



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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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	DATE: 03/12/2015	TIME: 10:18
	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.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	4 -REOPENED		
	5 -AMENDED		

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. JOSEPH'S REG MED CENTER S. BEND (15-0012) (PROVIDER NAME(S) AND NUMBER(S)); FOR THE COST REPORTING PERIOD BEGINNING 07/01/2013 AND ENDING 06/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 03/12/2015 10:18
QyBjzfwD9z2m:qZ9M6PzH3PxJQwdw0
oES2P0JUuRh9FJPQN8y36EioKjViyM
7.GP1cA9UX0zoHFN

(SIGNED) *Jamie L. Jones*
OFFICER OR ADMINISTRATOR OF PROVIDER(S)
CFO
TITLE
3/17/2015
DATE

PI Encryption: 03/12/2015 10:18
XrHVQR6K8AqChLtlUQ7SK6S0Kac7n0
YJepn0CoHNPx4p:2fPMnjBlyXeTDJ.
dVZ60XGjj00Ks9G2

PART III - SETTLEMENT SUMMARY

		TITLE XVIII				TITLE XIX	
		TITLE V	PART A	PART B	HIT		
		1	2	3	4	5	
1	HOSPITAL		-9,819	-75,562	1,246,991	106,611	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		115,243			1,531	3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		105,424	-75,562	1,246,991	108,142	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.



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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: 5215 HOLY CROSS PARKWAY	P.O. Box:							1	
2	City: MISHAWAKA	State: IN	ZIP Code: 46545	County: SAINT JOSEPH					2	
Hospital and Hospital-Based Component Identification:										
							Payment System (P, T, O, or N)			
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ST. JOSEPH'S REG MED CENTER S. BEND	15-0012	43780	1	07/01/1996	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF	ST JOSEPH REG MED CTR - REHAB	15-T012	43780	5	06/01/1983	N	P	P	5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19
20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2013	To: 06 / 30 / 2014							20
21	Type of control (see instructions)	1								21
Inpatient PPS Information										
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.							Y	N	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)							N	Y	22.01
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.							3	N	23
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1	2	3	4	5	6			
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	3,645	656	179	326	5,154	327		24	
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	333				105			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.				1				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.				1				27	
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								35	
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				Beginning:		Ending:		36	
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.								37	
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				Beginning:		Ending:		38	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)							N	N	39



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals					
		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	Y			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, 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)		32.00		62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67
Inpatient Psychiatric 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, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.			Y	N		76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86



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WORKSHEET S-2
PART I

		V	XIX		
Title V and XIX Services		1	2		
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90	
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91	
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92	
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93	
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94	
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95	
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96	
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97	
Rural Providers		1	2		
105	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
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.	Physical	Occupational Speech Respiratory	109	
Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'	N		115	
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116	
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N		117	
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118	
118.01	List amounts of malpractice premiums and paid losses:	Premiums 96,972	Paid Losses 355,354	Self Insurance 792,133	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02	
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120	
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y		121	
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	15H034		140	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141	Name: ST JOSEPH REG MED CTR	Contractor's Name: WISCONSIN PROVIDER SERVICES CO Contractor's Number: 08102			141	
142	Street: 5215 HOLY CROSS PARKWAY	P.O. Box:			142	
143	City: MISHAWAKA	State: IN	ZIP Code: 46545		143	
144	Are provider based physicians' costs included in Worksheet A?	Y			144	
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	Y			145	
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146	
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N			147	
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N			148	
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N			149	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)						
		Title XVIII				
		Part A	Part B	Title V	Title XIX	
			1	2	3	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10
Multicampus						
165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N				165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.					166
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.		Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)					168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)		0.50			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			07/01/2013	06/30/2014	170



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
		1	2		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	Y			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	Y			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
BAD DEBTS		Y/N	Y/N		
		1	2		
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	Y			12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.	N			13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.	N			14
BED COMPLEMENT		Y/N	Y/N		
		1	2		
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y			15
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	09/30/2014	Y	09/30/2014
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N	
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	



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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 COSTS			
22	HAVE ASSETS BEEN RELIEVED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35
HOME OFFICE COSTS		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
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.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: CRAIG	LAST NAME: NIETCH	TITLE: DIRECTOR OF REIMBURSEMENT
42	EMPLOYER: SAINT JOSEPH REGIONAL MEDICAL CENTER		
43	PHONE NUMBER: 574-335-4653	E-MAIL ADDRESS: NIETCHC@SJRM.COM	



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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				
						TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	214	78,110			21,108	1,799	48,666	1
2	HMO AND OTHER (see instructions)						8,662	4,821		2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER						504	105		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)		214	78,110			21,108	1,799	48,666	7
8	INTENSIVE CARE UNIT	31	28	10,220			2,167	649	5,282	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	NEONATAL INTENSIVE CARE UNIT	35	12	4,380				1,055	1,933	12
13	NURSERY	43						1,650	3,363	13
14	TOTAL (see instructions)		254	92,710			23,275	5,153	59,244	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41	40	14,600			3,643	333	5,942	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								26
27	TOTAL (sum of lines 14-26)		294					620	9,316	27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)		4	1,460				313	759	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33



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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)					5,089	2,018	13,716	1
2	HMO AND OTHER (see instructions)					1,792			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	NEONATAL INTENSIVE CARE UNIT								12
13	NURSERY								13
14	TOTAL (see instructions)	26.67	1,356.00	24.68		5,089	2,018	13,716	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF	0.38	43.00			272	22	422	17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)	27.05	1,399.00	24.68					27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32



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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	76,399,973		76,399,973	2,933,545.00	26.04	1
2							2
3							3
4		483,281		483,281	2,859.00	169.04	4
4.01		1,357,164		1,357,164	13,218.00	102.68	4.01
5							5
6							6
7	21	1,528,789	290,715	1,819,504	54,922.00	33.13	7
7.01							7.01
8							8
9	44						9
10		6,129,197	30,919	6,160,116	212,215.00	29.03	10
OTHER WAGES & RELATED COSTS							
11		260,012		260,012	5,423.00	47.95	11
12		127,296		127,296	2,080.00	61.20	12
13		416,619		416,619	2,747.00	151.66	13
14		30,259,042		30,259,042	597,335.00	50.66	14
15							15
16							16
WAGE-RELATED COSTS							
17		23,919,516		23,919,516			17
18		21,699		21,699			18
19		2,523,651		2,523,651			19
20							20
21							21
22		106,322		106,322			22
22.01		298,576		298,576			22.01
23							23
24							24
25		536,511		536,511			25
OVERHEAD COSTS - DIRECT SALARIES							
26		-25,010	25,010				26
27		2,928,028	-55,929	2,872,099	130,168.00	22.06	27
28		262,616		262,616	768.00	341.95	28
29							29
30		1,779,164		1,779,164	72,595.00	24.51	30
31		134,251		134,251	12,224.00	10.98	31
32		1,857,063		1,857,063	143,707.00	12.92	32
33							33
34		1,938,037	-620,172	1,317,865	89,712.00	14.69	34
35		164,802		164,802	4,160.00	39.62	35
36			620,172	620,172	42,217.00	14.69	36
37							37
38		2,091,660		2,091,660	73,526.00	28.45	38
39		379,214		379,214	22,472.00	16.87	39
40		2,838,204		2,838,204	72,008.00	39.42	40
41		1,512,069		1,512,069	71,861.00	21.04	41
42		1,606,848		1,606,848	51,447.00	31.23	42
43		582,091		582,091	36,465.00	15.96	43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	73,941,438	-290,715	73,650,723	2,870,333.00	25.66	1
2	EXCLUDED AREA SALARIES (see instructions)	6,129,197	30,919	6,160,116	212,215.00	29.03	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	67,812,241	-321,634	67,490,607	2,658,118.00	25.39	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	31,062,969		31,062,969	607,585.00	51.13	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	24,047,537		24,047,537		35.63%	5
6	TOTAL (sum of lines 3 through 5)	122,922,747	-321,634	122,601,113	3,265,703.00	37.54	6
7	TOTAL OVERHEAD COST (see instructions)	18,049,037	-30,919	18,018,118	823,330.00	21.88	7



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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	3,914,244	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	8,512,133	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	9,270,421	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	834,032	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	153,230	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	148,086	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	425,158	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	-864,231	16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	4,891,228	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	100,275	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	27,384,576	24
	PART B - OTHER THAN CORE RELATED COST		
25	OTHER WAGE RELATED (OTHER WAGE REL	21,699	25



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ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	Supporting Exhibit for Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

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

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

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD				
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE	7/01/2012		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5	7/01/2015		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIB- UTION(S)	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)	36		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2	12		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX				
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)	8,512,133		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)	8,512,133		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	8,512,133		19



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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

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



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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)		0.299696	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID		32,336,000	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		105,000,000	6
7	MEDICAID COST (line 1 times line 6)		31,468,080	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 AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE			17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS			18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)			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	14,010,380	1,785,815	15,796,195	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	4,198,855	535,202	4,734,057	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	99,540		99,540	22
23	COST OF CHARITY CARE (line 21 minus line 22)	4,099,315	535,202	4,634,517	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)		22,703,000	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		497,124	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)		22,205,876	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)		6,655,012	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)		11,289,529	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)		11,289,529	31



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT				20,371,126	20,371,126	2,063,806	22,434,932	1
2	00200	CAP REL COSTS-MVBLE EQUIP				10,061,743	10,061,743		10,061,743	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	-25,010	201,920	176,910	25,010	201,920	680,376	882,296	4
5.01	00540	NONPATIENT TELEPHONES	228,880	67,539	296,419		296,419		296,419	5.01
5.04	00570	ADMITTING	1,145,160	494,653	1,639,813	-62	1,639,751	-250	1,639,501	5.04
5.06	00590	OTHER ADMINISTRATIVE & GENERAL	1,553,988	85,649,856	87,203,844	-20,773,788	66,430,056	-15,161,591	51,268,465	5.06
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	1,779,164	7,400,146	9,179,310	-972,651	8,206,659	-55,728	8,150,931	7
8	00800	LAUNDRY & LINEN SERVICE	134,251	1,022,631	1,156,882		1,156,882		1,156,882	8
9	00900	HOUSEKEEPING	1,857,063	1,078,215	2,935,278	-11,501	2,923,777		2,923,777	9
10	01000	DIETARY	1,938,037	3,055,152	4,993,189	-2,038,663	2,954,526	-259,315	2,695,211	10
11	01100	CAFETERIA				1,842,233	1,842,233	-1,656,961	185,272	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	2,091,660	811,932	2,903,592	-30,146	2,873,446	-695	2,872,751	13
14	01400	CENTRAL SERVICES & SUPPLY	379,214	575,556	954,770	-7,648	947,122		947,122	14
15	01500	PHARMACY	2,838,204	11,628,797	14,467,001	-10,849,447	3,617,554		3,617,554	15
16	01600	MEDICAL RECORDS & LIBRARY	1,512,069	2,451,295	3,963,364	-19,543	3,943,821	-31,495	3,912,326	16
17	01700	SOCIAL SERVICE	1,606,848	954,730	2,561,578		2,561,578	-1,682	2,559,896	17
18	01850	STERILE SUPPLY	582,091	1,664,108	2,246,199	-119,329	2,126,870		2,126,870	18
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,528,789	640,977	2,169,766	198,825	2,368,591	-188,885	2,179,706	21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,578,770	657,402	2,236,172	55,118	2,291,290	-476,686	1,814,604	22
23	02300	PARAMED ED PRGM-(SPECIFY)	64,487	167,149	231,636		231,636	-75,834	155,802	23
23.01	02301	CLINICAL PASTORAL EDUCATION	207,716	76,073	283,789	38,496	322,285	-12,338	309,947	23.01
23.02	02302	PHARMACY RESIDENCY PROGRAM	435,319	171,622	606,941		606,941		606,941	23.02
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	18,299,233	10,018,597	28,317,830	-4,920,996	23,396,834	-1,764,890	21,631,944	30
31	03100	INTENSIVE CARE UNIT	3,656,049	1,691,272	5,347,321	-202,620	5,144,701	-54,866	5,089,835	31
35	02060	NEONATAL INTENSIVE CARE UNIT	1,184,537	534,765	1,719,302	-45,451	1,673,851	-4,640	1,669,211	35
41	04100	SUBPROVIDER - IRF	2,021,008	2,960,551	4,981,559	-1,836,897	3,144,662	-24,004	3,120,658	41
43	04300	NURSERY				3,980,462	3,980,462		3,980,462	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	6,919,493	29,600,081	36,519,574	-16,657,784	19,861,790	-1,281,435	18,580,355	50
51	05100	RECOVERY ROOM	916,886	402,449	1,319,335	-3,397	1,315,938		1,315,938	51
52	05200	DELIVERY ROOM & LABOR ROOM				670,585	670,585		670,585	52
54	05400	RADIOLOGY-DIAGNOSTIC	2,953,382	3,087,180	6,040,562	-1,215,303	4,825,259	-64,390	4,760,869	54
55	05500	RADIOLOGY-THERAPEUTIC	110,931	104,900	215,831	-15,644	200,187		200,187	55
57	05700	CT SCAN	587,403	588,482	1,175,885	-176,558	999,327		999,327	57
58	05800	MRI		452,563	452,563		452,563		452,563	58
59	05900	CARDIAC CATHETERIZATION	2,092,483	8,443,160	10,535,643	-3,410,380	7,125,263	-11,117	7,114,146	59
60	06000	LABORATORY		13,294,010	13,294,010	-445,664	12,848,346		12,848,346	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	1,560,620	1,529,152	3,089,772	-253,138	2,836,634	-1,328	2,835,306	65
66	06600	PHYSICAL THERAPY	2,165,092	1,030,374	3,195,466	-261,419	2,934,047	-17,131	2,916,916	66
67	06700	OCCUPATIONAL THERAPY	628,828	399,454	1,028,282	-153,262	875,020		875,020	67
68	06800	SPEECH PATHOLOGY	303,173	103,953	407,126	-8,407	398,719		398,719	68
69	06900	ELECTROCARDIOLOGY	830,021	667,952	1,497,973	-355,042	1,142,931	-4,324	1,138,607	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		-355,741	-355,741		355,741			71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				17,811,418	17,811,418		17,811,418	72
73	07300	DRUGS CHARGED TO PATIENTS	298,024	435,377	733,401	10,485,114	11,218,515		11,218,515	73
74	07400	RENAL DIALYSIS		737,829	737,829		737,829		737,829	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				176,954	176,954		176,954	76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90.02	09001	MOBILE MEDICAL UNIT	79,602	81,167	160,769	-29,150	131,619	-26,214	105,405	90.02
90.03	09002	FAMILY MEDICINE CENTER	569,518	855,302	1,424,820	-281,725	1,143,095	-46,120	1,096,975	90.03
90.04	09003	WOUND HEALING CENTER	465,169	1,287,400	1,752,569	-304,307	1,448,262		1,448,262	90.04
90.05	09004	OUTPATIENT TREATMENT & INFUSION	455,070	148,035	603,105		603,105		603,105	90.05
90.06	09005	PEDIATRIC SPECIALTY CLINIC	238,853	444,410	683,263	-89,320	593,943	-147,596	446,347	90.06
90.07	09006	SPORTS MED FELLOWSHIP CLINIC	388,383	249,936	638,319	-134,393	503,926	-127,807	376,119	90.07
90.08	09007	PODIATRY RESIDENCY CLINIC	342,482	224,860	567,342	-363,686	203,656	-28,041	175,615	90.08
90.09	09008	FACULTY PRACTICE CLINIC	333,020	193,589	526,609	-40,337	486,272	-198,985	287,287	90.09
91	09100	EMERGENCY	4,163,346	2,127,971	6,291,317	-45,167	6,246,150	-375,181	5,870,969	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE								113
118		SUBTOTALS (sum of lines 1-117)	72,999,306	200,108,783	273,108,089		273,108,089	-19,355,347	253,752,742	118
		NONREIMBURSABLE COST CENTERS								



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN								190
192	19200	PHYSICIANS' PRIVATE OFFICES								192
192.01	19201	MATERNAL FETAL MEDICINE/LABORIST		12,863	12,863		12,863		12,863	192.01
192.02	19202	NEONATOLOGISTS	824,070	334,342	1,158,412		1,158,412		1,158,412	192.02
192.03	19203	HOSPITALISTS/INTENSIVISTS	218,024	5,692,109	5,910,133		5,910,133		5,910,133	192.03
194	07950	SPORTS MED-ATHLETIC TRAINERS	174,962	53,181	228,143		228,143		228,143	194
194.01	07951	OUTREACH SERVICES	1,861,447	1,275,938	3,137,385		3,137,385		3,137,385	194.01
194.02	07952	KINDRED/OUR LADY OF PEACE	316,286	48,251	364,537		364,537		364,537	194.02
194.03	07953	ADVANCED SPECIALTIES	5,878	121,542	127,420		127,420		127,420	194.03
200		TOTAL (sum of lines 118-199)	76,399,973	207,647,009	284,046,982		284,046,982	-19,355,347	264,691,635	200



