Health Financia	al Systems	MEMORIAL HOSPITAL OF SOU	UTH BEND, INC	In Lie	eu of Form CMS-	-2552-1
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Failu	ire to report can re	sult in all interim	FORM APPROVED	5
payments made	since the beginning of the cost	reporting period being d	leemed overpayments	(42 USC 1395g).	OMB NO. 0938-	-0050
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION   Provider CCN: 150058   Period: From 01/01/2014   To 12/31/2014						
PART I - COST	REPORT STATUS					
	1. [ X ] Electronically filed cos			Date: 5/29/20	D15 Time: '	9:45 an
use only	2. [ ] Manually submitted cost	report				
	3. [ 0 ] If this is an amended re 4. [ F ] Medicare Utilization. E			r resubmitted this o	ost report	
Contractor use only	5. [ 1 ]Cost Report Status 6. (1) As Submitted 7. (2) Settled without Audit 8.	Contractor No.	this Provider CCN 1	O. NPR Date: 1. Contractor's Vend 2. [ O ]If line 5, co	olumn 1 is 4: E	
	(3) Sattled with Audit 9.	[ N ] Final Report for th	nis Provider CCN	number of ti	mes reopened =	0-9

PART II - CERTIFICATION

(4) Reopened (5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL OF SOUTH BEND, INC (150058) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)						
_		Offi cer	or	Admi ni strator	of Provid	der(s)
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			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	150, 247	-69, 303	-64, 097	0	1.00
2.00	Subprovider - IPF	0	90	0		0	2.00
3.00	Subprovider - IRF	0	22, 168	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	172, 505	-69, 303	-64, 097	0	200. 00

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 and review the 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 the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150058 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 9:20 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 615 N MICHIGAN ST 1.00 PO Box: 1.00 State: IN 2.00 City: SOUTH BEND Zip Code: 46601 County: ST. **JOSEPH** 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type V XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 MEMORIAL HOSPITAL OF 150058 43780 01/01/1984 Ν Р Р 3.00 1 SOUTH BEND, INC Subprovider - IPF PSYCHIATRIC UNIT 43780 Р 4.00 15S058 04/07/2011 Р 4 00 4 N 5.00 Subprovider - IRF REHABILITATION UNIT 15T058 43780 5 01/01/1984 Ν Ρ Ρ 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2014 12/31/2014 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Υ N 22.00 share hospital adjustment, 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 Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Υ Υ 22.01 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) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23 00 3 Ν 23 00 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 enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for ves or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days el i gi bl e unpai d unpai d davs 1.00 2.00 3. 00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 11, 886 7, 980 2, 656 7, 996 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 625 320 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

Heal th	Financial Systems MEMORIAL HOSP	PLTAL O	F SOUTH BEND,	INC	I	n Lie	u of Form	n CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der	F	Period: From 01/01, To 12/31,		Workshe Part I Date/Ti	me Pre	pared:
					Urban/Ru			Geogr	
26. 00	Enter your standard geographic classification (not wa			eginning of the	1.00	1	2.0	0	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	ige) sta	atus at the er	nd of the cost		1			27. 00
35. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	cation	in column 2.			0			35. 00
	jerreet in the cost reporting period.				Begi nni	_	Endi r		
36. 00	Enter applicable beginning and ending dates of SCH st		Subscript line	e 36 for number	1.00	)	2.0	0	36. 00
37. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter in effect in the cost reporting period.		umber of peric	ods MDH status		0			37. 00
38. 00	Enter applicable beginning and ending dates of MDH st of periods in excess of one and enter subsequent date		Subscript line	e 38 for number					38. 00
					1. 00		Y/N 2.0		
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	)? Ente Jui remer	er in column 1 nts in accorda	"Y" for yes ance with 42		<u>,                                      </u>	N N		39. 00
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	adjust er 1. E	tment? Enter " Enter "Y" for	Y" for yes or	N		N		40. 00
	Into the condimit 2, not an scharges on or after october 1.	(366 )	i iisti ucti olis)			V 1.00	XVIII 0 2.00	XI X 3. 00	
45.00	Prospective Payment System (PPS)-Capital		-1:						45.00
46. 00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce					N N	Y N	N N	45. 00 46. 00
47.00	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capi					N	N	N	47. 00
	Is the facility electing full federal capital payment Teaching Hospitals					N	N	N	48. 00
56. 00	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME program	ns? Enter "Y"	for yes	Y			56. 00
57. 00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	yes or th of th ", comp	r "N" for no i his cost repor plete Workshee	n column 1. If ting period?	column 1 Enter "Y"	N			57.00
58. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk	ursemer	nt for physici	ans' services	as	N			58. 00
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health	, compl costs 1	lete Wkst. D-2 for a program	that meets the		N Y			59. 00 60. 00
	provider-operated criteria under §413.85? Enter "Y"	for yes	s or "N" for r	no. (see instru Direct GME	ctions)		Di rect	GME	
		1. 00	2. 00	3. 00	4.00	)	5. 0		
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	Y				3. 00			61.00
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		16. 7	21. 7	6				61. 01
61. 02	instructions) 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		16. 7	27. 1	7				61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		16. 7	21.7	8				61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		19. 7	27. 1	7				61. 04
61. 05	current cost reporting period (see instructions). 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		3.0	5.3	9				61. 05
61. 06	61.04 minus line 61.03). (see instructions) 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)		3.0	3.0	o				61. 06
	pare or general surgery. (see this tructions)	I	I	1	1		I		I

Health Financial Systems	MEMORIAL HOSE	PITAL OF SOU	TH BEND, I	I NC	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ιΤΑ	Provi der		eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-2 Part I Date/Time Pre 5/29/2015 9:20	pared:
		Program	Name	Program Code	Unweighted IME FTE Count		
		1.0	0	2. 00	3.00	4.00	
61.10 Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instructions in the program code, enter in column 3, unweighted count and enter in confere unweighted count.  61.20 Of the FTEs in line 61.05, speci program specialty, if any, and the residents for each expanded program specialty, if any, and the residents for each expanded program column 1, enter in column 2, the program column 3, the IME FTE unweighted count 4, direct GME FTE unweighted count	er of FTE residents ructions) Enter in er in column 2, the the IME FTE olumn 4, direct GME fy each expanded the number of FTE gram. (see the program name, code, enter in column and enter in column				0. 00		61. 10
100 D 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				(UDCA)		1.00	
ACA Provisions Affecting the Hea 62.00 Enter the number of FTE resident					od for which	0.00	62. 00
your hospital received HRSA PCRE 62.01 Enter the number of FTE resident	funding (see instructs that rotated from a	ctions) a Teaching H	ealth Cent	ter (THC) into			62. 01
during in this cost reporting per Teaching Hospitals that Claim Re 63.00 Has your facility trained reside	esidents in Nonprovide	er Settings			period2 Enter	N	63. 00
"Y" for yes or "N" for no in col				instructions)			03.00
				Unwei ghted FTEs	FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der Si te	Hospi tal	2))	
Cootian FEOA of the ACA Door Vos	un ETE Dooi donto in No	anneaui dan C	ottingo "	1. 00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after a				illis base year	is your cost i	epor triig	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in yof (column 1 divided by (column	s yes, or your facilit aber of unweighted nor otations occurring in a number of unweighted our hospital. Enter ir	ty trained r n-primary ca all nonprov d non-primar n column 3 t	esidents re ider y care ne ratio	0. 00	0. 00	0. 000000	64.00
	Program Name	Program	Code	Unwei ghted		Ratio (col. 3/	
				FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
65.00 Enter in column 1, if line 63	1.00	2. C	0	3. 00	4. 00	5. 00 0. 000000	45.00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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)							

Heal th Financial Systems MEMORIAL HOSPITAL OF				n Lie	u of Form		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 150058	Peri od: From 01/01 To 12/31		Workshee Part I Date/Tir 5/29/20	ne Pre	pared:
			1. 00	)	XI X		
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospita	al sarvicas? Fr	nter "V" for	N		Y		90. 00
yes or "N" for no in the applicable column.  91.00 ls this hospital reimbursed for title V and/or XIX through t							91.00
full or in part? Enter "Y" for yes or "N" for no in the appl	icable column.		N		N		
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica	able column.				N		92. 00
93.00 Does this facility operate an ICF/MR facility for purposes o "Y" for yes or "N" for no in the applicable column.	of title V and	XIX? Enter	N		N		93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no	in the	N		N		94. 00
95.00 If line 94 is "Y", enter the reduction percentage in the app			N.	0. 00		0. 00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			N		N		96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	olicable column	1.		0. 00		0. 00	97. 00
105.00 Does this hospital qualify as a Critical Access Hospital (CA $106.00$ of this facility qualifies as a CAH, has it elected the all-		nod of navmen	+ N				105. 00 106. 00
for outpatient services? (see instructions)		. ,					
107.00 Column 1: If this facility qualifies as a CAH, is it eligible for I &R training programs? Enter "Y" for yes or "N" for no	in column 1.	(see					107. 00
instructions) If yes, the GME elimination would not be on Wk the program would be cost reimbursed. If yes complete Wkst.	D-2, Pt. II. (	Column 2: If					
this facility is a CAH, do I&Rs in an approved medical educa CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "			e				
instructions) 108.00 is this a rural hospital qualifying for an exception to the	CRNA fee sched	dul e? See 42	N				108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati ona		-h	Respi ra	atory	
	1.00	2.00	3.00		4. 0		100.00
109.00 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 no for each therapy.	N	N	N		N		109. 00
					1. 0	0	
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N"		on project (4	10A Demo)fo	or	N		110. 00
				1. 00	2.00	3.00	
Miscellaneous Cost Reporting Information  115 Ools this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no ir	column 1 I	f column 1		7   2.00	0	115 00
Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208.1.	If column 2 int for long ter	s "E", enter m care (incl	in column udes	N	2.00	0	115. 00
115.00 s this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider	If column 2 int for long terms) based on the	s "E", enter om care (incl ne definition of for no.	in column udes in CMS		2.00	0	115. 00 116. 00 117. 00
<ul> <li>115.00 s this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208.1.</li> <li>116.00 s this facility classified as a referral center? Enter "Y"</li> <li>117.00 s this facility legally-required to carry malpractice insurno.</li> <li>118.00 s the malpractice insurance a claims-made or occurrence pol</li> </ul>	If column 2 int for long terms) based on the for yes or "N" rance? Enter "N	s "E", enter m care (incl ne definition for no. " for yes or	in column udes in CMS "N" for	N	2.00	0	116. 00
<ul> <li>115.00 s this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208.1.</li> <li>116.00 s this facility classified as a referral center? Enter "Y"</li> <li>117.00 s this facility legally-required to carry malpractice insurno.</li> </ul>	If column 2 int for long terms) based on the for yes or "N" rance? Enter "N	s "E", enter m care (incl ne definition for no. " for yes or	in column udes in CMS "N" for	N N Y 1	Insura		116. 00 117. 00
<ul> <li>115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208. 1.</li> <li>116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insurno.</li> <li>118.00 Is the malpractice insurance a claims-made or occurrence pol</li> </ul>	If column 2 int for long terms) based on the for yes or "N" rance? Enter "N	s "E", enter m care (incl he definition for no. " for yes or f the policy	in column udes in CMS "N" for	N N Y 1			116. 00 117. 00
<ul> <li>115.00 s this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208.1.</li> <li>116.00 s this facility classified as a referral center? Enter "Y"</li> <li>117.00 s this facility legally-required to carry malpractice insurno.</li> <li>118.00 s the malpractice insurance a claims-made or occurrence pol</li> </ul>	If column 2 int for long terms) based on the for yes or "N" rance? Enter "N	s "E", enter m care (include definition for no. " for yes or f the policy Premiums	in column udes in CMS "N" for is	N N Y 1	Insura	ance	116. 00 117. 00
<ul> <li>115.00 s this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208.1.</li> <li>116.00 s this facility classified as a referral center? Enter "Y"</li> <li>117.00 s this facility legally-required to carry malpractice insurno.</li> <li>118.00 s the malpractice insurance a claims-made or occurrence pol</li> </ul>	If column 2 int for long terms) based on the for yes or "N" rance? Enter "N	s "E", enter m care (incl he definition for no. " for yes or f the policy	in column udes in CMS "N" for is Losse	N N Y 1	I nsura	ance 0	116. 00 117. 00
<ul> <li>115.00 is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208.1.</li> <li>116.00 is this facility classified as a referral center? Enter "Y" 117.00 is this facility legally-required to carry malpractice insurno.</li> <li>118.00 is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.</li> <li>118.01 List amounts of malpractice premiums and paid losses:</li> </ul>	If column 2 int for long ters) based on the for yes or "N" rance? Enter "Nicy? Enter 1 i	s "E", enterm care (include definition for no. for no. for yes or f the policy Premiums  1.00 958,2	in column udes in CMS "N" for is Losse	N N Y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	I nsura	o 0 05, 796	116. 00 117. 00 118. 00
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30.00 If this is a Medicare certified pa	ancreas transplant center,		ti fi cati on				130. 0
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34.00 If this is an organ procurement of		the OPO number	in column 1				134.
and termination date, if applicable All Providers	ie, in column 2.						
40.00 Are there any related organization	n or home office costs as	defined in CMS	Pub. 15-1,		Υ	15H013	140. (
chapter 10? Enter "Y" for yes or				S			
are claimed, enter in column 2 the	e home office chain number		tions)		3. 00		
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43. OO Ci ty: SOUTH BEND	State:	N	Zi p Cod	e:	4660	1	143.
14.00 Are provider based physicians' co	sts included in Worksheet	Λ2				1. 00 Y	144.
45.00 If costs for renal services are clonly? Enter "Y" for yes or "N" for	laimed on Worksheet A, lir		costs for in	pati en	t services	N	145.
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Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 47.00 Was there a change in the statistical 48.00 Was there a change in the order of 49.00 Was there a change to the simplification.  Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 66.00 Subprovider - IPF 67.00 Subprovider - IRF 68.00 SUBPROVIDER 69.00 SNF 69.00 HOME HEALTH AGENCY 61.00 CMHC	n column 1. (See CMS Pub. column 2. ical basis? Enter "Y" for f allocation? Enter "Y" for ied cost finding method? E	yes or "N" for or yes or "N" for Part A N N N N N N N N N N N N N N N N N N	no. or no. es or "N" fo  Part B  2.00 m the applic and Part B.  N N N N	cation (See	N N N N 3.00 of the lowe 42 CFR §413 N N N	Title XI)  4.00 r of costs .13)  N N N N N N 1.00	147. 148. 149. X 155. 156. 157. 158. 159. 160. 161.
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Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 47.00 Was there a change in the statistical 48.00 Was there a change in the order of 49.00 Was there a change to the simplification.  Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 66.00 Subprovider - IPF 67.00 Subprovider - IRF 68.00 SUBPROVIDER 69.00 SNF 69.00 HOME HEALTH AGENCY 61.00 CMHC	n column 1. (See CMS Pub. column 2. ical basis? Enter "Y" for f allocation? Enter "Y" for ied cost finding method? E	yes or "N" for or yes or "N" for Part A N N N N N N N N N N N N N N N N N N	no. or no. es or "N" fo  Part B  2.00 m the applic and Part B. N N N N N N N N N N N N N N N N N N N	cation (See	N N N N Title V 3.00 of the lowe 42 CFR \$413 N N N N N CBSAs?	Title XI)  4.00 r of costs .13)  N N N N N N 1.00	147. 148. 149. X 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in the approval date (mm/dd/yyyy) in the approval date (mm/dd/yyyy) in the statistical statistic	n column 1. (See CMS Pub. column 2. ical basis? Enter "Y" for f allocation? Enter "Y" for ied cost finding method? Enter that qualifies for an "N" for no for each compose ampus hospital that has or	yes or "N" for or yes or "N" for Part A N N N N N N N N N N N N N N N N N N	no. or no. es or "N" fo  Part B  2.00 m the applic and Part B. N N N N N N N N N N N N N N N N N N N	cation (See	N N N N Title V 3.00 of the lowe 42 CFR \$413 N N N N N CBSAs?	Title XI) 4.00 r of costs .13)  N N N N N N T 1.00  FTE/Campu 5.00	147. 148. 149. X 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 17.00 Was there a change in the statistical 18.00 Was there a change in the order of 19.00 Was there a change to the simplification.  Does this facility contain a provor charges? Enter "Y" for yes or 18.00 Subprovider - IPF 18.00 Subprovider - IRF 18.00 Subprovider - IRF 18.00 SUBPROVIDER 19.00 SNF 19.00 SNF 19.00 SNF 19.00 CMHC  Multicampus 19.00 Is this hospital part of a Multicampus 19.00 Is this	n column 1. (See CMS Pub. column 2. ical basis? Enter "Y" for fallocation? Enter "Y" for ied cost finding method? Enter that qualifies for an "N" for no for each compose ampus hospital that has or	15-2, § 4020)  yes or "N" for yes or yes or "N" for yes or "N" for yes or yes or "N" for	no. or no. es or "N" fo  Part B  2.00 m the applicand Part B. N N N N N N S N N S N N N N N N N N N	eation (See	N N N N N Title V 3.00 of the lowe 42 CFR \$413 N N N N CBSAs?	Title XI) 4.00 r of costs .13)  N N N N N N T 1.00  FTE/Campu 5.00	147. 148. 149. X 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in the approval date of the simplification.  Does this facility contain a provor charges? Enter "Y" for yes or "N" for no.  Multicampus  15.00  Multicampus  15.00  If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	n column 1. (See CMS Pub. column 2. ical basis? Enter "Y" for fallocation? Enter "Y" for ied cost finding method? Enter that qualifies for an "N" for no for each compose ampus hospital that has or	15-2, § 4020)  yes or "N" for yes or yes or "N" for yes or "N" for yes or yes or "N" for	no. or no. es or "N" fo  Part B  2.00 m the applicand Part B. N N N N N N S N N S N N N N N N N N N	eation (See	N N N N N Title V 3.00 of the lowe 42 CFR \$413 N N N N CBSAs?	Title XI) 4.00 r of costs .13)  N N N N N N T 1.00 N FTE/Campu 5.00 0	147. 148. 149. X 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 17.00 Was there a change in the statistic 18.00 Was there a change in the order or 19.00 Was there a change to the simplification.  Does this facility contain a provor charges? Enter "Y" for yes or 18.00 Subprovider - IPF 18.00 Subprovider - IRF 18.	n column 1. (See CMS Pub. column 2. ical basis? Enter "Y" for fallocation? Enter "Y" for ied cost finding method? Enter that qualifies for an "N" for no for each compose ampus hospital that has or Name	yes or "N" for or yes or "N" for Part A N N N N N N N N N N N N N N N N N N	no. or no. es or "N" fo  Part B 2.00 m the applic and Part B. N N N N S uses in diff  State Z 2.00	reation (See	N N N N N Title V 3.00 of the I owe 42 CFR §413 N N N N CBSAS? e CBSA 4.00	Title XI) 4.00 r of costs .13)  N N N N N N T 1.00  FTE/Campu 5.00	147. 148. 149. X 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in the approval date of the simplification of the simplificati	n column 1. (See CMS Pub. column 2. ical basis? Enter "Y" for fallocation? Enter "Y" for ied cost finding method? Enter that qualifies for an "N" for no for each compose ampus hospital that has or Name 0	15-2, § 4020)  yes or "N" for or yes or "N" for the second of the second	no. or no. es or "N" fo  Part B 2.00 m the applic and Part B. N N N N N N S Uses in diff  State Z 2.00  d Reinvestme	cation (See  Gerent  ip Cod 3.00	N N N N N STITLE V 3.00 OF the lowe 42 CFR \$413 N N N N N CBSAs? e CBSA 4.00	Title XI) 4.00 r of costs .13)  N N N N N 1.00  FTE/Campu 5.00 0	147. 148. 149. X 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in the statistic terms of the simplification of th	n column 1. (See CMS Pub. column 2. ical basis? Enter "Y" for fallocation? Enter "Y" for ied cost finding method? E ider that qualifies for an "N" for no for each compose ampus hospital that has or Name 0	15-2, § 4020)  yes or "N" for yes or	no. or no. es or "N" fo  Part B 2.00 m the applicand Part B. N N N N N N S State Z 2.00  d Reinvestme yes or "N"	cation (See	N N N N N N Title V 3.00 of the lowe 42 CFR §413 N N N N N CBSAs? e CBSA 4.00	Title XI) 4.00 r of costs .13)  N N N N N N T 1.00 N FTE/Campu 5.00 0	147. 148. 149. X 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in the statistic statist	n column 1. (See CMS Pub. column 2. ical basis? Enter "Y" for fallocation? Enter "Y" for ied cost finding method? Eider that qualifies for an "N" for no for each compose ampus hospital that has or Name 0  Name 0  T) incentive in the American under Section §1886(n)? O5 is "Y") and is a meaning HIT assets (see instruction of the column of	yes or "N" for yes or	no. or no. es or "N" fo  Part B  2.00 m the applic and Part B. N N N N N N  State Z 2.00  d Reinvestme yes or "N" e 167 is "Y"	cation (See  ip Cod 3.00	N N N N N Sitle V 3.00 of the lowe 42 CFR §413 N N N N N CBSAS?  e CBSA 4.00	Title XI) 4.00 r of costs .13)  N N N N N N S T 1.00  N FTE/Campu 5.00  0	147. 148. 149. X 155. 156. 157. 158. 159. 160. 161.

Health Financial Systems	u of Form CMS-2	2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLET	X IDENTIFICATION DATA	Provi der CCN: 150058	Peri od:	Worksheet S-2	
			From 01/01/2014	Part I	
			To 12/31/2014	Date/Time Pre	
				5/29/2015 9: 2	<u>O am</u>
	Begi nni ng	Endi ng			
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date and ending date	e for the reporting	01/01/2014	12/31/2014	170. 00
				1.00	1
171.00 If line 167 is "Y", does this prov	ider have any days for indivi	duals enrolled in secti	on 1876	N	171. 00
Medicare cost plans reported on Wk	st. S-3, Pt. I, line 2, col.	6? Enter "Y" for yes ar	nd "N" for no.		
(see instructions)					

		RIAL HOSPITAL OF SOUT				u of Form CMS-	
HOSPI <sup>-</sup>	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 150058	Peri od: From 01/01/2014 To 12/31/2014		epared:
					Y/N	Date	
	Ta				1. 00	2. 00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format.	oonses. Enter N for a	all NO re	esponses. Ente	er all dates in t	he	
	COMPLETED BY ALL HOSPITALS						
1. 00	Provider Organization and Operation  Has the provider changed ownership immediatel	v prior to the begin	nni na of	the cost	Υ	12/01/2011	1.0
	reporting period? If yes, enter the date of t			instructions			1.0
				Y/N	Date	V/I	
2. 00	Has the provider terminated participation in	the Medicare Program	n? If	1.00 N	2. 00	3. 00	2.0
	yes, enter in column 2 the date of termination voluntary or "I" for involuntary.	on and in column 3, "	'V" for				
3. 00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel	., chain home offices d to the provider or	s, drug its	N			3.00
	of directors through ownership, control, or 1 relationships? (see instructions)						
				Y/N	Type	Date	
	Financial Data and Reports			1.00	2. 00	3. 00	
. 00	Column 1: Were the financial statements pre Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Con	mpiled,	Y	А		4. 00
. 00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total	ructions. revenues different f	from	N			5. 0
	those on the filed financial statements? If y	yes, submit reconcili	ation.		Y/N	Legal Oper.	
					1. 00	2. 00	
. 00	Approved Educational Activities  Column 1: Are costs claimed for nursing scho	ool 2 Column 2: If we	s is th	he provider is	s N		6.00
. 00	the legal operator of the program?	,		ne provider 1.			0.0
. 00	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health programs? cost reporting period? If yes, see instruction	grams approved and/or		d during the	Y N		7. 00 8. 00
. 00	Are costs claimed for Intern-Resident program yes, see instructions.	ms claimed on the cur		·			9. 0
0.00	Was an Intern-Resident program been initiated period? If yes, see instructions.  Are GME cost directly assigned to cost center			•	g N Y		10.0
11.00	Teaching Program on Worksheet A? If yes, see		п ап Ар	proved	Ť		11. 0
						Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad	<b>.</b> .				Y	12. 0
	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a		Ü	Ü		N N	13. 0
	Bed Complement Did total beds available change from the price			yes, see ins	tructions.	Y	15. 0
		Doggani nti on		Y/N	art A Date	Part B Y/N	
		Description 0		1.00	2. 00	3. 00	
	PS&R Data						
6. 00	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			N		N	16. 0
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records			Y	04/15/2015	Y	17. 0
0 00	for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			V		V	10.0
18. 00	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			Y		Y	18. 00
	this cost report? If yes, see instructions.	1		1	1		

20.00

Ν

Ν

 $i\, nstructi\, ons.$ 

the other adjustments:

this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of

20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe

other PS&R Report information? If yes, see

lealth Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of

f Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE RELMBURSEMENT OUESTLONNALRE Provi der CCN: 150058 Peri od Worksheet S-2 From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/29/2015 9:20 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see . instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provi der-Based Physi ci ans Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs Were home office costs claimed on the cost report? 36, 00 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? Υ 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position DEBRA DFGUC7 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. 42.00 | Enter the employer/company name of the cost report BEACON HEALTH SYSTEM 42.00 preparer. DDEGUCZ@BEACONHEALTHSYSTEM. 0 43.00 Enter the telephone number and email address of the cost 574-647-3843 43.00 report preparer in columns 1 and 2, respectively.

