	1	2	3	4

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C  
PART I**

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	4,683,009		4,683,009		4,683,009	30
31	Intensive Care Unit	88,699		88,699		88,699	31
43	Nursery	691,734		691,734	23,245	714,979	43
<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	4,116,785		4,116,785		4,116,785	50
51	Recovery Room	84,288		84,288		84,288	51
52	Delivery Room & Labor Room	1,299,341		1,299,341		1,299,341	52
53	Anesthesiology	312,791		312,791	8,784	321,575	53
54	Radiology-Diagnostic	3,752,523		3,752,523		3,752,523	54
57	CT Scan	1,144,151		1,144,151		1,144,151	57
58	MRI	549,264		549,264		549,264	58
60	Laboratory	5,336,685		5,336,685	31,890	5,368,575	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	218,338		218,338		218,338	63
65	Respiratory Therapy	879,592		879,592	28,155	907,747	65
66	Physical Therapy	3,210,246		3,210,246	22,990	3,233,236	66
69	Electrocardiology	163,958		163,958		163,958	69
70	Electroencephalography	149,745		149,745		149,745	70
71	Medical Supplies Charged to Patients	1,074,069		1,074,069		1,074,069	71
72	Impl. Dev. Charged to Patients	439,567		439,567		439,567	72
73	Drugs Charged to Patients	1,895,018		1,895,018		1,895,018	73
76.97	CARDIAC REHABILITATION	291,679		291,679		291,679	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	6,341,031		6,341,031		6,341,031	88
88.01	RHC II						88.01
91	Emergency	2,454,518		2,454,518	32,920	2,487,438	91
91.01	PRIORITY CARE CARLYLE	821,315		821,315		821,315	91.01
91.02	PRIORITY CARE NEW BADEN						91.02
92	Observation Beds (Non-Distinct Part)	608,076		608,076		608,076	92
<b>OTHER REIMBURSABLE COST CENTERS</b>							
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	40,606,422		40,606,422	147,984	40,754,406	200
201	Less Observation Beds	608,076		608,076		608,076	201
202	Total (line 200 minus line 201)	39,998,346		39,998,346		40,146,330	202

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8				
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	3,758,357		3,758,357				30
31	Intensive Care Unit	32,887		32,887				31
43	Nursery	1,164,030		1,164,030				43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	1,400,497	9,835,386	11,235,883	0.366396	0.366396	0.366396	50
51	Recovery Room	125,776	708,411	834,187	0.101042	0.101042	0.101042	51
52	Delivery Room & Labor Room	1,798,938	467,212	2,266,150	0.573369	0.573369	0.573369	52
53	Anesthesiology	304,912	1,947,585	2,252,497	0.138864	0.138864	0.142764	53
54	Radiology-Diagnostic	773,667	11,775,640	12,549,307	0.299022	0.299022	0.299022	54
57	CT Scan	1,372,636	10,864,680	12,237,316	0.093497	0.093497	0.093497	57
58	MRI	66,007	4,847,201	4,913,208	0.111793	0.111793	0.111793	58
60	Laboratory	2,789,513	22,077,947	24,867,460	0.214605	0.214605	0.215888	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
63	Blood Storing, Processing & Trans.	285,549	442,242	727,791	0.300001	0.300001	0.300001	63
65	Respiratory Therapy	885,075	571,690	1,456,765	0.603798	0.603798	0.623125	65
66	Physical Therapy	120,146	4,529,414	4,649,560	0.690441	0.690441	0.695385	66
69	Electrocardiology	137,243	1,455,780	1,593,023	0.102923	0.102923	0.102923	69
70	Electroencephalography	2,830	700,821	703,651	0.212811	0.212811	0.212811	70
71	Medical Supplies Charged to Patients	1,722,956	2,006,718	3,729,674	0.287979	0.287979	0.287979	71
72	Impl. Dev. Charged to Patients	223,159	398,712	621,871	0.706846	0.706846	0.706846	72
73	Drugs Charged to Patients	1,909,838	3,557,208	5,467,046	0.346626	0.346626	0.346626	73
76.97	CARDIAC REHABILITATION		251,190	251,190	1.161189	1.161189	1.161189	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic							88
88.01	RHC II							88.01
91	Emergency	880,159	6,986,326	7,866,485	0.312022	0.312022	0.316207	91
91.01	PRIORITY CARE CARLYLE	9,675	1,101,102	1,110,777	0.739406	0.739406	0.739406	91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct Part)	89,298	490,543	579,841	1.048694	1.048694	1.048694	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	19,853,148	85,015,808	104,868,956				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	19,853,148	85,015,808	104,868,956				202

**KPMG LLP Compu-Max 2552-10**

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D  
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	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)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	378,757		378,757	3,997	94.76	1,407	133,327	30
31	Intensive Care Unit	19,858		19,858	14	1,418.43	12	17,021	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	53,988		53,988	1,329	40.62			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	452,603		452,603	5,340		1,419	150,348	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0145