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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	
1	RECLASS NEGATIVE COST CTR EXP TOTAL	A	MEDICAL SUPPLIES CHARGED TO P	71		355,741	1
2			EMPLOYEE BENEFITS DEPARTMENT	4	25,010		2
500	TOTAL RECLASSIFICATIONS				25,010	355,741	500
	CODE LETTER - A						
1	DEPRECIATION RECLASS	B	CAP REL COSTS-MVBLE EQUIP	2		62	1
2			CAP REL COSTS-BLDG & FIXT	1		4,274,097	2
3			CAP REL COSTS-MVBLE EQUIP	2		4,120,317	3
4			CAP REL COSTS-BLDG & FIXT	1		359,796	4
5			CAP REL COSTS-MVBLE EQUIP	2		612,855	5
6			CAP REL COSTS-MVBLE EQUIP	2		11,501	6
7			CAP REL COSTS-BLDG & FIXT	1		16,491	7
8			CAP REL COSTS-MVBLE EQUIP	2		179,939	8
9			CAP REL COSTS-MVBLE EQUIP	2		30,146	9
10			CAP REL COSTS-MVBLE EQUIP	2		7,648	10
11			CAP REL COSTS-MVBLE EQUIP	2		360,653	11
12			CAP REL COSTS-BLDG & FIXT	1		15,644	12
13			CAP REL COSTS-MVBLE EQUIP	2		3,899	13
14			CAP REL COSTS-BLDG & FIXT	1		7,548	14
15			CAP REL COSTS-MVBLE EQUIP	2		109,671	15
16			CAP REL COSTS-BLDG & FIXT	1		144,322	16
17			CAP REL COSTS-MVBLE EQUIP	2		1,112	17
18			CAP REL COSTS-BLDG & FIXT	1		2,285	18
19			CAP REL COSTS-MVBLE EQUIP	2		267,126	19
20			CAP REL COSTS-BLDG & FIXT	1		39,915	20
21			CAP REL COSTS-MVBLE EQUIP	2		162,705	21
22			CAP REL COSTS-MVBLE EQUIP	2		45,451	22
23			CAP REL COSTS-BLDG & FIXT	1		930,578	23
24			CAP REL COSTS-MVBLE EQUIP	2		243,251	24
25			CAP REL COSTS-BLDG & FIXT	1		9,162	25
26			CAP REL COSTS-MVBLE EQUIP	2		2,251,592	26
27			CAP REL COSTS-MVBLE EQUIP	2		3,397	27
28			CAP REL COSTS-BLDG & FIXT	1		227,802	28
29			CAP REL COSTS-MVBLE EQUIP	2		987,501	29
30			CAP REL COSTS-BLDG & FIXT	1		15,644	30
31			CAP REL COSTS-BLDG & FIXT	1		315	31
32			CAP REL COSTS-MVBLE EQUIP	2		176,243	32
33			CAP REL COSTS-BLDG & FIXT	1		140,054	33
34			CAP REL COSTS-MVBLE EQUIP	2		21,035	34
35			CAP REL COSTS-BLDG & FIXT	1		148,816	35
36			CAP REL COSTS-MVBLE EQUIP	2		104,322	36
37			CAP REL COSTS-BLDG & FIXT	1		252,505	37
38			CAP REL COSTS-MVBLE EQUIP	2		8,914	38
39			CAP REL COSTS-BLDG & FIXT	1		153,262	39
40			CAP REL COSTS-BLDG & FIXT	1		8,407	40
41			CAP REL COSTS-BLDG & FIXT	1		125,815	41
42			CAP REL COSTS-MVBLE EQUIP	2		229,227	42
43			CAP REL COSTS-MVBLE EQUIP	2		3,680	43
44			CAP REL COSTS-MVBLE EQUIP	2		29,150	44
45			CAP REL COSTS-BLDG & FIXT	1		237,328	45
46			CAP REL COSTS-MVBLE EQUIP	2		44,397	46
47			CAP REL COSTS-BLDG & FIXT	1		110,632	47
48			CAP REL COSTS-MVBLE EQUIP	2		15,399	48
49			CAP REL COSTS-BLDG & FIXT	1		85,658	49
50			CAP REL COSTS-MVBLE EQUIP	2		3,662	50
51			CAP REL COSTS-BLDG & FIXT	1		54,628	51
52			CAP REL COSTS-MVBLE EQUIP	2		5,147	52
53			CAP REL COSTS-BLDG & FIXT	1		38,927	53
54			CAP REL COSTS-BLDG & FIXT	1		40,337	54
55			CAP REL COSTS-BLDG & FIXT	1		23,388	55
56			CAP REL COSTS-MVBLE EQUIP	2		21,741	56
500	TOTAL RECLASSIFICATIONS					17,525,099	500
	CODE LETTER - B						
1	RECLASS CHAPLAIN COST TO CPE PROGRA	C	CLINICAL PASTORAL EDUCATION	23.01	30,919	7,577	1
500	TOTAL RECLASSIFICATIONS				30,919	7,577	500
	CODE LETTER - C						
1	RECLASS CAFETERIA FROM DIETARY	D	CAFETERIA	11	620,172	1,222,061	1
500	TOTAL RECLASSIFICATIONS				620,172	1,222,061	500
	CODE LETTER - D						
1	RECLASS DRUGS	E	DRUGS CHARGED TO PATIENTS	73		10,488,794	1
500	TOTAL RECLASSIFICATIONS					10,488,794	500
	CODE LETTER - E						



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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
1	RECLASS INTEREST EXPENSE	F	INTEREST EXPENSE	113		11,960,127	1
2			INTEREST EXPENSE	113		663,068	2
3			CAP REL COSTS-BLDG & FIXT	1		11,960,127	3
4			CAP REL COSTS-BLDG & FIXT	1		663,068	4
500	TOTAL RECLASSIFICATIONS					25,246,390	500
	CODE LETTER - F						
1	RECLASS HYPERBARIC FROM WOUND CARE	G	HYPERBARIC OXYGEN THERAPY	76.98	35,882	141,072	1
500	TOTAL RECLASSIFICATIONS				35,882	141,072	500
	CODE LETTER - G						
1	OBSTETRIC RECLASS TO L&D AND NURSER	H	DELIVERY ROOM & LABOR ROOM	52	21,608	648,977	1
2			NURSERY	43	1,895,067	2,085,395	2
500	TOTAL RECLASSIFICATIONS				1,916,675	2,734,372	500
	CODE LETTER - H						
1	SBMF CAPITAL RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		284,575	1
500	TOTAL RECLASSIFICATIONS					284,575	500
	CODE LETTER - I						
1	RECLASS IMPLANTS	J	IMPL. DEV. CHARGED TO PATIENT	72		17,811,418	1
2							2
3							3
4							4
5							5
6							6
500	TOTAL RECLASSIFICATIONS					17,811,418	500
	CODE LETTER - J						
1	RESIDENT OT OTHER MEDICAL EDUCATION	M	I&R SERVICES-OTHER PRGM COSTS	22	4,635	195,917	1
500	TOTAL RECLASSIFICATIONS				4,635	195,917	500
	CODE LETTER - M						
1	RECLASS PODIATRY-SPS MED TO MED ED	N	I&R SERVICES-SALARY & FRINGES	21	56,862	17,756	1
2			I&R SERVICES-SALARY & FRINGES	21	238,488	86,271	2
500	TOTAL RECLASSIFICATIONS				295,350	104,027	500
	CODE LETTER - N						
	GRAND TOTAL (INCREASES)				2,928,643	76,117,043	

(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 NEGATIVE COST CTR EXP TOTAL	A	OTHER ADMINISTRATIVE & GENERA	5.06		355,741		
2			OTHER ADMINISTRATIVE & GENERA	5.06	25,010			
500	TOTAL RECLASSIFICATIONS				25,010	355,741	500	
	CODE LETTER - A							
1	DEPRECIATION RECLASS	B	ADMITTING	5.04		62	9	
2			OTHER ADMINISTRATIVE & GENERA	5.06		4,274,097	10	
3			OTHER ADMINISTRATIVE & GENERA	5.06		4,120,317	9	
4			OPERATION OF PLANT	7		359,796	10	
5			OPERATION OF PLANT	7		612,855	9	
6			HOUSEKEEPING	9		11,501	9	
7			DIETARY	10		16,491	10	
8			DIETARY	10		179,939	9	
9			NURSING ADMINISTRATION	13		30,146	9	
10			CENTRAL SERVICES & SUPPLY	14		7,648	9	
11			PHARMACY	15		360,653	9	
12			MEDICAL RECORDS & LIBRARY	16		15,644	10	
13			MEDICAL RECORDS & LIBRARY	16		3,899	9	
14			STERILE SUPPLY	18		7,548	10	
15			STERILE SUPPLY	18		109,671	9	
16			I&R SERVICES-OTHER PRGM COSTS	22		144,322	10	
17			I&R SERVICES-OTHER PRGM COSTS	22		1,112	9	
18			ADULTS & PEDIATRICS	30		2,285	10	
19			ADULTS & PEDIATRICS	30		267,126	9	
20			INTENSIVE CARE UNIT	31		39,915	10	
21			INTENSIVE CARE UNIT	31		162,705	9	
22			NEONATAL INTENSIVE CARE UNIT	35		45,451	9	
23			SUBPROVIDER - IRF	41		930,578	10	
24			SUBPROVIDER - IRF	41		243,251	9	
25			OPERATING ROOM	50		9,162	10	
26			OPERATING ROOM	50		2,251,592	9	
27			RECOVERY ROOM	51		3,397	9	
28			RADIOLOGY-DIAGNOSTIC	54		227,802	10	
29			RADIOLOGY-DIAGNOSTIC	54		987,501	9	
30			RADIOLOGY-THERAPEUTIC	55		15,644	10	
31			CT SCAN	57		315	10	
32			CT SCAN	57		176,243	9	
33			LABORATORY	60		140,054	10	
34			LABORATORY	60		21,035	9	
35			RESPIRATORY THERAPY	65		148,816	10	
36			RESPIRATORY THERAPY	65		104,322	9	
37			PHYSICAL THERAPY	66		252,505	10	
38			PHYSICAL THERAPY	66		8,914	9	
39			OCCUPATIONAL THERAPY	67		153,262	10	
40			SPEECH PATHOLOGY	68		8,407	10	
41			ELECTROCARDIOLOGY	69		125,815	10	
42			ELECTROCARDIOLOGY	69		229,227	9	
43			DRUGS CHARGED TO PATIENTS	73		3,680	9	
44			MOBILE MEDICAL UNIT	90.02		29,150	9	
45			FAMILY MEDICINE CENTER	90.03		237,328	10	
46			FAMILY MEDICINE CENTER	90.03		44,397	9	
47			WOUND HEALING CENTER	90.04		110,632	10	
48			WOUND HEALING CENTER	90.04		15,399	9	
49			PEDIATRIC SPECIALTY CLINIC	90.06		85,658	10	
50			PEDIATRIC SPECIALTY CLINIC	90.06		3,662	9	
51			SPORTS MED FELLOWSHIP CLINIC	90.07		54,628	10	
52			SPORTS MED FELLOWSHIP CLINIC	90.07		5,147	9	
53			PODIATRY RESIDENCY CLINIC	90.08		38,927	10	
54			FACULTY PRACTICE CLINIC	90.09		40,337	10	
55			EMERGENCY	91		23,388	10	
56			EMERGENCY	91		21,741	9	
500	TOTAL RECLASSIFICATIONS					17,525,099	500	
	CODE LETTER - B							
1	RECLASS CHAPLAIN COST TO CPE PROGRA	C	OTHER ADMINISTRATIVE & GENERA	5.06	30,919	7,577	1	
500	TOTAL RECLASSIFICATIONS				30,919	7,577	500	
	CODE LETTER - C							
1	RECLASS CAFETERIA FROM DIETARY	D	DIETARY	10	620,172	1,222,061	1	
500	TOTAL RECLASSIFICATIONS				620,172	1,222,061	500	
	CODE LETTER - D							
1	RECLASS DRUGS	E	PHARMACY	15		10,488,794	1	
500	TOTAL RECLASSIFICATIONS					10,488,794	500	
	CODE LETTER - E							



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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		
1	RECLASS INTEREST EXPENSE	F	OTHER ADMINISTRATIVE & GENERA	5.06		11,960,127	11	1
2			SUBPROVIDER - IRF	41		663,068	11	2
3			INTEREST EXPENSE	113		11,960,127	11	3
4			INTEREST EXPENSE	113		663,068	11	4
500	TOTAL RECLASSIFICATIONS					25,246,390		500
	CODE LETTER - F							
1	RECLASS HYPERBARIC FROM WOUND CARE	G	WOUND HEALING CENTER	90.04	35,882	141,072		1
500	TOTAL RECLASSIFICATIONS				35,882	141,072		500
	CODE LETTER - G							
1	OBSTETRIC RECLASS TO L&D AND NURSER	H	ADULTS & PEDIATRICS	30	21,608	648,977		1
2			ADULTS & PEDIATRICS	30	1,895,067	2,085,395		2
500	TOTAL RECLASSIFICATIONS				1,916,675	2,734,372		500
	CODE LETTER - H							
1	SBMF CAPITAL RECLASS	I	LABORATORY	60		284,575	9	1
500	TOTAL RECLASSIFICATIONS					284,575		500
	CODE LETTER - I							
1	RECLASS IMPLANTS	J	STERILE SUPPLY	18		2,110		1
2			ADULTS & PEDIATRICS	30		538		2
3			OPERATING ROOM	50		14,397,030		3
4			CARDIAC CATHETERIZATION	59		3,410,380		4
5			WOUND HEALING CENTER	90.04		1,322		5
6			EMERGENCY	91		38		6
500	TOTAL RECLASSIFICATIONS					17,811,418		500
	CODE LETTER - J							
1	RESIDENT OT OTHER MEDICAL EDUCATION	M	I&R SERVICES-SALARY & FRINGES	21	4,635	195,917		1
500	TOTAL RECLASSIFICATIONS				4,635	195,917		500
	CODE LETTER - M							
1	RECLASS PODIATRY-SPS MED TO MED ED	N	SPORTS MED FELLOWSHIP CLINIC	90.07	56,862	17,756		1
2			PODIATRY RESIDENCY CLINIC	90.08	238,488	86,271		2
500	TOTAL RECLASSIFICATIONS				295,350	104,027		500
	CODE LETTER - N							
	GRAND TOTAL (DECREASES)					2,928,643	76,117,043	

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



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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIRE- MENTS	ENDING BALANCE	FULLY DEPREC- IATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND	3,538,880				1,985,491	1,553,389		1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES	232,018,371	349,098		349,098	6,550,669	225,816,800	2,314,451	3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	183,316,683	8,622,358		8,622,358	2,473,000	189,466,041	17,677,380	6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	418,873,934	8,971,456		8,971,456	11,009,160	416,836,230	19,991,831	8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	418,873,934	8,971,456		8,971,456	11,009,160	416,836,230	19,991,831	10

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

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

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

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

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of cols. 9 through 14)	
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	6,127,149	3,684,588	12,623,195					22,434,932	1
2	CAP REL COSTS-MVBLE EQUIP	10,061,743							10,061,743	2
3	TOTAL (sum of lines 1-2)	16,188,892	3,684,588	12,623,195					32,496,675	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)	B	-3,778,768	CAP REL COSTS-BLDG & FIXT	1	10
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)					4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)					5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)					6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)					7
8	TELEVISION AND RADIO SERVICE (chapter 21)	A	-31,807	OPERATION OF PLANT	7	8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-4,302,647			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	7,445,880			12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-1,656,961	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					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			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND					32
33	DONATIONS	B	-1,266,816	OTHER ADMINISTRATIVE & GENERAL	5.06	33
34	MEDICAID PROVIDER BED TAX	A	-14,732,117	OTHER ADMINISTRATIVE & GENERAL	5.06	34
35	PURCHASE DISCOUNTS	A	-9,567	OTHER ADMINISTRATIVE & GENERAL	5.06	35
36	PROPERTY TAXES	A	-1,128	RESPIRATORY THERAPY	65	36
37	OTHER REVENUE	B	-68,821	OTHER ADMINISTRATIVE & GENERAL	5.06	37
38	OTHER REVENUE	B	-23,921	OPERATION OF PLANT	7	38
39						39
40	OTHER REVENUE	B	-259,315	DIETARY	10	40
41	OTHER REVENUE	B	-1,682	SOCIAL SERVICE	17	41
42	OTHER REVENUE - MED ED GRANTS	B	-188,885	I&R SERVICES-SALARY & FRINGES APPRVD	21	42
43	OTHER REVENUE	B	-109,985	I&R SERVICES-OTHER PRGM COSTS APPRVD	22	43
44	OTHER REVENUE	B	-16,495	PARAMED ED PRGM-(SPECIFY)	23	44
45	OTHER REVENUE	B	-12,338	CLINICAL PASTORAL EDUCATION	23.01	45
46	OTHER REVENUE	B	-38,950	ADULTS & PEDIATRICS	30	46
47	OTHER REVENUE	B	-2,140	NEONATAL INTENSIVE CARE UNIT	35	47
47.10	OTHER REVENUE	B	-24,004	SUBPROVIDER - IRF	41	47.10
47.20	OTHER REVENUE	B	-40,680	OPERATING ROOM	50	47.20
47.30	OTHER REVENUE	B	-17,131	PHYSICAL THERAPY	66	47.30
47.40	OTHER REVENUE	B	-25,884	MOBILE MEDICAL UNIT	90.02	47.40
47.50	OTHER REVENUE	B	-46,120	FAMILY MEDICINE CENTER	90.03	47.50
47.60	OTHER REVENUE	B	42,684	PEDIATRIC SPECIALTY CLINIC	90.06	47.60
47.70	OTHER REVENUE	B	-19,166	SPORTS MED FELLOWSHIP CLINIC	90.07	47.70
47.80	OTHER REVENUE	B	-5,565	PODIATRY RESIDENCY CLINIC	90.08	47.80
47.90	OTHER REVENUE	B	-163,018	EMERGENCY	91	47.90
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-19,355,347			50

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



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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 COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	

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

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



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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
1	2	3	4	5	6	7	
1	5.06	OTHER ADMINISTRATIVE & GENERAL	HO NON CAPITAL COSTS	44,150,305	45,990,494	-1,840,189	1
2	4	EMPLOYEE BENEFITS DEPARTMENT	WORKER'S COMP	253,255	471,058	-217,803	2
3	5.06	OTHER ADMINISTRATIVE & GENERAL	INSURANCE	1,277,401	2,499,000	-1,221,599	3
3.01	5.06	OTHER ADMINISTRATIVE & GENERAL	PENSION	8,321,258	4,336,540	3,984,718	3.01
3.02	4	EMPLOYEE BENEFITS DEPARTMENT	RETIREE HEALTH COSTS	33,948	-864,231	898,179	3.02
3.03	1	CAP REL COSTS-BLDG & FIXT	HO CAPITAL COSTS	5,842,574		5,842,574	9
4							4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			59,878,741	52,432,861	7,445,880	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			
			NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
6	G	100.00	CHE TRINTIY HEALTH	100.00	HO OF PARENT COMPANY	6
7	G	100.00	SJPMC - INC	100.00	PARENT COMPANY	7
8	G	100.00	SJPMC- PLYMOUTH CAMPUS	100.00	HOSPITAL	8
9						9
10						10

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

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



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	59	CARDIAC CATHETERIZAT A	18,121		18,121	171,400	85	7,004	350	1
2	91	EMERGENCY B	256,006	84,949	170,957	208,000	1,074	107,400	5,370	2
3	30	ADULTS & PEDIATRICS C	69,039		69,039	142,500	784	53,712	2,686	3
4	13	NURSING ADMINISTRATI D	1,860		1,860	142,500	17	1,165	58	4
5	5.04	ADMITTING E	250	250		142,500				5
6	5.06	OTHER ADMINISTRATIVE F	13,023	348	12,675	142,500	85	5,823	291	6
7	22	I&R SERVICES-OTHER P G	1,070,980		1,070,980	142,500	10,280	704,279	35,214	7
8	90.07	SPORTS MED FELLOWSHI H	251,141		251,141	142,500	2,080	142,500	7,125	8
9	90.08	PODIATRY RESIDENCY C I	81,257		81,257	142,500	858	58,781	2,939	9
10	90.09	FACULTY PRACTICE CLI J	198,985	198,985		142,500				10
11	16	MEDICAL RECORDS & LI K	58,967		58,967	142,500	401	27,472	1,374	11
12	30	ADULTS & PEDIATRICS L	24,724		24,724	142,500	165	11,304	565	12
13	30	ADULTS & PEDIATRICS M	33,360		33,360	142,500	238	16,305	815	13
14	30	ADULTS & PEDIATRICS N	13,125		13,125	142,500	105	7,194	360	14
15	31	INTENSIVE CARE UNIT O	56,368		56,368	142,500	251	17,196	860	15
16	31	INTENSIVE CARE UNIT P	7,917		7,917	142,500	13	891	45	16
17	50	OPERATING ROOM Q	149,976		149,976	142,500	633	43,367	2,168	17
18	65	RESPIRATORY THERAPY R	817		817	142,500	9	617	31	18
19	69	ELECTROCARDIOLOGY S	6,242		6,242	142,500	28	1,918	96	19
20	90.02	MOBILE MEDICAL UNIT T	3,550		3,550	142,500	47	3,220	161	20
21	54	RADIOLOGY-DIAGNOSTIC U	76,448	42,128	34,320	142,500	176	12,058	603	21
23	90.06	PEDIATRIC SPECIALTY W	196,103	187,188	8,915	142,500	85	5,823	291	23
24	50	OPERATING ROOM X	1,133,266	1,105,130	28,136	142,500	186	12,743	637	24
25	50	OPERATING ROOM Y	20,748		20,748	142,500	104	7,125	356	25
26	35	NEONATAL INTENSIVE C Z	2,500	2,500		142,500				26
27	91	EMERGENCY AA	170,957		170,957	208,000	1,074	107,400	5,370	27
28	30	ADULTS & PEDIATRICS AB	1,360,091	1,360,091		142,500				28
29	30	ADULTS & PEDIATRICS AC	22,644		22,644	142,500	204	13,976	699	29
30	31	INTENSIVE CARE UNIT AD	22,644		22,644	142,500	204	13,976	699	30
31	30	ADULTS & PEDIATRICS AE	305,448	305,448		142,500				31
32	23	PARAMED ED PRGM-(SPE AF	108,255		108,255	142,500	714	48,916	2,446	32
200		TOTAL	5,734,812	3,287,017	2,447,695		19,900	1,432,165	71,609	200