21.00

In Lieu of Form CMS-2552-10 Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 150058 Peri od: Worksheet S-2 From 01/01/2014 To 12/31/2014 Part II Date/Time Prepared: 5/29/2015 9:20 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 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) 17.00 Was the cost report prepared using the PS&R 04/15/2015 17.00 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)

18.00 If line 16 or 17 is yes, were adjustments 18.00 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 this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see

	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position	REI MBURSEMENT	ANALYST	41.00
	held by the cost report preparer in columns 1, 2, and 3,			
	respecti vel y.			
42.00	Enter the employer/company name of the cost report			42.00
	preparer.			
43.00	Enter the telephone number and email address of the cost			43.00
	report preparer in columns 1 and 2, respectively.			

3.00

instructions.

instructions.

the other adjustments:

20.00 | If line 16 or 17 is yes, were adjustments

21.00 Was the cost report prepared only using the provider's records? If yes, see

made to PS&R Report data for Other? Describe

Provi der CCN: 150058

Peri od: Worksheet S-3
From 01/01/2014 Part I
To 12/31/2014 Date/Time Prepared: 5/29/2015 9: 20 am

							5/29/2015 9: 20	o am
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2.00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		324	118, 260	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3. 00	HMO IPF Subprovider							3. 00
4.00	HMO I RF Subprovi der						_	4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			324	118, 260	0.00	0	7. 00
0.00	beds) (see instructions)	04.00		20	44 (0)			0.00
8.00	INTENSIVE CARE UNIT	31.00		32				8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT	31. 01		36	13, 140	0.00	0	8. 01
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT		ŀ					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00	ŀ					12.00
13.00	NURSERY	43. 00	ŀ	200	440.000		0	13.00
14.00	Total (see instructions)			392	143, 080	0.00		14. 00
15. 00 16. 00	CAH visits	40. 00	ŀ	24	0.7//		0	15. 00 16. 00
	SUBPROVIDER - I PF	41. 00	ŀ	24			0	
17. 00 18. 00	SUBPROVI DER	41.00	ŀ	20	7, 300	,	U	17. 00 18. 00
19. 00	1		ŀ					19. 00
20. 00	SKILLED NURSING FACILITY NURSING FACILITY		ŀ					20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY		ŀ					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )		ŀ					23. 00
24. 00	HOSPICE		ŀ					24. 00
24. 10	HOSPICE (non-distinct part)	30. 00	ŀ					24. 10
25. 00	CMHC - CMHC	30.00	ŀ					25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)		ŀ	436				27. 00
28. 00	Observation Bed Days		ŀ	430			0	28. 00
29. 00	Ambul ance Tri ps		ŀ					29. 00
30. 00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see l'istraction)		ŀ					31. 00
32. 00	Labor & delivery days (see instructions)			9	3, 285			32. 00
32. 00	Total ancillary labor & delivery room			,	3, 200			32. 00
32.01	outpatient days (see instructions)							52.01
33. 00	LTCH non-covered days							33. 00
55. 50	1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =	l .	1		1	1	1	50.00

Health Financial Systems MEMORIAL HOSE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 150058

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared:

				1	0 12/31/2014	5/29/2015 9:2	
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	24, 387	11, 784	76, 011			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2.00	for the portion of LDP room available beds) HMO and other (see instructions)	8, 634	18, 539				2.00
3. 00	HMO IPF Subprovider	0,034	10, 539				3.00
4.00	HMO IRF Subprovider		320				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF		0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	١	o	0			6.00
7. 00	Total Adults and Peds. (exclude observation	24, 387	11, 784	76, 011			7. 00
	beds) (see instructions)		·				
8.00	INTENSIVE CARE UNIT	3, 055	0	7, 156			8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT	0	0	7, 978			8. 01
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)			. 705			12.00
13.00	NURSERY	27 442	11 704	4, 725		2 102 21	13.00
14. 00 15. 00	Total (see instructions) CAH visits	27, 442	11, 784	95, 870 0		2, 183. 21	14. 00 15. 00
16. 00	SUBPROVIDER - IPF	3, 418	1, 431	5, 041		32. 30	
17. 00	SUBPROVIDER - I RF	1, 424	625	4, 212			
18. 00	SUBPROVI DER	1, 727	023	7, 212	0.00	25. 55	18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER				07.47	0 000 07	26. 25
27. 00 28. 00	Total (sum of lines 14-26)		0	8. 070	27. 17	2, 239. 06	27. 00 28. 00
29. 00	Observation Bed Days Ambulance Trips	o	۷	8,070			29.00
30. 00	Employee discount days (see instruction)	٩		1, 426			30.00
31. 00				1, 420			31.00
32. 00	Labor & delivery days (see instructions)	0	195	475			32.00
32. 01	Total ancillary labor & delivery room		173	0			32. 01
52.51	outpatient days (see instructions)			Ö			32.31
33. 00	LTCH non-covered days	o					33. 00
	•		·				•

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 150058

Peri od: Worksheet S-3 From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

5/29/2015 9:20 am Full Time Di scharges Equi val ents Title V Title XVIII Total All Component Nonpai d Title XIX Workers Pati ents 14.00 12.00 13.00 11.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 5, 234 1, 672 18, 568 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 1,690 3, 008 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.00 8.01 NEONATAL INTENSIVE CARE UNIT 8.01 9.00 CORONARY CARE UNIT 9.00 10.00 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 89. 28 14.00 5, 234 1, 672 18, 568 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 0.00 287 118 412 16.00 SUBPROVIDER - IRF 17.00 0.00 95 26 244 17.00 SUBPROVI DER 18.00 18.00 19 00 SKILLED NURSING FACILITY 19 00 NURSING FACILITY 20.00 20.00 21.00 OTHER LONG TERM CARE 21.00 HOME HEALTH AGENCY 22.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23 00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 27.00 Total (sum of lines 14-26) 89. 28 27.00 Observation Bed Days 28.00 28.00 29 00 Ambul ance Trips 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 32.00 32.00 Total ancillary labor & delivery room 32.01 outpatient days (see instructions)

LTCH non-covered days

Provi der CCN: 150058

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | Part II | P

					To	12/31/2014	Date/Time Pre 5/29/2015 9:2	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Salaries (col.2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col . 4	COI. 3)	
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1. 00	Total salaries (see	200. 00	135, 342, 237	0	135, 342, 237	4, 939, 787. 00	27. 40	1. 00
0.00	instructions)					0.00		
2. 00	Non-physician anesthetist Part		0	0	U	0. 00	0. 00	2. 00
3.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4. 00	B Physician-Part A -		0	_	0	0. 00	0.00	4. 00
4.00	Administrative		O			0.00	0.00	4.00
4. 01	Physicians - Part A - Teaching		2, 002, 709		2, 002, 709	16, 930. 70	1	
5. 00 6. 00	Physician-Part B Non-physician-Part B		0	1	0	0. 00 0. 00	l .	
7. 00	Interns & residents (in an	21. 00	0		2, 134, 189	56, 520. 00	1	
7. 01	approved program) Contracted interns and		0		0	0.00	0. 00	7. 01
7.01	resi dents (in an approved		U	0	U	0.00	0.00	7.01
0.00	programs)					0.00		
8. 00 9. 00	Home office personnel	44. 00	0	0	0	0. 00 0. 00		
10.00	Excluded area salaries (see	00	6, 780, 940	ő	6, 780, 940	398, 707. 06		1
	instructions) OTHER WAGES & RELATED COSTS							-
11. 00	Contract labor: Direct Patient		2, 720, 143	0	2, 720, 143	73, 818. 79	36. 85	11. 00
40.00	Care							40.00
12. 00	Contract labor: Top level management and other		0	0	0	0. 00	0.00	12. 00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		1 404 101	0	1 404 101	12, 061. 00	140 47	12 00
13.00	A - Administrative		1, 694, 191	0	1, 694, 191	12, 061. 00	140. 47	13. 00
14. 00	Home office salaries &		12, 920, 230	0	12, 920, 230	245, 002. 00	52. 74	14. 00
15. 00	wage-related costs Home office: Physician Part A		0	0	0	0. 00	0.00	15. 00
	- Admi ni strati ve		_	_				
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 00
	WAGE-RELATED COSTS	L						
17. 00	Wage-related costs (core) (see instructions)		36, 408, 092	0	36, 408, 092			17. 00
18. 00	Wage-related costs (other)		0	0	0			18. 00
40.00	(see instructions)		4 050 470		4 050 470			40.00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 952, 170 0	0	1, 952, 170 0			19. 00 20. 00
	A		_	_				
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		0	0	0			22. 00
22. 01	Administrative		200 (0)		200 (0)			22.01
23. 00	Physician Part A - Teaching Physician Part B		209, 606 0	0	209, 606 0			22. 01 23. 00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24. 00
25. 00	Interns & residents (in an approved program)		393, 910	0	393, 910			25. 00
	OVERHEAD COSTS - DIRECT SALARIE	S						
26. 00	Employee Benefits Department Administrative & General	4.00	370, 027			8, 312. 00		
27. 00 28. 00	Administrative & General under	5. 00	7, 289, 833 733, 410		7, 289, 833	253, 454. 00 2, 225. 00		•
	contract (see inst.)							
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	577, 676 2, 657, 034		577, 676 2, 657, 034	17, 118. 00 118, 160. 00		
31. 00	Laundry & Linen Service	8. 00	2,037,034	ő	2,037,034	0.00		
32.00	Housekeepi ng	9. 00	3, 098, 321	0	3, 098, 321	184, 562. 00		
33. 00	Housekeeping under contract (see instructions)		0	0	0	0. 00	0. 00	33. 00
34. 00	Di etary	10. 00	2, 951, 304	-1, 229, 693	1, 721, 611	112, 188. 00		
35. 00	Di etary under contract (see instructions)		0	0	0	60, 409. 00	0. 00	35. 00
36. 00	Cafeteria	11. 00	0	1, 229, 693	1, 229, 693	0.00	0.00	36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38. 00 39. 00	Nursing Administration Central Services and Supply	13. 00 14. 00	1, 272, 141 1, 932, 438		1, 272, 141 1, 932, 438	47, 358. 00 96, 256. 00		38. 00 39. 00
	Pharmacy	15. 00	5, 806, 282			148, 840. 00		40.00
	·	<u>'</u>			'			

Health Financial Systems	MEMOR	IAL HOSPITAL (	OF SOUTH BEND,	I NC	In Li€	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der	CCN: 150058 F	Peri od:	Worksheet S-3	
					rom 01/01/2014		
				7	Γο 12/31/2014		
						5/29/2015 9: 2	O am
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical Records Library	16. 00	2, 243, 795	0	2, 243, 795	99, 522. 00	22. 55	41. 00
42.00 Social Service	17. 00	2, 775, 705	0	2, 775, 705	68, 263. 00	40. 66	42. 00
43.00 Other General Service	18. 00	C	0	(	0.00	0.00	43. 00

Total (sum of lines 3 thru 5)

Total overhead cost (see

instructions)

6.00

7.00

6.00

7.00

36. 80

26.06

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 150058 Worksheet S-3 Peri od: From 01/01/2014 To 12/31/2014 Part III Date/Time Prepared: 5/29/2015 9:20 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col. Salaries in col . 5) (from Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 134, 072, 938 -2, 134, 189 131, 938, 749 4, 928, 970. 30 26. 77 1.00 instructions) 2.00 6, 780, 940 6, 780, 940 398, 707. 06 17.01 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 127, 291, 998 -2, 134, 189 125, 157, 809 4, 530, 263. 24 27.63 3.00 minus line 2) 4.00 Subtotal other wages & related 17, 334, 564 17, 334, 564 330, 881. 79 52.39 4.00 costs (see inst.) Subtotal wage-related costs 5.00 36, 408, 092 36, 408, 092 0.00 29.09 5.00 (see inst.)

-2, 134, 189

178, 900, 465

31, 707, 966

4, 861, 145. 03

1, 216, 667. 00

181, 034, 654

31, 707, 966

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part IV | To 12/31/2014 | Date/Time Prepared: | Part IV | P Health Financial Systems
HOSPITAL WAGE RELATED COSTS MEMORIAL HOSPITAL OF SOUTH BEND, INC
Provider CCN: 150058

	10 12/31/2014	5/29/2015 9: 20	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	3, 957, 762	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 055, 694	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		ĺ
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		ĺ
8.00	Health Insurance (Purchased or Self Funded)	20, 429, 671	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	285, 272	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	152, 014	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	342, 703	14.00
15.00	'Workers' Compensation Insurance	39, 208	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	9, 750, 981	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unempl oyment Insurance	165, 295	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00		0	22. 00
23. 00	Tuition Reimbursement	321, 040	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	36, 499, 640	24.00
	Part B - Other than Core Related Cost		
25 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150058	Peri od: Worksheet S-3

		F	rom 01/01/2014	Part V	
		Т	o 12/31/2014	Date/Time Pre	
				5/29/2015 9: 2	0 am
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0	1.00
2.00	Hospi tal		0	0	2. 00
3.00	Subprovi der - I PF		0	0	3. 00
4.00	Subprovi der - I RF		0	0	4. 00
5.00	Subprovi der - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF				8. 00
9.00	Hospi tal -Based NF				9. 00
10.00	Hospi tal -Based OLTC				10.00
11.00	Hospi tal -Based HHA				11. 00
12.00	Separately Certified ASC				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15. 00
16.00	Hospi tal -Based-CMHC				16. 00
17.00	Renal Dialysis				17. 00
18.00	Other		0	0	18. 00
	•				

Uncompensated and indigent care cost computation    Uncompensated and indigent care cost computation   1.00	ealth Financial Systems MEMORIAL HOSPITAL OF				u of Form CMS-2	
Uncompensated and indigent care cost computation  Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  October 1, 202 column 1, 202 column 2, 203 column 3 divided by line 202 column 8)  Net revenue from Medicaid 56, 5528, 457 (2015)  Net revenue from Medicaid 57, 40, 44, 286 (2015)  If line 4 is 'no', then enter DSH or supplemental payments from Medicaid?  If line 4 is 'no', then enter DSH or supplemental payments from Medicaid 67, 40, 44, 286 (215, 512, 481)  October 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	OSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150058	Peri od:	Worksheet S-10	0
Cost to charge ratio (Worksheet C, Part   line 202 column 3 divided by line 202 column 8)   Medical d (see instructions for each line)   See, 528, 457						
Cost to charge ratio (Worksheet C, Part   line 202 column 3 divided by line 202 column 8)   Medical d (see instructions for each line)   See, 528, 457						
Ocst to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  October Medicaid (see instructions for each line)  Net revenue from Medicaid 56, 528, 457 / 101 dyou receive DSH or supplemental payments from Medicaid?  October Medicaid 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?  October Medicaid charges 215, 512, 481 / 201 lif line 4 is "no", then enter DSH or supplemental payments from Medicaid 2					1. 00	
Medicaid (see instructions for each line)  Net revenue From Medicaid  Net revenue From Medicaid  Net revenue From Medicaid  Net revenue SSH or supplemental payments from Medicaid?  Net revenue A is "no", then enter DSH or supplemental payments from Medicaid  Nedicaid charges  Medicaid cost (line 1 times line 6)  Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if care to then enter zero)  State Children's Health Insurance Program (SCHIP) (see instructions for each line)  Net revenue From Stand-alone SCHIP  Stand-alone SCHIP cost (line 1 times line 10)  Net revenue From Stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  Net revenue From state or local indigent care program (Not included on lines 2, 5 or 9)  Net revenue from state or local indigent care program (Not included in lines 6 or 10)  Net revenue from state or local indigent care program (Not included in lines 6 or 10)  Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)  Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)  Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)  Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)  Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)  Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)  Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)  Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)  Difference between net revenue and costs for state or local indigent care program		41	202!	- 0)	0. 270120	1
Net revenue from Medicaid  Did you receive DSH or supplemental payments from Medicaid?  If line 4 is "no", then enter DSH or supplemental payments from Medicaid?  If line 4 is "no", then enter DSH or supplemental payments from Medicaid?  N 4, 044, 286 supplemental payments from Medicaid?  Medicaid charges  Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)  State Children's Health Insurance Program (SCHIP) (see instructions for each line)  Net revenue from stand-alone SCHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Stand-alone SCHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (Not included on lines 2, 5 or 9)  Other state or local indigent care program (Not included on lines 2, 5 or 9)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 10)  Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 24,604,789 10)  Difference between net revenue and costs for state or local indigent care programs (sum of lines 24,604,789 10)  Total unreimbursed cost for Medicaid , SCHIP and state and local ind		arvidea by it	ne 202 cor um	11 8)	0. 278120	1.
10   10   dyou receive DSH or supplemental payments from Medicaid?   1   11   11   11   11   11   11   1					56 528 457	2.
If I in e 3 is "yes", does in e 2 include all DSH or supplemental payments from Medicaid?   N   4,044,286   1   1   1   1   1   1   1   1   1						3.
1 Filine 4 is "no", then enter DSH or supplemental payments from Medicaid 21, 542, 848 (215, 512, 481 (248) 848 (215, 512, 481 (248) 848		tal navments	from Medicai	d2		4.
Medicaid cost (line 1 times line 6)  Medicaid cost (line 1 times line 6)  Medicaid cost (line 1 times line 6)  Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 2 and 5; if 59, 338, 331 cost of lines 3 and 3 cost of lines 3 cost of lines 3 cost of lines 3 cost of lines 4 and 5; if 59, 338, 331 cost of lines 4 and 5; if 59, 338, 331 cost of lines 4 cost of lines 5 cost of lines 5 cost of lines 5 cost of lines 6			Trom wearear	u:		5.
0 Medicaid cost (line 1 times line 6) 0 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if czero then enter zero)  State Children's Health Insurance Program (SCHIP) (see instructions for each line) 0 Net revenue from stand-alone SCHIP charges 88,435,462 109 Stand-alone SCHIP charges 88,435,462 109 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero) 0 Other state or local government indigent care program (see instructions for each line) 0 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 10 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 0 State or local indigent care program cost (line 1 times line 14) 0 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 10) 0 State or local indigent care program cost (line 1 times line 14) 0 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 10) 0 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 10) 0 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 10) 0 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 10) 0 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 10) 0 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 10) 0 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 10) 0 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 10) 0 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 10) 0 Difference b	11 13	rom meareara				6.
0 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)  Net revenue from stand-alone SCHIP  Net revenue from stand-alone SCHIP  Stand-alone SCHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then 24,513,738 12  Total initial obligation of patients approved for charity care (line)  Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then 24,513,738 12  Stand-alone SCHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then 24,513,738 12  Total initial obligation of patients approved for charity care (line 1 times minus line 9; if < zero then 24,513,738 12  Band-alone SCHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then 24,513,738 12  Total unreimbursed care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 12  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 12  Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 24,604,789 14)  Difference between net revenue and costs for support of hospital operations 0 18  Difference between neter zero)  Uncompensated care (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care programs (sum of lines 24,604,789 14)  Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 24,604,789 14)  Difference between neter zero)  Uncompensated care (see instructions for each line)  Uninsured patients patients patients patients approved for charity care (line 1 5,155,908 734,010 5,889,918 21 110 12 11 110 12 110 12 110 110 110						7.
State Children's Health Insurance Program (SCHIP) (see instructions for each line)   Net revenue from stand-alone SCHIP (line 1 times line 10)   Stand-alone SCHIP charges   88, 435, 462   10   24, 595, 671   17   17   17   18   19   19   19   19   19   19   19		m (line 7 min	nus sum of Li	nes 2 and 5: if		8.
State Children's Health Insurance Program (SCHIP) (see instructions for each line)  Net revenue from stand-alone SCHIP  Stand-alone SCHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 13; if < zero then enter zero)  Uncompensated care (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 24, 604, 789 16 1, 00 2, 00 3, 00 1, 00 1, 00 2, 00 3, 00 1		(**********************************		=,	_	-
Stand-al one SCHIP charges  Stand-al one SCHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 16)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 16)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 24,604,789 16)  Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility  Octor of initial obligation of patients approved for charity care (line 1 5,155,908 734,010 5,889,918 2 10)  Total payment by patients approved for charity care (line 1 5,155,908 734,010 5,889,918 2)  Departial payment by patients approved for charity care (line 1 78,047 269,073 2)		uctions for e	ach line)			
Stand-alone SCHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then 24, 595, 671 17 24, 513, 738 11 22, 513, 738 112, 738 112, 738 112, 738 112, 738 112, 738 112, 738 112, 738	Net revenue from stand-alone SCHIP		,		81, 933	9
Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)  Uncompensated care (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 24, 604, 789 16 1.00 2.00 3.00  Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility  Cost of initial obligation of patients approved for charity care (line 1 5, 155, 908 734, 010 5, 889, 918 2: 1 18, 538, 431 2, 649, 073 22  Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 851, 875 14  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91, 051 16  Both Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility  Cost of initial obligation of patients approved for charity care (line 1 5, 155, 908 734, 010 5, 889, 918 2: 11, 177, 615 20, 178, 047 269, 073 22	00 Stand-alone SCHIP charges				88, 435, 462	10
enter zero) Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Uncompensated care (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care (overnment grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 24,604,789 18, 12 and 16)  Uninsured patients patients  Uninsured patients patients  Private grants, donations, or endowment income restricted to funding charity care (at full charges excluding non-reimbursable cost centers) for the entire facility  Cost of initial obligation of patients approved for charity care (line 1 5,155,908 734,010 5,889,918 21 177,615 200 200 00 Partial payment by patients approved for charity care 91,026 178,047 269,073 22	00 Stand-alone SCHIP cost (line 1 times line 10)				24, 595, 671	11
Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)  Uncompensated care (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care 0 15 minus line 24, 604, 789 (sovernment grants, appropriations or transfers for support of hospital operations 0 16 mounts (sum of lines 2, 5 or 9)  Uncompensated care (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care 0 15 minus line 24, 604, 789 (sovernment grants, appropriations or transfers for support of hospital operations 0 16 mounts (sum of lines 2, 5 or 9)  Uninsured patients patients 1 mounts (sum of lines 2, 5 or 9)  1.00  Total unreimbursed cost for Medical (sovernment grants) 1 mounts (sovernment grants) 2 mounts (sum of lines 2, 5 or 9)  1.00  Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility (sovernment grants) 2, 639, 184 (sovernment gr	00 Difference between net revenue and costs for stand-alone SCHI	IP (line 11 m	ninus line 9;	if < zero then	24, 513, 738	12
Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Net revenue from state or local indigent care program (Not included in lines 6 or 10)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 851, 875 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91, 051 or 13; if < zero then enter zero)  Uncompensated care (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care 0 or 17 or 18 or 19 o		<u> </u>				
Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 91,051 16 13; if < zero then enter zero)  Uncompensated care (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care 0 15 Government grants, appropriations or transfers for support of hospital operations 0 16 Government grants, appropriations or transfers for support of hospital operations 0 18 24,604,789 16 24,604,789 16 24 24,604,789 17 25 26 27 27 28 29 29 29 29 29 29 29 29 29 29 29 29 29						
10) State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Uncompensated care (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 24,604,789 16 8, 12 and 16)  Uninsured patients patients + col. 2)  1.00 2.00 3.00  Total initial obligation of patients approved for charity care (at full 18,538,431 2,639,184 21,177,615 20 charges excluding non-reimbursable cost centers) for the entire facility  Cost of initial obligation of patients approved for charity care (line 1 5,155,908 734,010 5,889,918 21 charges in the 20)  Partial payment by patients approved for charity care 91,026 178,047 269,073 22						
236, 923 15  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)  Uncompensated care (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care		are program (	Not included	in lines 6 or	851, 875	14
Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Uncompensated care (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care 0 Covernment grants, appropriations or transfers for support of hospital operations 0 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients + col. 2) 1.00 2.00 3.00  Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 0 Cost of initial obligation of patients approved for charity care (line 1 times line 20)  Partial payment by patients approved for charity care 91,026 178,047 269,073 22	1 - 7	_				
13; if < zero then enter zero) Uncompensated care (see instructions for each line)  00 Private grants, donations, or endowment income restricted to funding charity care 00 Government grants, appropriations or transfers for support of hospital operations 01 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 24,604,789 10 24,604,789 10 24,604,789 10 24,604,789 10 25 26,004 27 27 28 29 29 20 20 20 20 20 20 20 20 20 20 20 20 20					· ·	
Uncompensated care (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 24,604,789 10 24,		indigent care	program (li	ne 15 minus line	91, 051	16
Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients 1 + col. 2)  1.00 2.00 3.00  Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility  Cost of initial obligation of patients approved for charity care (line 1 times line 20)  Partial payment by patients approved for charity care  Private grants, donations, or endowment income restricted to funding charity care (sum of lines 24,604,789 16  24,604,789 16  15,100 2.00 3.00  Total initial obligation of patients approved for charity care (at full 5,155,908 734,010 5,889,918 26)  Partial payment by patients approved for charity care 91,026 178,047 269,073 22						
Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 24,604,789 19 24,604,789 19 24,604,789 19 24,604,789 19 25 26,604,789 19 26,604,789		funding char	ity caro		0	17
Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 24,604,789 16 8, 12 and 16)  Uninsured patients   Insured patients   Total (col. 1 + col. 2)					-	
8, 12 and 16)  Uninsured patients   Insured patients   Total (col. 1 patients   1.00   2.00   3.00    Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility   18,538,431   2,639,184   21,177,615   20,00   2.00   2.00   3.00    Cost of initial obligation of patients approved for charity care (line 1 times line 20)   5,155,908   734,010   5,889,918   20,000   20,				ms (sum of lines	-	
Uninsured patients Total (col. 1 patients patients patients Total (col. 1 patients patients patients patients patients 1.00 2.00 3.00  Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility Cost of initial obligation of patients approved for charity care (line 1 times line 20)  Partial payment by patients approved for charity care 91,026 178,047 269,073 22	·	ocai indigent	. care progra	ilis (suili 01 1111es	24, 004, 709	17
patients patients + col. 2)  1.00 2.00 3.00  Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility  Cost of initial obligation of patients approved for charity care (line 1 times line 20)  Partial payment by patients approved for charity care  patients patients + col. 2)  1.00 2.00 3.00  21,177,615 20  5,155,908 734,010 5,889,918 20  6,178,047 269,073 22	0, 12 and 10)		Uni nsured	Insured	Total (col 1	
Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility Cost of initial obligation of patients approved for charity care (line 1 times line 20)  Partial payment by patients approved for charity care  1.00 2.00 3.00 2.00 3.00 5,889,918 2,639,184 21,177,615 20 5,155,908 734,010 5,889,918 21 269,073 22					,	
Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility Cost of initial obligation of patients approved for charity care (line 1 times line 20)  On Partial payment by patients approved for charity care  Total initial obligation of patients approved for the entire facility 5, 155, 908  Total initial obligation of patients approved for the entire facility 5, 155, 908  Total initial obligation of patients approved for the entire facility 5, 155, 908  Total initial obligation of patients approved for the entire facility 5, 155, 908  Total initial obligation of patients approved for the entire facility 5, 155, 908  Total initial obligation of patients approved for the entire facility 5, 155, 908  Total initial obligation of patients approved for the entire facility 5, 155, 908  Total initial obligation of patients approved for the entire facility 5, 155, 908  Total initial obligation of patients approved for charity care (line 1 times line 20)				<del></del>		
charges excluding non-reimbursable cost centers) for the entire facility Cost of initial obligation of patients approved for charity care (line 1 times line 20)  Partial payment by patients approved for charity care  91,026  734,010  5,889,918  2  269,073  22	00 Total initial obligation of patients approved for charity can	re (at full				20
times line 20) 00 Partial payment by patients approved for charity care 91,026 178,047 269,073 22				,	, , , , , ,	
00 Partial payment by patients approved for charity care 91,026 178,047 269,073 22			1	734, 010	5, 889, 918	21
	times line 20)	•				
00   Cost of charity care (line 21 minus line 22)   5,064,882   555,963   5,620,845   2;	00 Partial payment by patients approved for charity care		91, 0	178, 047	269, 073	22
	00 Cost of charity care (line 21 minus line 22)		5, 064, 8	82 <u>555</u> , 963	5, 620, 845	23