WORKSHEET D  
PART II

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

(A)	Cost Center Description	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)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	459,303	11,235,883	0.040878	338,172	13,824	50
51	Recovery Room	29,898	834,187	0.035841	38,128	1,367	51
52	Delivery Room & Labor Room	100,531	2,266,150	0.044362	5,445	242	52
53	Anesthesiology	66,565	2,252,497	0.029552	84,240	2,489	53
54	Radiology-Diagnostic	450,213	12,549,307	0.035876	465,545	16,702	54
57	CT Scan	150,878	12,237,316	0.012329	832,079	10,259	57
58	MRI	62,921	4,913,208	0.012807	52,774	676	58
60	Laboratory	577,371	24,867,460	0.023218	1,471,809	34,172	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>						62.30
63	Blood Storing, Processing & Tra	11,190	727,791	0.015375	137,392	2,112	63
65	Respiratory Therapy	45,410	1,456,765	0.031172	610,178	19,020	65
66	Physical Therapy	240,635	4,649,560	0.051754	101,061	5,230	66
69	Electrocardiology	40,471	1,593,023	0.025405	104,635	2,658	69
70	Electroencephalography	16,274	703,651	0.023128	2,830	65	70
71	Medical Supplies Charged to Pat	70,643	3,729,674	0.018941	893,046	16,915	71
72	Impl. Dev. Charged to Patients	10,567	621,871	0.016992	118,075	2,006	72
73	Drugs Charged to Patients	108,395	5,467,046	0.019827	847,399	16,801	73
76.97	<b>CARDIAC REHABILITATION</b>	35,423	251,190	0.141021			76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>						76.98
76.99	<b>LITHOTRIPSY</b>						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	Rural Health Clinic	302,919					88
88.01	RHC II						88.01
91	Emergency	206,231	7,866,485	0.026216	575,959	15,099	91
91.01	PRIORITY CARE CARLYLE	64,453	1,110,777	0.058025	5,608	325	91.01
91.02	PRIORITY CARE NEW BADEN						91.02
92	Observation Beds (Non-Distinct	49,181	579,841	0.084818	45,992	3,901	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	3,099,472	99,913,682		6,730,367	163,863	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

Check  Title V  PPS  
 Applicable  Title XVIII, Part A  TEFRA  
 Boxes:  Title XIX  Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
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 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6		7		8	9	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	3,997		1,407		30
31	Intensive Care Unit	14		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	1,329				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	5,340		1,419		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0145**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	1	2	3	4	5	6	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	<b>CARDIAC REHABILITATION</b>							76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>							76.98
76.99	<b>LITHOTRIPSY</b>							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic							88
88.01	RHC II							88.01
91	Emergency							91
91.01	PRIORITY CARE CARLYLE							91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0145**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	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)	
7		8		9	10	11	12	13	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	11,235,883			338,172		2,929,244		50
51	Recovery Room	834,187			38,128		198,986		51
52	Delivery Room & Labor Room	2,266,150			5,445				52
53	Anesthesiology	2,252,497			84,240		595,637		53
54	Radiology-Diagnostic	12,549,307			465,545		3,750,562		54
57	CT Scan	12,237,316			832,079		3,791,516		57
58	MRI	4,913,208			52,774		1,266,410		58
60	Laboratory	24,867,460			1,471,809		2,987,044		60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
63	Blood Storing, Processing & Tra	727,791			137,392		163,127		63
65	Respiratory Therapy	1,456,765			610,178		213,999		65
66	Physical Therapy	4,649,560			101,061		1,164,088		66
69	Electrocardiology	1,593,023			104,635		686,160		69
70	Electroencephalography	703,651			2,830		299,427		70
71	Medical Supplies Charged to Pat	3,729,674			893,046		502,195		71
72	Impl. Dev. Charged to Patients	621,871			118,075		195,421		72
73	Drugs Charged to Patients	5,467,046			847,399		1,416,011		73
76.97	<b>CARDIAC REHABILITATION</b>	251,190					139,939		76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>								76.98
76.99	<b>LITHOTRIPSY</b>								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic								88
88.01	RHC II								88.01
91	Emergency	7,866,485			575,959		2,134,929		91
91.01	<b>PRIORITY CARE CARLYLE</b>	1,110,777			5,608		124,976		91.01
91.02	<b>PRIORITY CARE NEW BADEN</b>								91.02
92	Observation Beds (Non-Distinct)	579,841			45,992		204,120		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	99,913,682			6,730,367		22,763,791		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0145