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	59	CARDIAC CATHETERIZAT A					7,004	11,117	11,117	1
2	91	EMERGENCY B					107,400	63,557	148,606	2
3	30	ADULTS & PEDIATRICS C					53,712	15,327	15,327	3
4	13	NURSING ADMINISTRATI D					1,165	695	695	4
5	5.04	ADMITTING E							250	5
6	5.06	OTHER ADMINISTRATIVE F					5,823	6,852	7,200	6
7	22	I&R SERVICES-OTHER P G					704,279	366,701	366,701	7
8	90.07	SPORTS MED FELLOWSHI H					142,500	108,641	108,641	8
9	90.08	PODIATRY RESIDENCY C I					58,781	22,476	22,476	9
10	90.09	FACULTY PRACTICE CLI J							198,985	10
11	16	MEDICAL RECORDS & LI K					27,472	31,495	31,495	11
12	30	ADULTS & PEDIATRICS L					11,304	13,420	13,420	12
13	30	ADULTS & PEDIATRICS M					16,305	17,055	17,055	13
14	30	ADULTS & PEDIATRICS N					7,194	5,931	5,931	14
15	31	INTENSIVE CARE UNIT O					17,196	39,172	39,172	15
16	31	INTENSIVE CARE UNIT P					891	7,026	7,026	16
17	50	OPERATING ROOM Q					43,367	106,609	106,609	17
18	65	RESPIRATORY THERAPY R					617	200	200	18
19	69	ELECTROCARDIOLOGY S					1,918	4,324	4,324	19
20	90.02	MOBILE MEDICAL UNIT T					3,220	330	330	20
21	54	RADIOLOGY-DIAGNOSTIC U					12,058	22,262	64,390	21
23	90.06	PEDIATRIC SPECIALTY W					5,823	3,092	190,280	23
24	50	OPERATING ROOM X					12,743	15,393	1,120,523	24
25	50	OPERATING ROOM Y					7,125	13,623	13,623	25
26	35	NEONATAL INTENSIVE C Z							2,500	26
27	91	EMERGENCY AA					107,400	63,557	63,557	27
28	30	ADULTS & PEDIATRICS AB							1,360,091	28
29	30	ADULTS & PEDIATRICS AC					13,976	8,668	8,668	29
30	31	INTENSIVE CARE UNIT AD					13,976	8,668	8,668	30
31	30	ADULTS & PEDIATRICS AE							305,448	31
32	23	PARAMED ED PRGM-(SPE AF					48,916	59,339	59,339	32
200		TOTAL					1,432,165	1,015,530	4,302,647	200



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	NON- PATIENT TELEPHONES 5.01	ADMITTING 5.04	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	22,434,932	22,434,932					1
2	CAP REL COSTS-MVBLE EQUIP	10,061,743		10,061,743				2
4	EMPLOYEE BENEFITS DEPARTMENT	882,296	14,693	6,590	903,579			4
5.01	NONPATIENT TELEPHONES	296,419	22,691	10,177	2,707	331,994		5.01
5.04	ADMITTING	1,639,501	86,765	38,913	13,544	1,786	1,780,509	5.04
5.06	OTHER ADMINISTRATIVE & GENERAL	51,268,465	2,792,161	1,252,244	17,718	17,857		5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	8,150,931	5,939,101	2,663,602	21,042	9,077		7
8	LAUNDRY & LINEN SERVICE	1,156,882			1,588			8
9	HOUSEKEEPING	2,923,777	280,755	125,915	21,963	5,060		9
10	DIETARY	2,695,211	398,395	178,674	15,586	4,464		10
11	CAFETERIA	185,272	541,423	242,820	7,335	298		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,872,751	88,393	39,643	24,738	2,827		13
14	CENTRAL SERVICES & SUPPLY	947,122			4,485	3,274		14
15	PHARMACY	3,617,554	236,536	106,083	33,567	6,101		15
16	MEDICAL RECORDS & LIBRARY	3,912,326	45,336	20,332	17,883	26,935		16
17	SOCIAL SERVICE	2,559,896	27,573	12,366	19,004	8,780		17
18	STERILE SUPPLY	2,126,870	358,128	160,615	6,884	446		18
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	2,179,706			21,519			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,814,604	41,848	18,768	18,727	3,720		22
23	PARAMED ED PRGM-(SPECIFY)	155,802	14,926	6,694	763	149		23
23.01	CLINICAL PASTORAL EDUCATION	309,947			2,822	149		23.01
23.02	PHARMACY RESIDENCY PROGRAM	606,941			5,149			23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	21,631,944	5,291,244	2,373,047	193,752	37,649	212,044	30
31	INTENSIVE CARE UNIT	5,089,835	665,294	298,375	43,240	5,208	43,182	31
35	NEONATAL INTENSIVE CARE UNIT	1,669,211	235,373	105,561	14,010	2,083	12,373	35
41	SUBPROVIDER - IRF	3,120,658			23,902	5,804	18,145	41
43	NURSERY	3,980,462			22,413	744	8,228	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	18,580,355	2,221,444	996,285	81,837	30,655	364,594	50
51	RECOVERY ROOM	1,315,938	147,213	66,023	10,844	1,786	35,199	51
52	DELIVERY ROOM & LABOR ROOM	670,585			256		15,929	52
54	RADIOLOGY-DIAGNOSTIC	4,760,869	620,656	278,355	34,930	20,833	105,017	54
55	RADIOLOGY-THERAPEUTIC	200,187			1,312	9,226	910	55
57	CT SCAN	999,327	79,326	35,576	6,947	595	105,125	57
58	MRI	452,563					7,562	58
59	CARDIAC CATHETERIZATION	7,114,146	681,987	305,861	24,748	2,083	92,622	59
60	LABORATORY	12,848,346	91,508	41,040		3,274	192,488	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,835,306	166,974	74,886	18,457	4,018	28,922	65
66	PHYSICAL THERAPY	2,916,916	151,305	67,858	25,607	4,315	29,450	66
67	OCCUPATIONAL THERAPY	875,020			7,437	3,571	11,656	67
68	SPEECH PATHOLOGY	398,719			3,586	2,827	5,503	68
69	ELECTROCARDIOLOGY	1,138,607	125,080	56,096	9,817	5,655	43,301	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS	17,811,418					127,380	72
73	DRUGS CHARGED TO PATIENTS	11,218,515	21,761	9,760	3,525	1,042	176,141	73
74	RENAL DIALYSIS	737,829	52,682	23,627		1,042	3,824	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	176,954			424	149	3,231	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	105,405			941	149	794	90.02
90.03	FAMILY MEDICINE CENTER	1,096,975			6,736	8,482	6,756	90.03
90.04	WOUND HEALING CENTER	1,448,262			5,077	744	5,811	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	603,105	71,979	32,282	5,382	2,083	5,549	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	446,347			2,825	446	596	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	376,119			3,921	298	1,171	90.07
90.08	PODIATRY RESIDENCY CLINIC	175,615			1,230	298	488	90.08
90.09	FACULTY PRACTICE CLINIC	287,287			3,939	298	1,359	90.09
91	EMERGENCY	5,870,969	824,736	369,882	49,240	11,310	115,159	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	253,752,742	22,337,286	10,017,950	863,359	257,590	1,780,509	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		87,556	39,268				190
192	PHYSICIANS' PRIVATE OFFICES		5,394	2,419				192
192.01	MATERNAL FETAL MEDICINE/LABORIST	12,863	4,696	2,106				192.01



COMPU-MAX

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	NON- PATIENT TELEPHONES 5.01	ADMITTING 5.04	
192.02	NEONATOLOGISTS	1,158,412			9,746			192.02
192.03	HOSPITALISTS/INTENSIVISTS	5,910,133			2,579			192.03
194	SPORTS MED-ATHLETIC TRAINERS	228,143			2,069			194
194.01	OUTREACH SERVICES	3,137,385			22,015	1,042		194.01
194.02	KINDRED/OUR LADY OF PEACE	364,537			3,741	73,362		194.02
194.03	ADVANCED SPECIALTIES	127,420			70			194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	264,691,635	22,434,932	10,061,743	903,579	331,994	1,780,509	202



ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL (cols.0-4) 4A	OTHER ADMIN & GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY + LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.04	ADMITTING							5.04
5.06	OTHER ADMINISTRATIVE & GENERAL	55,348,445	55,348,445					5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	16,783,753	4,437,473	21,221,226				7
8	LAUNDRY & LINEN SERVICE	1,158,470	306,289		1,464,759			8
9	HOUSEKEEPING	3,357,470	887,685	438,747		4,683,902		9
10	DIETARY	3,292,330	870,462	622,587		140,317	4,925,696	10
11	CAFETERIA	977,148	258,349	846,102		190,692		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,028,352	800,669	138,135		31,132		13
14	CENTRAL SERVICES & SUPPLY	954,881	252,462					14
15	PHARMACY	3,999,841	1,057,522	369,643		83,309		15
16	MEDICAL RECORDS & LIBRARY	4,022,812	1,063,595	70,848		15,967		16
17	SOCIAL SERVICE	2,627,619	694,719	43,090		9,711		17
18	STERILE SUPPLY	2,652,943	701,414	559,660		126,135		18
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	2,201,225	581,984					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,897,667	501,726	65,398		14,739		22
23	PARAMED ED PRGM-(SPECIFY)	178,334	47,150	23,325		5,257		23
23.01	CLINICAL PASTORAL EDUCATION	312,918	82,733					23.01
23.02	PHARMACY RESIDENCY PROGRAM	612,090	161,831					23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	29,739,680	7,862,896	8,268,826	174,390	1,863,609	3,710,743	30
31	INTENSIVE CARE UNIT	6,145,134	1,624,718	1,039,680	35,514	234,320	210,826	31
35	NEONATAL INTENSIVE CARE UNIT	2,038,611	538,990	367,826	10,175	82,900	13,370	35
41	SUBPROVIDER - IRF	3,168,509	837,725		14,923		505,828	41
43	NURSERY	4,011,847	1,060,696		6,767			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	22,275,170	5,889,354	3,471,534	300,277	782,405		50
51	RECOVERY ROOM	1,577,003	416,945	230,055	28,948	51,849		51
52	DELIVERY ROOM & LABOR ROOM	686,770	181,576		13,101			52
54	RADIOLOGY-DIAGNOSTIC	5,820,660	1,538,930	969,922	86,369	218,599		54
55	RADIOLOGY-THERAPEUTIC	211,635	55,954		748			55
57	CT SCAN	1,226,896	324,380	123,965	86,458	27,939		57
58	MRI	460,125	121,653		6,219			58
59	CARDIAC CATHETERIZATION	8,221,447	2,173,677	1,065,766	76,174	240,200		59
60	LABORATORY	13,176,656	3,483,789	143,003	158,307	32,230		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,128,563	827,164	260,937	23,786	58,809		65
66	PHYSICAL THERAPY	3,195,451	844,848	236,449	24,220	53,290		66
67	OCCUPATIONAL THERAPY	897,684	237,340		9,586			67
68	SPEECH PATHOLOGY	410,635	108,568		4,526			68
69	ELECTROCARDIOLOGY	1,378,556	364,478	195,467	35,612	44,054		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS	17,938,798	4,742,857		104,761			72
73	DRUGS CHARGED TO PATIENTS	11,430,744	3,022,186	34,007	144,863	7,664		73
74	RENAL DIALYSIS	819,004	216,537	82,329	3,145	18,555		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	180,758	47,791		2,657			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	107,289	28,366		653			90.02
90.03	FAMILY MEDICINE CENTER	1,118,949	295,840		5,556			90.03
90.04	WOUND HEALING CENTER	1,459,894	385,983		4,779			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	720,380	190,462	112,484	4,563	25,351	1,351	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	450,214	119,033		490			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	381,509	100,868		963			90.07
90.08	PODIATRY RESIDENCY CLINIC	177,631	46,964		401			90.08
90.09	FACULTY PRACTICE CLINIC	292,883	77,436		1,118			90.09
91	EMERGENCY	7,241,296	1,914,533	1,288,846	94,710	290,477		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	253,496,679	52,388,600	21,068,631	1,464,759	4,649,510	4,442,118	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	126,824	33,531	136,827		30,838		190
192	PHYSICIANS' PRIVATE OFFICES	7,813	2,066	8,429		1,900		192
192.01	MATERNAL FETAL MEDICINE/LABORIST	19,665	5,199	7,339		1,654		192.01



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL (cols.0-4) 4A	OTHER ADMIN & GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY + LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
192.02	NEONATOLOGISTS	1,168,158	308,850					192.02
192.03	HOSPITALISTS/INTENSIVISTS	5,912,712	1,563,268					192.03
194	SPORTS MED-ATHLETIC TRAINERS	230,212	60,866					194
194.01	OUTREACH SERVICES	3,160,442	835,592					194.01
194.02	KINDRED/OUR LADY OF PEACE	441,640	116,766				483,578	194.02
194.03	ADVANCED SPECIALTIES	127,490	33,707					194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	264,691,635	55,348,445	21,221,226	1,464,759	4,683,902	4,925,696	202



ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11	13	14	15	16	17	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.04	ADMITTING							5.04
5.06	OTHER ADMINISTRATIVE & 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	2,272,291						11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	75,186	4,073,474					13
14	CENTRAL SERVICES & SUPPLY	22,974		1,230,317				14
15	PHARMACY	73,098			5,583,413			15
16	MEDICAL RECORDS & LIBRARY	73,098				5,246,320		16
17	SOCIAL SERVICE	50,124			15,182		3,440,445	17
18	STERILE SUPPLY	37,593			20			18
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	54,301						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	22,974						22
23	PARAMED ED PRGM-(SPECIFY)	2,089						23
23.01	CLINICAL PASTORAL EDUCATION	18,797						23.01
23.02	PHARMACY RESIDENCY PROGRAM	10,443						23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	655,783	1,658,977	146,538	925	624,778	2,865,510	30
31	INTENSIVE CARE UNIT	123,222	311,719	29,842	292	127,233	344,853	31
35	NEONATAL INTENSIVE CARE UNIT	37,593	95,101	8,550	601	36,455	39,874	35
41	SUBPROVIDER - IRF		227,185	12,539	20	53,463		41
43	NURSERY	68,921	174,351	5,686		24,243		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	244,355	618,154	251,813	54,610	1,074,403	7,544	50
51	RECOVERY ROOM	33,416	84,534	24,325		103,711		51
52	DELIVERY ROOM & LABOR ROOM	20,885		11,008		46,935		52
54	RADIOLOGY-DIAGNOSTIC	106,514		72,575	234,404	309,428		54
55	RADIOLOGY-THERAPEUTIC	4,177		629		2,681		55
57	CT SCAN	18,797		72,650	62,315	309,747		57
58	MRI			5,226		22,280		58
59	CARDIAC CATHETERIZATION	64,744	163,784	64,009	60,056	272,906		59
60	LABORATORY			133,024		567,156		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	54,301		19,987	402	85,217		65
66	PHYSICAL THERAPY	64,744		20,352	820	86,772		66
67	OCCUPATIONAL THERAPY	20,885		8,055	231	34,344		67
68	SPEECH PATHOLOGY	8,354		3,803		16,215		68
69	ELECTROCARDIOLOGY	29,239	73,967	29,924	93	127,583		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS			88,029		375,320		72
73	DRUGS CHARGED TO PATIENTS	8,354		121,727	5,046,758	518,992		73
74	RENAL DIALYSIS			2,643	494	11,267		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY			2,233		9,519		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT		10,567	549		2,339		90.02
90.03	FAMILY MEDICINE CENTER	31,328	79,250	4,669	16,845	19,906		90.03
90.04	WOUND HEALING CENTER	18,797	47,550	4,016	28,845	17,121		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	14,620	36,984	3,835	203	16,349		90.05
90.06	PEDIATRIC SPECIALTY CLINIC	8,354	21,133	412	344	1,755		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	8,354	21,133	809	2,040	3,449		90.07
90.08	PODIATRY RESIDENCY CLINIC	12,531	31,700	337	290	1,438		90.08
90.09	FACULTY PRACTICE CLINIC	8,354	21,133	939	16,782	4,005		90.09
91	EMERGENCY	156,638	396,252	79,584	24	339,310	182,664	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	2,263,937	4,073,474	1,230,317	5,542,596	5,246,320	3,440,445	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,354						190
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	MATERNAL FETAL MEDICINE/LABORIST							192.01



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ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11	13	14	15	16	17	
192.02	NEONATOLOGISTS							192.02
192.03	HOSPITALISTS/INTENSIVISTS							192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES				40,817			194.01
194.02	KINDRED/OUR LADY OF PEACE							194.02
194.03	ADVANCED SPECIALTIES							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,272,291	4,073,474	1,230,317	5,583,413	5,246,320	3,440,445	202



ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	STERILE SUPPLY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	CLINICAL PASTORAL EDUCATION	PHARMACY RESIDENCY PROGRAM	
		18	21	22	23	23.01	23.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.04	ADMITTING							5.04
5.06	OTHER ADMINISTRATIVE & 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
18	STERILE SUPPLY	4,077,765						18
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		2,837,510					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD			2,502,504				22
23	PARAMED ED PRGM-(SPECIFY)				256,155			23
23.01	CLINICAL PASTORAL EDUCATION					414,448		23.01
23.02	PHARMACY RESIDENCY PROGRAM						784,364	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	72,746	1,259,976	1,111,223		305,011		30
31	INTENSIVE CARE UNIT	1,586	133,168	117,446		77,665		31
35	NEONATAL INTENSIVE CARE UNIT	5,551	46,097	40,654				35
41	SUBPROVIDER - IRF		148,534	130,998				41
43	NURSERY		81,950	72,274		9,179		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	3,633,358	179,265	158,100				50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM		40,975	36,137				52
54	RADIOLOGY-DIAGNOSTIC	17,235	51,219	45,172				54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION	17,922	46,097	40,654				59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	12,001						65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		92,193	81,309				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS						784,364	73
74	RENAL DIALYSIS		46,097	40,654				74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT		76,828	67,757				90.02
90.03	FAMILY MEDICINE CENTER	46,048	97,315	85,826				90.03
90.04	WOUND HEALING CENTER	8,247	76,828	67,757				90.04
90.05	OUTPATIENT TREATMENT & INFUSION		76,828	67,757				90.05
90.06	PEDIATRIC SPECIALTY CLINIC		76,828	67,757				90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	211	76,828	67,757				90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC	2,802						90.09
91	EMERGENCY	5,393	230,484	203,272	256,155	22,593		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	3,823,100	2,837,510	2,502,504	256,155	414,448	784,364	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	MATERNAL FETAL MEDICINE/LABORIST	5,181						192.01