25.00

26.00

27.00

28.00

29.00

30.00

Ν

35, 599, 378

35, 010, 239

9, 737, 048

15, 357, 893

589, 139

39, 962, 682 31. 00

24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit

Total bad debt expense for the entire hospital complex (see instructions)

Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)

Medicare bad debts for the entire hospital complex (see instructions)

31.00 | Total unreimbursed and uncompensated care cost (line 19 plus line 30)

30.00 Cost of uncompensated care (line 23 column 3 plus line 29)

imposed on patients covered by Medicaid or other indigent care program?

If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit

26.00

27. 00

28.00

Provi der CCN: 150058

Peri od: From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/29/2015 9:20 am

				5/29/2015 9:	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation	1	
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-3, 042, 725	14, 430, 636		1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	425, 579			2. 00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-47, 351	2, 221, 360		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-34, 378, 474	41, 799, 833	l e e e e e e e e e e e e e e e e e e e	5. 00
6.00	00600 MAI NTENANCE & REPAI RS	-153, 943	4, 760, 810		6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	-108, 271 0	8, 268, 108 1, 678, 658		7. 00 8. 00
9. 00	00900 HOUSEKEEPING	-400	5, 166, 656	l e e e e e e e e e e e e e e e e e e e	9. 00
10. 00	01000 DI ETARY	-170, 582	3, 209, 500		10.00
11. 00	01100 CAFETERI A	-1, 628, 788			11. 00
13.00	01300 NURSING ADMINISTRATION	0	1, 855, 156		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	-80, 153	6, 180, 863		14. 00
15. 00	01500 PHARMACY	327, 287	13, 350, 703		15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	-17, 130			16.00
17. 00	01700 SOCIAL SERVICE	0	3, 847, 808	l e e e e e e e e e e e e e e e e e e e	17. 00
21. 00 22. 00	02100   I&R SERVICES-SALARY & FRINGES APPRVD   02200   I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2, 134, 189 4, 792, 163	l e e e e e e e e e e e e e e e e e e e	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	-13, 110			23. 00
23. 01	02301 PARAMED ED	0	0	l e e e e e e e e e e e e e e e e e e e	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			1	
30.00	03000 ADULTS & PEDI ATRI CS	-41, 692	42, 424, 137		30. 00
31. 00	03100 I NTENSI VE CARE UNI T	100		•	31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	-116, 879			31. 01
40.00	04000 SUBPROVI DER - I PF	0	2, 288, 657		40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	1, 924, 885 1, 579, 297		41. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	0	1, 317, 271		43.00
50.00	05000 OPERATI NG ROOM	-35, 941	22, 440, 106		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-1, 489, 876			52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-129, 285	13, 709, 256		54.00
57. 00	05700 CT SCAN	0	1, 728, 879		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	603, 612	l e e e e e e e e e e e e e e e e e e e	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	-5, 476	2, 073, 872	l control of the cont	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	12, 561, 611 0		60. 00 60. 01
65. 00	06500 RESPIRATORY THERAPY	82	4, 146, 649		65. 00
66. 00	06600 PHYSI CAL THERAPY	-260, 615	3, 407, 182		66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	-418	1, 342, 829		66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0	385, 063		66. 10
67. 00	06700 OCCUPATI ONAL THERAPY	-67, 592	1, 746, 713		67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	250, 522		67. 10
68. 00	06800 SPEECH PATHOLOGY	0	1, 026, 948		68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0	192, 225		68. 10
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 896, 815		70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0			72.00
	07300 DRUGS CHARGED TO PATIENTS	-70, 233			73. 00
76.00	03020 CARDI OLOGY	-55, 379			76. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	l e e e e e e e e e e e e e e e e e e e	90.00
90. 10 90. 30	09001 FAMILY PRACTICE CLINIC 09002 HEMATOLOGY ONCOLOGY CLINIC	0	914, 550		90. 10 90. 30
90. 50	09004 SLEEP DI SORDERS CLINIC	-6, 692	828, 315		90. 50
91. 00	09100 EMERGENCY	-9, 585, 194		•	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7,000,171	11, 1,0,002		92. 00
	SPECIAL PURPOSE COST CENTERS				
	11300 INTEREST EXPENSE	0	0		113. 00
118. 00		-50, 753, 151	349, 208, 840	)	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	_		190.00
	19301 HEALTH PROPERTIES	0	4, 452, 744		193. 10
	19303 LEIGHTON CENTER	0	0		193. 40
	19305 WELLNESS CENTER	0	1, 568, 240		193. 50
193. 80	19308 UNUSED SPACE	0	0		193. 80
	19309 OCCUPATI ONAL HEALTH	0	0	)	193. 90
	19310 RESEARCH AND PROTOCOL	0	0		193. 91
	2 19311 CCOP	0	165	•	193. 92
193. 93 200. 00	19312  REASEARCH ADMIN   TOTAL (SUM OF LINES 118-199)	0 -50, 753, 151	366, 725 357, 215, 192		193. 93 200. 00
∠∪∪. ∪(	P   TOTAL (SUM OF LINES 118-199)	-50,753,151	J JUI, 215, 192	·I	1200. UU

	Financial Systems	MEMORI	AL HOSPITAL OF				u of Form CMS-255
LASS	SIFICATIONS			Provi der	CCN: 150058	From 01/01/2014	Worksheet A-6 Date/Time Prepar 5/29/2015 9:20 a
		Increases					1 3/24/2013 4.20 a
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00			
	A - DRUGS CHARGED TO PATIENTS						
0	DRUGS CHARGED TO PATIENTS  O		0	<u>14, 941, 6</u> 5 <u>1</u> 14, 941, 651			1
	B - SUPPLIES CHARGED TO PATIEN		- 1				
0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	37, 933, 296			1
0		0.00	O	0			2
0		0. 00 0. 00	0	0			3
0		0.00	0	0			Ĺ
0 0		0. 00 0. 00	0	0			-
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00 00		0. 00 0. 00	0	0			10
00		0.00	o	0			12
00 00		0. 00 0. 00	0	0			13
00		0.00	0	0			15
00		0.00	0_	0			16
	C - AMORTIZATION TO CAPITAL		0	37, 933, 296			
0	NEW CAP REL COSTS-BLDG &	1.00	0	73, 403			1
	FIXT	+		73, 403			
	D - INTEREST TO CAPITAL						
0	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	4, 998, 430			
	0		0	4, 998, 430			
0	G - PT UTILIZATION FROM H&L PHYSICAL THERAPY EAST BANK	66. 01	O	9, 283			1
0	0			9, 283			
0	H - EE UTILIZATION OF H&L EMPLOYEE BENEFITS DEPARTMENT	4.00	O	542, 720			1
0	0			542, 720			
0	I - MEDICAL DIRECTOR RECLASS SUBPROVIDER - IRF	41.00	0	36, 601			
U	0	41.00	0	36, 601			
0	O - CAFETERIA FROM DIET SALARI		1 220 (02				
0	CAFETERI A		<u>1, 229, 693</u> 1, 229, 693	$ \frac{0}{0}$			•
	V - MEDICAL DIRECTOR RECLASS						
0	ADULTS & PEDIATRICS	30.00	0	<u>42, 402</u> 42, 402			
	W - WORKERS COMP EH&W		<u> </u>				
0	EMPLOYEE BENEFITS DEPARTMENT			22 <u>9, 6</u> 58 229, 658			
	X - PROPERTY INSURANCE TO CAPI	TAL	<u> </u>	229, 038			
0	NEW CAP REL COSTS-BLDG &	1. 00	0	387, 859			
	FIXT	+					
0	Y - GARAGE TO A&G	- nol		454 070			
0	ADMI NI STRATI VE & GENERAL 0			15 <u>1, 2</u> 79 151, 279			
_	AB - DEPRECIATION TO CAPITAL		-1				
0	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	12, 277, 610			
0	NEW CAP REL COSTS-MVBLE	2. 00	0	14, 990, 761			2
	<u>EQUIP</u>	+					
_	BA - IMPLANTS CHARGED TO PATIE		- 1				
0	I MPL. DEV. CHARGED TO PATIENTS	72. 00	0	32, 893, 878			1
0		0. 00	О	0			2
0		0.00		<u>32,</u> 893, 878			3
	DA - DACC TP CAPITAL		U	JZ, 073, 8/8			
0	NEW CAP REL COSTS-MVBLE	2. 00	0	248			
0	EQUIP NEW CAP REL COSTS-MVBLE	2. 00	o	44, 346			
	EQUI P						
0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	9, 883			3

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2014 To 12/31/2014 Date/Ti me Prepared: 5/29/2015 9: 20 am Provi der CCN: 150058

					5/29/2015 9: 20 a
	Cost Conton	Increases	Sal assi	Other	
	Cost Center 2.00	Li ne # 3. 00	Sal ary 4.00	0ther 5.00	
4. 00	NEW CAP REL COSTS-MVBLE	2.00	4.00	590	 
	EQUI P		1		
5. 00	NEW CAP REL COSTS-MVBLE	2.00	0	332, 474	5
6. 00	NEW CAP REL COSTS-MVBLE	2. 00	o	51, 505	
0.00	EQUI P	2.00		01,000	
7.00	NEW CAP REL COSTS-MVBLE	2.00	0	3, 000	7
8. 00	EQUIP NEW CAP REL COSTS-MVBLE	2.00	0	5, 667	3
8.00	EQUIP	2.00	٥	5, 007	
9. 00	NEW CAP REL COSTS-MVBLE	2.00	0	6, 630	ç
10.00	EQUIP NEW CAP REL COSTS-MVBLE	2. 00	0	7 100	10
10. 00	EQUIP	2.00	U U	7, 180	
11. 00	NEW CAP REL COSTS-MVBLE	2.00	0	92, 443	11
10.00	EQUI P			0 500 040	4.5
12. 00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2, 528, 318	12
13. 00	NEW CAP REL COSTS-MVBLE	2.00	O	84, 804	13
	EQUI P		_		
14. 00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	22, 484	14
15. 00	NEW CAP REL COSTS-MVBLE	2.00	0	20, 432	15
	EQUI P				
16. 00	NEW CAP REL COSTS-MVBLE	2.00	0	434	16
17. 00	EQUIP NEW CAP REL COSTS-MVBLE	2. 00	0	2, 364	17
17.00	EQUI P	2.00		2,001	''
18. 00	NEW CAP REL COSTS-MVBLE	2.00	0	7, 579	18
19. 00	EQUIP NEW CAP REL COSTS-MVBLE	2.00	0	8	19
1 7. 00	EQUI P	2.00	9	0	
20. 00	NEW CAP REL COSTS-MVBLE	2.00	О	174, 297	20
21. 00	EQUIP NEW CAP REL COSTS-MVBLE	2.00	0	35, 776	21
21.00	EQUIP	2.00	٥	33, 776	21
22. 00	NEW CAP REL COSTS-MVBLE	2.00	0	36, 236	22
20.00	EQUI P			05 000	
23. 00	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	85, 298	23
24. 00	NEW CAP REL COSTS-MVBLE	2.00	O	141, 092	24
	EQUI P		+		
	DD - INTEREST EXPENSE		0	3, 693, 088	
1. 00	INTEREST EXPENSE	113.00	0	4, 998, 430	1
	0			4, 998, 430	
	IR - INTERNS SALARY FROM LN				
. 00	I &R SERVI CES-SALARY &	21. 00	2, 134, 189	0	1
	FRI NGES APPRVD	++	2, 134, 189	— — <sub>ō</sub>	
	00 - CAFETERIA FROM DIET NOM	N-SALARI ES	=, := :, 101		
. 00	CAFETERI A	11.00	0	<u>1, 185, 0</u> 16	 1
	O YY - PROPERTIES		0	1, 185, 016	
. 00	HEALTH PROPERTIES	193. 10	0	263, 941	
	0	<del>                                     </del>		263, 941	
500.00	Grand Total: Increases		3, 363, 882	129, 649, 306	500

RECLASSI FI CATIONS Provider CCN: 150058 Peri od:

Worksheet A-6 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/29/2015 9:20 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 A - DRUGS CHARGED TO PATIENTS PHARMACY 1.00 15.00 14, 941, 651 0 1.00 14, 941, 651 SUPPLIES CHARGED TO PATIENTS 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 34, 315 0 1.00 PHARMACY 0 0 2.00 15.00 165 2.00 3.00 ADULTS & PEDIATRICS 30.00 ol 602.376 0 3.00 0 INTENSIVE CARE UNIT 31.00 0 4.00 196, 114 4.00 5.00 NEONATAL INTENSIVE CARE UNIT 31.01 0 41, 221 0 5.00 6.00 SUBPROVIDER - IPF 40.00 5, 954 0 6.00 4, 920 7 00 SUBPROVIDER - IRF 41 00 0 0 7 00 0 8.00 NURSERY 43.00 0 457 8.00 9.00 OPERATING ROOM 50.00 31, 032, 600 0 9.00 10.00 DELIVERY ROOM & LABOR ROOM 52.00 0 293, 415 0 10.00 RADI OLOGY-DI AGNOSTI C 0 0 54 00 3 569 400 11 00 11 00 0 12.00 CARDIAC CATHETERIZATION 59.00 0 1, 912, 834 12.00 13.00 RESPIRATORY THERAPY 65.00 o 91, 907 0 13.00 14.00 PHYSICAL THERAPY 66.00 0 61, 311 0 14.00 0 HEMATOLOGY ONCOLOGY CLINIC 90 30 0 15.00 252 15.00 16.00 EMERGENCY 91.00 86,055 0 16.00 37, 933, 296 C - AMORTIZATION TO CAPITAL 1.00 ADMINISTRATIVE & GENERAL 5.00 73, 403 11 1.00 73, 403 D - INTEREST TO CAPITAL 4, 998, 430 1.00 INTEREST EXPENSE 113.00 0 11 1.00 4, 998, 430 G - PT UTILIZATION FROM H&L 9, 283 1.00 193.50 WELLNESS CENTER 0 1.00 9.283 EE UTILIZATION OF H&I 1.00 WELLNESS CENTER 193. 50 542, 720 0 1.00 ō 542, 720 - MEDICAL DIRECTOR RECLASS PHYSI CAL THERAPY 36, 601 1.00 66.00 0 1.00 36, 601 O - CAFETERIA FROM DIET SALARIES 1.00 DI ETARY 10.00 1, 229, 693 0 1.00 229, 693 V - MEDICAL DIRECTOR RECLASS ADMI NI STRATI VE & GENERAL 1.00 5.00 42, 402 0 1.00 42, 402 W - WORKERS COMP EH&W 0 1.00 ADMINISTRATIVE & GENERAL 5.00 229, 658 0 1.00 229, 658 - PROPERTY INSURANCE TO CAPITAL 1.00 ADMINISTRATIVE & GENERAL 5.00 387, 859 1.00 12 387, 859 Y - GARAGE TO A&G 1.00 HEALTH PROPERTIES 193. 10 151, 279 0 1.00 0 151, 279 AB - DEPRECIATION TO CAPITAL 1.00 ADMINISTRATIVE & GENERAL 5.00 0 27, 268, 371 a 1.00 9 2.00 0.00 2.00 ō 27, 268, 371 - IMPLANTS CHARGED TO PATIENTS 1.00 RADI OLOGY-DI AGNOSTI C 54.00 0 0 1.00 6.691 2.00 CARDIAC CATHETERIZATION 59.00 0 4, 850, 706 0 2.00 MEDICAL SUPPLIES CHARGED TO 0 3.00 71.00 28, 036, 481 0 3.00 PATI ENTS ō 32, 893, 878 DA - DACC TP CAPITAL 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 248 10 1.00

ADMINISTRATIVE & GENERAL

CENTRAL SERVICES & SUPPLY

NEONATAL INTENSIVE CARE UNIT

OPERATION OF PLANT

ADULTS & PEDIATRICS

INTENSIVE CARE UNIT

RADI OLOGY-DI AGNOSTI C

DI ETARY

PHARMACY

SOCIAL SERVICE

OPERATING ROOM

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MEMORIAL HOSPITAL OF SOUTH BEND, INC
Provider CCN: 150058 Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2014 To 12/31/2014 Worksheet A-6 Date/Time Prepared: 5/29/2015 9:20 am

					<u> </u>	5/29/2015 9: 20 am
		Decreases				
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7.00	8. 00	9. 00	10. 00	
13.00	CARDIAC CATHETERIZATION	59.00	0	84, 804		13. 00
14.00	LABORATORY	60.00	0	22, 484	10	14. 00
15. 00	RESPIRATORY THERAPY	65.00	0	20, 432	10	15. 00
16.00	PHYSI CAL THERAPY	66.00	0	434	10	16. 00
17.00	SPEECH PATHOLOGY	68.00	0	2, 364	10	17. 00
18. 00	CARDI OLOGY	76.00	0	7, 579	10	18. 00
19. 00	HEMATOLOGY ONCOLOGY CLINIC	90. 30	0	8	10	19. 00
20.00	SLEEP DISORDERS CLINIC	90. 50	0	174, 297	10	20.00
21.00	EMERGENCY	91.00	o	35, 776	10	21. 00
22.00	NONPALD WORKERS	193.00	o	36, 236	10	22. 00
23.00	HEALTH PROPERTIES	193. 10	o	85, 298	10	23. 00
24.00	WELLNESS CENTER	193. 50	o	141, 092	10	24. 00
	0 — — — — — —	- $  +$		3, 693, 088		
	DD - INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	4, 998, 430	0	1.00
	0 — — — — — —			4, 998, 430		
	IR - INTERNS SALARY FROM LN 2	22 TO LN 21				
1.00	I&R SERVICES-OTHER PRGM	22.00	2, 134, 189	0	0	1. 00
	COSTS APPRVD					
	0		2, 134, 189	0		
	OO - CAFETERIA FROM DIET NON-	-SALARI ES				
1.00	DI ETARY	10.00	0_	<u>1, 185, 0</u> 16	0	1.00
	0			1, 185, 016		
	YY - PROPERTIES					
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	263, 941	14	1. 00
	FI XT					
	0		0	263, 941		
500.00	Grand Total: Decreases		3, 363, 882	129, 649, 306		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 150058 Peri od: Worksheet A-7 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 9:20 am Acqui si ti ons Begi nni ng Purchases Di sposal s and Donati on Total Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 21, 922, 667 0 1.00 3, 046, 358 2.00 Land Improvements 0 0 0 0 2.00 3. 00 3.00 380, 272, 883 14, 060, 808 14, 060, 808 Buildings and Fixtures 0 Building Improvements 4.00 851, 999 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 255, 103, 430 18, 383, 430 0 0 0 18, 383, 430 0 6.00 7.00 HIT designated Assets 7.00 0 8.00 Subtotal (sum of lines 1-7) 661, 197, 337 32, 444, 238 32, 444, 238 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 661, 197, 337 10.00 10.00 32, 444, 238 0 32, 444, 238 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 21, 922, 667 0 1.00 2.00 Land Improvements 3, 046, 358 0 2.00 3.00 Buildings and Fixtures 394, 333, 691 0 3.00 0 4.00 Building Improvements 851, 999 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 273, 486, 860 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 693, 641, 575 0 8.00 9.00 Reconciling Items 9.00