WORKSHEET D  
PART V

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

(A)	Cost Center Description	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.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	0.366396	2,929,244			1,073,263			50
51	Recovery Room	0.101042	198,986			20,106			51
52	Delivery Room & Labor Room	0.573369							52
53	Anesthesiology	0.138864	595,637			82,713			53
54	Radiology-Diagnostic	0.299022	3,750,562			1,121,501			54
57	CT Scan	0.093497	3,791,516			354,495			57
58	MRI	0.111793	1,266,410			141,576			58
60	Laboratory	0.214605	2,987,044	4,280		641,035	919		60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
63	Blood Storing, Processing & Tra	0.300001	163,127			48,938			63
65	Respiratory Therapy	0.603798	213,999	11,781		129,212	7,113		65
66	Physical Therapy	0.690441	1,164,088			803,734			66
69	Electrocardiology	0.102923	686,160			70,622			69
70	Electroencephalography	0.212811	299,427			63,721			70
71	Medical Supplies Charged to Pat	0.287979	502,195	288		144,622	83		71
72	Impl. Dev. Charged to Patients	0.706846	195,421			138,133			72
73	Drugs Charged to Patients	0.346626	1,416,011		16,976	490,826		5,884	73
76.97	<b>CARDIAC REHABILITATION</b>	1.161189	139,939			162,496			76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>								76.98
76.99	<b>LITHOTRIPSY</b>								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic								88
88.01	RHC II								88.01
91	Emergency	0.312022	2,134,929			666,145			91
91.01	PRIORITY CARE CARLYLE	0.739406	124,976			92,408			91.01
91.02	PRIORITY CARE NEW BADEN								91.02
92	Observation Beds (Non-Distinct)	1.048694	204,120			214,059			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)		22,763,791	16,349	16,976	6,459,605	8,115	5,884	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		22,763,791	16,349	16,976	6,459,605	8,115	5,884	202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D  
PART I**

Check  Title V  
 Applicable  Title XVIII, Part A  
 Boxes:  Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	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)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	378,757		378,757	3,997	94.76	729	69,080	30
31	Intensive Care Unit	19,858		19,858	14	1,418.43			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	53,988		53,988	1,329	40.62	182	7,393	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	452,603		452,603	5,340		911	76,473	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0145

WORKSHEET D  
PART II

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

(A)	Cost Center Description	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)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	459,303	11,235,883	0.040878			50
51	Recovery Room	29,898	834,187	0.035841			51
52	Delivery Room & Labor Room	100,531	2,266,150	0.044362			52
53	Anesthesiology	66,565	2,252,497	0.029552			53
54	Radiology-Diagnostic	450,213	12,549,307	0.035876			54
57	CT Scan	150,878	12,237,316	0.012329			57
58	MRI	62,921	4,913,208	0.012807			58
60	Laboratory	577,371	24,867,460	0.023218			60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>						62.30
63	Blood Storing, Processing & Tra	11,190	727,791	0.015375			63
65	Respiratory Therapy	45,410	1,456,765	0.031172			65
66	Physical Therapy	240,635	4,649,560	0.051754			66
69	Electrocardiology	40,471	1,593,023	0.025405			69
70	Electroencephalography	16,274	703,651	0.023128			70
71	Medical Supplies Charged to Pat	70,643	3,729,674	0.018941			71
72	Impl. Dev. Charged to Patients	10,567	621,871	0.016992			72
73	Drugs Charged to Patients	108,395	5,467,046	0.019827			73
76.97	<b>CARDIAC REHABILITATION</b>						76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>						76.98
76.99	<b>LITHOTRIPSY</b>						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	Rural Health Clinic	302,919					88
88.01	RHC II						88.01
91	Emergency	206,231	7,866,485	0.026216			91
91.01	<b>PRIORITY CARE CARLYLE</b>						91.01
91.02	<b>PRIORITY CARE NEW BADEN</b>						91.02
92	Observation Beds (Non-Distinct	49,181	579,841	0.084818			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	3,099,472	99,913,682				200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

Check  Title V  PPS  
 Applicable  Title XVIII, Part A  TEFRA  
 Boxes:  Title XIX  Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
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 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

Check  Title V  PPS  
 Applicable  Title XVIII, Part A  TEFRA  
 Boxes:  Title XIX  Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6		7		8	9	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	3,997		729		30
31	Intensive Care Unit	14				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	1,329		182		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	5,340		911		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0145**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	1	2	3	4	5	6	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	<b>CARDIAC REHABILITATION</b>							76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>							76.98
76.99	<b>LITHOTRIPSY</b>							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic							88
88.01	RHC II							88.01
91	Emergency							91
91.01	PRIORITY CARE CARLYLE							91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0145**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	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)	
7		8		9	10	11	12	13	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	11,235,883							50
51	Recovery Room	834,187							51
52	Delivery Room & Labor Room	2,266,150							52
53	Anesthesiology	2,252,497							53
54	Radiology-Diagnostic	12,549,307							54
57	CT Scan	12,237,316							57
58	MRI	4,913,208							58
60	Laboratory	24,867,460							60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
63	Blood Storing, Processing & Tra	727,791							63
65	Respiratory Therapy	1,456,765							65
66	Physical Therapy	4,649,560							66
69	Electrocardiology	1,593,023							69
70	Electroencephalography	703,651							70
71	Medical Supplies Charged to Pat	3,729,674							71
72	Impl. Dev. Charged to Patients	621,871							72
73	Drugs Charged to Patients	5,467,046							73
76.97	CARDIAC REHABILITATION	251,190							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic								88
88.01	RHC II								88.01
91	Emergency	7,866,485							91
91.01	PRIORITY CARE CARLYLE	1,110,777							91.01
91.02	PRIORITY CARE NEW BADEN								91.02
92	Observation Beds (Non-Distinct)	579,841							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	99,913,682							200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0145