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	STERILE SUPPLY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	CLINICAL PASTORAL EDUCATION	PHARMACY RESIDENCY PROGRAM	
		18	21	22	23	23.01	23.02	
192.02	NEONATOLOGISTS							192.02
192.03	HOSPITALISTS/INTENSIVISTS							192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES	162,939						194.01
194.02	KINDRED/OUR LADY OF PEACE	86,545						194.02
194.03	ADVANCED SPECIALTIES							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	4,077,765	2,837,510	2,502,504	256,155	414,448	784,364	202



ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		24	25	26		
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS DEPARTMENT					4
5.01	NONPATIENT TELEPHONES					5.01
5.04	ADMITTING					5.04
5.06	OTHER ADMINISTRATIVE & 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
18	STERILE SUPPLY					18
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
23.01	CLINICAL PASTORAL EDUCATION					23.01
23.02	PHARMACY RESIDENCY PROGRAM					23.02
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	60,321,611	-2,371,199	57,950,412		30
31	INTENSIVE CARE UNIT	10,557,218	-250,614	10,306,604		31
35	NEONATAL INTENSIVE CARE UNIT	3,362,348	-86,751	3,275,597		35
41	SUBPROVIDER - IRF	5,099,724	-279,532	4,820,192		41
43	NURSERY	5,515,914	-154,224	5,361,690		43
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	38,940,342	-337,365	38,602,977		50
51	RECOVERY ROOM	2,550,786		2,550,786		51
52	DELIVERY ROOM & LABOR ROOM	1,037,387	-77,112	960,275		52
54	RADIOLOGY-DIAGNOSTIC	9,471,027	-96,391	9,374,636		54
55	RADIOLOGY-THERAPEUTIC	275,824		275,824		55
57	CT SCAN	2,253,147		2,253,147		57
58	MRI	615,503		615,503		58
59	CARDIAC CATHETERIZATION	12,507,436	-86,751	12,420,685		59
60	LABORATORY	17,694,165		17,694,165		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	4,471,167		4,471,167		65
66	PHYSICAL THERAPY	4,526,946		4,526,946		66
67	OCCUPATIONAL THERAPY	1,208,125		1,208,125		67
68	SPEECH PATHOLOGY	552,101		552,101		68
69	ELECTROCARDIOLOGY	2,452,475	-173,502	2,278,973		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					71
72	IMPL. DEV. CHARGED TO PATIENTS	23,249,765		23,249,765		72
73	DRUGS CHARGED TO PATIENTS	21,119,659		21,119,659		73
74	RENAL DIALYSIS	1,240,725	-86,751	1,153,974		74
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY	242,958		242,958		76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90.02	MOBILE MEDICAL UNIT	294,348	-144,585	149,763		90.02
90.03	FAMILY MEDICINE CENTER	1,801,532	-183,141	1,618,391		90.03
90.04	WOUND HEALING CENTER	2,119,817	-144,585	1,975,232		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	1,271,167	-144,585	1,126,582		90.05
90.06	PEDIATRIC SPECIALTY CLINIC	746,320	-144,585	601,735		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	663,921	-144,585	519,336		90.07
90.08	PODIATRY RESIDENCY CLINIC	271,292		271,292		90.08
90.09	FACULTY PRACTICE CLINIC	425,452		425,452		90.09
91	EMERGENCY	12,702,231	-433,756	12,268,475		91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
	OTHER REIMBURSABLE COST CENTERS					
	SPECIAL PURPOSE COST CENTERS					
113	INTEREST EXPENSE					113
118	SUBTOTALS (sum of lines 1-117)	249,562,433	-5,340,014	244,222,419		118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	336,374		336,374		190
192	PHYSICIANS' PRIVATE OFFICES	20,208		20,208		192
192.01	MATERNAL FETAL MEDICINE/LABORIST	39,038		39,038		192.01



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		24	25	26				
192.02	NEONATOLOGISTS	1,477,008		1,477,008				192.02
192.03	HOSPITALISTS/INTENSIVISTS	7,475,980		7,475,980				192.03
194	SPORTS MED-ATHLETIC TRAINERS	291,078		291,078				194
194.01	OUTREACH SERVICES	4,199,790		4,199,790				194.01
194.02	KINDRED/OUR LADY OF PEACE	1,128,529		1,128,529				194.02
194.03	ADVANCED SPECIALTIES	161,197		161,197				194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	264,691,635	-5,340,014	259,351,621				202



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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	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		14,693	6,590	21,283	21,283		4
5.01	NONPATIENT TELEPHONES		22,691	10,177	32,868	64	32,932	5.01
5.04	ADMITTING		86,765	38,913	125,678	319	177	5.04
5.06	OTHER ADMINISTRATIVE & GENERAL		2,792,161	1,252,244	4,044,405	418	1,771	5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		5,939,101	2,663,602	8,602,703	496	900	7
8	LAUNDRY & LINEN SERVICE					37		8
9	HOUSEKEEPING		280,755	125,915	406,670	518	502	9
10	DIETARY		398,395	178,674	577,069	368	443	10
11	CAFETERIA		541,423	242,820	784,243	173	30	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		88,393	39,643	128,036	584	280	13
14	CENTRAL SERVICES & SUPPLY					106	325	14
15	PHARMACY		236,536	106,083	342,619	792	605	15
16	MEDICAL RECORDS & LIBRARY		45,336	20,332	65,668	422	2,672	16
17	SOCIAL SERVICE		27,573	12,366	39,939	448	871	17
18	STERILE SUPPLY		358,128	160,615	518,743	162	44	18
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD					508		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		41,848	18,768	60,616	442	369	22
23	PARAMED ED PRGM-(SPECIFY)		14,926	6,694	21,620	18	15	23
23.01	CLINICAL PASTORAL EDUCATION					67	15	23.01
23.02	PHARMACY RESIDENCY PROGRAM					121		23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		5,291,244	2,373,047	7,664,291	4,537	3,735	30
31	INTENSIVE CARE UNIT		665,294	298,375	963,669	1,020	517	31
35	NEONATAL INTENSIVE CARE UNIT		235,373	105,561	340,934	330	207	35
41	SUBPROVIDER - IRF					564	576	41
43	NURSERY					529	74	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		2,221,444	996,285	3,217,729	1,931	3,041	50
51	RECOVERY ROOM		147,213	66,023	213,236	256	177	51
52	DELIVERY ROOM & LABOR ROOM					6		52
54	RADIOLOGY-DIAGNOSTIC		620,656	278,355	899,011	824	2,067	54
55	RADIOLOGY-THERAPEUTIC					31	915	55
57	CT SCAN		79,326	35,576	114,902	164	59	57
58	MRI							58
59	CARDIAC CATHETERIZATION		681,987	305,861	987,848	584	207	59
60	LABORATORY		91,508	41,040	132,548		325	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		166,974	74,886	241,860	435	399	65
66	PHYSICAL THERAPY		151,305	67,858	219,163	604	428	66
67	OCCUPATIONAL THERAPY					175	354	67
68	SPEECH PATHOLOGY					85	280	68
69	ELECTROCARDIOLOGY		125,080	56,096	181,176	232	561	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS		21,761	9,760	31,521	83	103	73
74	RENAL DIALYSIS		52,682	23,627	76,309		103	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY					10	15	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT					22	15	90.02
90.03	FAMILY MEDICINE CENTER					159	841	90.03
90.04	WOUND HEALING CENTER					120	74	90.04
90.05	OUTPATIENT TREATMENT & INFUSION		71,979	32,282	104,261	127	207	90.05
90.06	PEDIATRIC SPECIALTY CLINIC					67	44	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC					92	30	90.07
90.08	PODIATRY RESIDENCY CLINIC					29	30	90.08
90.09	FACULTY PRACTICE CLINIC					93	30	90.09
91	EMERGENCY		824,736	369,882	1,194,618	1,162	1,122	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		22,337,286	10,017,950	32,355,236	20,334	25,555	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		87,556	39,268	126,824			190
192	PHYSICIANS' PRIVATE OFFICES		5,394	2,419	7,813			192
192.01	MATERNAL FETAL MEDICINE/LABORIST		4,696	2,106	6,802			192.01



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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	
192.02	NEONATOLOGISTS					230		192.02
192.03	HOSPITALISTS/INTENSIVISTS					61		192.03
194	SPORTS MED-ATHLETIC TRAINERS					49		194
194.01	OUTREACH SERVICES					519	103	194.01
194.02	KINDRED/OUR LADY OF PEACE					88	7,274	194.02
194.03	ADVANCED SPECIALTIES					2		194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		22,434,932	10,061,743	32,496,675	21,283	32,932	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	ADMITTING	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	
		5.04	5.06	7	8	9	10	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.04	ADMITTING	126,174						5.04
5.06	OTHER ADMINISTRATIVE & GENERAL		4,046,594					5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		324,430	8,928,529				7
8	LAUNDRY & LINEN SERVICE		22,393		22,430			8
9	HOUSEKEEPING		64,900	184,596		657,186		9
10	DIETARY		63,641	261,945		19,688	923,154	10
11	CAFETERIA		18,888	355,986		26,756		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		58,538	58,118		4,368		13
14	CENTRAL SERVICES & SUPPLY		18,458					14
15	PHARMACY		77,317	155,522		11,689		15
16	MEDICAL RECORDS & LIBRARY		77,761	29,808		2,240		16
17	SOCIAL SERVICE		50,792	18,129		1,363		17
18	STERILE SUPPLY		51,281	235,469		17,698		18
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		42,550					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		36,682	27,515		2,068		22
23	PARAMED ED PRGM-(SPECIFY)		3,447	9,814		738		23
23.01	CLINICAL PASTORAL EDUCATION		6,049					23.01
23.02	PHARMACY RESIDENCY PROGRAM		11,832					23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	15,042	574,860	3,478,990	2,717	261,477	695,453	30
31	INTENSIVE CARE UNIT	3,063	118,785	437,431	553	32,877	39,512	31
35	NEONATAL INTENSIVE CARE UNIT	878	39,406	154,758	159	11,631	2,506	35
41	SUBPROVIDER - IRF	1,287	61,247		233		94,800	41
43	NURSERY	584	77,549		105			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	25,733	430,579	1,460,598	4,286	109,777		50
51	RECOVERY ROOM	2,497	30,483	96,792	451	7,275		51
52	DELIVERY ROOM & LABOR ROOM	1,130	13,275		204			52
54	RADIOLOGY-DIAGNOSTIC	7,450	112,513	408,081	1,346	30,671		54
55	RADIOLOGY-THERAPEUTIC	65	4,091		12			55
57	CT SCAN	7,457	23,716	52,157	1,347	3,920		57
58	MRI	536	8,894		97			58
59	CARDIAC CATHETERIZATION	6,570	158,921	448,406	1,187	33,702		59
60	LABORATORY	13,655	254,705	60,167	2,467	4,522		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,052	60,475	109,786	371	8,251		65
66	PHYSICAL THERAPY	2,089	61,768	99,483	377	7,477		66
67	OCCUPATIONAL THERAPY	827	17,352		149			67
68	SPEECH PATHOLOGY	390	7,938		71			68
69	ELECTROCARDIOLOGY	3,072	26,647	82,240	555	6,181		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS	9,036	346,757		1,632			72
73	DRUGS CHARGED TO PATIENTS	12,495	220,956	14,308	2,257	1,075		73
74	RENAL DIALYSIS	271	15,831	34,639	49	2,603		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	229	3,494		41			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	56	2,074		10			90.02
90.03	FAMILY MEDICINE CENTER	479	21,629		87			90.03
90.04	WOUND HEALING CENTER	412	28,220		74			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	394	13,925	47,326	71	3,557	253	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	42	8,703		8			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	83	7,375		15			90.07
90.08	PODIATRY RESIDENCY CLINIC	35	3,434		6			90.08
90.09	FACULTY PRACTICE CLINIC	96	5,661		17			90.09
91	EMERGENCY	8,169	139,974	542,263	1,476	40,756		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	126,174	3,830,196	8,864,327	22,430	652,360	832,524	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,452	57,568		4,327		190
192	PHYSICIANS' PRIVATE OFFICES		151	3,546		267		192
192.01	MATERNAL FETAL MEDICINE/LABORIST		380	3,088		232		192.01



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	ADMITTING	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	
		5.04	5.06	7	8	9	10	
192.02	NEONATOLOGISTS		22,580					192.02
192.03	HOSPITALISTS/INTENSIVISTS		114,293					192.03
194	SPORTS MED-ATHLETIC TRAINERS		4,450					194
194.01	OUTREACH SERVICES		61,091					194.01
194.02	KINDRED/OUR LADY OF PEACE		8,537				90,630	194.02
194.03	ADVANCED SPECIALTIES		2,464					194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	126,174	4,046,594	8,928,529	22,430	657,186	923,154	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11	13	14	15	16	17	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.04	ADMITTING							5.04
5.06	OTHER ADMINISTRATIVE & 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	1,186,076						11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	39,245	289,169					13
14	CENTRAL SERVICES & SUPPLY	11,992		30,881				14
15	PHARMACY	38,155			626,699			15
16	MEDICAL RECORDS & LIBRARY	38,155				216,726		16
17	SOCIAL SERVICE	26,163						17
18	STERILE SUPPLY	19,623			1,704		139,409	18
19	NONPHYSICIAN ANESTHETISTS				2			19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	28,344						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	11,992						22
23	PARAMED ED PRGM-(SPECIFY)	1,090						23
23.01	CLINICAL PASTORAL EDUCATION	9,811						23.01
23.02	PHARMACY RESIDENCY PROGRAM	5,451						23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	342,304	117,769	3,688	104	25,814	116,111	30
31	INTENSIVE CARE UNIT	64,318	22,128	751	33	5,257	13,974	31
35	NEONATAL INTENSIVE CARE UNIT	19,623	6,751	215	67	1,506	1,616	35
41	SUBPROVIDER - IRF		16,127	316	2	2,209		41
43	NURSERY	35,975	12,377	143		1,002		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	127,547	43,882	6,257	6,130	44,356	306	50
51	RECOVERY ROOM	17,442	6,001	612		4,285		51
52	DELIVERY ROOM & LABOR ROOM	10,901		277		1,939		52
54	RADIOLOGY-DIAGNOSTIC	55,597		1,826	26,310	12,785		54
55	RADIOLOGY-THERAPEUTIC	2,180		16		111		55
57	CT SCAN	9,811		1,828	6,994	12,798		57
58	MRI			132		921		58
59	CARDIAC CATHETERIZATION	33,794	11,627	1,611	6,741	11,276		59
60	LABORATORY			3,348		23,433		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	28,344		503	45	3,521		65
66	PHYSICAL THERAPY	33,794		512	92	3,585		66
67	OCCUPATIONAL THERAPY	10,901		203	26	1,419		67
68	SPEECH PATHOLOGY	4,361		96		670		68
69	ELECTROCARDIOLOGY	15,262	5,251	753	10	5,271		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS			2,215		15,507		72
73	DRUGS CHARGED TO PATIENTS	4,361		3,063	566,463	21,443		73
74	RENAL DIALYSIS			67	55	466		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY			56		393		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT		750	14		97		90.02
90.03	FAMILY MEDICINE CENTER	16,352	5,626	117	1,891	822		90.03
90.04	WOUND HEALING CENTER	9,811	3,376	101	3,238	707		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	7,631	2,625	96	23	675		90.05
90.06	PEDIATRIC SPECIALTY CLINIC	4,361	1,500	10	39	73		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	4,361	1,500	20	229	142		90.07
90.08	PODIATRY RESIDENCY CLINIC	6,541	2,250	8	33	59		90.08
90.09	FACULTY PRACTICE CLINIC	4,361	1,500	24	1,884	165		90.09
91	EMERGENCY	81,761	28,129	2,003	3	14,019	7,402	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,181,715	289,169	30,881	622,118	216,726	139,409	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,361						190
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	MATERNAL FETAL MEDICINE/LABORIST							192.01



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11	13	14	15	16	17	
192.02	NEONATOLOGISTS							192.02
192.03	HOSPITALISTS/INTENSIVISTS							192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES				4,581			194.01
194.02	KINDRED/OUR LADY OF PEACE							194.02
194.03	ADVANCED SPECIALTIES							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,186,076	289,169	30,881	626,699	216,726	139,409	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	STERILE SUPPLY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	CLINICAL PASTORAL EDUCATION	PHARMACY RESIDENCY PROGRAM	
		18	21	22	23	23.01	23.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.04	ADMITTING							5.04
5.06	OTHER ADMINISTRATIVE & 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
18	STERILE SUPPLY	843,022						18
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		71,402					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD			139,684				22
23	PARAMED ED PRGM-(SPECIFY)				36,742			23
23.01	CLINICAL PASTORAL EDUCATION					15,942		23.01
23.02	PHARMACY RESIDENCY PROGRAM						17,404	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	15,039						30
31	INTENSIVE CARE UNIT	328						31
35	NEONATAL INTENSIVE CARE UNIT	1,148						35
41	SUBPROVIDER - IRF							41
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	751,147						50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC	3,563						54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION	3,705						59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,481						65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT							90.02
90.03	FAMILY MEDICINE CENTER	9,520						90.03
90.04	WOUND HEALING CENTER	1,705						90.04
90.05	OUTPATIENT TREATMENT & INFUSION							90.05
90.06	PEDIATRIC SPECIALTY CLINIC							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	44						90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC	579						90.09
91	EMERGENCY	1,115						91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	790,374						118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	MATERNAL FETAL MEDICINE/LABORIST	1,071						192.01



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	STERILE SUPPLY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	CLINICAL PASTORAL EDUCATION	PHARMACY RESIDENCY PROGRAM	
		18	21	22	23	23.01	23.02	
192.02	NEONATOLOGISTS							192.02
192.03	HOSPITALISTS/INTENSIVISTS							192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES	33,685						194.01
194.02	KINDRED/OUR LADY OF PEACE	17,892						194.02
194.03	ADVANCED SPECIALTIES							194.03
200	CROSS FOOT ADJUSTMENTS		71,402	139,684	36,742	15,942	17,404	200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	843,022	71,402	139,684	36,742	15,942	17,404	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		24	25	26			
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	NONPATIENT TELEPHONES						5.01
5.04	ADMITTING						5.04
5.06	OTHER ADMINISTRATIVE & 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
18	STERILE SUPPLY						18
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
23.01	CLINICAL PASTORAL EDUCATION						23.01
23.02	PHARMACY RESIDENCY PROGRAM						23.02
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	13,321,931		13,321,931			30
31	INTENSIVE CARE UNIT	1,704,216		1,704,216			31
35	NEONATAL INTENSIVE CARE UNIT	581,735		581,735			35
41	SUBPROVIDER - IRF	177,361		177,361			41
43	NURSERY	128,338		128,338			43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	6,233,299		6,233,299			50
51	RECOVERY ROOM	379,507		379,507			51
52	DELIVERY ROOM & LABOR ROOM	27,732		27,732			52
54	RADIOLOGY-DIAGNOSTIC	1,562,044		1,562,044			54
55	RADIOLOGY-THERAPEUTIC	7,421		7,421			55
57	CT SCAN	235,153		235,153			57
58	MRI	10,580		10,580			58
59	CARDIAC CATHETERIZATION	1,706,179		1,706,179			59
60	LABORATORY	495,170		495,170			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	458,523		458,523			65
66	PHYSICAL THERAPY	429,372		429,372			66
67	OCCUPATIONAL THERAPY	31,406		31,406			67
68	SPEECH PATHOLOGY	13,891		13,891			68
69	ELECTROCARDIOLOGY	327,211		327,211			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS	375,147		375,147			72
73	DRUGS CHARGED TO PATIENTS	878,128		878,128			73
74	RENAL DIALYSIS	130,393		130,393			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,238		4,238			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT	3,038		3,038			90.02
90.03	FAMILY MEDICINE CENTER	57,523		57,523			90.03
90.04	WOUND HEALING CENTER	47,838		47,838			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	181,171		181,171			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	14,847		14,847			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	13,891		13,891			90.07
90.08	PODIATRY RESIDENCY CLINIC	12,425		12,425			90.08
90.09	FACULTY PRACTICE CLINIC	14,410		14,410			90.09
91	EMERGENCY	2,063,972		2,063,972			91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)	31,628,090		31,628,090			118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	195,532		195,532			190
192	PHYSICIANS' PRIVATE OFFICES	11,777		11,777			192
192.01	MATERNAL FETAL MEDICINE/LABORIST	11,573		11,573			192.01