693, 641, 575

0

10.00 Total (line 8 minus line 9)

					To 12/31/2014		pared: O am
	·		SU	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	instructions)	
		9.00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	0		0 0	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0		0	0	3. 00
		SUMMARY OF	F CAPITAL				
	Cost Center Description	Other 7	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUMI	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	0				1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00	Total (sum of lines 1-2)	0	0				3. 00

Health Financial Systems MEMOF	RIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
				From 01/01/2014 To 12/31/2014		aarad.
				10 12/31/2014	Date/Time Prep 5/29/2015 9: 20	oareu. O am
	COME	PUTATION OF RAT	TI OS	ALLOCATION OF		J Gill
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col			
			2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				_		
1.00 NEW CAP REL COSTS-BLDG & FLXT	395, 185, 690		395, 185, 69		0	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	273, 486, 860		273, 486, 86		0	2.00
3.00 Total (sum of lines 1-2)	668, 672, 550		668, 672, 55			3. 00
	ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY 0	F CAPITAL	
			I =			
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NIERS	_	1			
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0		0 11, 054, 667	167, 916	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 14, 990, 761	5, 037, 720	2. 00
3.00 Total (sum of lines 1-2)	0	0		0 26, 045, 428	5, 205, 636	3. 00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
cost center bescription	Tittelest	instructions)	,			
		THISTI UCTI UNS)	I IIS LI UC LI ONS)	d Costs (see	through 14)	
				instructions)		

5, 071, 833 -919, 053 4, 152, 780

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
NEW CAP REL COSTS-BLDG & FIXT 5

NEW CAP REL COSTS-MVBLE EQUIP

Total (sum of lines 1-2)

12.00

387, 859

387, 859

13.00

0 0 0

instructions)

14.00

-2, 251, 639

-2, 251, 639

15.00

14, 430, 636 19, 109, 428 33, 540, 064

1.00

2.00

3. 00

1.00

2.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10 Provi der CCN: 150058 Peri od: From 01/01/2014 To 12/31/2014 Worksheet A-8 Date/Time Prepared: 5/29/2015 9:20 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted

	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	·	1.00	2. 00	3.00	4. 00	5. 00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		0	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	2)   Investment income - other   (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)	В	-36, 853	ADMINISTRATIVE & GENERAL	5. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)	В	-1, 090, 602	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter 21)		0		0. 00	0	7. 00
8. 00	Television and radio service (chapter 21)		0		0.00	0	
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -14, 369, 311		0. 00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	1, 723, 654			0	12. 00
13.00	Laundry and linen service		0		0.00	0	13.00
	Cafeteria-employees and guests	1	-1, 368, 248	CAFETERI A	11. 00		
	Rental of quarters to employee and others		0		0.00		
	Sale of medical and surgical supplies to other than patients		0		0. 00	0	16. 00
	Sale of drugs to other than patients		0		0.00		17. 00
	Sale of medical records and abstracts	В	-5, 332	MEDICAL RECORDS & LIBRARY	16. 00		18. 00
	Nursing school (tuition, fees, books, etc.)		0		0.00		19. 00
	Vending machines Income from imposition of interest, finance or penalty	В	-967, 305 0	ADMINISTRATIVE & GENERAL	5. 00 0. 00		20. 00 21. 00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22. 00
23. 00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
24. 00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
25. 00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FLXT		0	NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
	Physicians' assistant		0		0.00		29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
30. 99	Himitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
31.00	pathology costs in excess of limitation (chapter 14)	"	O	5. 2231 1711102001	55.00		51.00
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00

MCRI F32 - 7. 2. 157. 2

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10

ADJUSTMENTS TO EXPENSES Provider CCN: 150058 From 01/01/2014 To 12/31/2014 Date/Time Prepared:

				To	12/31/2014	Date/Time Prep 5/29/2015 9: 20	
				Expense Classification on To/From Which the Amount is		0,2,7,20.10 ,7.2	. am
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	oost center beserveron	1.00	2.00	3. 00	4. 00	5. 00	
33. 00 33. 01	OTHER ADJUSTMENTS (SPECIFY) OTHER REVENUE - MED STAFF OFFIC	В	0 -500	ADMINISTRATIVE & GENERAL	0. 00 5. 00	0	33. 00 33. 01
33. 02	OTHER REVENUE - PEDS	В	· ·	ADULTS & PEDIATRICS	30.00	0	33. 02
33. 03 33. 04	OTHER REVENUE - PICU OTHER REVENUE - CBU	B B	1	INTENSIVE CARE UNIT DELIVERY ROOM & LABOR ROOM	31. 00 52. 00	0	33. 03 33. 04
33. 05	TAXABLE SALES - FCMC	В		ADULTS & PEDIATRICS	30. 00	0	33. 05
33. 06 33. 07	OTHER REVENUE - ER OTHER REVENUE - EMPLOYEE	B B	· ·	EMERGENCY EMPLOYEE BENEFITS DEPARTMENT	91. 00 4. 00	0	33. 06 33. 07
33. 10 33. 11	BENEFITS CONTRACTED SERVICES INTEREST INCOME - WORKING	B B		ADMINISTRATIVE & GENERAL NEW CAP REL COSTS-MVBLE	5. 00 2. 00	0 11	33. 10 33. 11
33. 12	CAPIT OTHER REVENUE - DISTRIBUTION	В	4 902	EQUI P CENTRAL SERVI CES & SUPPLY	14. 00	0	33. 12
33. 13	OTHER REVENUE - STERILE PROCESS	В	· ·	CENTRAL SERVICES & SUPPLY	14. 00	0	33. 13
33. 14	OTHER REVENUE - BIOMED PROGRAM MEAL OFFSET	B B		MAINTENANCE & REPAIRS	6.00	0	33. 14
33. 15 33. 16	VISITOR MEAL OFFSET	B B	-127, 843 -260, 540	CAFETERI A	10. 00 11. 00	0	33. 15 33. 16
33. 17	OTHER REVENUE - ENGINEERING	В	-108, 271	OPERATION OF PLANT	7. 00	0	33. 17
33. 18 33. 19	OTHER REVENUE - PICU TRANSPORT OTHER REVENUE - REHAB ADMIN	B B		ADULTS & PEDIATRICS PHYSICAL THERAPY	30. 00 66. 00	0	33. 18 33. 19
33. 22	OTHER REVENUE - RADI OLOGY DI AGN	В	· ·	RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 22
33. 23	OTHER REVENUE - MED ED	В	-246	ADMINISTRATIVE & GENERAL	5. 00	0	33. 23
33. 24 33. 26	OTHER REVENUE - NI CU OTHER REVENUE - NEONATAL	B B		NEONATAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 01 31. 01	0	33. 24 33. 26
33. 28	SERVICES PACE CONSULTING AMORTIZATION	А	1, 350	NEW CAP REL COSTS-BLDG &	1. 00	10	33. 28
33. 30	OTHER REVENUE - DRIVER'S ED CON	В		OCCUPATI ONAL THERAPY	67. 00		33. 30
33. 31 33. 35	OTHER REVENUE BCC NONALLOWABLE CAPITALIZED INTERE	B A		RADIOLOGY-DIAGNOSTIC NEW CAP REL COSTS-BLDG & FIXT	54. 00 1. 00	0 10	33. 31 33. 35
33. 39	PACE COMPONENT DEPREC 29 V 23	A	35, 087	NEW CAP REL COSTS-BLDG &	1.00	10	33. 39
33. 42	EXCESS CAPITALIZED INTEREST PAC	A	-9, 762	NEW CAP REL COSTS-BLDG & FLXT	1. 00	10	33. 42
33. 46	ALLOWABLE CAPITALZED INTEREST	A	10, 626	NEW CAP REL COSTS-BLDG & FIXT	1. 00	10	33. 46
33. 48	NONALLOWABLE CAPITALIZED INTERE	A		NEW CAP REL COSTS-BLDG & FLXT	1. 00	10	33. 48
	INCORRECT LIFING ON ASBESTOS AN	A		NEW CAP REL COSTS-BLDG & FIXT	1. 00		33. 50
33. 55	OTHER REVENUE - RENT	В		NEW CAP REL COSTS-BLDG &	1. 00		33. 55
33. 57 33. 58	MEMBERSHIP REVENUE SPECIAL PROGRAM REVENUE	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00		
33. 59	SEMI NAR REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00		33. 59
33. 63 33. 66	STERILIZATION REVENUE OTHER REVENUE - NUTRITIONAL	B B		DELIVERY ROOM & LABOR ROOM DIETARY	52. 00 10. 00		33. 63 33. 66
33. 71	SER OTHER REVENUE - SURGERY	В	-12 906	OPERATING ROOM	50. 00	0	33. 71
33. 76	OTHER REVENUE - CATH LAB	В	· ·	CARDIAC CATHETERIZATION	59. 00		33. 76
33. 88	OTHER REVENUE - SBCSC PT	В		PHYSI CAL THERAPY	66.00		33. 88
33. 94 33. 96	EDUC SERVICES EMS PARKING GARAGE - OPERATING	B A		PARAMED ED PRGM-(SPECIFY) ADMINISTRATIVE & GENERAL	23. 00 5. 00		33. 94 33. 96
33. 97	PARKING GARAGE - CAPITAL	A	-19, 720	NEW CAP REL COSTS-BLDG &	1. 00		
34. 03	NON ALLOWABLE 1999 INTEREST	А	-844, 708	NEW CAP REL COSTS-MVBLE EQUIP	2. 00		
34. 23 34. 31	ADMISSION REVENUE SKYWAY INTEREST AMORTIZATION	B A	3, 580	ADMINISTRATIVE & GENERAL NEW CAP REL COSTS-BLDG &	5. 00 1. 00		
34. 36	OLD CAPITAL - BUILDING	A	26, 887	FIXT NEW CAP REL COSTS-BLDG & FIXT	1.00	14	34. 36
34. 37	NEW CAPITAL BUILDING	A	-5, 543	NEW CAP REL COSTS-BLDG & FIXT	1.00	14	34. 37
	ı	1	ı			·	

ADJUSTMENTS TO EXPENSES Provi der CCN: 150058 Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/29/2015 9:20 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 35. 02 OTHER REVENUE - AMBULANCE -69, 352 CENTRAL SERVICES & SUPPLY 35. 02 В 14.00 SUPPL 36.00 AFFILIATE RENT В -1, 222, 943 NEW CAP REL COSTS-BLDG & 1.00 36.00 FI XT 36. 01 LOBBY EXPENSE -12,063 ADMINISTRATIVE & GENERAL 5.00 36. 01 36.05 HAF EXPENSE -21, 679, 785 ADMI NI STRATI VE & GENERAL 5.00 36.05 Α -159, 278 ADMINI STRATI VE & GENERAL TRUSTEE FEES 36. 18 5.00 36. 18 Α 36. 23 CONTRI BUTI ONS Α -891, 699 ADMI NI STRATI VE & GENERAL 5.00 36.23 NON-ALLOWED EXPENSES -2, 527 ADMINISTRATIVE & GENERAL 36. 25 36. 25 Α 5.00 ENTRY FEES -316, 811 ADMI NI STRATI VE & GENERAL 36. 26 5.00 В 36, 26 37.00 OTHER REVENUE - MATERNAL CHILD В -20, 576 ADULTS & PEDIATRICS 30.00 37.00 ADMI N 66. 01 37.01 OTHER REVENUE - OSTC В -418 PHYSICAL THERAPY EAST BANK 37.01 -16, 195 EMERGENCY 37.03 OTHER REV - TRAUMA SVCS В 91.00 37.03 OTHER REVENUE - TEAM PHARMACY OTHER REVENUE - PEDS REHAB OT 327, 287 PHARMACY 39 00 15.00 39.00 В -49, 837 OCCUPATI ONAL THERAPY 40.00 В 67.00 40.00 OTHER REVENUE - FCMC -4, 518 ADULTS & PEDIATRICS 30.00 41.00 41.00 В OTHER REVENUE - PULMONARY 82 RESPIRATORY THERAPY 42.00 42.00 В 65.00 MED/SURG OTHER REVENUE - ENV SVCS OTHER REVENUE - PHARMACY -400 HOUSEKEEPI NG 44.02 В 9.00 44.02 -70, 233 DRUGS CHARGED TO PATIENTS 73.00 44.06 44.06 В TOTAL (sum of lines 1 thru 49) 50.00 -50, 753, 151 50.00

(Transfer to Worksheet A, column 6, line 200.)

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

<sup>(2)</sup> Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

Provider CCN: 150058 | Period: From 01/01/2014 To 12/31/2014 | Date/Time Prepared: 5/29/2015 9: 20 am

					5/29/2015 9: 2	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	1
	HOME OFFICE COSTS:					
1.00	0.00		HOME OFFICE OLD CAP-BUILD	0	0	1.00
2.00	0.00		HOME OFFICE OLD CAP-EQUIP	0	0	2.00
3.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE NEW CAP-BUILD	160, 728	0	3.00
4.00	2. 00	NEW CAP REL COSTS-MVBLE EQUI	HOME OFFICE NEW CAP-EQUIP	1, 344, 632	O	4.00
4.01	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE NON-CAPITAL	24, 796, 649	O	4. 01
4.02	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE NON-ALLOWABLE	0	24, 578, 355	4. 02
5.00	TOTALS (sum of lines 1-4).			26, 302, 009	24, 578, 355	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

\* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2.00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	В	0.00 BEACON HLTH SYS 100.00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9. 00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- $(1) \ \ \text{Use the following symbols to indicate interrelationship to related organizations:}$
- 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.

Financial Syste	ems		MEMORIAL HOS	SPITAL OF S	OUTH BEND,	INC			In Lie	u of Form CMS-	2552-10
NT OF COSTS OF	SERVICES FROM	RELATED OR	GANIZATIONS .	AND HOME	Provi der	CCN:	150058	Peri od:		Worksheet A-8	3-1
COSTS											
								To 12	2/31/2014		
										5/29/2015 9: 2	10 am
Net	Wkst. A-7 Ref.										
Adjustments											
(col. 4 minus											
col. 5)*											
6. 00	7. 00										
A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUI	RED AS A RES	JULT OF TRAN	ISACTIONS V	VI TH R	ELATED C	RGANI ZAT	TIONS OR (	CLAI MED	
HOME OFFICE CO	STS:										
0	0										1.00
0	0										2.00
160, 728	10										3.00
1, 344, 632	10										4.00
	Net Adjustments (col. 4 minus col. 5)* 6.00 A. COSTS INCUR HOME OFFICE CO 0 160,728	Net Adj ustments (col . 4 mi nus col . 5)*  6.00 7.00  A. COSTS INCURRED AND ADJUSTI HOME OFFICE COSTS:  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Net Adj ustments (col. 4 minus col. 5)*  6.00  A. COSTS INCURRED AND ADJUSTMENTS REQUIHOME OFFICE COSTS:  0 0 0 0 160,728 10	Net Adjustments (col. 4 minus col. 5)*  6.00  A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESHOME OFFICE COSTS:  0 0 0 0 0 160,728 10	Net Adjustments (col. 4 minus col. 5)*  A. COSTS I NCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANHOME OFFICE COSTS:	Net Adjustments (col. 4 minus col. 5)*  A. COSTS I NCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WHOME OFFICE COSTS:  O O O O O O O O O O O O O O O O O O O	Net Adjustments (col. 4 minus col. 5)*  6.00  7.00  A. COSTS I NCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RHOME OFFICE COSTS:  0 0 0 160,728 10	Net Adjustments (col. 4 minus col. 5)*  6.00  7.00  A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED CHOME OFFICE COSTS:  0 0 0 0 160,728 10	Net Adjustments (col. 4 minus col. 5)*  6.00  7.00  A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS AND HOME Provider CCN: 150058  Period: From 01 To 12  Net Adjustments (col. 4 minus col. 5)*  6.00  7.00  A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONE OFFICE COSTS:	Net Adjustments (col. 4 minus col. 5)*  A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR (HOME OFFICE COSTS:  O 0 0 0 0 0 0 160,728 10	Net Adjustments (col. 4 minus col. 5)*  A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:  O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

\* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

4.01

4 02

5.00

	Related Organization(s) and/or Home Office							
	Type of Business							
	6. 00							
B.	B. INTERRELATIONSHIP TO 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	HOME OFFICE	6.00
7. 00 8. 00		7.00
8.00		8.00
9.00		9.00
10. 00 100. 00		10.00
100.00		100.00

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

0

0

- 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.

4.01

4 02

5.00

24, 796, 649

-24, 578, 355

1, 723, 654

Heal th Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

0

17.00

5/29/2015 9:20 am Physi ci an/Prov Wkst. A Line # Cost Center/Physician Professi onal Provi der RCE Amount Total ider Component Identi fi er Remuneration Component Component Hours 1. 00 2.00 4.00 3.00 5. 00 6. 00 7.00 1.00 5. 00 DR. A 2.850 0 2.850 171, 400 1 00 2.00 5. 00 DR. F 120, 169 0 120, 169 171, 400 1,008 2.00 3.00 5. 00 DR. H 171, 400 9, 195 0 9, 195 61 3.00 4.00 5.00 DR. M 171, 400 4.00 150 0 150 2 5.00 5. 00 DR. AN 171, 675 0 171, 675 142,500 938 5.00 5. 00 DR. N 6.00 2, 295 2, 295 171, 400 6.00 7.00 5. 00 AGGREGATE-ADMINISTRATIVE & 2, 848, 922 2, 848, 922 0 7.00 GENERAL 8.00 5.00 DR. S 3,038 0 3,038 171, 400 20 8.00 9.00 5. 00 DR. W 41, 563 0 41,563 171, 400 331 9.00 10.00 16.00 DR. I 5, 563 0 5, 563 171, 400 10.00 16.00 DR. AS 14, 475 97 11 00 0 14, 475 171, 400 11 00 31. 01 DR. L 12.00 54, 618 54, 618 0 12.00 13.00 31. 01 AGGREGATE-NEONATAL INTENSIVE 1, 425 1, 425 0 0 13.00 CARE UN 14.00 31. 01 AGGREGATE-NEONATAL INTENSIVE 0 157 23, 550 23, 550 152, 100 14.00 CARE UN 50.00 DR. C 191 15.00 28,650 0 28,650 204, 100 15.00 16.00 50.00 DR. AH 31, 792 0 31, 792 204, 100 204 16.00 17.00 50.00 DR. AS 3, 315 3, 315 204, 100 20 17.00 18.00 52. 00 AGGREGATE-DELIVERY ROOM & 1, 469, 450 1, 469, 450 0 18.00 LABOR ROOM 19.00 54.00 DR. D 1,700 0 1,700 231,000 9 19.00 51, 942 54.00 DR. F 51, 942 20.00 0 231,000 336 20.00 21.00 54.00 DR. J 9, 375 O 9, 375 231, 100 59 21.00 54. 00 AGGREGATE-RADI OLOGY-DI AGNOST 85, 000 22.00 85,000 0 22.00 lı C 48, 000 54. 00 AGGREGATE-RADI OLOGY-DI AGNOST 0 240 23.00 48,000 231,000 23.00 24.00 54. 00 AGGREGATE-RADI OLOGY-DI AGNOST 1, 200 0 1, 200 231,000 24.00 6 lı C 4, 785 4, 785 25 00 54. 00 DR. T 0 231,000 32 25 00 26.00 59.00 DR. M 3,000 0 3,000 231,000 26.00 60. 00 AGGREGATE-LABORATORY 27.00 137, 500 0 137,500 219,500 3, 192 27 00 66.00 DR. AC 8, 338 171, 400 21 28.00 8.338 0 28.00 66. 00 DR. AL 29 00 30, 600 0 30,600 171, 400 124 29 00 30.00 76.00 DR. AA 20, 325 20, 325 171, 400 30.00 0 32 9 31.00 76.00 DR. AP 5, 370 5, 370 171, 400 31.00 76. 00 AGGREGATE-CARDI OLOGY 32.00 4.000 4.000 0 32.00 33.00 76. 00 AGGREGATE-CARDI OLOGY 29, 063 29,063 0 33.00 90. 50 DR. BA 14,850 171, 400 99 34.00 14,850 0 34.00 35.00 91.00 DR. BB 100,001 100,001 171, 400 647 35.00 0 91. 00 AGGREGATE-EMERGENCY 36.00 2.012.882 2,012,882 0 36, 00 37.00 91. 00 AGGREGATE-EMERGENCY 7, 050, 131 7, 050, 131 0 37.00 91.00 DR. R 38.00 8, 563 8,563 171, 400 69 38.00 39.00 91.00 DR. BS 356, 200 356, 200 171, 400 2,091 39.00 0 91.00 DR. BT 40.00 434, 164 434, 164 171, 400 2,061 40.00 15, 249, 684 13, 555, 491 1, 694, 193 12,066 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of Identi fi er limit Unadjusted RCE Memberships & Component of Malpractice Share of col. Limit Conti nui ng Insurance Educati on 12 1.00 2.00 8.00 9.00 13.00 14.00 12.00 1.00 5. 00 DR. Α 12 1.00 0 0 5. 00 DR. 4, 153 0 2.00 83,063 2.00 0 3.00 5.00 DR. H 5,027 251 3.00 4.00 5.00 DR. M 165 8 0 0 0 4.00 5.00 5. 00 DR. AN 3, 213 0 0 0 64, 262 5.00 0 0 0 5. 00 DR. N 6.00 165 8 6.00 5. 00 AGGREGATE-ADMI NI STRATI VE & 7.00 0 0 0 7.00 GENERAL 8.00 5.00 DR. S 82 0 0 0 1,648 8.00 0 9.00 5.00 DR. W 0 0 9.00 27, 276 1.364 10.00 16.00 DR. I 247 12 0 0 10.00 16.00 DR. AS 7, 993 400 0 0 0 11.00 11.00 31. 01 DR. L 0 0 0 12.00 12.00 0 31. 01 AGGREGATE-NEONATAL INTENSIVE 0 o 0 13.00 0 13.00 CARE UN 31. 01 AGGREGATE-NEONATAL INTENSIVE 14.00 11, 481 574 0 C 0 14.00 CARE UN 15.00 50.00 DR. C 18, 742 937 0 0 0 15.00 16 00 50.00 DR. AH 20, 018 1,001 0 0 0 16.00