WORKSHEET D  
PART V

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

(A)	Cost Center Description	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.)
	1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	0.366396					50	
51	Recovery Room	0.101042					51	
52	Delivery Room & Labor Room	0.573369					52	
53	Anesthesiology	0.138864					53	
54	Radiology-Diagnostic	0.299022					54	
57	CT Scan	0.093497					57	
58	MRI	0.111793					58	
60	Laboratory	0.214605					60	
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>						62.30	
63	Blood Storing, Processing & Tra	0.300001					63	
65	Respiratory Therapy	0.603798					65	
66	Physical Therapy	0.690441					66	
69	Electrocardiology	0.102923					69	
70	Electroencephalography	0.212811					70	
71	Medical Supplies Charged to Pat	0.287979					71	
72	Impl. Dev. Charged to Patients	0.706846					72	
73	Drugs Charged to Patients	0.346626					73	
76.97	<b>CARDIAC REHABILITATION</b>	1.161189					76.97	
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>						76.98	
76.99	<b>LITHOTRIPSY</b>						76.99	
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic						88	
88.01	RHC II						88.01	
91	Emergency	0.312022					91	
91.01	PRIORITY CARE CARLYLE	0.739406					91.01	
91.02	PRIORITY CARE NEW BADEN						91.02	
92	Observation Beds (Non-Distinct)	1.048694					92	
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0145

WORKSHEET D-1  
PART I

Check  Title V - I/P                     Hospital                     SUB (Other)                     ICF/IID                     PPS  
Applicable  Title XVIII, Part A                     IPF                     SNF                     TEFRA  
Boxes:  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)	3,997	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,997	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)	3,172	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,407	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	4,683,009	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,683,009	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,683,009	37

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0145

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

							1	
		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		
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,171.63	38	
39	Program general inpatient routine service cost (line 9 x line 38)					1,648,483	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)					1,648,483	41	
42	Nursery (Titles V and XIX only)						42	
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit	88,699	14	6,335.64	12	76,028	43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,055,510	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					3,780,021	49	

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					150,348	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					163,863	51
52	Total Program excludable cost (sum of lines 50 and 51)					314,211	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					3,465,810	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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0145

WORKSHEET D-1  
PARTS III & IV

Check  Title V - I/P                     Hospital                     SUB (Other)                     ICF/IID                     PPS  
 Applicable  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)					519	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,171.63	88
89	Observation bed cost (line 87 x line 88) (see instructions)					608,076	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	378,757	4,683,009	0.080879	608,076	49,181	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0145

WORKSHEET D-1  
PART I

Check [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS  
 Applicable [ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA  
 Boxes: [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)	3,997	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,997	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)	3,172	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	729	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	1,329	15
16	Nursery days (title V or XIX only)	182	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)	4,683,009	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,683,009	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,683,009	37

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0145

WORKSHEET D-1  
PART II

Check [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS  
 Applicable [ ] Title XVIII, Part A [ ] IPF [ ] TEFRA  
 Boxes: [XX] Title XIX - I/P [ ] IRF [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)						1,171.63	38
39	Program general inpatient routine service cost (line 9 x line 38)						854,118	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)						854,118	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)	691,734	1,329	520.49	182	94,729		42
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit	88,699	14	6,335.64				43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47
								1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						948,847	49
								<b>PASS THROUGH COST ADJUSTMENTS</b>
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						76,473	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51
52	Total Program excludable cost (sum of lines 50 and 51)						76,473	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)							53
								<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>
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
								<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>
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                     Hospital             SUB (Other)                     ICF/IID             PPS  
Applicable     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)					519	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)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

**KPMG LLP Compu-Max 2552-10**

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0145

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		1,456,577		30
31	Intensive Care Unit		26,513		31
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.366396	338,172	123,905	50
51	Recovery Room	0.101042	38,128	3,853	51
52	Delivery Room & Labor Room	0.573369	5,445	3,122	52
53	Anesthesiology	0.142764	84,240	12,026	53
54	Radiology-Diagnostic	0.299022	465,545	139,208	54
57	CT Scan	0.093497	832,079	77,797	57
58	MRI	0.111793	52,774	5,900	58
60	Laboratory	0.215888	1,471,809	317,746	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>				62.30
63	Blood Storing, Processing & Trans.	0.300001	137,392	41,218	63
65	Respiratory Therapy	0.623125	610,178	380,217	65
66	Physical Therapy	0.695385	101,061	70,276	66
69	Electrocardiology	0.102923	104,635	10,769	69
70	Electroencephalography	0.212811	2,830	602	70
71	Medical Supplies Charged to Patients	0.287979	893,046	257,178	71
72	Impl. Dev. Charged to Patients	0.706846	118,075	83,461	72
73	Drugs Charged to Patients	0.346626	847,399	293,731	73
76.97	<b>CARDIAC REHABILITATION</b>	1.161189			76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>				76.98
76.99	<b>LITHOTRIPSY</b>				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
88	Rural Health Clinic				88
88.01	RHC II				88.01
91	Emergency	0.316207	575,959	182,122	91
91.01	<b>PRIORITY CARE CARLYLE</b>	0.739406	5,608	4,147	91.01
91.02	<b>PRIORITY CARE NEW BADEN</b>				91.02
92	Observation Beds (Non-Distinct Part)	1.048694	45,992	48,232	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		6,730,367	2,055,510	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		6,730,367		202