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		24	25	26			
192.02	NEONATOLOGISTS	22,810		22,810			192.02
192.03	HOSPITALISTS/INTENSIVISTS	114,354		114,354			192.03
194	SPORTS MED-ATHLETIC TRAINERS	4,499		4,499			194
194.01	OUTREACH SERVICES	99,979		99,979			194.01
194.02	KINDRED/OUR LADY OF PEACE	124,421		124,421			194.02
194.03	ADVANCED SPECIALTIES	2,466		2,466			194.03
200	CROSS FOOT ADJUSTMENTS	281,174		281,174			200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	32,496,675		32,496,675			202



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON-PATIENT TELEPHONES PHONE EXTENSIONS	ADMITTING GROSS REVENUE	RECONCILIATION	
		1	2	4	5.01	5.04	5A.06	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	482,492						1
2	CAP REL COSTS-MVBLE EQUIP		482,492					2
4	EMPLOYEE BENEFITS DEPARTMENT	316	316	76,399,973				4
5.01	NONPATIENT TELEPHONES	488	488	228,880	2,231			5.01
5.04	ADMITTING	1,866	1,866	1,145,160	12	814,900,051		5.04
5.06	OTHER ADMINISTRATIVE & GENERAL	60,049	60,049	1,498,059	120		-55,348,445	5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	127,728	127,728	1,779,164	61			7
8	LAUNDRY & LINEN SERVICE			134,251				8
9	HOUSEKEEPING	6,038	6,038	1,857,063	34			9
10	DIETARY	8,568	8,568	1,317,865	30			10
11	CAFETERIA	11,644	11,644	620,172	2			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,901	1,901	2,091,660	19			13
14	CENTRAL SERVICES & SUPPLY			379,214	22			14
15	PHARMACY	5,087	5,087	2,838,204	41			15
16	MEDICAL RECORDS & LIBRARY	975	975	1,512,069	181			16
17	SOCIAL SERVICE	593	593	1,606,848	59			17
18	STERILE SUPPLY	7,702	7,702	582,091	3			18
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			1,819,504				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	900	900	1,583,405	25			22
23	PARAMED ED PRGM-(SPECIFY)	321	321	64,487	1			23
23.01	CLINICAL PASTORAL EDUCATION			238,635	1			23.01
23.02	PHARMACY RESIDENCY PROGRAM			435,319				23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	113,795	113,795	16,382,558	253	97,045,334		30
31	INTENSIVE CARE UNIT	14,308	14,308	3,656,049	35	19,762,848		31
35	NEONATAL INTENSIVE CARE UNIT	5,062	5,062	1,184,537	14	5,662,475		35
41	SUBPROVIDER - IRF			2,021,008	39	8,304,278		41
43	NURSERY			1,895,067	5	3,765,588		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	47,775	47,775	6,919,493	206	166,885,503		50
51	RECOVERY ROOM	3,166	3,166	916,886	12	16,109,200		51
52	DELIVERY ROOM & LABOR ROOM			21,608		7,290,377		52
54	RADIOLOGY-DIAGNOSTIC	13,348	13,348	2,953,382	140	48,062,731		54
55	RADIOLOGY-THERAPEUTIC			110,931	62	416,366		55
57	CT SCAN	1,706	1,706	587,403	4	48,112,303		57
58	MRI					3,460,734		58
59	CARDIAC CATHETERIZATION	14,667	14,667	2,092,483	14	42,389,816		59
60	LABORATORY	1,968	1,968		22	88,095,060		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,591	3,591	1,560,620	27	13,236,572		65
66	PHYSICAL THERAPY	3,254	3,254	2,165,092	29	13,478,161		66
67	OCCUPATIONAL THERAPY			628,828	24	5,334,609		67
68	SPEECH PATHOLOGY			303,173	19	2,518,698		68
69	ELECTROCARDIOLOGY	2,690	2,690	830,021	38	19,817,235		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS					58,297,576		72
73	DRUGS CHARGED TO PATIENTS	468	468	298,024	7	80,613,890		73
74	RENAL DIALYSIS	1,133	1,133		7	1,750,134		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY			35,882	1	1,478,592		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT			79,602	1	363,262		90.02
90.03	FAMILY MEDICINE CENTER			569,518	57	3,091,990		90.03
90.04	WOUND HEALING CENTER			429,287	5	2,659,364		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	1,548	1,548	455,070	14	2,539,407		90.05
90.06	PEDIATRIC SPECIALTY CLINIC			238,853	3	272,569		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC			331,521	2	535,704		90.07
90.08	PODIATRY RESIDENCY CLINIC			103,994	2	223,316		90.08
90.09	FACULTY PRACTICE CLINIC			333,020	2	622,033		90.09
91	EMERGENCY	17,737	17,737	4,163,346	76	52,704,326		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	480,392	480,392	72,999,306	1,731	814,900,051	-55,348,445	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,883	1,883					190
192	PHYSICIANS' PRIVATE OFFICES	116	116					192
192.01	MATERNAL FETAL MEDICINE/LABORIST	101	101					192.01



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON- PATIENT TELEPHONES PHONE EXTENSIONS	ADMITTING GROSS REVENUE	RECON- CILIATION	
		1	2	4	5.01	5.04	5A.06	
192.02	NEONATOLOGISTS			824,070				192.02
192.03	HOSPITALISTS/INTENSIVISTS			218,024				192.03
194	SPORTS MED-ATHLETIC TRAINERS			174,962				194
194.01	OUTREACH SERVICES			1,861,447	7			194.01
194.02	KINDRED/OUR LADY OF PEACE			316,286	493			194.02
194.03	ADVANCED SPECIALTIES			5,878				194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	22,434,932	10,061,743	903,579	331,994	1,780,509		202
203	UNIT COST MULT-WS B PT I	46,498,039	20,853,699	0,011,827	148,809,502	0,002,185		203
204	COST TO BE ALLOC PER B PT II			21,283	32,932	126,174		204
205	UNIT COST MULT-WS B PT II			0,000,279	14,761,094	0,000,155		205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OTHER ADMIN & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY + LINEN SERVICE GROSS REVENUE	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	
		5.06	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.04	ADMITTING							5.04
5.06	OTHER ADMINISTRATIVE & GENERAL	209,343,190						5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	16,783,753	292,045					7
8	LAUNDRY & LINEN SERVICE	1,158,470		814,900,051				8
9	HOUSEKEEPING	3,357,470	6,038		286,007			9
10	DIETARY	3,292,330	8,568		8,568	102,053		10
11	CAFETERIA	977,148	11,644		11,644		1,088	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,028,352	1,901		1,901		36	13
14	CENTRAL SERVICES & SUPPLY	954,881						11
15	PHARMACY	3,999,841	5,087		5,087		35	15
16	MEDICAL RECORDS & LIBRARY	4,022,812	975		975		35	16
17	SOCIAL SERVICE	2,627,619	593		593		24	17
18	STERILE SUPPLY	2,652,943	7,702		7,702		18	18
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	2,201,225					26	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,897,667	900		900		11	22
23	PARAMED ED PRGM-(SPECIFY)	178,334	321		321		1	23
23.01	CLINICAL PASTORAL EDUCATION	312,918					9	23.01
23.02	PHARMACY RESIDENCY PROGRAM	612,090					5	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	29,739,680	113,795	97,045,334	113,795	76,881	314	30
31	INTENSIVE CARE UNIT	6,145,134	14,308	19,762,848	14,308	4,368	59	31
35	NEONATAL INTENSIVE CARE UNIT	2,038,611	5,062	5,662,475	5,062	277	18	35
41	SUBPROVIDER - IRF	3,168,509		8,304,278		10,480		41
43	NURSERY	4,011,847		3,765,588			33	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	22,275,170	47,775	166,885,503	47,775		117	50
51	RECOVERY ROOM	1,577,003	3,166	16,109,200	3,166		16	51
52	DELIVERY ROOM & LABOR ROOM	686,770		7,290,377			10	52
54	RADIOLOGY-DIAGNOSTIC	5,820,660	13,348	48,062,731	13,348		51	54
55	RADIOLOGY-THERAPEUTIC	211,635		416,366			2	55
57	CT SCAN	1,226,896	1,706	48,112,303	1,706		9	57
58	MRI	460,125		3,460,734				58
59	CARDIAC CATHETERIZATION	8,221,447	14,667	42,389,816	14,667		31	59
60	LABORATORY	13,176,656	1,968	88,095,060	1,968			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,128,563	3,591	13,236,572	3,591		26	65
66	PHYSICAL THERAPY	3,195,451	3,254	13,478,161	3,254		31	66
67	OCCUPATIONAL THERAPY	897,684		5,334,609			10	67
68	SPEECH PATHOLOGY	410,635		2,518,698			4	68
69	ELECTROCARDIOLOGY	1,378,556	2,690	19,817,235	2,690		14	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS	17,938,798		58,297,576				72
73	DRUGS CHARGED TO PATIENTS	11,430,744	468	80,613,890	468		4	73
74	RENAL DIALYSIS	819,004	1,133	1,750,134	1,133			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	180,758		1,478,592				76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	107,289		363,262				90.02
90.03	FAMILY MEDICINE CENTER	1,118,949		3,091,990			15	90.03
90.04	WOUND HEALING CENTER	1,459,894		2,659,364			9	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	720,380	1,548	2,539,407	1,548	28	7	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	450,214		272,569			4	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	381,509		535,704			4	90.07
90.08	PODIATRY RESIDENCY CLINIC	177,631		223,316			6	90.08
90.09	FACULTY PRACTICE CLINIC	292,883		622,033			4	90.09
91	EMERGENCY	7,241,296	17,737	52,704,326	17,737		75	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	198,148,234	289,945	814,900,051	283,907	92,034	1,084	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	126,824	1,883		1,883		4	190
192	PHYSICIANS' PRIVATE OFFICES	7,813	116		116			192
192.01	MATERNAL FETAL MEDICINE/LABORIST	19,665	101		101			192.01



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OTHER ADMIN & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY + LINEN SERVICE GROSS REVENUE	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	
		5.06	7	8	9	10	11	
192.02	NEONATOLOGISTS	1,168,158						192.02
192.03	HOSPITALISTS/INTENSIVISTS	5,912,712						192.03
194	SPORTS MED-ATHLETIC TRAINERS	230,212						194
194.01	OUTREACH SERVICES	3,160,442						194.01
194.02	KINDRED/OUR LADY OF PEACE	441,640				10,019		194.02
194.03	ADVANCED SPECIALTIES	127,490						194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	55,348,445	21,221,226	1,464,759	4,683,902	4,925,696	2,272,291	202
203	UNIT COST MULT-WS B PT I	0.264391	72.664233	0.001797	16.376879	48.266058	2,088.502757	203
204	COST TO BE ALLOC PER B PT II	4,046,594	8,928,529	22,430	657,186	923,154	1,186,076	204
205	UNIT COST MULT-WS B PT II	0.019330	30.572443	0.000028	2.297797	9.045829	1,090.143382	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION DIRECT NRSNG HRS	CENTRAL SERVICES & SUPPLY GROSS REVENUE	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	STERILE SUPPLY COSTED REQUIS	
		13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.04	ADMITTING							5.04
5.06	OTHER ADMINISTRATIVE & 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	771						13
14	CENTRAL SERVICES & SUPPLY		814,900,051					14
15	PHARMACY			11,606,119				15
16	MEDICAL RECORDS & LIBRARY				814,900,051			16
17	SOCIAL SERVICE			31,559		6,385		17
18	STERILE SUPPLY			42			77,131	18
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
23.01	CLINICAL PASTORAL EDUCATION							23.01
23.02	PHARMACY RESIDENCY PROGRAM							23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	314	97,045,334	1,922	97,045,334	5,318	1,376	30
31	INTENSIVE CARE UNIT	59	19,762,848	606	19,762,848	640	30	31
35	NEONATAL INTENSIVE CARE UNIT	18	5,662,475	1,249	5,662,475	74	105	35
41	SUBPROVIDER - IRF	43	8,304,278	41	8,304,278			41
43	NURSERY	33	3,765,588		3,765,588			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	117	166,885,503	113,516	166,885,503	14	68,725	50
51	RECOVERY ROOM	16	16,109,200		16,109,200			51
52	DELIVERY ROOM & LABOR ROOM		7,290,377		7,290,377			52
54	RADIOLOGY-DIAGNOSTIC		48,062,731	487,251	48,062,731		326	54
55	RADIOLOGY-THERAPEUTIC		416,366		416,366			55
57	CT SCAN		48,112,303	129,533	48,112,303			57
58	MRI		3,460,734		3,460,734			58
59	CARDIAC CATHETERIZATION	31	42,389,816	124,837	42,389,816		339	59
60	LABORATORY		88,095,060		88,095,060			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		13,236,572	836	13,236,572		227	65
66	PHYSICAL THERAPY		13,478,161	1,704	13,478,161			66
67	OCCUPATIONAL THERAPY		5,334,609	481	5,334,609			67
68	SPEECH PATHOLOGY		2,518,698		2,518,698			68
69	ELECTROCARDIOLOGY	14	19,817,235	193	19,817,235			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS		58,297,576		58,297,576			72
73	DRUGS CHARGED TO PATIENTS		80,613,890	10,490,587	80,613,890			73
74	RENAL DIALYSIS		1,750,134	1,027	1,750,134			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY		1,478,592		1,478,592			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	2	363,262		363,262			90.02
90.03	FAMILY MEDICINE CENTER	15	3,091,990	35,015	3,091,990		871	90.03
90.04	WOUND HEALING CENTER	9	2,659,364	59,960	2,659,364		156	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	7	2,539,407	421	2,539,407			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	4	272,569	716	272,569			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	4	535,704	4,241	535,704		4	90.07
90.08	PODIATRY RESIDENCY CLINIC	6	223,316	603	223,316			90.08
90.09	FACULTY PRACTICE CLINIC	4	622,033	34,884	622,033		53	90.09
91	EMERGENCY	75	52,704,326	49	52,704,326	339	102	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	771	814,900,051	11,521,273	814,900,051	6,385	72,314	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	MATERNAL FETAL MEDICINE/LABORIST						98	192.01



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY GROSS REVENUE	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	STERILE SUPPLY COSTED REQUIS	
		13	14	15	16	17	18	
192.02	NEONATOLOGISTS							192.02
192.03	HOSPITALISTS/INTENSIVISTS							192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES			84,846			3,082	194.01
194.02	KINDRED/OUR LADY OF PEACE						1,637	194.02
194.03	ADVANCED SPECIALTIES							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	4,073,474	1,230,317	5,583,413	5,246,320	3,440,445	4,077,765	202
203	UNIT COST MULT-WS B PT I	5,283,364462	0.001510	0.481075	0.006438	538.832420	52.868043	203
204	COST TO BE ALLOC PER B PT II	289,169	30.881	626,699	216,726	139,409	843,022	204
205	UNIT COST MULT-WS B PT II	375.057069	0.000038	0.053997	0.000266	21.833829	10.929743	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME	CLINICAL PASTORAL EDUCATION TIME SPENT	PHARMACY RESIDENCY PROGRAM PATIENT DAYS		
	21	22	23	23.01	23.02		

GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	NONPATIENT TELEPHONES						5.01
5.04	ADMITTING						5.04
5.06	OTHER ADMINISTRATIVE & 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
18	STERILE SUPPLY						18
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD	554					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		554				22
23	PARAMED ED PRGM-(SPECIFY)			100			23
23.01	CLINICAL PASTORAL EDUCATION				587		23.01
23.02	PHARMACY RESIDENCY PROGRAM					100	23.02
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	246	246		432		30
31	INTENSIVE CARE UNIT	26	26		110		31
35	NEONATAL INTENSIVE CARE UNIT	9	9				35
41	SUBPROVIDER - IRF	29	29				41
43	NURSERY	16	16		13		43
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	35	35				50
51	RECOVERY ROOM						51
52	DELIVERY ROOM & LABOR ROOM	8	8				52
54	RADIOLOGY-DIAGNOSTIC	10	10				54
55	RADIOLOGY-THERAPEUTIC						55
57	CT SCAN						57
58	MRI						58
59	CARDIAC CATHETERIZATION	9	9				59
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	18	18				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS					100	73
74	RENAL DIALYSIS	9	9				74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	15	15				90.02
90.03	FAMILY MEDICINE CENTER	19	19				90.03
90.04	WOUND HEALING CENTER	15	15				90.04
90.05	OUTPATIENT TREATMENT & INFUSION	15	15				90.05
90.06	PEDIATRIC SPECIALTY CLINIC	15	15				90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	15	15				90.07
90.08	PODIATRY RESIDENCY CLINIC						90.08
90.09	FACULTY PRACTICE CLINIC						90.09
91	EMERGENCY	45	45	100	32		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	554	554	100	587	100	118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME	CLINICAL PASTORAL EDUCATION TIME SPENT	PHARMACY RESIDENCY PROGRAM PATIENT DAYS		
		21	22	23	23.01	23.02		
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	MATERNAL FETAL MEDICINE/LABORIST							192.01
192.02	NEONATOLOGISTS							192.02
192.03	HOSPITALISTS/INTENSIVISTS							192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES							194.01
194.02	KINDRED/OUR LADY OF PEACE							194.02
194.03	ADVANCED SPECIALTIES							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,837,510	2,502,504	256,155	414,448	784,364		202
203	UNIT COST MULT-WS B PT I	5,121,859,206	4,517,155,235	2,561,550,000	706,044,293	7,843,640,000		203
204	COST TO BE ALLOC PER B PT II	71,402	139,684	36,742	15,942	17,404		204
205	UNIT COST MULT-WS B PT II	128,884,477	252,137,184	367,420,000	27,158,433	174,040,000		205



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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4