1, 962

98

0

0

50.00 DR. AS

17.00

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

PROVIDER BASED PHYSICIAN ADJUSTMENT						Period: From 01/01/2014 Fo 12/31/2014	Date/Time Pre	epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Conti nui ng	Component Share of col.	5/29/2015 9:2 Physician Cost of Malpractice Insurance	
	1. 00	2.00	8. 00	9. 00	Education 12.00	12 13. 00	14. 00	
18. 00		AGGREGATE-DELIVERY ROOM &	0	0				18. 00
19. 00	54.00	LABOR ROOM DR. D	1, 000	50	0	0	0	19. 00
20. 00	54.00		37, 315	1, 866			0	20. 00
21. 00		DR. J	6, 555	328	0	Ō	O	21. 00
22. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST	0	0	0	0	0	22. 00
23. 00	54. 00	I C AGGREGATE-RADI OLOGY-DI AGNOST I C	26, 654	1, 333	0	0	0	23. 00
24. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST I C	666	33	0	0	0	24. 00
25. 00	54. 00		3, 554	178	0		1	25. 00
26. 00 27. 00	59. 00 60. 00	DR. M AGGREGATE-LABORATORY	222 336, 848	11 16, 842	0			26. 00 27. 00
28. 00		DR. AC	1, 730	10, 042		-	0	28. 00
29. 00	66. 00	DR. AL	10, 218	511	0	0	0	29. 00
30.00		DR. AA	2, 637	132	0		0	30.00
31. 00 32. 00		DR. AP AGGREGATE-CARDI OLOGY	742	37 0	0		0	31. 00 32. 00
33. 00		AGGREGATE-CARDI OLOGY	0	0	0	_	1	33. 00
34.00	90. 50	DR. BA	8, 158	408	0	0	0	34.00
35. 00		DR. BB	53, 315	2, 666	0	0	0	35. 00
36. 00 37. 00		AGGREGATE-EMERGENCY AGGREGATE-EMERGENCY	0	0	0	0	0	36. 00 37. 00
38. 00		DR. R	5, 686	284			0	38. 00
39. 00		DR. BS	172, 306	8, 615	0	Ö	o	39. 00
40. 00	91. 00	DR. BT	169, 834	8, 492	0		0	40. 00
200.00	Wkst. A Line #	Cost Center/Physician	1, 079, 736 Provi der	53, 986 Adjusted RCE	RCE	Adjustment	0	200. 00
	WKSt. A Line #	I denti fi er	Component Share of col.	Li mi t	Di sal I owance	Auj ustilient		
	1. 00	2. 00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		DR. A	15.00	247	2, 603			1. 00
2.00	5. 00	DR. F	0	83, 063	37, 106	1		2. 00
3.00		DR. H	0	5, 027	4, 168		1	3.00
4. 00 5. 00		DR. M DR. AN	0	165 64, 262	0 107, 413	0 107, 413		4. 00 5. 00
6. 00		DR. N	0	165	2, 130		1	6. 00
7. 00		AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	2, 848, 922		7. 00
8. 00 9. 00		DR. S DR. W	0	1, 648 27, 276	1, 390 14, 287			8. 00 9. 00
10. 00	16. 00		0	27, 270	5, 316			10. 00
11. 00		DR. AS	0	7, 993	6, 482	6, 482		11. 00
12.00		DR. L	0	0	0			12.00
13. 00 14. 00		AGGREGATE-NEONATAL INTENSIVE CARE UN AGGREGATE-NEONATAL INTENSIVE	0	0 11, 481	12, 069	., .==		13. 00 14. 00
		CARE UN						
15. 00 16. 00	50. 00 50. 00	DR. C DR. AH	0	18, 742 20, 018	9, 908 11, 774			15. 00 16. 00
17. 00		DR. AS	Ö	1, 962	1, 353	1		17. 00
18. 00	52. 00	AGGREGATE-DELIVERY ROOM &	0	0	0	1, 469, 450		18. 00
19. 00	54 00	LABOR ROOM DR. D	n	1, 000	700	700		19. 00
20. 00	54. 00		o	37, 315	14, 627	•		20. 00
21. 00	54.00	DR. J	0	6, 555	2, 820			21. 00
22. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST I C	9	0	0	85, 000		22. 00
23. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST	0	26, 654	21, 346	21, 346		23. 00
24. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST	0	666	534	534		24. 00
25. 00	54. 00	DR. T	o	3, 554				25. 00
26.00		DR. M	0	222	2, 778			26.00
27. 00 28. 00		AGGREGATE-LABORATORY DR. AC	0	336, 848 1, 730	6, 608	0 6, 608		27. 00 28. 00
29. 00		DR. AL	ol	10, 218	20, 382			29. 00
30.00	76. 00	DR. AA	o	2, 637	17, 688			30. 00
31.00		DR. AP	0	742	4, 628			31.00
32. 00 33. 00		AGGREGATE-CARDI OLOGY AGGREGATE-CARDI OLOGY	0	0	0			32. 00 33. 00
JJ. UU	I /6.00	MOONEDATE-CARDI ULUUT	ı U	U		1 29,063		JJ. UU

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEI	ID, INC	In Lie	u of Form CMS-2552-10
PROVI DER BASED PHYSI CI AN ADJUSTMENT	Provi	der CCN: 150058	Peri od: From 01/01/2014	Worksheet A-8-2

						lo 12/31/2014	Date/lime Pro 5/29/2015 9:2	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
34.	00 90. 50	DR. BA	0	8, 158	6, 692	6, 692		34. 00
35.	00 91.00	DR. BB	0	53, 315	46, 686	46, 686		35. 00
36.	00 91.00	AGGREGATE-EMERGENCY	0	0	0	2, 012, 882		36. 00
37.	00 91.00	AGGREGATE-EMERGENCY	0	0	0	7, 050, 131		37. 00
38.	00 91.00	DR. R	0	5, 686	2, 877	2, 877		38. 00
39.	00 91.00	DR. BS	0	172, 306	183, 894	183, 894		39. 00
40.	00 91.00	DR. BT	0	169, 834	264, 330	264, 330		40. 00
200	00		1	1 079 736	813 820	14 369 311		200 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MEMORIAL HOSPITAL OF SOUTH BEND, INC

					o 12/31/2014	Date/Time Pre	
			CAPI TAL REI	ATED COSTS		5/29/2015 9: 2	O am
	Cook Cooker December 1	Not Francisco	NEW DLDC 0	NEW MADLE	EMDL OVEE	C	
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1.00	2.00	4. 00	4A	
4 00	GENERAL SERVICE COST CENTERS	44.400.404	44 400 (0)				4 00
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	14, 430, 636 19, 109, 428	14, 430, 636	19, 109, 428			1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 221, 360	120, 824				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	41, 799, 833	1, 140, 808	1		44, 586, 475	5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	4, 760, 810 8, 268, 108	42, 456 2, 256, 264			4, 870, 197 13, 561, 435	6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 678, 658	1, 878			1, 683, 023	8. 00
9.00	00900 HOUSEKEEPI NG	5, 166, 656	258, 156			5, 824, 108	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	3, 209, 500 785, 921	286, 779 55, 816			3, 907, 956 938, 447	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	1, 855, 156	220, 414			2, 391, 032	13. 00
14.00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	6, 180, 863	373, 233			7, 084, 166	
15. 00 16. 00	01600 MEDICAL RECORDS & LIBRARY	13, 350, 703 3, 579, 790	122, 578 68, 056			13, 743, 245 3, 779, 566	•
17. 00	01700 SOCIAL SERVICE	3, 847, 808	43, 650			4, 000, 719	17. 00
21.00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	2, 134, 189	0			2, 173, 755	
22. 00 23. 00	02200   &R SERVI CES-OTHER PRGM COSTS APPRVD 02300   PARAMED ED PRGM-(SPECIFY)	4, 792, 163 130, 932	198, 832 47, 780			5, 298, 644 243, 650	22. 00 23. 00
23. 01	02301 PARAMED ED	0	0			0	23. 01
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10 101 107	0.7/0.454	0 //7 005	550,007	40 444 070	00.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	42, 424, 137 8, 259, 083	2, 769, 451 210, 898			49, 411, 960 8, 846, 431	30. 00 31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	6, 938, 589	105, 984			7, 278, 362	31. 01
40.00	04000 SUBPROVI DER - I PF	2, 288, 657	155, 244			2, 677, 247	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	1, 924, 885 1, 579, 297	146, 226 57, 520			2, 291, 025 1, 735, 597	41. 00 43. 00
10. 00	ANCILLARY SERVICE COST CENTERS	1,077,277	07,020	70,107	22,011	1,700,077	10.00
50.00	05000 OPERATING ROOM	22, 440, 106				25, 535, 140	1
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	6, 006, 076 13, 709, 256	449, 387 734, 051			7, 128, 281 15, 574, 858	52. 00 54. 00
57. 00	05700 CT SCAN	1, 728, 879	35, 913			1, 834, 196	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	603, 612	54, 049		1	729, 235	1
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	2, 073, 872 12, 561, 611	214, 468 139, 384			2, 593, 315 12, 932, 741	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0	0	1	I	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	4, 146, 649	127, 019			4, 494, 568	1
66. 00 66. 01	06600 PHYSI CAL THERAPY 06602 PHYSI CAL THERAPY EAST BANK	3, 407, 182 1, 342, 829	148, 141 0		I	3, 801, 654 1, 361, 734	66. 00 66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	385, 063	0	Č		390, 906	66. 10
67.00	06700 OCCUPATIONAL THERAPY	1, 746, 713	96, 891	128, 305		1, 998, 810	1
67. 10 68. 00	06701 OCCUPATIONAL THERAPY LIVING CENTER 06800 SPEECH PATHOLOGY	250, 522 1, 026, 948	0 4, 329		.,	254, 157 1, 052, 136	ı
68. 10	06801 SPEECH THERAPY LIVING CENTER	192, 225	0		I	195, 169	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	- 1	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 896, 815 32, 893, 878	0		-	9, 896, 815 32, 893, 878	
73. 00	07300 DRUGS CHARGED TO PATIENTS	14, 871, 418	0	Č	- 1	14, 871, 418	
76. 00	03020 CARDI OLOGY	2, 966, 657	92, 450	122, 425	20, 237	3, 201, 769	76. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	0		ol	0	90. 00
90. 10	09001 FAMILY PRACTICE CLINIC	0	0	C	1	0	90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	914, 550	116, 446			1, 198, 182	90. 30
90. 50 91. 00	09004 SLEEP DI SORDERS CLINI C 09100 EMERGENCY	828, 315 14, 498, 502	434, 223	575, 010		839, 031 15, 682, 140	90. 50 91. 00
92. 00		11, 170, 002	101, 220	070,010	171, 100	0	
440.00	SPECIAL PURPOSE COST CENTERS						440.00
113. 00 118. 00	11300   INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1-117)	349, 208, 840	12, 558, 328	16, 630, 068	2, 432, 184	344, 787, 173	113.00
110.00	NONREI MBURSABLE COST CENTERS	017, 200, 010	12, 000, 020	10,000,000	2, 102, 101	011,707,170	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59, 224	78, 426		137, 650	
	19300   NONPALD WORKERS   19301   HEALTH PROPERTIES	1, 618, 478 4, 452, 744	1, 725, 934 0	2, 285, 527 (	I	5, 643, 666 4, 486, 169	
	19303 LEIGHTON CENTER	0	78, 393	1		182, 203	
	19305 WELLNESS CENTER	1, 568, 240	0	C	17, 540	1, 585, 780	
	19308 UNUSED SPACE   19309 OCCUPATIONAL HEALTH	0	0		0		193. 80 193. 90
	19310 RESEARCH AND PROTOCOL		0			0	193. 91
193. 92	2 19311 CCOP	165	3, 396	4, 497	o	8, 058	193. 92

Heal th Finar	ncial Systems ME	MORIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	eu of Form CMS-	2552-10
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
					From 01/01/2014 To 12/31/2014		narad.
					To 12/31/2014	Date/Time Pre 5/29/2015 9:2	Dareu: O am
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
		for Cost	FLXT	EQUI P	BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7)					
		0	1.00	2.00	4. 00	4A	
193. 93 19312	REASEARCH ADMIN	366, 725	5, 361	7, 10	0 5, 307	384, 493	193. 93
200.00	Cross Foot Adjustments					0	200. 00
201.00	Negative Cost Centers		0		0 0	0	201. 00
202.00	TOTAL (sum lines 118-201)	357, 215, 192	14, 430, 636	19, 109, 42	8 2, 502, 183	357, 215, 192	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150058

| Period: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/29/2015 9: 20 am

				72/31/2014	5/29/2015 9: 2	
Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	5. 00	6. 00	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00   00200   NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	44 504 475					4.00
5.00   00500   ADMINISTRATIVE & GENERAL 6.00   00600   MAINTENANCE & REPAIRS	44, 586, 475 694, 578	5, 564, 775				5. 00 6. 00
7. 00   00700   OPERATION OF PLANT	1, 934, 105	956, 505	1			7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	240, 029	796		1, 926, 691		8.00
9. 00   00900   HOUSEKEEPI NG	830, 623	109, 441	·	0	7, 154, 887	9. 00
10. 00 01000 DI ETARY	557, 345	121, 575	434, 036	0	9, 341	10.00
11. 00   01100   CAFETERI A	133, 839	23, 662	84, 476	0	0	11. 00
13.00 O1300 NURSING ADMINISTRATION	341, 004	93, 441		0	32, 068	13. 00
14. 00   01400   CENTRAL SERVI CES & SUPPLY	1, 010, 330	158, 226		19, 065	119, 520	14. 00
15. 00   01500   PHARMACY	1, 960, 034	51, 965		0	400, 632	15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE	539, 034 570, 575	28, 851 18, 505		0	9, 120 118, 196	16. 00 17. 00
21. 00   02100   I &R SERVICES-SALARY & FRINGES APPRVD	310, 017	16, 505	1	0	110, 190	21.00
22. 00   02200   L&R SERVI CES-OTHER PRGM COSTS APPRVD	755, 682	84, 291	300, 930	0	Ö	22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	34, 749	20, 255		0	0	23. 00
23. 01   02301   PARAMED ED	0	0	l I	0	0	23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	7, 047, 030	1, 174, 060		668, 097	2, 786, 550	30. 00
31. 00   03100   INTENSIVE CARE UNIT	1, 261, 660	89, 407		53, 625		31.00
31. 01   02060   NEONATAL   INTENSIVE CARE UNIT	1, 038, 025	44, 930		59, 730		31. 01
40. 00   04000   SUBPROVI DER -   1 PF 41. 00   04100   SUBPROVI DER -   1 RF	381, 824 326, 741	65, 813 61, 990		32, 149 71, 187	20, 815 275, 963	40. 00 41. 00
43. 00   04100   30BPROVIDER - 1 RF 43. 00   04300   NURSERY	247, 527	24, 385		17, 844	159, 017	43.00
ANCI LLARY SERVI CE COST CENTERS	247, 327	24, 303	07,030	17,044	137, 017	43.00
50. 00 05000 OPERATING ROOM	3, 641, 771	520, 899	1, 859, 668	255, 635	331, 053	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 016, 621	190, 510		88, 468	276, 184	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 221, 255	311, 188	1, 110, 977	184, 020	580, 832	54.00
57. 00  05700   CT   SCAN	261, 589	15, 225		0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	104, 002	22, 913		7, 419	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	369, 853	90, 920		73, 911	95, 322	59.00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	1, 844, 442	59, 089 0		0	191, 453 0	60. 00 60. 01
65. 00   06500   RESPI RATORY THERAPY	641, 006	53, 848	_	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	542, 184	62, 802		34, 460	85, 981	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	194, 208	02,002		0 1, 100	0	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	55, 750	0	О	0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	285, 066	41, 075	146, 643	0	4, 045	67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	36, 247	0	0	0	0	67. 10
68. 00 06800 SPEECH PATHOLOGY	150, 054	1, 835	6, 552	0	25, 007	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	27, 835	0	0	0	0	68. 10 70. 00
70.00   07000   ELECTROENCEPHALOGRAPHY 71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	0 1, 411, 464	0		0	0 0	70.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS	4, 691, 259	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 120, 932	0	ő	0		73. 00
76. 00   03020   CARDI OLOGY	456, 630	39, 193	139, 922	0	10, 371	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	0	0	0	0	0	90. 00
90. 10 09001 FAMILY PRACTICE CLINIC	0	0	0	0	0	90. 10
90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC	170, 882	49, 365	176, 239	30, 616		90. 30
90. 50   09004   SLEEP DI SORDERS CLINIC 91. 00   09100   EMERGENCY	119, 661 2, 236, 555	184, 082	657, 192	12, 319 134, 673	0 152, 986	90. 50 91. 00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	2, 230, 555	104, 002	037, 192	134, 073	132, 700	92.00
SPECIAL PURPOSE COST CENTERS						72.00
113. 00 11300   NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	42, 814, 017	4, 771, 042	13, 618, 329	1, 743, 218	6, 141, 134	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 631	25, 107		0		190. 00
193. 00 19300 NONPAI D WORKERS	804, 888	731, 680	2, 612, 180	0	1, 007, 795	
193. 10 19301 HEALTH PROPERTIES	639, 808	0	110 (47	0		193. 10
193. 40 19303  LEI GHTON CENTER 193. 50 19305  WELLNESS CENTER	25, 985	33, 233	118, 647	183, 473		193. 40 193. 50
193. 80 19308 UNUSED SPACE	226, 161	0		103, 473		193. 80
193. 90 19309 OCCUPATI ONAL HEALTH		0		0		193. 90
193. 91 19310 RESEARCH AND PROTOCOL		0	o o	0		193. 91
193. 92 19311 CCOP	1, 149	1, 440	5, 140	0		193. 92
193. 93 19312 REASEARCH ADMIN	54, 836	2, 273		0		193. 93
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00   TOTAL (sum lines 118-201)	44, 586, 475	5, 564, 775	16, 452, 045	1, 926, 691	7, 154, 887	202. 00

0 193. 50

0 193.80

0 193, 90

0 193. 91

0 193. 93

0 201.00

16, 384, 208 202. 00

200.00

133 193. 92

In Lieu of Form CMS-2552-10 Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150058 Peri od: Worksheet B From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 9:20 am Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 13.00 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 5, 030, 253 10 00 01100 CAFETERI A 1, 180, 424 11.00 11.00 01300 NURSING ADMINISTRATION 3, 202, 389 13.00 0 11, 250 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 27, 435 43 8, 983, 668 14.00 15.00 01500 PHARMACY 0 42, 811 16, 384, 208 15.00 0 01600 MEDICAL RECORDS & LIBRARY 17,091 16.00 16,00 28, 589 0 0 17.00 01700 SOCIAL SERVICE 29, 324 11,818 0 Ω 17.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 C 0 21.00 0 0 22.00 02200 & SERVICES-OTHER PRGM COSTS APPRVD 29, 922 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 23 00 1,016 Λ 23.00 23.01 02301 PARAMED ED 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4, 147, 303 1, 405, 043 0 6, 806 340, 417 30.00 03100 INTENSIVE CARE UNIT 31.00 385, 417 50, 524 273, 620 0 296 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 39, 765 213, 337 0 1,728 31.01 04000 SUBPROVIDER - IPF 0 40.00 269, 802 20, 593 57, 154 0 40.00 o 41 00 04100 SUBPROVIDER - IRF 227, 731 14, 134 59, 589 292 41 00 04300 NURSERY 43.00 0 11,800 51, 203 0 37 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 117, 561 433, 374 0 3, 469 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 40, 514 193, 565 21 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 81, 481 79, 795 0 5, 334 54.00 57.00 05700 CT SCAN 0 0 9,881 C 0 57.00 16 58 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 0 0 05900 CARDIAC CATHETERIZATION 59.00 10,041 25,858 873 59.00 06000 LABORATORY 0000 0 60.00 60.00 35, 503 C 0 60.01 06001 BLOOD LABORATORY 0 0 60.01 0 06500 RESPIRATORY THERAPY 26, 825 O 65 00 3.623 65 00 66.00 06600 PHYSI CAL THERAPY 21,655 0 723 66.00 06602 PHYSI CAL THERAPY EAST BANK 10, 237 66.01 66.01 66, 10 06601 PHYSICAL THERAPY LIVING CENTER 0 0 2, 326 0 0 0 66, 10 06700 OCCUPATIONAL THERAPY 0 67 00 12, 257 0 67.00 67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER 1,853 26 67.10 68.00 06800 SPEECH PATHOLOGY 0 0 6, 589 0 0 0 68.00 06801 SPEECH THERAPY LIVING CENTER 0 68.10 1, 115 0 68. 10 0 07000 ELECTROENCEPHALOGRAPHY 70.00 C 0 0 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 8, 983, 668 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 16, 340, 640 73.00 0 73.00 03020 CARDI OLOGY 18, 911 76.00 8, 179 0 706 76.00 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C C 0 n 90.00 09001 FAMILY PRACTICE CLINIC 0 90.10 0 0 0 90.10 90.30 09002 HEMATOLOGY ONCOLOGY CLINIC 0 5, 653 29, 502 0 168 90.30 90.50 09004 SLEEP DISORDERS CLINIC 0 5, 504 0 0 90.50 09100 EMERGENCY 13, 997 91.00 91.00 82, 954 303, 724 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 8, 983, 668 118.00 5, 030, 253 1, 127, 708 3<u>, 173, 627</u> 16, 378, 755 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 193.00 19300 NONPALD WORKERS 12, 057 3, 942 0 4, 200 193. 00 0 1, 120 193. 10 193. 10 19301 HEALTH PROPERTIES 24, 576 18, 338 193. 40 19303 LEI GHTON CENTER C 0 193. 40

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5, 030, 253

13, 360

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1, 180, 424

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6, 300

3, 202, 389

0

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0

o

8, 983, 668

193. 92 19311 CCOP

200.00

201.00

202.00

193. 50 19305 WELLNESS CENTER

193. 93 19312 REASEARCH ADMIN

193. 90 19309 OCCUPATIONAL HEALTH

193. 91 19310 RESEARCH AND PROTOCOL

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

193. 80 19308 UNUSED SPACE

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150058 | Period: From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

					T	o 12/31/2014	Date/Time Pre 5/29/2015 9: 20	
					INTERNS &	RESI DENTS	10,27,2010 7.2	
		Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
			RECORDS &		Y & FRINGES	PRGM COSTS	PRGM	
			16. 00	17. 00	21. 00	22. 00	23. 00	
1 00		AL SERVICE COST CENTERS		I	I			1 00
1. 00 2. 00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 6. 00	1	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00		OPERATION OF PLANT						7. 00
8.00	1	LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY						9. 00 10. 00
11. 00	1	CAFETERIA						11. 00
13.00	1	NURSING ADMINISTRATION						13.00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY						14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	4, 505, 253					16. 00
17. 00		SOCIAL SERVICE	0	4, 815, 201				17. 00
21. 00 22. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD   I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	,	6, 469, 469		21. 00 22. 00
23. 00	1	PARAMED ED PRGM-(SPECIFY)	ő	Ö		0, 407, 407	371, 984	
23. 01		PARAMED ED	0	0	0	o	0	23. 01
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	737, 018	2, 971, 946	1, 977, 427	5, 150, 600	0	30. 00
31. 00		INTENSIVE CARE UNIT	56, 369			0	0	31. 00
31. 01		NEONATAL INTENSIVE CARE UNIT	19, 729		·	51, 780	0	31. 01
40. 00 41. 00		SUBPROVIDER - IPF SUBPROVIDER - IRF	39, 458 18, 320			0	0	40. 00 41. 00
43. 00	1	NURSERY	14, 092	0		o	0	43. 00
F0 00		LARY SERVICE COST CENTERS	4 004 040	4.450	455 500	405 400		F0 00
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	1, 034, 362	1, 159 11, 925		405, 103 0	0	50. 00 52. 00
54. 00		RADI OLOGY-DI AGNOSTI C	777, 885			82, 239	0	54. 00
57. 00	1	CT SCAN	0	0	0	0	0	57. 00
58. 00 59. 00	1	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0	0	0	0	0	58. 00 59. 00
60.00		LABORATORY	349, 485	Ö	Ö	o	0	60.00
60. 01	1	BLOOD LABORATORY	0	0		0	0	60. 01
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	486, 178	0		164, 478 0	0	65. 00 66. 00
66. 01		PHYSICAL THERAPY EAST BANK	0	0	0	o	0	66. 01
66. 10	1	PHYSICAL THERAPY LIVING CENTER	110 702	0	0	0	0	66. 10
67. 00 67. 10		OCCUPATIONAL THERAPY OCCUPATIONAL THERAPY LIVING CENTER	119, 783 0		0		0	67. 00 67. 10
68. 00	06800	SPEECH PATHOLOGY	56, 369	0	0	o	0	68. 00
68. 10 70. 00	1	SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68. 10
71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	o	0	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72. 00
73. 00 76. 00		DRUGS CHARGED TO PATIENTS CARDIOLOGY	0 326, 937	0	_	0 179, 707	0	73. 00 76. 00
70.00		TIENT SERVICE COST CENTERS	320, 737		00, 774	177, 707	0	70.00
90.00		CLINIC	0	0	0	0	0	90.00
90. 10 90. 30		FAMILY PRACTICE CLINIC HEMATOLOGY ONCOLOGY CLINIC	0	79, 331	0 4, 678	12, 184	0	90. 10 90. 30
90. 50	09004	SLEEP DISORDERS CLINIC	ő	0	0	0	0	90. 50
91.00		EMERGENCY	469, 268	716, 550	145, 004	377, 690	371, 984	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) AL PURPOSE COST CENTERS						92. 00
	11300	INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4, 505, 253	4, 666, 558	2, 466, 231	6, 423, 781	371, 984	118. 00
190. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ol	0	190. 00
193.00	19300	NONPALD WORKERS	0	0	17, 541	45, 688	0	193. 00
		HEALTH PROPERTIES LEIGHTON CENTER	0	0	0	0		193. 10 193. 40
		WELLNESS CENTER	0	0	0	0		193. 40
193.80	19308	UNUSED SPACE	0	0	0	0	0	193. 80
	1	OCCUPATIONAL HEALTH RESEARCH AND PROTOCOL	0	148, 643	0	0		193. 90 193. 91
193. 91			0	0	o o		0	193. 92
		REASEARCH ADMIN	0	0	0	O	0	193. 93
200.00	יו	Cross Foot Adjustments		l	0	0	0	200. 00