(A) Worksheet A line numbers

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0145

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
43	Nursery				43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.366396			50
51	Recovery Room	0.101042			51
52	Delivery Room & Labor Room	0.573369			52
53	Anesthesiology	0.138864			53
54	Radiology-Diagnostic	0.299022			54
57	CT Scan	0.093497			57
58	MRI	0.111793			58
60	Laboratory	0.214605			60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>				62.30
63	Blood Storing, Processing & Trans.	0.300001			63
65	Respiratory Therapy	0.603798			65
66	Physical Therapy	0.690441			66
69	Electrocardiology	0.102923			69
70	Electroencephalography	0.212811			70
71	Medical Supplies Charged to Patients	0.287979			71
72	Impl. Dev. Charged to Patients	0.706846			72
73	Drugs Charged to Patients	0.346626			73
76.97	<b>CARDIAC REHABILITATION</b>	1.161189			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
88	Rural Health Clinic				88
88.01	RHC II				88.01
91	Emergency	0.312022			91
91.01	PRIORITY CARE CARLYLE	0.739406			91.01
91.02	PRIORITY CARE NEW BADEN				91.02
92	Observation Beds (Non-Distinct Part)	1.048694			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**WORKSHEET E  
PART A**

**PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	736,282			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	197,925	1,955,502		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)		10,152		2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	77,078	225,432		3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	47.58			4
	<b>Indirect Medical Education Adjustment Calculation for Hospitals</b>				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	<b>Disproportionate Share Adjustment</b>				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0107			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2501			31
32	Sum of lines 30 and 31	0.2608			32
33	Allowable disproportionate share percentage (see instructions)	0.1073	0.1073		33
34	Disproportionate share adjustment (see instructions)	25,060	52,456		34
		<b>Prior to October 1</b>	<b>On or after October 1</b>		
	<b>Uncompensated Care Adjustment</b>				
35	Total uncompensated care amount (see instructions)	9,046,380,143			35
35.01	Factor 3 (see instructions)	0.000030607			35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	276,883	199,971		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	69,790	149,567		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	219,357			36
	<b>Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)</b>				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	454			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

**KPMG LLP Compu-Max 2552-10**

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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**WORKSHEET E  
PART A**

**PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
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)	1,178,624	2,018,110		47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	985,600			48
49	Total payment for inpatient operating costs (see instructions)	3,196,734			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	228,974			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	3,425,708			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	3,425,708			61
62	Deductibles billed to program beneficiaries	438,296			62
63	Coinsurance billed to program beneficiaries				63
64	Allowable bad debts (see instructions)	53,912			64
65	Adjusted reimbursable bad debts (see instructions)	35,043			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	52,728			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,022,455			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	39,969			70.93
70.94	HRR adjustment amount (see instructions)	-2,949			70.94
70.96	Low volume adjustment for federal fiscal year (2014)	182,489			70.96
70.97	Low volume adjustment for federal fiscal year (2015)	428,458			70.97
71	Amount due provider (see instructions)	3,670,422			71
71.01	Sequestration adjustment (see instructions)	73,408			71.01
72	Interim payments	3,669,103			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-72,089			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	13,902			75

**TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)**

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

**HSP Bonus Payment Amount**

**Prior to 10/1      On or After 10/1**

100	HSP bonus amount (see instructions)				100
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**HVBP Adjustment for HSP Bonus Payment**