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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 DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	57,950,412		57,950,412	60,401	58,010,813	30
31	INTENSIVE CARE UNIT	10,306,604		10,306,604	54,866	10,361,470	31
35	NEONATAL INTENSIVE CARE UNIT	3,275,597		3,275,597		3,275,597	35
41	SUBPROVIDER - IRF	4,820,192		4,820,192		4,820,192	41
43	NURSERY	5,361,690		5,361,690		5,361,690	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	38,602,977		38,602,977	135,625	38,738,602	50
51	RECOVERY ROOM	2,550,786		2,550,786		2,550,786	51
52	DELIVERY ROOM & LABOR ROOM	960,275		960,275		960,275	52
54	RADIOLOGY-DIAGNOSTIC	9,374,636		9,374,636	22,262	9,396,898	54
55	RADIOLOGY-THERAPEUTIC	275,824		275,824		275,824	55
57	CT SCAN	2,253,147		2,253,147		2,253,147	57
58	MRI	615,503		615,503		615,503	58
59	CARDIAC CATHETERIZATION	12,420,685		12,420,685	11,117	12,431,802	59
60	LABORATORY	17,694,165		17,694,165		17,694,165	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	4,471,167		4,471,167	200	4,471,367	65
66	PHYSICAL THERAPY	4,526,946		4,526,946		4,526,946	66
67	OCCUPATIONAL THERAPY	1,208,125		1,208,125		1,208,125	67
68	SPEECH PATHOLOGY	552,101		552,101		552,101	68
69	ELECTROCARDIOLOGY	2,278,973		2,278,973	4,324	2,283,297	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS	23,249,765		23,249,765		23,249,765	72
73	DRUGS CHARGED TO PATIENTS	21,119,659		21,119,659		21,119,659	73
74	RENAL DIALYSIS	1,153,974		1,153,974		1,153,974	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	242,958		242,958		242,958	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT	149,763		149,763	330	150,093	90.02
90.03	FAMILY MEDICINE CENTER	1,618,391		1,618,391		1,618,391	90.03
90.04	WOUND HEALING CENTER	1,975,232		1,975,232		1,975,232	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	1,126,582		1,126,582		1,126,582	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	601,735		601,735	3,092	604,827	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	519,336		519,336	108,641	627,977	90.07
90.08	PODIATRY RESIDENCY CLINIC	271,292		271,292	22,476	293,768	90.08
90.09	FACULTY PRACTICE CLINIC	425,452		425,452		425,452	90.09
91	EMERGENCY	12,268,475		12,268,475	127,114	12,395,589	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	9,320,658		9,320,658		9,320,658	92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	253,543,077		253,543,077	550,448	254,093,525	200
201	LESS OBSERVATION BEDS	9,320,658		9,320,658		9,320,658	201
202	TOTAL (SEE INSTRUCTIONS)	244,222,419		244,222,419		244,772,867	202



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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	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	88,492,843		88,492,843				30
31	INTENSIVE CARE UNIT	19,762,848		19,762,848				31
35	NEONATAL INTENSIVE CARE UNIT	5,662,475		5,662,475				35
41	SUBPROVIDER - IRF	8,304,278		8,304,278				41
43	NURSERY	3,765,588		3,765,588				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	87,503,489	79,382,014	166,885,503	0.231314	0.231314	0.232127	50
51	RECOVERY ROOM	7,576,561	8,532,639	16,109,200	0.158343	0.158343	0.158343	51
52	DELIVERY ROOM & LABOR ROOM	7,250,957	39,420	7,290,377	0.131718	0.131718	0.131718	52
54	RADIOLOGY-DIAGNOSTIC	11,178,733	36,883,998	48,062,731	0.195050	0.195050	0.195513	54
55	RADIOLOGY-THERAPEUTIC	330,005	86,361	416,366	0.662456	0.662456	0.662456	55
57	CT SCAN	15,293,909	32,818,394	48,112,303	0.046831	0.046831	0.046831	57
58	MRI	2,912,343	548,391	3,460,734	0.177853	0.177853	0.177853	58
59	CARDIAC CATHETERIZATION	18,536,805	23,853,011	42,389,816	0.293011	0.293011	0.293273	59
60	LABORATORY	53,846,635	34,248,425	88,095,060	0.200853	0.200853	0.200853	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	8,535,758	4,700,814	13,236,572	0.337789	0.337789	0.337804	65
66	PHYSICAL THERAPY	5,806,308	7,671,853	13,478,161	0.335873	0.335873	0.335873	66
67	OCCUPATIONAL THERAPY	4,392,713	941,896	5,334,609	0.226469	0.226469	0.226469	67
68	SPEECH PATHOLOGY	1,985,802	532,896	2,518,698	0.219201	0.219201	0.219201	68
69	ELECTROCARDIOLOGY	7,248,476	12,568,759	19,817,235	0.115000	0.115000	0.115218	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS	45,467,280	12,830,296	58,297,576	0.398812	0.398812	0.398812	72
73	DRUGS CHARGED TO PATIENTS	53,824,429	26,789,461	80,613,890	0.261985	0.261985	0.261985	73
74	RENAL DIALYSIS	1,295,181	454,953	1,750,134	0.659363	0.659363	0.659363	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	2,304	1,476,288	1,478,592	0.164317	0.164317	0.164317	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT		363,262	363,262	0.412273	0.412273	0.413181	90.02
90.03	FAMILY MEDICINE CENTER	92,232	2,999,758	3,091,990	0.523414	0.523414	0.523414	90.03
90.04	WOUND HEALING CENTER	18,201	2,641,163	2,659,364	0.742746	0.742746	0.742746	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	42,459	2,496,948	2,539,407	0.443640	0.443640	0.443640	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	305	272,264	272,569	2.207643	2.207643	2.218987	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC		535,704	535,704	0.969446	0.969446	1.172246	90.07
90.08	PODIATRY RESIDENCY CLINIC		223,316	223,316	1.214835	1.214835	1.315481	90.08
90.09	FACULTY PRACTICE CLINIC	14,250	607,783	622,033	0.683970	0.683970	0.683970	90.09
91	EMERGENCY	13,509,153	39,195,173	52,704,326	0.232779	0.232779	0.235191	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	891,761	7,660,730	8,552,491	1.089818	1.089818	1.089818	92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	473,544,081	341,355,970	814,900,051				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	473,544,081	341,355,970	814,900,051				202



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V PPS
 APPLICABLE 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	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	13,321,931		13,321,931	57,982	229.76	21,108	4,849,774	30
31	INTENSIVE CARE UNIT	1,704,216		1,704,216	5,282	322.65	2,167	699,183	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	NEONATAL INTENSIVE CARE UNIT	581,735		581,735	1,933	300.95			35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF	177,361		177,361	5,942	29.85	3,643	108,744	41
42	SUBPROVIDER I								42
43	NURSERY	128,338		128,338	3,363	38.16			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	15,913,581		15,913,581	74,502		26,918	5,657,701	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0012

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] 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	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	6,233,299	166,885,503	0.037351	49,104,982	1,834,120	50
51	RECOVERY ROOM	379,507	16,109,200	0.023558	2,811,449	66,232	51
52	DELIVERY ROOM & LABOR ROOM	27,732	7,290,377	0.003804	16,823	64	52
54	RADIOLOGY-DIAGNOSTIC	1,562,044	48,062,731	0.032500	5,130,565	166,743	54
55	RADIOLOGY-THERAPEUTIC	7,421	416,366	0.017823	81,577	1,454	55
57	CT SCAN	235,153	48,112,303	0.004888	6,712,330	32,810	57
58	MRI	10,580	3,460,734	0.003057	1,599,109	4,888	58
59	CARDIAC CATHETERIZATION	1,706,179	42,389,816	0.040250	8,164,593	328,625	59
60	LABORATORY	495,170	88,095,060	0.005621	23,744,262	133,466	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	458,523	13,236,572	0.034641	3,903,595	135,224	65
66	PHYSICAL THERAPY	429,372	13,478,161	0.031857	1,632,195	51,997	66
67	OCCUPATIONAL THERAPY	31,406	5,334,609	0.005887	1,070,984	6,305	67
68	SPEECH PATHOLOGY	13,891	2,518,698	0.005515	496,637	2,739	68
69	ELECTROCARDIOLOGY	327,211	19,817,235	0.016511	3,610,794	59,618	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS	375,147	58,297,576	0.006435	1,025,752	6,601	72
73	DRUGS CHARGED TO PATIENTS	878,128	80,613,890	0.010893	22,882,897	249,263	73
74	RENAL DIALYSIS	130,393	1,750,134	0.074505	494,081	36,812	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,238	1,478,592	0.002866			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT	3,038	363,262	0.008363			90.02
90.03	FAMILY MEDICINE CENTER	57,523	3,091,990	0.018604			90.03
90.04	WOUND HEALING CENTER	47,838	2,659,364	0.017989	202	4	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	181,171	2,539,407	0.071344			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	14,847	272,569	0.054471	113	6	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	13,891	535,704	0.025930			90.07
90.08	PODIATRY RESIDENCY CLINIC	12,425	223,316	0.055639			90.08
90.09	FACULTY PRACTICE CLINIC	14,410	622,033	0.023166			90.09
91	EMERGENCY	2,063,972	52,704,326	0.039161	5,946,976	232,890	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,140,452	8,552,491	0.250272	504,806	126,339	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	17,854,961	688,912,019		138,934,722	3,476,200	200

(A) Worksheet A line numbers



ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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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

	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.)	
(A)		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)		305,011			305,011	30
31	INTENSIVE CARE UNIT		77,665			77,665	31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	NEONATAL INTENSIVE CARE UNIT						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY		9,179			9,179	43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)		391,855			391,855	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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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

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	57,982	5.26	21,108	111,028	30
31	INTENSIVE CARE UNIT	5,282	14.70	2,167	31,855	31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	NEONATAL INTENSIVE CARE UNIT	1,933				35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	5,942		3,643		41
42	SUBPROVIDER I					42
43	NURSERY	3,363	2.73			43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	74,502		26,918	142,883	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0012

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	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)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			784,364		784,364	784,364	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT							90.02
90.03	FAMILY MEDICINE CENTER							90.03
90.04	WOUND HEALING CENTER							90.04
90.05	OUTPATIENT TREATMENT & INFUSION							90.05
90.06	PEDIATRIC SPECIALTY CLINIC							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC							90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC							90.09
91	EMERGENCY			278,748		278,748	278,748	91
92	OBSERVATION BEDS (NON-DISTINCT PART)			49,008		49,008	49,008	92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			1,112,120		1,112,120	1,112,120	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0012

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	166,885,503			49,104,982		17,462,023		50
51	RECOVERY ROOM	16,109,200			2,811,449		1,498,987		51
52	DELIVERY ROOM & LABOR ROOM	7,290,377			16,823				52
54	RADIOLOGY-DIAGNOSTIC	48,062,731			5,130,565		8,344,497		54
55	RADIOLOGY-THERAPEUTIC	416,366			81,577		22,816		55
57	CT SCAN	48,112,303			6,712,330		8,457,656		57
58	MRI	3,460,734			1,599,109		266,792		58
59	CARDIAC CATHETERIZATION	42,389,816			8,164,593		4,457,651		59
60	LABORATORY	88,095,060			23,744,262		5,167,483		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	13,236,572			3,903,595		360,166		65
66	PHYSICAL THERAPY	13,478,161			1,632,195		27,663		66
67	OCCUPATIONAL THERAPY	5,334,609			1,070,984				67
68	SPEECH PATHOLOGY	2,518,698			496,637		1,058		68
69	ELECTROCARDIOLOGY	19,817,235			3,610,794		5,109,219		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
72	IMPL. DEV. CHARGED TO PATIENTS	58,297,576			1,025,752		3,868,554		72
73	DRUGS CHARGED TO PATIENTS	80,613,890	0.009730	0.009730	22,882,897	222,651	7,440,053	72,392	73
74	RENAL DIALYSIS	1,750,134			494,081		44,126		74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,478,592					616,320		76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90.02	MOBILE MEDICAL UNIT	363,262							90.02
90.03	FAMILY MEDICINE CENTER	3,091,990							90.03
90.04	WOUND HEALING CENTER	2,659,364			202		293,810		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	2,539,407					1,979,337		90.05
90.06	PEDIATRIC SPECIALTY CLINIC	272,569			113		2,492		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	535,704							90.07
90.08	PODIATRY RESIDENCY CLINIC	223,316							90.08
90.09	FACULTY PRACTICE CLINIC	622,033							90.09
91	EMERGENCY	52,704,326	0.005289	0.005289	5,946,976	31,454	7,035,473	37,211	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	8,552,491	0.005730	0.005730	504,806	2,893	1,138,439	6,523	92
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (sum of lines 50-199)	688,912,019			138,934,722	256,998	73,594,615	116,126	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0012

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/MR

(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	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.231314	17,462,023			4,039,210			50
51	RECOVERY ROOM	0.158343	1,498,987			237,354			51
52	DELIVERY ROOM & LABOR ROOM	0.131718							52
54	RADIOLOGY-DIAGNOSTIC	0.195050	8,344,497			1,627,594			54
55	RADIOLOGY-THERAPEUTIC	0.662456	22,816			15,115			55
57	CT SCAN	0.046831	8,457,656			396,080			57
58	MRI	0.177853	266,792			47,450			58
59	CARDIAC CATHETERIZATION	0.293011	4,457,651			1,306,141			59
60	LABORATORY	0.200853	5,167,483			1,037,904			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.337789	360,166			121,660			65
66	PHYSICAL THERAPY	0.335873	27,663			9,291			66
67	OCCUPATIONAL THERAPY	0.226469							67
68	SPEECH PATHOLOGY	0.219201	1,058			232			68
69	ELECTROCARDIOLOGY	0.115000	5,109,219			587,560			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
72	IMPL. DEV. CHARGED TO PATIENTS	0.398812	3,868,554			1,542,826			72
73	DRUGS CHARGED TO PATIENTS	0.261985	7,440,053		123,681	1,949,182		32,403	73
74	RENAL DIALYSIS	0.659363	44,126			29,095			74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.164317	616,320			101,272			76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	MOBILE MEDICAL UNIT	0.412273							90.02
90.03	FAMILY MEDICINE CENTER	0.523414							90.03
90.04	WOUND HEALING CENTER	0.742746	293,810			218,226			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.443640	1,979,337			878,113			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.207643	2,492			5,501			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	0.969446							90.07
90.08	PODIATRY RESIDENCY CLINIC	1.214835							90.08
90.09	FACULTY PRACTICE CLINIC	0.683970							90.09
91	EMERGENCY	0.232779	7,035,473			1,637,710			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.089818	1,138,439			1,240,691			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		73,594,615		123,681	17,028,207		32,403	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		73,594,615		123,681	17,028,207		32,403	202

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T012

WORKSHEET D
PART II

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX [XX] 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	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	6,233,299	166,885,503	0.037351	13,455	503	50
51	RECOVERY ROOM	379,507	16,109,200	0.023558			51
52	DELIVERY ROOM & LABOR ROOM	27,732	7,290,377	0.003804			52
54	RADIOLOGY-DIAGNOSTIC	1,562,044	48,062,731	0.032500	56,265	1,829	54
55	RADIOLOGY-THERAPEUTIC	7,421	416,366	0.017823	17,217	307	55
57	CT SCAN	235,153	48,112,303	0.004888	46,497	227	57
58	MRI	10,580	3,460,734	0.003057	24,205	74	58
59	CARDIAC CATHETERIZATION	1,706,179	42,389,816	0.040250			59
60	LABORATORY	495,170	88,095,060	0.005621	803,753	4,518	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	458,523	13,236,572	0.034641	5,494	190	65
66	PHYSICAL THERAPY	429,372	13,478,161	0.031857	1,564,512	49,841	66
67	OCCUPATIONAL THERAPY	31,406	5,334,609	0.005887	1,466,556	8,634	67
68	SPEECH PATHOLOGY	13,891	2,518,698	0.005515	491,588	2,711	68
69	ELECTROCARDIOLOGY	327,211	19,817,235	0.016511			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS	375,147	58,297,576	0.006435	5,366	35	72
73	DRUGS CHARGED TO PATIENTS	878,128	80,613,890	0.010893	978,360	10,657	73
74	RENAL DIALYSIS	130,393	1,750,134	0.074505	30,132	2,245	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,238	1,478,592	0.002866			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT	3,038	363,262	0.008363			90.02
90.03	FAMILY MEDICINE CENTER	57,523	3,091,990	0.018604			90.03
90.04	WOUND HEALING CENTER	47,838	2,659,364	0.017989			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	181,171	2,539,407	0.071344			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	14,847	272,569	0.054471			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	13,891	535,704	0.025930			90.07
90.08	PODIATRY RESIDENCY CLINIC	12,425	223,316	0.055639			90.08
90.09	FACULTY PRACTICE CLINIC	14,410	622,033	0.023166			90.09
91	EMERGENCY	2,063,972	52,704,326	0.039161	3,760	147	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		8,552,491				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	15,714,509	688,912,019		5,507,160	81,918	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T012

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	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)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			784,364		784,364	784,364	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT							90.02
90.03	FAMILY MEDICINE CENTER							90.03
90.04	WOUND HEALING CENTER							90.04
90.05	OUTPATIENT TREATMENT & INFUSION							90.05
90.06	PEDIATRIC SPECIALTY CLINIC							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC							90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC							90.09
91	EMERGENCY			278,748		278,748	278,748	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			1,063,112		1,063,112	1,063,112	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T012

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5 ÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6 ÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	166,885,503			13,455				50
51	RECOVERY ROOM	16,109,200							51
52	DELIVERY ROOM & LABOR ROOM	7,290,377							52
54	RADIOLOGY-DIAGNOSTIC	48,062,731			56,265				54
55	RADIOLOGY-THERAPEUTIC	416,366			17,217				55
57	CT SCAN	48,112,303			46,497				57
58	MRI	3,460,734			24,205				58
59	CARDIAC CATHETERIZATION	42,389,816							59
60	LABORATORY	88,095,060			803,753				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	13,236,572			5,494				65
66	PHYSICAL THERAPY	13,478,161			1,564,512				66
67	OCCUPATIONAL THERAPY	5,334,609			1,466,556				67
68	SPEECH PATHOLOGY	2,518,698			491,588				68
69	ELECTROCARDIOLOGY	19,817,235							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
72	IMPL. DEV. CHARGED TO PATIENTS	58,297,576			5,366				72
73	DRUGS CHARGED TO PATIENTS	80,613,890	0.009730	0.009730	978,360	9,519			73
74	RENAL DIALYSIS	1,750,134			30,132				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,478,592							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	MOBILE MEDICAL UNIT	363,262							90.02
90.03	FAMILY MEDICINE CENTER	3,091,990							90.03
90.04	WOUND HEALING CENTER	2,659,364							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	2,539,407							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	272,569							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	535,704							90.07
90.08	PODIATRY RESIDENCY CLINIC	223,316							90.08
90.09	FACULTY PRACTICE CLINIC	622,033							90.09
91	EMERGENCY	52,704,326	0.005289	0.005289	3,760	20			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	8,552,491							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	688,912,019			5,507,160	9,539			200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T012