Health Financial Systems	MEMORIAL HOSPITAL C	F SOUTH BEND,	I NC	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/29/2015 9: 2	
			INTERNS 8	RESIDENTS	3/2//2013 7.2	O dill
Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAI	R SERVI CES-OTHER	PARAMED ED	
	RECORDS &		Y & FRINGES	PRGM COSTS	PRGM	
	LI BRARY					
	16.00	17. 00	21. 00	22. 00	23. 00	
201.00 Negative Cost Centers	0	0	(	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	4, 505, 253	4, 815, 201	2, 483, 77	6, 469, 469	371, 984	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150058 Per

| Peri od: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | Part | Part | Prepared: | Part | Par

				То	12/31/2014	Date/Time Prepar 5/29/2015 9:20 a	
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	372772013 7.20	diii
				Residents Cost			
				& Post Stepdown			
				Adjustments			
		23. 01	24. 00	25.00	26. 00		
1 00	GENERAL SERVICE COST CENTERS	<u> </u>		ı ı			1 00
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS					,	6.00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15. 00
	01600 MEDI CAL RECORDS & LI BRARY						16. 00
17. 00	01700 SOCIAL SERVICE						17.00
21.00	02100   &R SERVI CES-SALARY & FRINGES APPRVD 02200   &R SERVI CES-OTHER PRGM COSTS APPRVD						21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)						23. 00
23. 01	02301 PARAMED ED	o					23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	82, 015, 790		74, 887, 763		30. 00
31.00	03100   INTENSI VE CARE UNI T	0	11, 868, 509		11, 868, 509		31. 00
31. 01 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	9, 210, 651 4, 084, 928	-71, 660 0	9, 138, 991 4, 084, 928		31. 01 40. 00
41. 00	04100 SUBPROVI DER - I RF		3, 716, 843		3, 716, 843		40. 00 41. 00
43. 00	04300 NURSERY	0	2, 348, 558		2, 348, 558		13. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	34, 294, 722	-560, 631	33, 734, 091		50.00
52. 00 54. 00	05200   DELIVERY ROOM & LABOR ROOM   05400   RADIOLOGY-DIAGNOSTIC	0	9, 626, 231	112 012	9, 626, 231		52. 00 54. 00
57. 00	05700 CT SCAN		21, 041, 437 2, 175, 260		20, 927, 625 2, 175, 260		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		945, 372		945, 372		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	3, 584, 688		3, 584, 688		59. 00
60.00	06000 LABORATORY	0	15, 623, 669	0	15, 623, 669	6	50.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0		50. 01
65. 00	06500 RESPI RATORY THERAPY	0	5, 639, 737		5, 412, 112		55. 00
66. 00 66. 01	06600 PHYSI CAL THERAPY 06602 PHYSI CAL THERAPY EAST BANK		5, 259, 847 1, 566, 179		5, 259, 847 1, 566, 179		56. 00 56. 01
66. 10	06601 PHYSI CAL THERAPY LIVING CENTER	0	448, 982		448, 982		66. 10
67. 00	06700 OCCUPATI ONAL THERAPY	o	2, 607, 679		2, 607, 679		57. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	o	292, 283		292, 283		57. 10
68. 00	06800 SPEECH PATHOLOGY	0	1, 298, 542	0	1, 298, 542		58. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0	224, 119	0	224, 119		58. 10
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20, 291, 947	0	0 20, 291, 947		70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS		37, 585, 137		37, 585, 137		72. 00
	07300 DRUGS CHARGED TO PATIENTS	o	33, 332, 990	1	33, 332, 990		73. 00
	03020 CARDI OLOGY	0	4, 451, 319		4, 202, 618		76. 00
	OUTPATIENT SERVICE COST CENTERS	1			ما		
	09000 CLINIC 09001 FAMILY PRACTICE CLINIC	0	0	0	0		90. 00 90. 10
	09001 PAWILT PRACTICE CLINIC		1, 850, 504	-16, 862	1, 833, 642		90. 10
	09004 SLEEP DI SORDERS CLINIC		976, 515		976, 515		90. 50
91.00	09100 EMERGENCY	0	21, 528, 799		21, 006, 105		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0		9	92.00
110 00	SPECIAL PURPOSE COST CENTERS					11	12.00
113.00	11300   INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1-117)	o	337, 891, 237	-8, 890, 012	329, 001, 225		13. 00 18. 00
110.00	NONREI MBURSABLE COST CENTERS	٩	337, 071, 237	0, 070, 012	327, 001, 223	' '	0.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	272, 023	0	272, 023	19	90.00
	19300 NONPALD WORKERS	0	10, 883, 637		10, 820, 408		93. 00
	19301 HEALTH PROPERTIES	0	5, 170, 011		5, 170, 011		93. 10
	19303 LEI GHTON CENTER	0	366, 026		366, 026		93. 40
	19305  WELLNESS CENTER   19308  UNUSED SPACE		2, 008, 774 0		2, 008, 774		93. 50 93. 80
	19308 UNUSED SPACE		148, 643	1	148, 643		93. 00 93. 90
	19310 RESEARCH AND PROTOCOL		318		318		93. 91
193. 92	19311 CCOP	0	15, 920		15, 920	19	93. 92
	19312 REASEARCH ADMIN	0	458, 603		458, 603		93. 93
200.00	Cross Foot Adjustments	0	0	0	0	20	00.00

0007 41100471011 05115041 05511105 00070	>† B
COST ALLOCATION - GENERAL SERVICE COSTS   Provider CCN: 150058   Period:   Worksho	J. D
From 01/01/2014   Part     To 12/31/2014   Date/Ti	me Prepared:
	15 9:20 am
Cost Center Description PARAMED ED Subtotal Intern & Total	
Resi dents Cost	
& Post	
Stepdown	
Adj ustments Adj ustments	
23.01 24.00 25.00 26.00	
201.00   Negative Cost Centers   0   0   0   0	201. 00
202.00   TOTAL (sum lines 118-201)   0  357, 215, 192  -8, 953, 241  348, 261, 951	202. 00

Provi der CCN: 150058

Peri od:

From 01/01/2014

ALLOCATION OF CAPITAL RELATED COSTS

Part II

Date/Time Prepared: 12/31/2014 5/29/2015 9:20 am CAPITAL RELATED COSTS Cost Center Description Directly NEW BLDG & NEW MVBLE Subtotal **EMPLOYEE** Assigned New FIXT **FOULP BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 120, 824 159, 999 280, 823 280, 823 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 0 0 0 1, 140, 808 1, 510, 688 2, 651, 496 15, 170 5.00 00600 MAINTENANCE & REPAIRS 1, 202 6.00 42, 456 98 677 6 00 56, 221 00700 OPERATION OF PLANT 7.00 2, 256, 264 2, 987, 804 5, 244, 068 5, 529 7.00 1, 878 8.00 00800 LAUNDRY & LINEN SERVICE 2, 487 4, 365 8.00 00900 HOUSEKEEPI NG 000000000000 341, 856 600.012 9.00 9 00 258, 156 6 448 01000 DI ETARY 10.00 286, 779 379, 760 666, 539 3, 583 10.00 11.00 01100 CAFETERI A 55, 816 73, 913 129, 729 2, 559 11.00 01300 NURSING ADMINISTRATION 13.00 220, 414 291, 878 512, 292 2, 647 13.00 01400 CENTRAL SERVICES & SUPPLY 373, 233 867 478 14 00 494 245 4 021 14 00 15.00 01500 PHARMACY 122, 578 162, 321 284, 899 12,083 15.00 01600 MEDICAL RECORDS & LIBRARY 90, 122 158, 178 16.00 68, 056 4.669 16.00 01700 SOCIAL SERVICE 43, 650 5,776 17.00 17.00 57, 802 101, 452 02100 I &R SERVICES-SALARY & FRINGES APPRVD 4, 441 21.00 21 00 C 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 198, 832 263, 298 462, 130 4, 978 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 47, 780 63, 271 111, 051 187 23.00 02301 PARAMED ED 23.01 23.01 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 2, 769, 451 3, 667, 385 6, 436, 836 61, 802 30.00 03100 INTENSIVE CARE UNIT 0 279, 277 490, 175 31.00 210, 898 10,908 31.00 0 02060 NEONATAL INTENSIVE CARE UNIT 105, 984 31.01 140.347 246, 331 10.489 31.01 04000 SUBPROVIDER - IPF 40.00 155, 244 205.578 360, 822 3, 117 40 00 04100 SUBPROVIDER - IRF 0 193, 636 339, 862 2, 950 41.00 41.00 146, 226 04300 NURSERY 43.00 57, 520 76, 169 133, 689 2, 538 43.00 ANCILLARY SERVICE COST CENTERS 0 50.00 05000 OPERATING ROOM 1, 228, 730 1, 627, 116 2, 855, 846 26.849 50 00 449, 387 05200 DELIVERY ROOM & LABOR ROOM 0 595, 090 1, 044, 477 8, 725 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 734, 051 972, 049 1, 706, 100 17, 904 54.00 57 00 05700 CT SCAN 47 556 83.469 57 00 35, 913 2, 452 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 54,049 71, 574 125, 623 Ω 58.00 05900 CARDIAC CATHETERIZATION 59.00 000000000000000 214, 468 284, 004 498, 472 2, 354 59.00 06000 LABORATORY 5, 295 60.00 184, 576 323, 960 139, 384 60, 00 06001 BLOOD LABORATORY 60.01 Λ 60.01 65.00 06500 RESPIRATORY THERAPY 127, 019 168, 202 295, 221 5, 915 65.00 06600 PHYSI CAL THERAPY 66.00 148, 141 196, 172 344.313 5.630 66.00 06602 PHYSI CAL THERAPY EAST BANK 2, 122 66.01  $\cap$ 66.01 06601 PHYSICAL THERAPY LIVING CENTER 66. 10 0 0 656 66.10 67.00 06700 OCCUPATIONAL THERAPY 96, 891 128, 305 225, 196 3,020 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 408 67.10 67.10 06800 SPEECH PATHOLOGY 68.00 4, 329 5, 732 10,061 1,698 68.00 68. 10 06801 SPEECH THERAPY LIVING CENTER 0 330 68.10 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS O 0 71 00 71 00 Ω 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 73.00 03020 CARDI OLOGY 0 92, 450 122, 425 214, 875 2, 272 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 09001 FAMILY PRACTICE CLINIC 0 90.10 90.10 0 09002 HEMATOLOGY ONCOLOGY CLINIC 90.30 116, 446 154, 200 270, 646 1.458 90.30 09004 SLEEP DISORDERS CLINIC 90.50 90.50 1.203 91.00 09100 EMERGENCY 0 434, 223 575, 010 1,009,233 19, 577 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 12, 558, 328 16, 630, 068 29, 188, 396 272, 965 118. 00 118.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 59 224 78 426 137 650 0 193. 00 19300 NONPALD WORKERS 1, 725, 934 2, 285, 527 4, 011, 461 1, 541 193. 00 3, 752 193. 10 193. 10 19301 HEALTH PROPERTIES 193. 40 19303 LEI GHTON CENTER 00000 78.393 103, 810 182, 203 0 193. 40 193. 50 19305 WELLNESS CENTER C 0 1, 969 193. 50 193. 80 19308 UNUSED SPACE 0 193.80 193. 90 19309 OCCUPATIONAL HEALTH 0 0 0 193. 90 193. 91 19310 RESEARCH AND PROTOCOL 0 193. 91 0 0 193. 92 19311 CCOP 3.396 4, 497 7.893 0 193. 92 193. 93 19312 REASEARCH ADMIN 5, 361 7, 100 12, 461 596 193. 93

Health Financial Systems	MEMORIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2014 To 12/31/2014		nared:
				12/31/2014	5/29/2015 9: 2	
		CAPI TAL REI	LATED COSTS			
				_		
Cost Center Description	Di rectl y	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Assigned New	FLXT	EQUI P		BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2.00	2A	4. 00	
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	14, 430, 636	19, 109, 42	33, 540, 064	280, 823	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150058

Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	5/29/2015 9: 2 HOUSEKEEPI NG	
Cost Center Description	& GENERAL	REPAI RS	PLANT	LINEN SERVICE	HOUSEKEEPING	
GENERAL SERVI CE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00   00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL	2, 666, 666	141 422				5.00
6.00   00600   MAI NTENANCE & REPAI RS 7.00   00700   OPERATI ON OF PLANT	41, 543 115, 679	141, 422 24, 308				6. 00 7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE	14, 356	24, 300		19, 672		8.00
9. 00   00900   HOUSEKEEPI NG	49, 680	2, 781	127, 996	0	786, 917	9. 00
10. 00   01000 DI ETARY	33, 335	3, 090		0	1, 027	10. 00
11. 00   01100   CAFETERI A	8, 005	601	27, 674	0	0	11.00
13. 00   01300   NURSI NG ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY	20, 396	2, 375		0 195	3, 527	13. 00 14. 00
15. 00   01500   PHARMACY	60, 428 117, 230	4, 021 1, 321		195	13, 145 44, 063	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	32, 240	733		0	1, 003	•
17.00   01700   SOCIAL SERVICE	34, 126	470		0	13, 000	17. 00
21. 00   02100   1 &R SERVI CES-SALARY & FRINGES APPRVD	18, 542	0		0	0	21. 00
22. 00   02200   1 &R SERVI CES-OTHER PRGM COSTS APPRVD	45, 197	2, 142		0	0	22. 00
23. 00   02300   PARAMED ED PRGM-(SPECIFY) 23. 01   02301   PARAMED ED	2, 078	515 0		0	0	23. 00 23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		0	<u> </u>	0	23.01
30. 00 03000 ADULTS & PEDI ATRI CS	421, 426	29, 836	1, 373, 121	6, 821	306, 474	30.00
31.00 03100 INTENSIVE CARE UNIT	75, 460	2, 272		547	27, 205	31. 00
31. 01   02060   NEONATAL   INTENSIVE CARE UNIT	62, 084	1, 142		610	12, 716	31. 01
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF	22, 837	1, 673		328	2, 289	40. 00 41. 00
41. 00   04100   SUBPROVI DER - I RF 43. 00   04300   NURSERY	19, 542 14, 805	1, 575 620		727 182	30, 351 17, 489	43.00
ANCI LLARY SERVI CE COST CENTERS	14, 003	020	20, 317	102	17, 407	43.00
50. 00 05000 OPERATING ROOM	217, 815	13, 238	609, 215	2, 610	36, 410	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	60, 804	4, 842		903	30, 376	52. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	132, 854	7, 908		1, 879	63, 882	54.00
57.00   05700   CT SCAN 58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)	15, 646 6, 220	387 582	· ·	0 76	0	57. 00 58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	22, 121	2, 311	· ·	755	10, 484	59.00
60. 00   06000   LABORATORY	110, 316	1, 502		0	21, 057	60.00
60. 01   06001   BL00D   LABORATORY	o	0	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	38, 339	1, 368		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	32, 428	1, 596		352	9, 456	66.00
66. 01   06602 PHYSICAL THERAPY EAST BANK 66. 10   06601 PHYSICAL THERAPY LIVING CENTER	11, 616 3, 334	0	_	0	0	66. 01 66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	17, 050	1, 044	-	0	445	67.00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	2, 168	0		0	0	67. 10
68.00 06800 SPEECH PATHOLOGY	8, 975	47	2, 146	0	2, 750	68. 00
68. 10   06801   SPEECH THERAPY LIVING CENTER	1, 665	0	0	0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0 84, 420	0	0	0	0	70.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00   07200   MPL. DEV. CHARGED TO PATIENTS	280, 585	0	0	0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	126, 853	0		0	0	73.00
76. 00 03020 CARDI OLOGY	27, 311	996	45, 837	0	1, 141	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLINIC	0	0	0	0	0	90.00
90. 10   09001 FAMILY PRACTICE CLINIC 90. 30   09002 HEMATOLOGY ONCOLOGY CLINIC	0 10, 220	1, 255	0 57, 735	0 313	0 10, 306	90. 10 90. 30
90. 50   09004 SLEEP DI SORDERS CLINIC	7, 157	1, 255	37, 733	126	0, 300	90. 50
91. 00   09100   EMERGENCY	133, 769	4, 678	215, 292	1, 375	16, 826	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
SPECIAL PURPOSE COST CENTERS			T			
113.00 11300 INTEREST EXPENSE 118.00  SUBTOTALS (SUM OF LINES 1-117)	2 540 455	121 240	4 441 277	17 700	47E 422	113.00
NONREI MBURSABLE COST CENTERS	2, 560, 655	121, 249	4, 461, 277	17, 799	675, 422	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 174	638	29, 364	0	0	190. 00
193. 00 19300 NONPALD WORKERS	48, 140	18, 595		0	110, 840	
193. 10 19301 HEALTH PROPERTIES	38, 267	0	0	0		193. 10
193. 40 19303 LEI GHTON CENTER	1, 554	845	38, 868	0		193. 40
193. 50 19305 WELLNESS CENTER 193. 80 19308 UNUSED SPACE	13, 527	0	0	1, 873		193. 50 193. 80
193. 90 19309 OCCUPATI ONAL HEALTH		0	0	0		193. 60
193. 91 19310 RESEARCH AND PROTOCOL	o	0	0	0		193. 91
193. 92 19311 CCOP	69	37	1, 684	0		193. 92
193. 93 19312 REASEARCH ADMIN	3, 280	58	2, 658	0	0	193. 93
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	2 444 444	141 422	5 200 504	10 473		201.00
202.00   TOTAL (sum lines 118-201)	2, 666, 666	141, 422	5, 389, 584	19, 672	786, 917	1202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	5/29/2015 9: 20 PHARMACY	
		10.00	11. 00	13. 00	14. 00	15. 00	
	NERAL SERVICE COST CENTERS						1 00
2.00 00 4.00 00 5.00 00 6.00 00 8.00 00 10.00 01 11.00 01 14.00 01 15.00 01 17.00 01 21.00 02	D100 NEW CAP REL COSTS-BLDG & FIXT D200 NEW CAP REL COSTS-MVBLE EQUIP D400 EMPLOYEE BENEFITS DEPARTMENT D500 ADMINISTRATIVE & GENERAL D600 MAINTENANCE & REPAIRS D700 OPERATION OF PLANT D800 LAUNDRY & LINEN SERVICE D900 HOUSEKEEPING D1000 DIETARY D100 CAFETERIA D300 NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY D500 PHARMACY 600 MEDICAL RECORDS & LIBRARY D700 SOCIAL SERVICE D100 L&R SERVICES-SALARY & FRINGES APPRVD D1200 L&R SERVICES-OTHER PRGM COSTS APPRVD	849, 761 0 0 0 0 0 0 0	168, 568 1, 607 3, 918 6, 114 4, 083 4, 188 0 4, 273	652, 127 9 0 3, 480 2, 407	1, 138, 267 0 0 0 0	526, 485 0 0 0 0	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 21. 00 22. 00
	2300 PARAMED ED PRGM-(SPECIFY)	o	145		0	0	23. 00
	2301 PARAMED ED	0	0	0	0	0	23. 01
30. 00 03 31. 00 03 31. 01 02 40. 00 04 41. 00 04 43. 00 04	IPATIENT ROUTINE SERVICE COST CENTERS  3000 ADULTS & PEDIATRICS  3100 INTENSIVE CARE UNIT  2060 NEONATAL INTENSIVE CARE UNIT  3000 SUBPROVIDER - IPF  3100 SUBPROVIDER - IRF  3300 NURSERY  ICILLARY SERVICE COST CENTERS	700, 604 65, 108 0 45, 578 38, 471	48, 610 7, 215 5, 679 2, 941 2, 018 1, 685	55, 719 43, 443 11, 639 12, 134	0 0 0 0 0	219 10 56 0 9	30. 00 31. 00 31. 01 40. 00 41. 00 43. 00
		0	16 788	88 251	0	111	50 00
50. 00	GOOO OPERATING ROOM GOOO OPERATING ROOM GOOO DELIVERY ROOM & LABOR ROOM GOOO DELIVERY ROOM & LABOR ROOM GOOO CT SCAN GOOO CARDIAC CATHETERIZATION GOOO CARDIAC CATHETAPY GOOO CERTICAL THERAPY GOOO COUPATIONAL THERAPY LIVING CENTER GOOO COUPATIONAL THERAPY LIVING CENTER GOOO SPEECH PATHOLOGY GOOO CELECTROENCEPHALOGRAPHY GOOO CELECTROENCEPHALOGRAPHY GOOO MEDICAL SUPPLIES CHARGED TO PATIENTS GOOO DRUGS CHARGED TO PATIENTS GOOO CARDIOLOGY GOOOT CARDIOLOGY GOOOT CLINIC GOOOT CHARGED TO PATIENTS GOOO CLINIC GOOOT CHARGED TO CONTROLOGY GOOOT CLINIC GOOOT CHARGEO COST CENTERS GOO	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	16, 788 5, 786 11, 636 1, 411 0 1, 434 5, 070 0 3, 831 3, 092 1, 462 332 1, 750 265 941 159 0 0 1, 168	39, 417 16, 249 0 0 5, 266 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	111 1 171 1 0 0 28 0 0 0 116 23 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 52. 00 54. 00 57. 00 58. 00 59. 00 60. 01 65. 00 66. 01 66. 10 67. 10 68. 00 68. 10 70. 00 71. 00 72. 00 73. 00 76. 00 90. 10 90. 00 90. 10 90. 50 91. 00 92. 00
	PECIAL PURPOSE COST CENTERS  1300   INTEREST EXPENSE						113. 00
118. 00 NO	SUBTOTALS (SUM OF LINES 1-117)  NREIMBURSABLE COST CENTERS	849, 761	161, 040	646, 270	1, 138, 267	526, 310	118. 00
190. 00 19 193. 00 19 193. 10 19 193. 40 19 193. 50 19 193. 80 19 193. 90 19 193. 91 19	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2300 NONPAID WORKERS 2301 HEALTH PROPERTIES 2303 LEIGHTON CENTER 2305 WELLNESS CENTER 2308 UNUSED SPACE 2309 OCCUPATIONAL HEALTH 2310 RESEARCH AND PROTOCOL 2311 CCOP 2312 REASEARCH ADMIN Cross Foot Adjustments	0 0 0 0 0 0 0 0	0 1, 722 3, 510 0 1, 908 0 0 19 0	3, 734 0 0 6 0 0 0 0 37 0 0	0 0 0 0 0 0 0 0	135 36 0 0 0 0 0 0	190.00 193.00 193.10 193.40 193.50 193.80 193.90 193.91 193.92 193.93 200.00
201.00	Negative Cost Centers TOTAL (sum lines 118-201)	0 849, 761	0 168, 568	0 652, 127	0 1, 138, 267	0 526, 485	201. 00
	1 110 2017		,				

Heal th Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150058 From 01/01/2014 To 12/31/2014 Date/Time Prepared:

					1	0 12/31/2014	Date/lime Pre 5/29/2015 9:20	
					INTERNS &	RESI DENTS		
		Cost Center Description	MEDI CAL	SOCIAL SERVICE	SEDVI CES_SALAD	SERVI CES-OTHER	PARAMED ED	
		cost center bescription	RECORDS &	SOCIAL SERVICE	Y & FRINGES	PRGM COSTS	PRGM	
			LI BRARY					
	CENED	AL SERVICE COST CENTERS	16. 00	17. 00	21.00	22. 00	23. 00	
1. 00		NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00	1	NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	1	ADMINISTRATIVE & GENERAL						5. 00
6. 00 7. 00	1	MAINTENANCE & REPAIRS OPERATION OF PLANT						6. 00 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE						8. 00
9.00		HOUSEKEEPI NG						9. 00
10. 00	1	DI ETARY						10. 00
11. 00 13. 00	1	CAFETERIA						11.00
14. 00	1	NURSING ADMINISTRATION   CENTRAL SERVICES & SUPPLY						13. 00 14. 00
15. 00	1	PHARMACY						15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	238, 129	1				16. 00
17. 00	1	SOCIAL SERVICE	0	183, 061				17. 00
21. 00 22. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD   I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	,	617, 303		21. 00 22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)				017, 303	137, 666	1
23. 01	1	PARAMED ED	0	Ö			,	23. 01
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	38, 956	1	•			30. 00 31. 00
31. 00 31. 01		NEONATAL INTENSIVE CARE UNIT	2, 979 1, 043	1	•			31.00
40. 00	1	SUBPROVI DER - I PF	2, 086		1			40. 00
41. 00	1	SUBPROVI DER - I RF	968	1				41. 00
43. 00		NURSERY	745	0				43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	54, 672	44	<u> </u>			50. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	01, 0,2	453	•			52. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	41, 116	0				54. 00
57. 00	1	CT SCAN	0	0	1			57. 00
58. 00 59. 00	1	MAGNETIC RESONANCE IMAGING (MRI)  CARDIAC CATHETERIZATION	0	0	1			58. 00 59. 00
60.00	1	LABORATORY	18, 472	1				60.00
60. 01	06001	BLOOD LABORATORY	0	1				60. 01
65.00	1	RESPI RATORY THERAPY	0 0	0				65.00
66. 00 66. 01	1	PHYSICAL THERAPY PHYSICAL THERAPY EAST BANK	25, 697	0				66. 00 66. 01
66. 10	1	PHYSICAL THERAPY LIVING CENTER						66. 10
67.00	1	OCCUPATIONAL THERAPY	6, 331	0				67. 00
67. 10	1	OCCUPATIONAL THERAPY LIVING CENTER	0	0				67. 10
68.00		SPEECH PATHOLOGY	2, 979					68. 00
68. 10 70. 00		SPEECH THERAPY LIVING CENTER ELECTROENCEPHALOGRAPHY	0					68. 10 70. 00
		MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	Ö				71. 00
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	l .			72. 00
73.00		DRUGS CHARGED TO PATIENTS	0	0	1			73.00
76. 00		CARDIOLOGY TIENT SERVICE COST CENTERS	17, 281	0				76. 00
90.00		CLINIC	0	0				90. 00
90. 10		FAMILY PRACTICE CLINIC	0	0				90. 10
90. 30		HEMATOLOGY ONCOLOGY CLINIC	0	3, 016				90. 30
90. 50 91. 00	1	SLEEP DISORDERS CLINIC EMERGENCY	24, 804	27, 241				90. 50 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	24,004	27, 271				92. 00
		AL PURPOSE COST CENTERS						
	1	INTEREST EXPENSE	000 400					113. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117)  IMBURSABLE COST CENTERS	238, 129	177, 410	0	0	0	118. 00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	О	0				190. 00
193.00	19300	NONPALD WORKERS	0	0				193. 00
		HEALTH PROPERTIES	0	0				193. 10
		LEIGHTON CENTER WELLNESS CENTER	0	0				193. 40 193. 50
	1	UNUSED SPACE	0					193. 50
		OCCUPATI ONAL HEALTH	0	5, 651				193. 90
		RESEARCH AND PROTOCOL	0	0				193. 91
193. 92		CCOP REASEARCH ADMIN	0	0				193. 92 193. 93
200.00		Cross Foot Adjustments		ή	22, 983	617, 303	137, 666	1
		, Jane 1 and	1	•	=, :00	, 230	, 230	

Health Financial Sys	stems MEMOR	RIAL HOSPITAL C	F SOUTH BEND,	I NC	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPIT	TAL RELATED COSTS		Provi der		Period: From 01/01/2014	Worksheet B Part II	
					To 12/31/2014		pared: 0 am
				INTERNS 8	RESI DENTS		
Cost Ce	enter Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	SERVICES-SALA Y & FRINGES	RSERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	-
		16.00	17. 00	21.00	22. 00	23. 00	
	ve Cost Centers	0	0		0	0	201. 00
202.00 TOTAL (	(sum lines 118-201)	238, 129	183, 061	22, 98	617, 303	137, 666	202. 00

Health Financial Systems In Lieu of Form CMS-2552-10 MEMORIAL HOSPITAL OF SOUTH BEND, INC ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150058 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/29/2015 9:20 am Cost Center Description PARAMED ED Subtotal Total Intern & Residents Cost & Post Stepdown Adjustments 23.01 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 02301 PARAMED ED 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 823, 812 0 9, 823, 812 30.00 03100 INTENSIVE CARE UNIT 852, 983 0 852, 983 31.00 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 442, 503 0 442, 503 31.01 04000 SUBPROVI DER - I PF 0 541, 120 40.00 40.00 541, 120 04100 SUBPROVI DER - I RF 0 41.00 526, 755 526, 755 41.00 04300 NURSERY 210, 700 43.00 210, 700 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 921, 849 50.00 3, 921, 849 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 418, 594 0 1, 418, 594 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 2, 363, 648 2, 363, 648 54.00 57.00 05700 CT SCAN 121, 172 0 121, 172 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 159, 299 58 00 159, 299 58 00 05900 CARDIAC CATHETERIZATION 649, 560 649, 560 59.00 59.00 06000 LABORATORY 0 60.00 554, 780 554, 780 60.00 06001 BLOOD LABORATORY 0 60.01 60.01 0 06500 RESPIRATORY THERAPY 407, 767 407, 767 65.00 65.00 496, 037 66,00 06600 PHYSI CAL THERAPY 496, 037 0 66, 00 06602 PHYSI CAL THERAPY EAST BANK 15, 200 0 15, 200 66.01 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0 4, 322 66.10 4, 322 66.10 67.00 06700 OCCUPATIONAL THERAPY 302, 875 302, 875 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 2, 842 2, 842 67.10 06800 SPEECH PATHOLOGY 29, 597 0 68.00 29, 597 68.00 68.10 06801 SPEECH THERAPY LIVING CENTER 2, 154 2, 154 68.10 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 222, 687 1, 222, 687 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 280, 585 280, 585 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 651, 938 651, 938 73.00 03020 CARDI OLOGY 0 76.00 314, 755 314, 755 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90 00 90.10 09001 FAMILY PRACTICE CLINIC 0 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 0 90.30 361, 769 361, 769 90.30 09004 SLEEP DISORDERS CLINIC 0 90.50 9 272 9 272 90.50 09100 EMERGENCY 0 91.00 1, 526, 941 1, 526, 941 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 27, 215, 516 0 118.00 27, 215, 516 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 168, 826 C 168, 826 190.00 193. 00 19300 NONPALD WORKERS 0 193. 00 5,048,970 5, 048, 970 193. 10 19301 HEALTH PROPERTIES 49, 299 0 49, 299 193. 10 193. 40 19303 LEI GHTON CENTER 0 193. 40 224, 125 224, 125 193. 50 19305 WELLNESS CENTER 19, 277 0 19, 277 193. 50 193.80 19308 UNUSED SPACE 0 193.80 193. 90 19309 OCCUPATIONAL HEALTH 193. 90 5, 651 5, 651 193. 91 19310 RESEARCH AND PROTOCOL 56 0 56 193. 91 0 9, 687 193. 92 19311 CCOP 9.687 193. 92

20, 705

777, 952

20, 705

777, 952

193. 93

200. 00

200.00

193. 93 19312 REASEARCH ADMIN

Cross Foot Adjustments

Health Financial Systems	MEMORIAL HOSPITAL O	F SOUTH BEND,	I NC	In Lie	u of Form CMS-25	52-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2014		
				To 12/31/2014	Date/Time Prepa 5/29/2015 9:20	am
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total		
			Residents Cos	t		
			& Post			
			Stepdown			
			Adjustments			
	23. 01	24. 00	25. 00	26. 00		
201.00 Negative Cost Centers	0	0		0 0	20	01. 00
202.00 TOTAL (sum lines 118-201)	0	33, 540, 064		0 33, 540, 064	20	02. 00

	Financial Systems MEMON NLLOCATION - STATISTICAL BASIS	RLAL HOSPLTAL OF			<u> </u>	eu of Form CMS-: Worksheet B-1	
000. /			11.01.40.	F	rom 01/01/2014 o 12/31/2014		
		CAPITAL REL	ATED COSTS			5/29/2015 9: 2	O am
	Cost Center Description	NEW BLDG &	NEW MVBLE	   EMPLOYEE	Doconci Li ati on	ADMI NI STRATI VE	
	cost center bescription	FLXT	EQUI P	BENEFITS	Reconciliation	& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS		(ACCUM. COST)	
		PEET)		SALARI ES)		(031)	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	4. 00	5A	5. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1, 160, 072					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		1, 160, 072				2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	9, 713 91, 709	9, 713 91, 709			312, 628, 717	4. 00 5. 00
6.00	00600 MAINTENANCE & REPAIRS	3, 413	3, 413	577, 676	0	4, 870, 197	6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	181, 380 151	181, 380 151				1
9. 00	00900 HOUSEKEEPI NG	20, 753	20, 753	3, 098, 321	0		1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	23, 054	23, 054				
13. 00	01300 NURSI NG ADMI NI STRATI ON	4, 487 17, 719	4, 487 17, 719				
14.00	01400 CENTRAL SERVICES & SUPPLY	30, 004	30, 004				1
15. 00 16. 00	O1500   PHARMACY   O1600   MEDI CAL RECORDS & LI BRARY	9, 854 5, 471	9, 854 5, 471				
17. 00	01700 SOCIAL SERVICE	3, 509	3, 509	2, 775, 705	0	4, 000, 719	17. 00
21. 00 22. 00	02100   &R SERVI CES-SALARY & FRINGES APPRVD 02200   &R SERVI CES-OTHER PRGM COSTS APPRVD	0 15, 984	0 15, 984	_, ,			21. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	3, 841	3, 841				
23. 01	02301   PARAMED ED     I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	) C	0	0	23. 01
30. 00	03000 ADULTS & PEDIATRICS	222, 635	222, 635	29, 724, 193	0	49, 411, 960	30.00
31.00	03100 I NTENSI VE CARE UNI T	16, 954	16, 954				•
31. 01 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	8, 520 12, 480	8, 520 12, 480				
41. 00	04100 SUBPROVI DER - I RF	11, 755	11, 755	1, 417, 432	0	2, 291, 025	41.00
43. 00	04300   NURSERY   ANCI LLARY SERVICE COST CENTERS	4, 624	4, 624	1, 219, 632	0	1, 735, 597	43.00
50. 00	05000 OPERATI NG ROOM	98, 777	98, 777	12, 901, 860	0	25, 535, 140	50.00
52. 00 54. 00	O5200   DELI VERY ROOM & LABOR ROOM   O5400   RADI OLOGY-DI AGNOSTI C	36, 126 59, 010	36, 126 59, 010				1
57. 00	05700 CT SCAN	2, 887	2, 887				
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 345	4, 345	1	_		
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	17, 241 11, 205	17, 241 11, 205				1
60. 01	06001 BLOOD LABORATORY	0	0	) c	0	0	60. 01
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	10, 211 11, 909	10, 211 11, 909			.,,	1
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	0	1, 019, 747	0	1, 361, 734	66. 01
	06601 PHYSICAL THERAPY LIVING CENTER 06700 OCCUPATIONAL THERAPY	0 7, 789	0 7, 789			390, 906 1, 998, 810	
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	7, 789	7, 789	196, 060			
68.00	06800 SPEECH PATHOLOGY	348	348			1, 052, 136	
68. 10 70. 00	06801 SPEECH THERAPY LIVING CENTER 07000 ELECTROENCEPHALOGRAPHY	0	0	) 158, 815 ) C	0	195, 169 0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	) 0	0	9, 896, 815	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0	32, 893, 878 14, 871, 418	
	03020 CARDI OLOGY	7, 432	7, 432	1, 091, 590	Ō		•
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		0	) C	0	Ι ο	90.00
90. 10	09001 FAMILY PRACTICE CLINIC	O	Ö			ő	90. 10
90. 30 90. 50	09002 HEMATOLOGY ONCOLOGY CLINIC 09004 SLEEP DISORDERS CLINIC	9, 361	9, 361	700, 485 578, 006		1, 198, 182 839, 031	
91.00	I I	34, 907	34, 907				
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
113. 00	SPECIAL PURPOSE COST CENTERS   11300   INTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1, 009, 558	1, 009, 558	131, 196, 418	-44, 586, 475	300, 200, 698	1
190. 00	NONREIMBURSABLE COST CENTERS     1900  GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 761	4, 761		0	137, 650	190. 00
193.00	19300 NONPALD WORKERS	138, 747	138, 747	740, 418		5, 643, 666	193. 00
	19301   HEALTH PROPERTI ES   19303   LEI GHTON CENTER	6, 302	6, 302	1 .,,	0	4, 486, 169 182, 203	1
193. 50	19305 WELLNESS CENTER	0	0	946, 126	Ö	1, 585, 780	193. 50
	19308 UNUSED SPACE  19309 OCCUPATIONAL HEALTH	0	0		0		193. 80 193. 90
193. 91	19310 RESEARCH AND PROTOCOL	0	0	) c	0	0	193. 91
193. 92	2 19311 CCOP	273	273	s  c	0	8, 058	193. 92

Health Financial Systems ME	MORIAL HOSPITAL OF SOUTH BE	ID, INC	In Lie	u of Form CMS-255	52-10
COST ALLOCATION - STATISTICAL BASIS	Provi		Period: From 01/01/2014	Worksheet B-1	
		-	Го 12/31/2014	Date/Time Prepar 5/29/2015 9:20 a	
	CAPITAL RELATED COSTS				

						5/29/2015 9: 2	0 am
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	FMPLOYFF	Reconciliation	ADMI NI STRATI VE	
		FLXT	EQUI P	BENEFITS		& GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
		ŕ	ŕ	SALARI ES)		,	
		1. 00	2. 00	4. 00	5A	5. 00	
193. 93 193	12 REASEARCH ADMIN	431	431	286, 275	0	384, 493	193. 93
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	14, 430, 636	19, 109, 428	2, 502, 183		44, 586, 475	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	12. 439431	16. 472622	0. 018539		0. 142618	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			280, 823		2, 666, 666	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 002081		0. 008530	205. 00

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150058 | Period: From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

Cost Center Description					T	nom 01/01/2014 o 12/31/2014		
COUNTRY   FEET   COUNTRY		Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		o am
FEFT		<b>'</b>						
Figure 1. Service Cost Development   9.00   7.09   8.00   9.00   10.00			,	•	· `	SERVICE)	SERVED)	
EREMENT SERVICE DOST DENTESS  1 00 00000 MORE CAP REL COSTS MINET FOUR P  2 00 00000 MORE CAP REL COSTS MINET FOUR P  2 00 00000 MORE CAP REL COSTS MINET FOUR P  3 00 00000 MORE STATE VERY SERVICE  5 00 00000 MORE STATE VERY SERVICE  6 00 00000 MORE STATE VERY SERVICE  6 00 00000 MORE STATE VERY SERVICE  7 00 00000 MORE STATE VERY SERVICE  8 00 00000 MORE STATE VERY SERVICE  9 00 00000 MORE STATE VERY SERVICE  9 00 00000 MORE STATE VERY SERVICE  10 00 000000 MORE STATE VERY SERVICE  10 00 00000 MORE STATE VERY SERVICE  10 00 000000 MORE STATE VERY SERVICE  10 00 00000 MORE STATE VERY SERVICE  10					†	9. 00	10.00	
2.00   DODGO REST CAP HEL COSTS-WISEL EQUIP		GENERAL SERVICE COST CENTERS		* * • • •				
0-0400   DIPLOYEE BRIEFET TS   DEPARTWENT								•
5.00   0.0000 JAMI INSTRATIVE & CEMERAL   0.055.237   0.00000 JAMI INTERNACE & REPRIALS   1.055.237   0.0000 JAMI INTERNACE & REPRIALS   1.055.237   0.0000 JAMI INTERNACE & REPRIALS   0.0000 JAMI JAMI SERVICE   0.0000 JAMI JAMI SERVICE   0.0000 JAMI JAMI SERVICE   0.0000 JAMI JAMI SERVICE   0.0000 JAMI JAMI JAMI JAMI JAMI JAMI JAMI JAMI								1
0.00   0.0000   MAINTENANCE & REPAIRS   1,055,237   2,00   2070   0.0070   0.00870   0.00871								1
0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000			1, 055, 237					1
0.00 0.0900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   0009000   000900   000900   000900   000900   000900   000900   00090000   000900000000				873, 857				1
10.00   01000   DETARY			1					1
11.00 0 1100 CAFETERIA					1		242 (22	
13.00   01300   MIRES INCA ADMINISTRATION			1	•	0	I .		1
15.00   01500   PHARMACY   9,884   9,884   0 5,447   0 15.00   17.00			1		ő	-		ı
16. 00   10.000   MIDICAL, RECORDS & LIBRARY   5. 471   5. 471   0. 124   0. 10. 00   1. 00			30, 004	30, 004	31, 113	1, 625	0	14. 00
17.00   01700   SOCIAL SERVICES - SALARY & FRINGES APPRVD   15.00   21.00   0100   018 SERVICES-SALARY & FRINGES APPRVD   15.00   15.00   0.				•			-	1
21.00   02100   IAS SERVICES-SALARY & FENROES APPRIVO   0   0   0   0   0   0   22.00					_		0	1
22.00   02200  RAY SERVICES-OTHER PROX LOSTS APPRIVD   15, 964   15, 964   0			1		0		0	1
10   2301   PARAMED ED   10   20   0   0   0   22.0			15, 984	15, 984	0	O	0	
INVADIT   ENT ROUTH NE SERVICE COST CENTERS   222,635   1,090,312   37,886   283,315   30,00   31,00   03000   ADULTS & PEDIDATRICS   222,635   222,635   1,090,312   37,886   283,315   30,00   31,01   30,000   ADULTS & PEDIDATRICS   222,635   222,635   3,000   40,000   ADULTS & PEDIDATRICS   222,635   3,000   40,000   40,000   ADULTS & PEDIDATRICS   222,632   31,431   40,000   40,000   ADULTS & PEDIDATRICS   222,635   41,000   40,000   ADULTS & PEDIDATRICS   222,635   41,000   40,000   ADULTS & PEDIDATRICS   222,635   41,000   43,000   ADULTS & PEDIDATRICS   222,635   41,000   43,000   ADULTS & PEDIDATRICS   44,624   4,624   20,120   22,162   50,400   ADULTS & PEDIDATRICS   44,624   4,624   20,120   22,162   50,400   ADULTS & PEDIDATRICS   44,624   4,624		, , , , , , , , , , , , , , , , , , , ,	3, 841	3, 841	0	0	0	1
30 00   30000   ADULTS & PEDI ATRICS   222, 635   1,090, 312   37, 886   283, 315   30, 00   310   01 NIENSIVE CARE UNIT   16, 954   16, 954   87, 514   3, 363   26, 329   31, 00   310   01 00000   01 NIENSIVE CARE UNIT   8, 520   8, 520   97, 477   1, 572   0 31, 01   01 000   04000   SUBPROVIDER - IPF   12, 480   12, 480   52, 466   283   18, 431   40, 00   410   00 04100   SUBPROVIDER - IPF   12, 480   12, 480   52, 466   283   18, 431   40, 00   410   00 04100   SUBPROVIDER - IPF   11, 755   11, 755   116, 175   3, 752   15, 557   41, 00   00   410   00   00   00   00   00	23. 01		0	0	0	0	0	23. 01
33.10   023000   INTENSIVE CARE UNIT	30.00		222 635	222 635	1 090 312	37 886	283 315	30 00
31 01   02000 NEONATAL INTENSIVE CARE UNIT					1			1
41.00   04-100   SUBPROVI DER - I RF   11, 755   116, 175   3, 752   15, 557   41, 00   43, 00   430, 00   MURSERY   4, 624   4, 624   29, 120   2, 162   0   43, 00   05, 00   0500   OFERATION FROM   98, 777   98, 777   417, 188   4, 501   0, 50, 00   0500   OFERATION FROM   98, 777   98, 777   417, 188   4, 501   0, 50, 00   0500   OFERATION FROM   98, 777   98, 777   417, 188   4, 501   0, 50, 00   0500   OFERATION FROM   84, 501   0, 50, 00   0500   OFERATION FROM   84, 501   0, 50, 00   0500   OFERATION OF ANOMAL PROMOM   36, 126   36, 126   144, 376   3, 755   0, 52, 00   37, 00   0570   OFERATION   43, 45   4, 45   12, 108   0   0, 57, 00   0500   CT SCAN   43, 435   4, 445   12, 108   0   0, 58, 00   0500   CAROBATORY   17, 205				8, 520	1		•	•
A					l			•
ANCIL LARY SERVICE COST CENTERS					l			•
50.00   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000	43.00		4,624	4, 624	29, 120	2, 162	0	43.00
S2.00   OS200   OS200   OS200   OS200   OS200   OS200   OS200   OS200   OS300   OS30	50. 00		98, 777	98, 777	417, 188	4, 501	0	50.00
57:00   05700   CT SCAN   2,887   2,887   0 0 0   0   57.00   58:00   05900   05900   CARDITIC RESONANCE IMAGING (MRI)   4,345   4,345   12,108   0   0   58.00   59:00   05900   05900   CARDITIC RESONANCE IMAGING (MRI)   17,241   17,241   120,620   1,296   0   59.00   60:00   05000   LABORATORY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1		l		0	ı
SB. 00   OSBOO   MAGNETI C RESONANCE I MACI NG (MRI)			1		1			1
59.00   05900   CARDIAC CATHETERIZATION   17, 241   17, 241   120, 620   1, 296   0   59, 00					1	-	-	1
60.0   06000   LABORATORY   11, 205   11, 205   0   2, 603   0   0   0   0   0   0   0   0   0			1			- 1	0	1
65.00   06500   RESPI RATORY THERAPY   10, 211   10, 211   0   0   0   65.00   66.01   06600   PHYSI CAL THERAPY   11, 909   11, 909   56, 237   1,169   0   66.00   66.01   06601   PHYSI CAL THERAPY EAST BANK   0   0   0   0   0   0   0   66.10   06601   PHYSI CAL THERAPY EAST BANK   0   0   0   0   0   0   0   66.10   06601   PHYSI CAL THERAPY EAST BANK   0   0   0   0   0   0   0   0   66.10   06601   PHYSI CAL THERAPY LIVING CENTER   0   0   0   0   0   0   0   0   67.10   06701   0CCUPATIONAL THERAPY LIVING CENTER   0   0   0   0   0   0   0   0   68.10   06600   SPECH PATHOLOGY   348   348   0   340   0   68.00   68.10   06600   SPECH PATHOLOGY   348   348   0   340   0   68.00   68.10   06600   SPECH PATHOLOGY   348   348   0   340   0   68.00   68.10   06600   SPECH PATHOLOGY   1   1   1   1   1   60.00   07000   1   1   1   1   1   1   60.00   07000   1   1   1   1   1   60.00   07000   1   1   1   1   1   60.00   07000   1   1   1   1   1   60.00   07000   1   1   1   1   60.00   07000   1   1   1   1   60.00   07000   1   1   1   60.00   0   0   0   60.00   0   0   0   0   60.00   0   0   0   0   60.00   0   0   0   60.00   0   0   0   0   60.00   0   0   0   0   60.00   0   0   0   60.00   0   0   0   60.00   0   0   0   60.00   0   0   0   60.00   0   0   0   60.00   0   0   0   60.00			1				0	1
66.00   06600   PHYSI CAL THERAPY   EAST BANK   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
66.01   06602 PHYSI CAL THERAPY LIVIN GENTER   0   0   0   0   0   66.01   67.00   06700   0CCUPATI ONAL THERAPY LIVIN GENTER   0   0   0   0   0   0   0   0   67.10   06701   0CCUPATI ONAL THERAPY LIVIN GENTER   0   0   0   0   0   0   0   0   0   67.10   06701   0CCUPATI ONAL THERAPY LIVIN GENTER   0   0   0   0   0   0   0   0   0						-	-	1
66.10   06601 PHYSICAL THERAPY LIVING CENTER   0   0   0   0   0   0   66.10   67.00   06700   0CCUPATI ONAL THERAPY   1VING CENTER   0   0   0   0   0   0   0   0   67.10   06701   0CCUPATI ONAL THERAPY LIVING CENTER   0   0   0   0   0   0   0   0   68.00   06800   SPEECH PATHOLOGY   348   348   348   0   340   0   68.00   68.10   06801   SPEECH HERAPY LIVING CENTER   0   0   0   0   0   0   0   0   0   67.10   07000   07000   07000   07000   0			1				-	1
67. 00   06700   0500   0500   0500   0500   0500   067. 00   067. 00   067. 00   0670   0500   0670   0600   067. 00   0670   0600   0600   0			1	ŭ	1		-	1
68. 10 06800 SPECH PATHOLOGY			7, 789	7, 789	Ō	55	0	1
68.10   06.801   SPECH THERAPY LIVING CENTER   0   0   0   0   0   0   68.10   70.00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   72.00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   74.00   03022   CARDIOLOGY   74.32   74.432   74.432   0   141   0   76.00   75.00   03022   CARDIOLOGY   74.432   74.432   74.432   0   141   0   76.00   76.00   03022   CARDIOLOGY   74.432   74.432   74.432   0   141   0   76.00   76.00   03022   CARDIOLOGY   74.432   74.432   74.432   0   141   0   76.00   76.00   03022   CARDIOLOGY   74.432   74.432   74.432   0   141   0   76.00   76.00   09000   CLINI C   0   0   0   0   0   0   0   0   0			0	0	0	-	0	1
70. 00   07000   ELECTROENCEPHALGGRAPHY   0   0   0   0   0   70. 00			1			l .	-	•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73. 00 07300 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 76. 00 03020 CARDI OLOGY 7, 432 7, 432 0 141 0 76. 00 76. 00 03020 CARDI OLOGY 7, 432 7, 432 0 141 0 76. 00 77. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	-	1	-	-	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   76. 00   03020   CARDI OLOGY   7, 432   7, 432   0   141   0   76. 00    OUTPATI ENT SERVICE COST CENTERS  90. 00   09000   CLINI C   0   0   0   0   0   0   0   0   90. 10   09000   CLINI C   0   0   0   0   0   0   0   90. 30   09002   HEMATOLOGY ONCOLOGY CLINI C   9, 361   9, 361   49, 964   1, 274   0   90. 30   90. 50   09004   SLEEP DI SORDERS CLINI C   0   0   0   20, 105   0   0   90. 50   91. 00   09100   EMERGENCY   34, 907   34, 907   219, 782   2, 080   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   92. 00    SPECIAL PURPOSE COST CENTERS  113. 00   11300   INTEREST EXPENSE   1130   INTEREST EXPENSE   138, 747   138, 747   0   13, 702   0   193. 00   193. 00   19300   NONPAI D WORKERS   138, 747   138, 747   0   13, 702   0   193. 00   193. 10   19300   HEALTH PROPERTIES   0   0   0   0   0   193. 10   193. 10   19301   HEALTH PROPERTIES   0   0   0   0   0   193. 40   193. 50   19305   WELLNESS CENTER   0   0   0   0   0   193. 40   193. 90   19300   OCUPATIONAL HEALTH   0   0   0   0   0   193. 90   193. 91   19310   RESEARCH ADMIN   431   431   0   0   0   0   193. 93   193. 92   19311   CCOP   273   273   273   0   0   0   0   193. 93   200. 00   Cross Foot Adjustments   200. 00   Cross Foot Adjustments   200. 00   Cross Foot Adjustments   200. 00   0   0   193. 93   200. 00   Cross Foot Adjustments   200. 00   Cross Foot Adjustments   200. 00   193. 90   200. 00   Cross Foot Adjustments   200. 00   0   193. 93   200. 00   Cross Foot Adjustments   200. 00   0   193. 93   200. 00   Cross Foot Adjustments   200. 00   200. 0			1	-		o	-	•
76.00	72.00		0	0	0	0	0	
90. 00   0000   CLI NI C   0   0   0   0   0   0   0   0   0			1	-	· ·	0		1
90. 00   09000   CLINIC   0   0   0   0   0   0   0   0   0	76. 00		7, 432	7, 432	. 0	141	0	76.00
90. 10	90 00		0	0	0	0	0	90 00
90. 30			o	0	Ö	Ö		•
91. 00	90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	9, 361	9, 361	49, 964	1, 274	0	•
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   SPECI AL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   SUBTOTALS (SUM OF LI NES 1-117)   904, 723   723, 343   2, 844, 872   83, 495   343, 632   118. 00   NONREI MBURSABLE COST CENTERS   118. 00   NONREI MBURSABLE COST CENTERS   138, 747   138, 747   0   13, 702   0   190. 00   193. 00   193. 00   19300   NONPAI D WORKERS   138, 747   138, 747   0   0   0   0   0   193. 00   193. 10   19301   HEALTH PROPERTI ES   0   0   0   0   0   193. 10   193. 40   19303   LEI GHTON CENTER   6, 302   6, 302   0   81   0   193. 40   193. 80   19308   UNUSED SPACE   0   0   0   0   0   193. 80   193. 90   19309   OCCUPATI ONAL HEALTH   0   0   0   0   0   0   193. 90   193. 91   19310   RESEARCH AND PROTOCOL   0   0   0   0   0   193. 91   193. 92   19311   CCOP   273   273   0   0   0   193. 93   193. 92   19311   REASEARCH ADMIN   431   431   0   0   0   0   193. 93   193. 92   193. 90   193. 90   193. 91   193. 10   Cross Foot Adjustments   200. 00   0   193. 93   193. 90   193. 9			0	0		0		
113. 00   11300   INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1-117)   904, 723   723, 343   2, 844, 872   83, 495   343, 632   118. 00   NONREI MBURSABLE COST CENTERS   904, 723   723, 343   2, 844, 872   83, 495   343, 632   118. 00   NONREI MBURSABLE COST CENTERS   90, 90, 90, 90, 90, 90, 90, 90, 90, 90,			34, 907	34, 907	219, 782	2, 080	0	
113. 00   11300   INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1-117)   904, 723   723, 343   2, 844, 872   83, 495   343, 632   118. 00   NONREI MBURSABLE COST CENTERS	72.00							72.00
NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   4,761   4,761   0   0   0   190. 00	113.00							
190. 00   1900	118. 00		904, 723	723, 343	2, 844, 872	83, 495	343, 632	118. 00
193. 00       19300       NONPAI D WORKERS       138, 747       0       13, 702       0       193. 00         193. 10       19301       HEALTH PROPERTIES       0       0       0       0       0       193. 10         193. 40       19303       LEI GHTON CENTER       6, 302       6, 302       0       81       0       193. 40         193. 50       19305       WELLNESS CENTER       0       0       299, 422       0       0       193. 50         193. 90       19309       UNUSED SPACE       0       0       0       0       0       0       0       193. 80         193. 91       19309       OCCUPATI ONAL HEALTH       0       0       0       0       0       0       193. 90         193. 91       19310       RESEARCH AND PROTOCOL       0       0       0       0       0       0       0       193. 93         193. 93       19312       CCOP       273       273       0       0       0       193. 93         200. 00       Cross Foot Adjustments       431       431       0       0       0       193. 93	100 00		4 741	1 741	1 0	٥١	0	100 00
193. 10   19301   HEALTH PROPERTIES 0 0 0 0 0 0 193. 10   193. 40   19303   LEI GHTON CENTER 6, 302 6, 302 0 81 0 193. 40   193. 50   19305   WELLNESS CENTER 0 0 0 299, 422 0 0 193. 50   193. 80   19308   UNUSED SPACE 0 0 0 0 0 0 0 0 193. 80   193. 90   19309   OCCUPATI ONAL HEALTH 0 0 0 0 0 0 193. 91   19310   RESEARCH AND PROTOCOL 0 0 0 0 0 193. 91   193. 91   19310   COP 273 273 0 0 0 0 193. 92   193. 93   19312   REASEARCH ADMIN 431 431 0 0 0 0 193. 93   200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1		1	13 702		1
193. 40     19303     LEI GHTON CENTER     6, 302     0     81     0     193. 40       193. 50     19305     WELLNESS CENTER     0     0     299, 422     0     0     193. 50       193. 80     19308     UNUSED SPACE     0     0     0     0     0     0     193. 80       193. 90     19309     OCCUPATI ONAL HEALTH     0     0     0     0     0     0     193. 91       193. 91     19310     RESEARCH AND PROTOCOL     0     0     0     0     0     193. 92       193. 92     19311     CCOP     273     273     0     0     0     193. 92       193. 93     19312     REASEARCH ADMIN     431     431     0     0     0     193. 93       200. 00     Cross Foot Adjustments     200. 00			0		i	0		1
193. 80   19308   UNUSED SPACE			6, 302	6, 302	1	81		
193. 90   19309   OCCUPATI ONAL HEALTH			0	0	299, 422	0		
193. 91   19310   RESEARCH AND PROTOCOL			0	0	0	0		1
193. 92 19311 CCOP 273 273 0 0 193. 92 193. 93 19312 REASEARCH ADMIN 431 431 0 0 193. 93 200. 00 Cross Foot Adjustments 273 273 0 0 0 193. 93 200. 00				0	n	0		1
200.00 Cross Foot Adjustments 200.00			273	273	Ö	Ö		1
			431	431	0	0	0	
201. 00		, ,						
	201.00	megative cost cellers	<u> </u>		<u> </u>			1201.00