**Prior to 10/1      On or After 10/1**

101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

**HRR Adjustment for HSP Bonus Payment**

**Prior to 10/1      On or After 10/1**

103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

**KPMG LLP Compu-Max 2552-10**

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

**EXHIBIT 4**

	(Amt. from Wkst. E, Pt. A or L Pt. I)	Pre/Post Entitlement	10/01/2013 through 09/30/2014	10/01/2014 through 09/30/2015	Total (col. 2 through 4)	
	1	2	3	4	5	
1	DRG Amounts Other Than Outlier Payments			3.01	4.01	1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	736,282	736,282		736,282	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	2,153,427	197,925	1,955,502	2,153,427	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1					1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1					1.04
2	Outlier payments for discharges	10,152		10,152	10,152	2
2.01	Outlier payment for discharges for Model 4 BPCI					2.01
3	Operating outlier reconciliation					3
4	Managed Care Simulated Payments	302,510	77,078	225,432	302,510	4
	<b>Indirect Medical Education Adjustment</b>					
5	Amount from Worksheet E Part A, line 21					5
6	IME payment adjustment					6
6.01	IME payment adjustment for managed care					6.01
	<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
7	IME payment adjustment factor					7
8	IME add-on adjustment amount					8
8.01	IME payment adjustment add-on for managed care					8.01
9	Total IME payment (sum of lines 6 and 8)					9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)					9.01
	<b>Disproportionate Share Adjustment</b>					
10	Allowable disproportionate share percentage	0.1073	0.1073	0.1073	0.1073	10
11	Disproportionate share adjustment	77,516	25,060	52,456	77,516	11
11.01	Uncompensated care payments	219,357	69,790	149,567	219,357	11.01
	<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
12	Total ESRD additional payment					12
13	Subtotal	3,196,734	1,029,057	2,167,677	3,196,734	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	985,600	985,600		985,600	14
15	Total payment for inpatient operating costs SCH and MDH only	3,196,734	1,029,057	2,167,677	3,196,734	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	228,974	48,935	180,039	228,974	16
17	Special add-on payments for new technologies					17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)					17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG					17.02
18	Capital outlier reconciliation adjustment amount					18
19	<b>SUBTOTAL</b>		1,077,992	2,347,716	3,425,708	19
20	Capital DRG other than outlier	227,483	48,935	178,548	227,483	20
20.01	Model 4 BPCI Capital DRG other than outlier					20.01
21	Capital DRG outlier payments	1,491		1,491	1,491	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	228,974	48,935	180,039	228,974	26
27	<b>Low volume adjustment factor</b>		0.169286	0.182500		27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.96)(prior to 10/1)		182,489		182,489	28
29	Low Volume Adjustment (transfer amount to Worksheet E, Part A, line 70.97)(on/after 10/1)			428,458	428,458	29

**KPMG LLP Compu-Max 2552-10**

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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**COMPONENT CCN: 14-0145**

**WORKSHEET E  
PART B**

Check applicable box:       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)	13,999			1
2	Medical and other services reimbursed under OPPS (see instructions)	6,459,605			2
3	PPS payments	4,433,460			3
4	Outlier payment (see instructions)	7,029			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.845			5
6	Line 2 times line 5	5,458,366			6
7	Sum of line 3 and line 4 divided by line 6	0.8135			7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	13,999			11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
12	Ancillary service charges	33,325			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	33,325			14
	<b>CUSTOMARY CHARGES</b>				
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)	33,325			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	19,326			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)	13,999			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	4,440,489			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	992,293			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,462,195			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)	3,462,195			30
31	Primary payer payments	222			31
32	Subtotal (line 30 minus line 31)	3,461,973			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	84,695			34
35	Adjusted reimbursable bad debts (see instructions)	55,052			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	72,056			36
37	Subtotal (see instructions)	3,517,025			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	3,517,025			40
40.01	Sequestration adjustment (see instructions)	70,341			40.01
41	Interim payments	3,455,465			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-8,781			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

**TO BE COMPLETED BY CONTRACTOR**

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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0145

WORKSHEET E-1  
PART I

Check  Hospital  SUB (Other)  
 Applicable  IPF  SNF  
 Boxes:  IRF  Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider		3,610,977		3,449,762	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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	02/27/2015	58,126	02/27/2015	5,703	3.01
						3.02
	Program					3.03
	to					3.04
	Provider					3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
	Provider					3.52
	to					3.53
	Program					3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99	58,126		5,703	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)		3,669,103		3,455,465	4
<b>TO BE COMPLETED BY CONTRACTOR</b>						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					5.01
						5.02
	Program					5.03
	to					5.04
	Provider					5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
	Provider					5.52
	to					5.53
	Program					5.54
						5.55
						5.56
						5.57
						5.58
						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) based on the cost report (1)	.02	-72,089		-8,781	6.02
7	Total Medicare program liability (see instructions)		3,597,014		3,446,684	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.

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT**

**WORKSHEET E-1  
PART II**

Check applicable box:             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 (Wkst. S-3, Pt. I, col. 15, line 14)	1,396	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,419	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	150	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	3,492	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	104,868,956	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	2,009,323	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	469,415	8
9	Sequestration adjustment amount (see instructions)	9,388	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	460,027	10

**INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH**

30	Initial/interim HIT payment(s)	512,441	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-52,414	32

(\* ) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0145

WORKSHEET E-3  
PART VII

Check  Title V                       Hospital                       NF                       PPS  
 Applicable  Title XIX                       SUB (Other)                       ICF/IID                       TEFRA  
 Boxes:  SNF                       SNF                       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	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1	Inpatient hospital/SNF/NF services	948,847		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	948,847		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	948,847		7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>REASONABLE CHARGES</b>				
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
<b>CUSTOMARY CHARGES</b>				
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)	1.000000	1.000000	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)	948,847		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
<b>PROSPECTIVE PAYMENT AMOUNT</b>				
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30	Excess of reasonable cost (from line 18)	948,847		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**BALANCE SHEET**