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [XX] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			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	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.231314							50
51	RECOVERY ROOM	0.158343							51
52	DELIVERY ROOM & LABOR ROOM	0.131718							52
54	RADIOLOGY-DIAGNOSTIC	0.195050							54
55	RADIOLOGY-THERAPEUTIC	0.662456							55
57	CT SCAN	0.046831							57
58	MRI	0.177853							58
59	CARDIAC CATHETERIZATION	0.293011							59
60	LABORATORY	0.200853							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.337789							65
66	PHYSICAL THERAPY	0.335873							66
67	OCCUPATIONAL THERAPY	0.226469							67
68	SPEECH PATHOLOGY	0.219201							68
69	ELECTROCARDIOLOGY	0.115000							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
72	IMPL. DEV. CHARGED TO PATIENTS	0.398812							72
73	DRUGS CHARGED TO PATIENTS	0.261985							73
74	RENAL DIALYSIS	0.659363							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.164317							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	MOBILE MEDICAL UNIT	0.412273							90.02
90.03	FAMILY MEDICINE CENTER	0.523414							90.03
90.04	WOUND HEALING CENTER	0.742746							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.443640							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.207643							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	0.969446							90.07
90.08	PODIATRY RESIDENCY CLINIC	1.214835							90.08
90.09	FACULTY PRACTICE CLINIC	0.683970							90.09
91	EMERGENCY	0.232779							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.089818							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V PPS
 APPLICABLE 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	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	13,321,931		13,321,931	57,982	229.76	1,799	413,338	30
31	INTENSIVE CARE UNIT	1,704,216		1,704,216	5,282	322.65	649	209,400	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	NEONATAL INTENSIVE CARE UNIT	581,735		581,735	1,933	300.95	1,055	317,502	35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF	177,361		177,361	5,942	29.85	333	9,940	41
42	SUBPROVIDER I								42
43	NURSERY	128,338		128,338	3,363	38.16	1,650	62,964	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	15,913,581		15,913,581	74,502		5,486	1,013,144	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0012

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] TEFRA
 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	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	6,233,299	166,885,503	0.037351	5,752,166	214,849	50
51	RECOVERY ROOM	379,507	16,109,200	0.023558	475,042	11,191	51
52	DELIVERY ROOM & LABOR ROOM	27,732	7,290,377	0.003804	3,385,164	12,877	52
54	RADIOLOGY-DIAGNOSTIC	1,562,044	48,062,731	0.032500	1,283,901	41,727	54
55	RADIOLOGY-THERAPEUTIC	7,421	416,366	0.017823	10,606	189	55
57	CT SCAN	235,153	48,112,303	0.004888	1,558,257	7,617	57
58	MRI	10,580	3,460,734	0.003057	355,915	1,088	58
59	CARDIAC CATHETERIZATION	1,706,179	42,389,816	0.040250	900,723	36,254	59
60	LABORATORY	495,170	88,095,060	0.005621	5,868,054	32,984	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	458,523	13,236,572	0.034641	1,767,033	61,212	65
66	PHYSICAL THERAPY	429,372	13,478,161	0.031857	229,743	7,319	66
67	OCCUPATIONAL THERAPY	31,406	5,334,609	0.005887	165,203	973	67
68	SPEECH PATHOLOGY	13,891	2,518,698	0.005515	102,180	564	68
69	ELECTROCARDIOLOGY	327,211	19,817,235	0.016511			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS	375,147	58,297,576	0.006435	1,772,045	11,403	72
73	DRUGS CHARGED TO PATIENTS	878,128	80,613,890	0.010893	7,797,358	84,937	73
74	RENAL DIALYSIS	130,393	1,750,134	0.074505	104,147	7,759	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,238	1,478,592	0.002866	2,304	7	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT	3,038	363,262	0.008363			90.02
90.03	FAMILY MEDICINE CENTER	57,523	3,091,990	0.018604			90.03
90.04	WOUND HEALING CENTER	47,838	2,659,364	0.017989			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	181,171	2,539,407	0.071344	1,987	142	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	14,847	272,569	0.054471	192	10	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	13,891	535,704	0.025930			90.07
90.08	PODIATRY RESIDENCY CLINIC	12,425	223,316	0.055639			90.08
90.09	FACULTY PRACTICE CLINIC	14,410	622,033	0.023166			90.09
91	EMERGENCY	2,063,972	52,704,326	0.039161	1,368,009	53,573	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,140,452	8,552,491	0.250272	64,458	16,132	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	17,854,961	688,912,019		32,964,487	602,807	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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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

		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.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)		305,011			305,011	30
31	INTENSIVE CARE UNIT		77,665			77,665	31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	NEONATAL INTENSIVE CARE UNIT						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY		9,179			9,179	43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)		391,855			391,855	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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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

		TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	57,982	5.26	1,799	9,463	30
31	INTENSIVE CARE UNIT	5,282	14.70	649	9,540	31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	NEONATAL INTENSIVE CARE UNIT	1,933		1,055		35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	5,942		333		41
42	SUBPROVIDER I					42
43	NURSERY	3,363	2.73	1,650	4,505	43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	74,502		5,486	23,508	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0012

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			784,364		784,364	784,364	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT							90.02
90.03	FAMILY MEDICINE CENTER							90.03
90.04	WOUND HEALING CENTER							90.04
90.05	OUTPATIENT TREATMENT & INFUSION							90.05
90.06	PEDIATRIC SPECIALTY CLINIC							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC							90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC							90.09
91	EMERGENCY			278,748		278,748	278,748	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			1,063,112		1,063,112	1,063,112	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0012

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5 ÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6 ÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	166,885,503			5,752,166				50
51	RECOVERY ROOM	16,109,200			475,042				51
52	DELIVERY ROOM & LABOR ROOM	7,290,377			3,385,164				52
54	RADIOLOGY-DIAGNOSTIC	48,062,731			1,283,901				54
55	RADIOLOGY-THERAPEUTIC	416,366			10,606				55
57	CT SCAN	48,112,303			1,558,257				57
58	MRI	3,460,734			355,915				58
59	CARDIAC CATHETERIZATION	42,389,816			900,723				59
60	LABORATORY	88,095,060			5,868,054				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	13,236,572			1,767,033				65
66	PHYSICAL THERAPY	13,478,161			229,743				66
67	OCCUPATIONAL THERAPY	5,334,609			165,203				67
68	SPEECH PATHOLOGY	2,518,698			102,180				68
69	ELECTROCARDIOLOGY	19,817,235							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
72	IMPL. DEV. CHARGED TO PATIENTS	58,297,576			1,772,045				72
73	DRUGS CHARGED TO PATIENTS	80,613,890	0.009730	0.009730	7,797,358	75,868			73
74	RENAL DIALYSIS	1,750,134			104,147				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,478,592			2,304				76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90.02	MOBILE MEDICAL UNIT	363,262							90.02
90.03	FAMILY MEDICINE CENTER	3,091,990							90.03
90.04	WOUND HEALING CENTER	2,659,364							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	2,539,407			1,987				90.05
90.06	PEDIATRIC SPECIALTY CLINIC	272,569			192				90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	535,704							90.07
90.08	PODIATRY RESIDENCY CLINIC	223,316							90.08
90.09	FACULTY PRACTICE CLINIC	622,033							90.09
91	EMERGENCY	52,704,326	0.005289	0.005289	1,368,009	7,235			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	8,552,491			64,458				92
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (sum of lines 50-199)	688,912,019			32,964,487	83,103			200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0012

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/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			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
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.231314						50
51	RECOVERY ROOM	0.158343						51
52	DELIVERY ROOM & LABOR ROOM	0.131718						52
54	RADIOLOGY-DIAGNOSTIC	0.195050						54
55	RADIOLOGY-THERAPEUTIC	0.662456						55
57	CT SCAN	0.046831						57
58	MRI	0.177853						58
59	CARDIAC CATHETERIZATION	0.293011						59
60	LABORATORY	0.200853						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.337789						65
66	PHYSICAL THERAPY	0.335873						66
67	OCCUPATIONAL THERAPY	0.226469						67
68	SPEECH PATHOLOGY	0.219201						68
69	ELECTROCARDIOLOGY	0.115000						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.398812						72
73	DRUGS CHARGED TO PATIENTS	0.261985						73
74	RENAL DIALYSIS	0.659363						74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.164317						76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	0.412273						90.02
90.03	FAMILY MEDICINE CENTER	0.523414						90.03
90.04	WOUND HEALING CENTER	0.742746						90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.443640						90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.207643						90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	0.969446						90.07
90.08	PODIATRY RESIDENCY CLINIC	1.214835						90.08
90.09	FACULTY PRACTICE CLINIC	0.683970						90.09
91	EMERGENCY	0.232779						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.089818						92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T012

WORKSHEET D
PART II

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [XX] TITLE XIX [XX] 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	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	6,233,299	166,885,503	0.037351			50
51	RECOVERY ROOM	379,507	16,109,200	0.023558			51
52	DELIVERY ROOM & LABOR ROOM	27,732	7,290,377	0.003804			52
54	RADIOLOGY-DIAGNOSTIC	1,562,044	48,062,731	0.032500	1,966	64	54
55	RADIOLOGY-THERAPEUTIC	7,421	416,366	0.017823			55
57	CT SCAN	235,153	48,112,303	0.004888			57
58	MRI	10,580	3,460,734	0.003057			58
59	CARDIAC CATHETERIZATION	1,706,179	42,389,816	0.040250	975	39	59
60	LABORATORY	495,170	88,095,060	0.005621	62,687	352	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	458,523	13,236,572	0.034641			65
66	PHYSICAL THERAPY	429,372	13,478,161	0.031857	169,509	5,400	66
67	OCCUPATIONAL THERAPY	31,406	5,334,609	0.005887	154,493	910	67
68	SPEECH PATHOLOGY	13,891	2,518,698	0.005515	101,092	558	68
69	ELECTROCARDIOLOGY	327,211	19,817,235	0.016511			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS	375,147	58,297,576	0.006435			72
73	DRUGS CHARGED TO PATIENTS	878,128	80,613,890	0.010893	157,325	1,714	73
74	RENAL DIALYSIS	130,393	1,750,134	0.074505	7,200	536	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,238	1,478,592	0.002866			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT	3,038	363,262	0.008363			90.02
90.03	FAMILY MEDICINE CENTER	57,523	3,091,990	0.018604			90.03
90.04	WOUND HEALING CENTER	47,838	2,659,364	0.017989			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	181,171	2,539,407	0.071344			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	14,847	272,569	0.054471			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	13,891	535,704	0.025930			90.07
90.08	PODIATRY RESIDENCY CLINIC	12,425	223,316	0.055639			90.08
90.09	FACULTY PRACTICE CLINIC	14,410	622,033	0.023166			90.09
91	EMERGENCY	2,063,972	52,704,326	0.039161			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		8,552,491				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	15,714,509	688,912,019		655,247	9,573	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T012

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	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)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			784,364		784,364	784,364	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT							90.02
90.03	FAMILY MEDICINE CENTER							90.03
90.04	WOUND HEALING CENTER							90.04
90.05	OUTPATIENT TREATMENT & INFUSION							90.05
90.06	PEDIATRIC SPECIALTY CLINIC							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC							90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC							90.09
91	EMERGENCY			278,748		278,748	278,748	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			1,063,112		1,063,112	1,063,112	200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T012

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5 ÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6 ÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	166,885,503							50
51	RECOVERY ROOM	16,109,200							51
52	DELIVERY ROOM & LABOR ROOM	7,290,377							52
54	RADIOLOGY-DIAGNOSTIC	48,062,731			1,966				54
55	RADIOLOGY-THERAPEUTIC	416,366							55
57	CT SCAN	48,112,303							57
58	MRI	3,460,734							58
59	CARDIAC CATHETERIZATION	42,389,816			975				59
60	LABORATORY	88,095,060			62,687				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	13,236,572							65
66	PHYSICAL THERAPY	13,478,161			169,509				66
67	OCCUPATIONAL THERAPY	5,334,609			154,493				67
68	SPEECH PATHOLOGY	2,518,698			101,092				68
69	ELECTROCARDIOLOGY	19,817,235							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
72	IMPL. DEV. CHARGED TO PATIENTS	58,297,576							72
73	DRUGS CHARGED TO PATIENTS	80,613,890	0.009730	0.009730	157,325	1,531			73
74	RENAL DIALYSIS	1,750,134			7,200				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,478,592							76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90.02	MOBILE MEDICAL UNIT	363,262							90.02
90.03	FAMILY MEDICINE CENTER	3,091,990							90.03
90.04	WOUND HEALING CENTER	2,659,364							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	2,539,407							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	272,569							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	535,704							90.07
90.08	PODIATRY RESIDENCY CLINIC	223,316							90.08
90.09	FACULTY PRACTICE CLINIC	622,033							90.09
91	EMERGENCY	52,704,326	0.005289	0.005289					91
92	OBSERVATION BEDS (NON-DISTINCT PART)	8,552,491							92
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (sum of lines 50-199)	688,912,019			655,247	1,531			200

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T012

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [XX] TITLE XIX - O/P [XX] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			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	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.231314							50
51	RECOVERY ROOM	0.158343							51
52	DELIVERY ROOM & LABOR ROOM	0.131718							52
54	RADIOLOGY-DIAGNOSTIC	0.195050							54
55	RADIOLOGY-THERAPEUTIC	0.662456							55
57	CT SCAN	0.046831							57
58	MRI	0.177853							58
59	CARDIAC CATHETERIZATION	0.293011							59
60	LABORATORY	0.200853							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.337789							65
66	PHYSICAL THERAPY	0.335873							66
67	OCCUPATIONAL THERAPY	0.226469							67
68	SPEECH PATHOLOGY	0.219201							68
69	ELECTROCARDIOLOGY	0.115000							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
72	IMPL. DEV. CHARGED TO PATIENTS	0.398812							72
73	DRUGS CHARGED TO PATIENTS	0.261985							73
74	RENAL DIALYSIS	0.659363							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.164317							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	MOBILE MEDICAL UNIT	0.412273							90.02
90.03	FAMILY MEDICINE CENTER	0.523414							90.03
90.04	WOUND HEALING CENTER	0.742746							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.443640							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.207643							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	0.969446							90.07
90.08	PODIATRY RESIDENCY CLINIC	1.214835							90.08
90.09	FACULTY PRACTICE CLINIC	0.683970							90.09
91	EMERGENCY	0.232779							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.089818							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0012

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	57,982	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	57,982	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	48,666	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	21,108	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	58,010,813	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	58,010,813	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 - line 36)	58,010,813	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0012

WORKSHEET D-1
PART II

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) PPS
 APPLICABLE 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)					1,000.50	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					21,118,554	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)					21,118,554	41
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	10,361,470	5,282	1,961.66	2,167	4,250,917	43	
44						44	
45						45	
46						46	
47	3,275,597	1,933	1,694.57			47	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					31,978,782	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					57,348,253	49
PASS-THROUGH COST ADJUSTMENTS							
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					5,691,840	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					3,733,198	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					9,425,038	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					47,923,215	53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0012

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR 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)					9,316	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,000.50	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					9,320,658	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 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	13,321,931	58,010,813	0.229646	9,320,658	2,140,452	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST	305,011	58,010,813	0.005258	9,320,658	49,008	92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T012

WORKSHEET D-1
PART I

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR 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)	5,942	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	5,942	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	5,942	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	3,643	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,820,192	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,820,192	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 - line 36)	4,820,192	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T012

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	811.21	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	2,955,238	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)	2,955,238	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	1,439,876	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	4,395,114	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	108,744	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	91,457	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	200,201	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	4,194,913	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0012

WORKSHEET D-1
PART I

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR 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)	57,982	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	57,982	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	48,666	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,799	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)	3,363	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	1,650	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)	58,010,813	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	58,010,813	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 - line 36)	58,010,813	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0012

WORKSHEET D-1
PART II

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) PPS
 APPLICABLE 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)				1,000.50	38	
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)				1,799,900	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)				1,799,900	41	
42	NURSERY (Titles V and XIX only)	5,361,690	3,363	1,594.32	1,650	2,630,628	42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS							
43	INTENSIVE CARE UNIT	10,361,470	5,282	1,961.66	649	1,273,117	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	NEONATAL INTENSIVE CARE UNIT	3,275,597	1,933	1,694.57	1,055	1,787,771	47
PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)							
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)				7,639,173	48	
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)				15,130,589	49	
PASS-THROUGH COST ADJUSTMENTS							
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)				1,026,712	50	
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)				685,910	51	
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)				1,712,622	52	
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)				13,417,967	53	
TARGET AMOUNT AND LIMIT COMPUTATION							
54	PROGRAM DISCHARGES					54	
55	TARGET AMOUNT PER DISCHARGE					55	
56	TARGET AMOUNT (line 54 x line 55)					56	
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)					57	
58	BONUS PAYMENT (see instructions)					58	
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET					59	
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET					60	
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)					61	
62	RELIEF PAYMENT (see instructions)					62	
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)					63	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					64	
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					65	
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)					66	
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)					67	
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)					68	
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)					69	



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0012

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR 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)					9,316	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL 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 COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T012

WORKSHEET D-1
PART I

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR 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)	5,942	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	5,942	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	5,942	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	333	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,820,192	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,820,192	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 - line 36)	4,820,192	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T012

WORKSHEET D-1
PART II

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) PPS
 APPLICABLE 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
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	811.21 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	270,133 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)	270,133 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	173,305 48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	443,438 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	9,940 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	11,104 51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	21,044 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	422,394 53
TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES	54
55	TARGET AMOUNT PER DISCHARGE	55
56	TARGET AMOUNT (line 54 x line 55)	56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)	57
58	BONUS PAYMENT (see instructions)	58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)	61
62	RELIEF PAYMENT (see instructions)	62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)	63
PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)	69



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ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0012

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		36,043,580		30
31	INTENSIVE CARE UNIT		7,899,239		31
35	NEONATAL INTENSIVE CARE UNIT				35
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.232127	49,104,982	11,398,592	50
51	RECOVERY ROOM	0.158343	2,811,449	445,173	51
52	DELIVERY ROOM & LABOR ROOM	0.131718	16,823	2,216	52
54	RADIOLOGY-DIAGNOSTIC	0.195513	5,130,565	1,003,092	54
55	RADIOLOGY-THERAPEUTIC	0.662456	81,577	54,041	55
57	CT SCAN	0.046831	6,712,330	314,345	57
58	MRI	0.177853	1,599,109	284,406	58
59	CARDIAC CATHETERIZATION	0.293273	8,164,593	2,394,455	59
60	LABORATORY	0.200853	23,744,262	4,769,106	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.337804	3,903,595	1,318,650	65
66	PHYSICAL THERAPY	0.335873	1,632,195	548,210	66
67	OCCUPATIONAL THERAPY	0.226469	1,070,984	242,545	67
68	SPEECH PATHOLOGY	0.219201	496,637	108,863	68
69	ELECTROCARDIOLOGY	0.115218	3,610,794	416,028	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				71
72	IMPL. DEV. CHARGED TO PATIENTS	0.398812	1,025,752	409,082	72
73	DRUGS CHARGED TO PATIENTS	0.261985	22,882,897	5,994,976	73
74	RENAL DIALYSIS	0.659363	494,081	325,779	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.164317			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.02	MOBILE MEDICAL UNIT	0.413181			90.02
90.03	FAMILY MEDICINE CENTER	0.523414			90.03
90.04	WOUND HEALING CENTER	0.742746	202	150	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.443640			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.218987	113	251	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	1.172246			90.07
90.08	PODIATRY RESIDENCY CLINIC	1.315481			90.08
90.09	FACULTY PRACTICE CLINIC	0.683970			90.09
91	EMERGENCY	0.235191	5,946,976	1,398,675	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.089818	504,806	550,147	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		138,934,722	31,978,782	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		138,934,722		202

(A) Worksheet A line numbers



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T012

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
35	NEONATAL INTENSIVE CARE UNIT				35
41	SUBPROVIDER - IRF		5,085,907		41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.232127	13,455	3,123	50
51	RECOVERY ROOM	0.158343			51
52	DELIVERY ROOM & LABOR ROOM	0.131718			52
54	RADIOLOGY-DIAGNOSTIC	0.195513	56,265	11,001	54
55	RADIOLOGY-THERAPEUTIC	0.662456	17,217	11,406	55
57	CT SCAN	0.046831	46,497	2,178	57
58	MRI	0.177853	24,205	4,305	58
59	CARDIAC CATHETERIZATION	0.293273			59
60	LABORATORY	0.200853	803,753	161,436	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.337804	5,494	1,856	65
66	PHYSICAL THERAPY	0.335873	1,564,512	525,477	66
67	OCCUPATIONAL THERAPY	0.226469	1,466,556	332,129	67
68	SPEECH PATHOLOGY	0.219201	491,588	107,757	68
69	ELECTROCARDIOLOGY	0.115218			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				71
72	IMPL. DEV. CHARGED TO PATIENTS	0.398812	5,366	2,140	72
73	DRUGS CHARGED TO PATIENTS	0.261985	978,360	256,316	73
74	RENAL DIALYSIS	0.659363	30,132	19,868	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.164317			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.02	MOBILE MEDICAL UNIT	0.413181			90.02
90.03	FAMILY MEDICINE CENTER	0.523414			90.03
90.04	WOUND HEALING CENTER	0.742746			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.443640			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.218987			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	1.172246			90.07
90.08	PODIATRY RESIDENCY CLINIC	1.315481			90.08
90.09	FACULTY PRACTICE CLINIC	0.683970			90.09
91	EMERGENCY	0.235191	3,760	884	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.089818			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		5,507,160	1,439,876	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		5,507,160		202

(A) Worksheet A line numbers



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0012

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		9,837,722		30
31	INTENSIVE CARE UNIT		2,061,410		31
35	NEONATAL INTENSIVE CARE UNIT		2,739,145		35
41	SUBPROVIDER - IRF				41
43	NURSERY		1,754,744		43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.232127	5,752,166	1,335,233	50
51	RECOVERY ROOM	0.158343	475,042	75,220	51
52	DELIVERY ROOM & LABOR ROOM	0.131718	3,385,164	445,887	52
54	RADIOLOGY-DIAGNOSTIC	0.195513	1,283,901	251,019	54
55	RADIOLOGY-THERAPEUTIC	0.662456	10,606	7,026	55
57	CT SCAN	0.046831	1,558,257	72,975	57
58	MRI	0.177853	355,915	63,301	58
59	CARDIAC CATHETERIZATION	0.293273	900,723	264,158	59
60	LABORATORY	0.200853	5,868,054	1,178,616	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.337804	1,767,033	596,911	65
66	PHYSICAL THERAPY	0.335873	229,743	77,164	66
67	OCCUPATIONAL THERAPY	0.226469	165,203	37,413	67
68	SPEECH PATHOLOGY	0.219201	102,180	22,398	68
69	ELECTROCARDIOLOGY	0.115218			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				71
72	IMPL. DEV. CHARGED TO PATIENTS	0.398812	1,772,045	706,713	72
73	DRUGS CHARGED TO PATIENTS	0.261985	7,797,358	2,042,791	73
74	RENAL DIALYSIS	0.659363	104,147	68,671	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.164317	2,304	379	76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.02	MOBILE MEDICAL UNIT	0.413181			90.02
90.03	FAMILY MEDICINE CENTER	0.523414			90.03
90.04	WOUND HEALING CENTER	0.742746			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.443640	1,987	882	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.218987	192	426	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	1.172246			90.07
90.08	PODIATRY RESIDENCY CLINIC	1.315481			90.08
90.09	FACULTY PRACTICE CLINIC	0.683970			90.09
91	EMERGENCY	0.235191	1,368,009	321,743	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.089818	64,458	70,247	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		32,964,487	7,639,173	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		32,964,487		202

(A) Worksheet A line numbers



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T012

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/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
35	NEONATAL INTENSIVE CARE UNIT				35
41	SUBPROVIDER - IRF		579,459		41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.232127			50
51	RECOVERY ROOM	0.158343			51
52	DELIVERY ROOM & LABOR ROOM	0.131718			52
54	RADIOLOGY-DIAGNOSTIC	0.195513	1,966	384	54
55	RADIOLOGY-THERAPEUTIC	0.662456			55
57	CT SCAN	0.046831			57
58	MRI	0.177853			58
59	CARDIAC CATHETERIZATION	0.293273	975	286	59
60	LABORATORY	0.200853	62,687	12,591	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.337804			65
66	PHYSICAL THERAPY	0.335873	169,509	56,933	66
67	OCCUPATIONAL THERAPY	0.226469	154,493	34,988	67
68	SPEECH PATHOLOGY	0.219201	101,092	22,159	68
69	ELECTROCARDIOLOGY	0.115218			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				71
72	IMPL. DEV. CHARGED TO PATIENTS	0.398812			72
73	DRUGS CHARGED TO PATIENTS	0.261985	157,325	41,217	73
74	RENAL DIALYSIS	0.659363	7,200	4,747	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.164317			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.02	MOBILE MEDICAL UNIT	0.413181			90.02
90.03	FAMILY MEDICINE CENTER	0.523414			90.03
90.04	WOUND HEALING CENTER	0.742746			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.443640			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.218987			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	1.172246			90.07
90.08	PODIATRY RESIDENCY CLINIC	1.315481			90.08
90.09	FACULTY PRACTICE CLINIC	0.683970			90.09
91	EMERGENCY	0.235191			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.089818			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		655,247	173,305	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		655,247		202

(A) Worksheet A line numbers



ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK

APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	10,231,287			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	30,657,831			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	1,560,882			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	15,312,949			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	232.48			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)	17.61			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)	1.02			7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)	5.87			8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)	22.46			9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	26.67			10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS	5.00			11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)	27.46			12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	26.46			13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	25.46			14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	26.46			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	26.46			18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)	0.113816			19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)	0.112980			20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)	0.112980			21
22	IME PAYMENT ADJUSTMENT (see instructions)	3,361,558			22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)	4.21			24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)	3,361,558			29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0421			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.1714			31
32	SUM OF LINES 30 AND 31	0.2135			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0762			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	1,363,656			34
		PRIOR TO	ON OR AFTER		
		OCTOBER 1	OCTOBER 1		
	UNCOMPENSATED CARE ADJUSTMENT				
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		2,607,154		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		1,950,008		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	1,950,008			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40



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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK

APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
41.01	TOTAL ESRD MEDICARE COVERED AND PAID DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41.01
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41.01 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41.01)				46
47	SUBTOTAL (see instructions)	49,125,222			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	49,125,222			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	4,238,456			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)	1,474,400			52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	282,829			53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS	142,883			57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)	256,998			58
59	TOTAL (sum of amounts on lines 49 through 58)	55,520,788			59
60	PRIMARY PAYER PAYMENTS	20,409			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	55,500,379			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	4,492,544			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	132,776			63
64	ALLOWABLE BAD DEBTS (see instructions)	308,367			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	200,439			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	51,075,498			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	15,293			70.93
71	AMOUNT DUE PROVIDER (see instructions)	51,090,791			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	1,021,816			71.01
72	INTERIM PAYMENTS	50,078,794			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	-9,819			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	1,814,766			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2				91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)				94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (see instructions)				95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)				96



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0012

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)	32,403			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)	16,912,081			2
3	PPS PAYMENTS	15,833,557			3
4	OUTLIER PAYMENT (see instructions)	84,538			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)	0,906			5
6	LINE 2 TIMES LINE 5	15,322,345			6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200	116,126			9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	32,403			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	123,681			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	123,681			14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)	123,681			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	91,278			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)	32,403			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	16,034,221			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	3,282,939			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	12,783,685			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)	407,335			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	13,191,020			30
31	PRIMARY PAYER PAYMENTS	8,323			31
32	SUBTOTAL (line 30 minus line 31)	13,182,697			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	455,775			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	296,254			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)	13,478,951			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	13,478,951			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	269,579			40.01
41	INTERIM PAYMENTS	13,284,934			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-75,562			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (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



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T012

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				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)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL ((lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)				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)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (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



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-0012

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	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		49,473,253		13,188,131	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)	PROGRAM	.01 02/13/2014 39,600	02/13/2014	58,200	3.01
		TO	.02 02/10/2015 565,941	02/10/2015	38,603	3.02
		PROVIDER	.03			3.03
			.04			3.04
			.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)		605,541		96,803	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)		50,078,794		13,284,934	4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
		PROGRAM	.01			5.01
		TO	.02			5.02
		PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.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)					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)		.01			6.01
			.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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



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ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-T012

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	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		4,780,098		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)				
					3.01
					3.02
					3.03
					3.04
					3.05
					3.06
					3.07
					3.08
					3.09
					3.10
					3.10
					3.50
					3.51
					3.52
					3.53
					3.54
					3.55
					3.56
					3.57
					3.58
					3.59
					3.99
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-36,514		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)		4,743,584		4
TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)				
					5.01
					5.02
					5.03
					5.04
					5.05
					5.06
					5.07
					5.08
					5.09
					5.10
					5.10
					5.51
					5.52
					5.53
					5.54
					5.55
					5.56
					5.57
					5.58
					5.59
					5.99
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)				6.01
					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	
					8

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL [] CAH
APPLICABLE BOX:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	13,716	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	23,275	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	8,662	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	55,881	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	814,900,051	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	15,796,195	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	1,315,205	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	26,304	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,288,901	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	41,910	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	1,246,991	32



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T012

WORKSHEET E-3
PART III

CHECK [] HOSPITAL
 APPLICABLE [XX] SUBPROVIDER IRF
 BOX:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	4,717,697		1
2	MEDICARE SSI RATIO (see instructions)	0.015700		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	190,123		3
4	OUTLIER PAYMENTS			4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (see instructions)	0.38		5
5.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)			5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)			6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)	0.38		7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)	0.38		9
10	AVERAGE DAILY CENSUS (see instructions)	16,279,452		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)	0.015992	0.023727	11
12	TEACHING ADJUSTMENT (see instructions)	75,445		12
13	TOTAL PPS PAYMENT (see instructions)	4,983,265		13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)			14
15	ORGAN ACQUISITION			15
16	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			16
17	SUBTOTAL (see instructions)	4,983,265		17
18	PRIMARY PAYER PAYMENTS			18
19	SUBTOTAL (line 17 less line 18)	4,983,265		19
20	DEDUCTIBLES	25,184		20
21	SUBTOTAL (line 19 minus line 20)	4,958,081		21
22	COINSURANCE	10,064		22
23	SUBTOTAL (line 21 minus line 22)	4,948,017		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	663		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	431		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			26
27	SUBTOTAL (sum of lines 23 and 25)	4,948,448		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)	9,539		29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	4,957,987		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	99,160		32.01
33	INTERIM PAYMENTS	4,743,584		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	115,243		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	21,905		36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART III, LINE 4 (see instructions)			50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)			51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)			52
53	TIME VALUE OF MONEY (see instructions)			53



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0012

WORKSHEET E-3
PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9	32,964,487		9
10			10
11			11
12	32,964,487		12
CUSTOMARY CHARGES			
13			13
14			14
15	1	1	15
16	32,964,487		16
17	32,964,487		17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26	106,611		26
27	106,611		27
28			28
29	106,611		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	106,611		31
32			32
33			33
34			34
35			35
36	106,611		36
37			37
38	106,611		38
39			39
40	106,611		40
41			41
42	106,611		42
43			43



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ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T012

WORKSHEET E-3
PART VII

CHECK TITLE V HOSPITAL NF PPS
 APPLICABLE TITLE XIX SUBPROVIDER IRF ICF/MR TEFRA
 BOXES: 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	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9	655,247		9
10			10
11			11
12	655,247		12
CUSTOMARY CHARGES			
13			13
14			14
15	1	1	15
16	655,247		16
17	655,247		17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26	1,531		26
27	1,531		27
28			28
29	1,531		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	1,531		31
32			32
33			33
34			34
35			35
36	1,531		36
37			37
38	1,531		38
39			39
40	1,531		40
41			41
42	1,531		42
43			43



ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII
 BOX: [] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			22.87	1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			2.14	3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011)			7.00	4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			27.73	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)			27.23	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			27.23	7
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	26.67	0.25	26.92	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	26.67	0.25	26.92	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		4.00		10
11	TOTAL WEIGHTED FTE COUNT	26.67	4.25		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	24.96	4.00		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	26.04	3.00		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	25.89	3.75		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	25.89	3.75		17
18	PER RESIDENT AMOUNT	115,694.60	92,982.64		18
19	APPROVED AMOUNT FOR RESIDENT COSTS	2,995,333	348,685	3,344,018	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)			3,344,018	25
COMPUTATION OF PROGRAM PATIENT LOAD					
26	INPATIENT DAYS	26,918	9,166		26
27	TOTAL INPATIENT DAYS (see instructions)	61,823	61,823		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.435404	0.148262		28
29	PROGRAM DIRECT GME AMOUNT	1,455,999	495,791		29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		70,055		30
31	NET PROGRAM DIRECT GME AMOUNT			1,881,735	31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)			1,750,134	33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)				36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME					
PART A REASONABLE COST					
37	REASONABLE COST (see instructions)			61,743,367	37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)			20,409	40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			61,722,958	41
PART B REASONABLE COST					
42	REASONABLE COST (see instructions)			17,060,610	42
43	PRIMARY PAYER PAYMENTS (see instructions)			8,323	43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			17,052,287	44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			78,775,245	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			0.783532	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)			0.216468	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	TOTAL PROGRAM GME PAYMENT (line 31)			1,881,735	48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)			1,474,400	49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)			407,335	50



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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII
 BOX: [XX] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
		PRIMARY CARE	OTHER	TOTAL
		1	2	3
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)			2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))			4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)			6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			7
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.00	0.00	0.00
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.00	0.00	0.00
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00	
11	TOTAL WEIGHTED FTE COUNT	0.00	0.00	
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.00	0.00	
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.00	0.00	
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.00	0.00	
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00	
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00	
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.00	0.00	
18	PER RESIDENT AMOUNT	0.00	0.00	
19	APPROVED AMOUNT FOR RESIDENT COSTS			
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)			21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)			22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)			23
24	MULTIPLY LINE 22 TIMES LINE 23			24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)			25
COMPUTATION OF PROGRAM PATIENT LOAD				
26	INPATIENT DAYS	3,836	4,926	26
27	TOTAL INPATIENT DAYS (see instructions)	61,823	61,823	27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.062048	0.079679	28
29	PROGRAM DIRECT GME AMOUNT			29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE			30
31	NET PROGRAM DIRECT GME AMOUNT			31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)			32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)			33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)			34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)			35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)			36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
PART A REASONABLE COST				
37	REASONABLE COST (see instructions)			37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)			38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)			39
40	PRIMARY PAYER PAYMENTS (see instructions)			40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			41
PART B REASONABLE COST				
42	REASONABLE COST (see instructions)			42
43	PRIMARY PAYER PAYMENTS (see instructions)			43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)			47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (line 31)			48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)			49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)			50



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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)

ASSETS (Omit Cents)		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	39,177,000				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	55,873,000				4
5	OTHER RECEIVABLES	2,877,000				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-13,709,000				6
7	INVENTORY	5,235,000				7
8	PREPAID EXPENSES	1,669,000				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	91,122,000				11
FIXED ASSETS						
12	LAND					12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	322,821,000				15
16	ACCUMULATED DEPRECIATION					16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT					23
24	ACCUMULATED DEPRECIATION					24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	322,821,000				30
OTHER ASSETS						
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	2,877,000				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	2,877,000				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	416,820,000				36
LIABILITIES AND FUND BALANCES						
LIABILITIES AND FUND BALANCES (Omit Cents)		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	9,296,000				37
38	SALARIES, WAGES & FEES PAYABLE	7,605,000				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	7,365,000				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	3,499,000				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	27,765,000				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	317,523,000				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	3,004,000				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	320,527,000				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	348,292,000				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	68,528,000				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	68,528,000				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	416,820,000				60



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		58,976,982			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		9,551,018			2
3	TOTAL (sum of line 1 and line 2)		68,528,000			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		68,528,000			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		68,528,000			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)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19



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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	475,274,000		475,274,000	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	475,274,000		475,274,000	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	NEONATAL INTENSIVE CARE UNIT				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	475,274,000		475,274,000	17
18	ANCILLARY SERVICES		344,503,000	344,503,000	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	475,274,000	344,503,000	819,777,000	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		284,046,982	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		284,046,982	43



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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	819,777,000	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	533,512,000	2
3	NET PATIENT REVENUES (line 1 minus line 2)	286,265,000	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	284,046,982	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	2,218,018	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER REVENUE)	6,359,000	24
24.02	OTHER (RESTRICTED ASSETS RELEASED)	974,000	24.02
25	TOTAL OTHER INCOME (sum of lines 6-24)	7,333,000	25
26	TOTAL (line 5 plus line 25)	9,551,018	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	9,551,018	29



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0012

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	3,247,855	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	684,978	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	153.10	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)	26.46	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)	5.00	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)	162,393	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0421	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.1714	8
9	SUM OF LINES 7 AND 8	0.2135	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0441	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	143,230	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	4,238,456	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0012

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17



COMPU-MAX

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 03/12/2015 Run Time: 10:18 Version: 2014.10
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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	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	NONPATIENT TELEPHONES						5.01
5.04	ADMITTING						5.04
5.06	OTHER ADMINISTRATIVE & 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
18	STERILE SUPPLY						18
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
23.01	CLINICAL PASTORAL EDUCATION						23.01
23.02	PHARMACY RESIDENCY PROGRAM						23.02
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
31	INTENSIVE CARE UNIT						31
35	NEONATAL INTENSIVE CARE UNIT						35
41	SUBPROVIDER - IRF						41
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
51	RECOVERY ROOM						51
52	DELIVERY ROOM & LABOR ROOM						52
54	RADIOLOGY-DIAGNOSTIC						54
55	RADIOLOGY-THERAPEUTIC						55
57	CT SCAN						57
58	MRI						58
59	CARDIAC CATHETERIZATION						59
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT						90.02
90.03	FAMILY MEDICINE CENTER						90.03
90.04	WOUND HEALING CENTER						90.04
90.05	OUTPATIENT TREATMENT & INFUSION						90.05
90.06	PEDIATRIC SPECIALTY CLINIC						90.06
90.07	SPORTS MED FELLOWSHIP CLINIC						90.07
90.08	PODIATRY RESIDENCY CLINIC						90.08
90.09	FACULTY PRACTICE CLINIC						90.09
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192	PHYSICIANS' PRIVATE OFFICES						192
192.01	MATERNAL FETAL MEDICINE/LABORIST						192.01



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
192.02	NEONATOLOGISTS							192.02
192.03	HOSPITALISTS/INTENSIVISTS							192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES							194.01
194.02	KINDRED/OUR LADY OF PEACE							194.02
194.03	ADVANCED SPECIALTIES							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202