**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
<b>Assets</b> (Omit Cents)		1	2	3	4	
<b>CURRENT ASSETS</b>						
1	Cash on hand and in banks	4,590,475				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	25,352,380				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-15,763,295				6
7	Inventory	633,724				7
8	Prepaid expenses	244,870				8
9	Other current assets	2,720,701				9
10	Due from other funds	45,840				10
11	Total current assets (sum of lines 1-10)	17,824,695				11
<b>FIXED ASSETS</b>						
12	Land	1,495,338				12
13	Land improvements	3,834,614				13
14	Accumulated depreciation	-2,506,101				14
15	Buildings	19,732,716				15
16	Accumulated depreciation	-9,596,256				16
17	Leasehold improvements	261,106				17
18	Accumulated depreciation	-30,462				18
19	Fixed equipment	36,626,664				19
20	Accumulated depreciation	-29,276,126				20
21	Audomobiles 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)	20,541,493				30
<b>OTHER ASSETS</b>						
31	Investments	108,654,925				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	126,335				34
35	Total other assets (sum of lines 31-34)	108,781,260				35
36	Total assets (sum of lines 11, 30 and 35)	147,147,448				36
<b>Liabilities and Fund Balances</b> (Omit Cents)						
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	Accounts payable	1,048,134				37
38	Salaries, wages and fees payable	2,725,198				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	2,485,452				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	6,480,575				44
45	Total current liabilities (sum of lines 37 thru 44)	12,739,359				45
<b>LONG TERM LIABILITIES</b>						
46	Mortgage payable	5,801,981				46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	18,500,168				49
50	Total long term liabilities (sum of lines 46 thru 49)	24,302,149				50
51	Total liabilities (sum of lines 45 and 50)	37,041,508				51
<b>CAPITAL ACCOUNTS</b>						
52	General fund balance	110,105,940				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	110,105,940				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	147,147,448				60

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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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		97,128,993			1
2	Net income (loss) (from Worksheet G-3, line 29)		7,318,106			2
3	Total (sum of line 1 and line 2)		104,447,099			3
4	Additions (credit adjustments) (specify)	5,658,846				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)		5,658,846			10
11	Subtotal (line 3 plus line 10)		110,105,945			11
12	Deductions (debit adjustments) (specify)					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)		5			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		110,105,940			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	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) (specify)					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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2  
PARTS I & II**

**PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	Hospital	3,590,660		3,590,660	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)	3,590,660		3,590,660	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	Intensive Care Unit	31,972		31,972	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)	31,972		31,972	16
17	Total inpatient routine care services (sum of lines 10 and 16)	3,622,632		3,622,632	17
18	Ancillary services	17,672,005	90,811,872	108,483,877	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)		7,483,937	7,483,937	20
20.01	RHC II				20.01
21	Federally Qualified Health Center (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)	21,294,637	98,295,809	119,590,446	28

**PART II - OPERATING EXPENSES**

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		47,583,237	29
30	Add (specify)			30
31	BAD DEBT EXPENSE			31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)		-6	37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)		-6	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		47,583,231	43

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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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)	119,590,446	1
2	Less contractual allowances and discounts on patients' accounts	67,177,339	2
3	Net patient revenues (line 1 minus line 2)	52,413,107	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	47,583,231	4
5	Net income from service to patients (line 3 minus line 4)	4,829,876	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	936,025	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (MISCELLANEOUS INCOME)	1,552,205	24
24.01	Other (NET ASSETRS RELEASED)		24.01
25	Total other income (sum of lines 6-24)	2,488,230	25
26	Total (line 5 plus line 25)	7,318,106	26
29	Net income (or loss) for the period (line 26 minus line 28)	7,318,106	29



**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES**

**WORKSHEET L-1  
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	<b>GENERAL SERVICE COST CENTERS</b>							
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
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
43	Nursery							43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic							88
88.01	RHC II							88.01
91	Emergency							91
91.01	PRIORITY CARE CARLYLE							91.01
91.02	PRIORITY CARE NEW BADEN							91.02
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)							118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices							192
194	LIFELINE							194
194.0	DEVELOPMENT							194.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER COSTS**

**COMPONENT CCN: 14-8503**

**WORKSHEET M-1**

Check applicable box:       RHC I                                       FQHC

	COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
	1	2	3	4	5	6	7	
<b>FACILITY HEALTH CARE STAFF COSTS</b>								
1 Physician	34,964	1,186,125	1,221,089	14,430	1,235,519		1,235,519	1
2 Physician Assistant	153,692		153,692	29,136	182,828		182,828	2
3 Nurse Practitioner	128,947		128,947	45,236	174,183		174,183	3
4 Visiting Nurse								4
5 Other Nurse								5
6 Clinical Psychologist								6
7 Clinical Social Worker								7
8 Laboratory Techincian								8
9 Other Facility Health Care Staff Costs	230,083	167,349	397,432	66,750	464,182		464,182	9
10 Subtotal (sum of lines 1 through 9)	547,686	1,353,474	1,901,160	155,552	2,056,712		2,056,712	10
<b>COSTS UNDER AGREEMENT</b>								
11 Physician Services Under Agreement								11
12 Physician SUPervision Under Agreement								12
13 Other Costs Under Agreement								13
14 Subtotal (sum of lines 11 through 13)								14
<b>OTHER HEALTH CARE COSTS</b>								
15 Medical Supplies		18,164	18,164	4,374	22,538		22,538	15
16 Transportation (Health Care Staff)								16
17 Deperciation-Medical Equipment								17
18 Professional Liability Insurance								18
19 Other Health Care Costs		3,611	3,611	1,557	5,168		5,168	19
20 Allowable GME Costs								20
21 Subtotal (sum of lines 15 through 20)		21,775	21,775	5,931	27,706		27,706	21
22 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	547,686	1,375,249	1,922,935	161,483	2,084,418		2,084,418	22
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>								
23 Pharmacy		311,721	311,721	57,888	369,609		369,609	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 through 27)		311,721	311,721	57,888	369,609		369,609	28
<b>FACILITY OVERHEAD</b>								
29 Facility Costs								29
30 Administrative Costs	381,249	1,015,271	1,396,520	84,067	1,480,587		1,480,587	30
31 Total Facility Overhead (sum of lines 29 and 30)	381,249	1,015,271	1,396,520	84,067	1,480,587		1,480,587	31
32 Total faciltly costs (sum of lines 22, 28 and 31)	928,935	2,702,241	3,631,176	303,438	3,934,614		3,934,614	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.

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES**

**COMPONENT CCN: 14-8503**

**WORKSHEET M-2**

Check applicable box:       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	5.55	37,285	4,200	23,310		1
2	Physician Assistants	1.42	6,640	2,100	2,982		2
3	Nurse Practitioners	0.10	60	2,100	210		3
4	Subtotal (sum of lines 1 through 3)	7.07	43,985		26,502	43,985	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 through 7)	7.07	43,985			43,985	8
9	Physician Services Under Agreements						9

**DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES**

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,084,418	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					369,609	11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,454,027	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.849387	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)					1,480,587	14
15	Parent provider overhead allocated to facility (see instructions)					2,406,417	15
16	Total overhead (sum of lines 14 and 15)					3,887,004	16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtotal (see instructions)					3,887,004	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)					3,301,571	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					5,385,989	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 1 thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.





**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**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:       RHC I                               FQHC

			Part B		
DESCRIPTION			mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider			770,493	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 zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter zero (1)				
		.01	02/27/2015	19,616	3.01
		.02	06/25/2015	2,794	3.02
	Program	.03	06/25/2015	5,745	3.03
	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		28,155	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)			798,648	
<b>TO BE COMPLETED BY CONTRACTOR</b>					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter zero (1)				
		.01			5.01
		.02			5.02
	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	Determine net settlement amount (balance due) based on the cost report (1)	.01		63,998	6.01
7	Total Medicare program liability (see instructions)	.02		862,646	6.02
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.

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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**ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER COSTS**

**COMPONENT CCN: 14-8502**

**WORKSHEET M-1**

Check applicable box:       RHC II                               FQHC

	COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
	1	2	3	4	5	6	7	
<b>FACILITY HEALTH CARE STAFF COSTS</b>								
1 Physician	14,430		14,430	-14,430				1
2 Physician Assistant	29,136		29,136	-29,136				2
3 Nurse Practitioner	45,236		45,236	-45,236				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	66,750		66,750	-66,750				9
10 Subtotal (sum of lines 1 through 9)	155,552		155,552	-155,552				10
<b>COSTS UNDER AGREEMENT</b>								
11 Physician Services Under Agreement								11
12 Physician Supervision Under Agreement								12
13 Other Costs Under Agreement								13
14 Subtotal (sum of lines 11 through 13)								14
<b>OTHER HEALTH CARE COSTS</b>								
15 Medical Supplies		4,374	4,374	-4,374				15
16 Transportation (Health Care Staff)								16
17 Depreciation-Medical Equipment								17
18 Professional Liability Insurance								18
19 Other Health Care Costs		1,557	1,557	-1,557				19
20 Allowable GME Costs								20
21 Subtotal (sum of lines 15 through 20)		5,931	5,931	-5,931				21
22 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	155,552	5,931	161,483	-161,483				22
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>								
23 Pharmacy		57,888	57,888	-57,888				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 through 27)		57,888	57,888	-57,888				28
<b>FACILITY OVERHEAD</b>								
29 Facility Costs								29
30 Administrative Costs	63,431	47,083	110,514	-110,514				30
31 Total Facility Overhead (sum of lines 29 and 30)	63,431	47,083	110,514	-110,514				31
32 Total facility costs (sum of lines 22, 28 and 31)	218,983	110,902	329,885	-329,885				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.

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPH'S HOSPITAL Provider CCN: 14-0145	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:47 Version: 2015.10 (11/24/2015)
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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-8502

WORKSHEET M-2

Check applicable box:       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 through 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 through 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 Wkst. M-1, col. 7, line 22)						10
11	Total nonreimbursable costs (from Wkst. M-1, col. 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 Wkst. M-1, col. 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	Subtotal (see instructions)						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 1 thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.