Health Fina	ncial Systems MEMO	RIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					rom 01/01/2014		
				[7	To 12/31/2014	Date/Time Pre	
						5/29/2015 9: 2	<u>0 am</u>
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(HOURS OF	(MEALS	
		(SQUARE	(SQUARE	(POUNDS OF	SERVICE)	SERVED)	
		FEET)	FEET)	LAUNDRY)			
		6.00	7. 00	8. 00	9. 00	10.00	
202. 00	Cost to be allocated (per Wkst. B,	5, 564, 775	16, 452, 045	1, 926, 691	7, 154, 887	5, 030, 253	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	5. 273484	18. 826930	0. 612758	73. 550926	14. 638488	203. 00
204.00	Cost to be allocated (per Wkst. B,	141, 422	5, 389, 584	19, 672	786, 917	849, 761	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 134019	6. 167581	0.006256	8. 089362	2. 472881	205. 00
	• •	•	'	•			

Health Financial Syste		RIAL HOSPITAL O			<u> </u>	u of Form CMS-1 Worksheet B-1	
0001 712200711 011			7.00.000		rom 01/01/2014	Date/Time Pre 5/29/2015 9:2	pared:
Cost Cente	er Description	CAFETERI A (HOURS OF SERVI CE)	NURSI NG ADMI NI STRATI ON (DI RECT	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME	
		11.00	NRSING HRS) 13.00	REQUI S. ) 14. 00	15. 00	SPENT) 16.00	
GENERAL SERVICE							
2. 00 00200 NEW CAP RE 4. 00 00400 EMPLOYEE E 5. 00 00500 ADMI NI STR/6. 00 00600 MAI NTENANO 00700 OPERATI ON 8. 00 00800 LAUNDRY & 9. 00 00900 HOUSEKEEPI 10. 00 01100 CAFETERI A 13. 00 01300 NURSI NG AU 14. 00 01400 CENTRAL SE 15. 00 01500 PHARMACY	CE & REPAIRS OF PLANT LINEN SERVICE NG  OMINISTRATION ERVICES & SUPPLY  ECORDS & LIBRARY	3, 661, 592 34, 897 85, 100 132, 798 88, 681 90, 962	1, 340, 480 18	100 0 0	14, 981, 490 0	3, 197 0	l
21. 00   02100   I &R SERVI ( 22. 00   02200   I &R SERVI ( 23. 00   02300   PARAMED EI	CES-SALARY & FRINGES APPRVD CES-OTHER PRGM COSTS APPRVD O PRGM-(SPECIFY)	0 92, 817 3, 151	0 0 0	0	0 0	0 0 0	21. 00 22. 00 23. 00
23. 01   02301   PARAMED EL	NE SERVICE COST CENTERS	0	0	0	0	0	23. 01
30. 00 03000 ADULTS & F 31. 00 03100 I NTENSI VE	PEDIATRICS CARE UNIT NTENSIVE CARE UNIT ER - IPF	1, 055, 949 156, 721 123, 349 63, 877 43, 842 36, 602	114, 534 89, 300 23, 924 24, 943	0 0 0 0 0	271 1, 580 0 267	523 40 14 28 13 10	31. 00 31. 01 40. 00 41. 00
ANCI LLARY SERVI		2/4 //5	101 405	0	2 172	724	F0 00
50. 00   05000   0PERATI NG   52. 00   05200   DELI VERY   F	ROOM & LABOR ROOM DIAGNOSTIC RESONANCE IMAGING (MRI) ATHETERIZATION  PRATORY RY THERAPY HERAPY HERAPY EAST BANK HERAPY LIVING CENTER HAL THERAPY LIVING CENTER HOLOGY RAPY LIVING CENTER HOLOGY RAPY LIVING CENTER CEPHALOGRAPHY PPPLIES CHARGED TO PATIENTS CHARGED TO PATIENTS RECED TO PATIENTS CEC COST CENTERS	364, 665 125, 671 252, 748 30, 649 0 31, 148 110, 127 0 83, 208 67, 173 31, 756 7, 215 38, 020 5, 748 20, 439 3, 459 0 0 0 25, 371	81, 024 33, 401 0 0 10, 824 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19 4, 877 15 0 798 0 3, 313 661 0 0 0 24 0 0	734 0 552 0 0 0 248 0 0 345 0 0 85 0 0 0 0 0 249 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52. 00 54. 00 57. 00 58. 00 59. 00 60. 01 65. 00 66. 01 66. 10 67. 00 67. 10 68. 10 70. 00 71. 00 72. 00 73. 00 76. 00
90. 50   09004   SLEEP DI SC 91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATI C SPECI AL PURPOSE	ONCOLOGY CLINIC ORDERS CLINIC ON BEDS (NON-DISTINCT PART) COST CENTERS	0 17, 536 17, 074 257, 318	o	0 0 0 0	0 154 0 12, 799	0 0 0 333	90. 30 90. 50 91. 00 92. 00
113. 00 11300 I NTEREST E 118. 00 SUBTOTALS NONREI MBURSABLE	(SUM OF LINES 1-117)	3, 498, 071	1, 328, 441	100	14, 976, 504	3, 197	113. 00 118. 00
190. 00 19000 GIFT, FLOW 193. 00 19300 NONPALD WO 193. 10 19301 HEALTH PRO 193. 40 19305 WELLNESS COMMENT OF THE PROPERTY OF T	VER, COFFEE SHOP & CANTEEN ORKERS OPERTIES CENTER CENTER OCE UAL HEALTH AND PROTOCOL	0 37, 400 76, 233 0 41, 442 0 421 0 8, 025	7, 676 0 0 0 0 76 0	0 0 0 0 0 0 0 0	0 3, 840 1, 024 0 0 0 0 0 0 122	0 0 0 0 0 0 0	190. 00 193. 00 193. 10 193. 40 193. 50 193. 80 193. 90 193. 91 193. 92 193. 93 200. 00

Health Fin	nancial Systems MEMOI	RIAL HOSPITAL C	F SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2014	D-+- /T: D	
					To 12/31/2014	Date/Time Pre 5/29/2015 9:2	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	F	(HOURS OF	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		SERVICE)		SUPPLY	REQUIS.)	LI BRARY	
			(DI RECT	(COSTED		(TIME	
			NRSING HRS)	REQUIS.)		SPENT)	
		11.00	13.00	14.00	15. 00	16.00	
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 180, 424	3, 202, 389	8, 983, 66	8 16, 384, 208	4, 505, 253	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 322380	2. 388987	89, 836. 68000	0 1. 093630	1, 409. 212699	203. 00
204.00	Cost to be allocated (per Wkst. B,	168, 568	652, 127	1, 138, 26	7 526, 485	238, 129	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 046037	0. 486488	11, 382. 67000	0. 035142	74. 485142	205. 00
	11)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150058 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/29/2015 9:20 am INTERNS & RESIDENTS PARAMED ED SOCI AL SERVI CESERVI CES-SALAR SERVI CES-OTHER PARAMED ED Cost Center Description Y & FRINGES PRGM COSTS PRGM (ASSLGNED (ASSI GNFD (ASSI GNED (ASSI GNED TIME) (TIME SPENT) TIME) TIME) TIME) 22.00 23.00 23.01 17.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6 00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 58, 148 17.00 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 21 00 2.124 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 0 2, 124 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 100 23.00 02301 PARAMED ED 23. 01 23.01 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 35, 889 1, 691 1, 691 30.00 0 0 03100 INTENSIVE CARE UNIT 0 31.00 31.00 3, 437 0 0 02060 NEONATAL INTENSIVE CARE UNIT 0 31.01 31.01 2,021 17 17 0 04000 SUBPROVIDER - IPF 0 40.00 3.443 C 0 40.00 1, 794 04100 SUBPROVIDER - IRF 0 0 0 0 41.00 41.00 04300 NURSERY 0 43.00 0 0 43.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 14 133 133 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 144 0 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 27 27 0 54.00 0 57 00 05700 CT SCAN 57 00 C 0 Λ 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 C 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 000000000000000 0 0 0 0 0 0 0 0 0 0 0 0 59.00 06000 LABORATORY 60.00 0 60.00 0 0 06001 BLOOD LABORATORY 0 60.01 C 0 60.01 65.00 06500 RESPIRATORY THERAPY 54 54 0 65.00 06600 PHYSI CAL THERAPY 66.00 C 66.00 06602 PHYSI CAL THERAPY EAST BANK 0 0 66.01 Λ 66.01 06601 PHYSICAL THERAPY LIVING CENTER 66.10 C 0 0 66.10 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 0 0 67.10 0 67.10 06800 SPEECH PATHOLOGY 0 68.00 C 0 68.00 68. 10 06801 SPEECH THERAPY LIVING CENTER 0 68.10 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS Ω 0 71 00 71 00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 73.00 03020 CARDI OLOGY 0 59 59 0 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09001 FAMILY PRACTICE CLINIC 0 0 0 0 90.10 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 90.30 958 4 0 0 90.30 09004 SLEEP DISORDERS CLINIC 90.50 0 90.50 0 0 0 91.00 09100 EMERGENCY 8,653 124 124 100 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 56, 353 2, 109 2, 109 100 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 0 190 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 193. 00 19300 NONPALD WORKERS 0 15 15 0 0 193.00 193. 10 19301 HEALTH PROPERTIES 0 0 193. 10 0 0 0 0 0 0 193. 40 19303 LEI GHTON CENTER 0 0 0 0 193. 40 193. 50 19305 WELLNESS CENTER 0 0 0 0 193.50 193. 80 19308 UNUSED SPACE 0 0 193. 80 193. 90 19309 OCCUPATIONAL HEALTH 1, 795 0 0 0 193. 90 193. 91 19310 RESEARCH AND PROTOCOL 0 0 0 193, 91 0 0 193. 92 19311 CCOP 0 0 0 193. 92 193. 93 19312 REASEARCH ADMIN 0 0 0 193. 93

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BE	END, INC	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Prov	ider CCN: 150058	From 01/01/2014 To 12/31/2014	Worksheet B-1  Date/Time Prepared: 5/29/2015 9:20 am

					12/01/2011	5/29/2015 9: 2	
			INTERNS &	RESI DENTS			
	Cost Center Description	SOCIAL SERVICE			PARAMED ED	PARAMED ED	
			Y & FRINGES	PRGM COSTS	PRGM	(ASSI GNED	
		(TIME	(ASSI GNED	(ASSI GNED	(ASSI GNED	TIME)	
		SPENT)	TIME)	TIME)	TIME)		
		17. 00	21.00	22. 00	23.00	23. 01	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	4, 815, 201	2, 483, 772	6, 469, 469	371, 984	0	202.00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	82. 809400	1, 169. 384181	3, 045. 889360	3, 719. 840000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B,	183, 061	22, 983	617, 303	137, 666	0	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	3. 148191	10. 820621	290. 632298	1, 376. 660000	0.000000	205.00
	11)						

				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
·	(from Wkst. B,	Ādj.		Di sal I owance		
	Part I, col.					
	26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•					
30. 00 03000 ADULTS & PEDI ATRI CS	74, 887, 763		74, 887, 763	0	74, 887, 763	30. 00
31. 00 03100 I NTENSI VE CARE UNIT	11, 868, 509		11, 868, 509		11, 868, 509	31. 00
31. 01   02060   NEONATAL   NTENSI VE CARE UNIT	9, 138, 991		9, 138, 991		9, 151, 060	31. 01
40. 00   04000   SUBPROVI DER -   PF	4, 084, 928		4, 084, 928		4, 084, 928	40. 00
41. 00   04100   SUBPROVI DER -   RF	3, 716, 843		3, 716, 843		3, 716, 843	
43. 00   04300   NURSERY	2, 348, 558		2, 348, 558		2, 348, 558	43. 00
ANCI LLARY SERVI CE COST CENTERS	2, 340, 330		2, 340, 330	١	2, 340, 330	43.00
50. 00 05000 OPERATING ROOM	33, 734, 091		33, 734, 091	23, 035	33, 757, 126	50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	9, 626, 231		9, 626, 231		9, 626, 231	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C			20, 927, 625		20, 968, 883	54.00
	20, 927, 625			· ·		
57. 00   05700   CT   SCAN	2, 175, 260		2, 175, 260		2, 175, 260	57. 00
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	945, 372		945, 372		945, 372	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	3, 584, 688		3, 584, 688		3, 587, 466	59. 00
60. 00   06000   LABORATORY	15, 623, 669		15, 623, 669	0	15, 623, 669	60.00
60. 01   06001   BLOOD   LABORATORY	C		0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	5, 412, 112		5, 412, 112		5, 412, 112	65. 00
66. 00 06600 PHYSI CAL THERAPY	5, 259, 847		5, 259, 847		5, 286, 837	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	1, 566, 179		1, 566, 179		1, 566, 179	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	448, 982		448, 982		448, 982	66. 10
67. 00  06700 OCCUPATI ONAL THERAPY	2, 607, 679	0	2, 607, 679	0	2, 607, 679	67. 00
67.10  06701 OCCUPATIONAL THERAPY LIVING CENTER	292, 283	0	292, 283		292, 283	67. 10
68.00   06800   SPEECH PATHOLOGY	1, 298, 542	0	1, 298, 542	0	1, 298, 542	68. 00
68. 10   06801   SPEECH THERAPY LIVING CENTER	224, 119	0	224, 119	0	224, 119	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	C		0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 291, 947		20, 291, 947	0	20, 291, 947	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	37, 585, 137		37, 585, 137	0	37, 585, 137	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	33, 332, 990		33, 332, 990	0	33, 332, 990	73. 00
76. 00 03020 CARDI OLOGY	4, 202, 618		4, 202, 618	22, 316	4, 224, 934	76. 00
OUTPATIENT SERVICE COST CENTERS			., . ,	,	., .,	
90. 00 09000 CLI NI C	C		0	0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC	i c		0	0	0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	1, 833, 642		1, 833, 642	0	1, 833, 642	90. 30
90. 50   09004   SLEEP DI SORDERS CLINIC	976, 515		976, 515		983, 207	90. 50
91. 00   09100   EMERGENCY	21, 006, 105		21, 006, 105		21, 503, 892	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 187, 626		7, 187, 626		7, 187, 626	92. 00
SPECIAL PURPOSE COST CENTERS	7, 107, 020		7, 107, 020		7, 107, 020	72.00
113. 00 11300   NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	336, 188, 851	0	336, 188, 851	632, 925	336, 821, 776	
201.00 Less Observation Beds	7, 187, 626		7, 187, 626		7, 187, 626	
202.00 Total (see instructions)	329, 001, 225					
202.00   Total (See Tristructions)	329,001,225	ı o	329, 001, 225	032, 925	329, 034, 150	<sub>1</sub> 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150058 Peri od: Worksheet C From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 9:20 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 156, 111, 351 156, 111, 351 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 29, 836, 085 29, 836, 085 31.00 02060 NEONATAL INTENSIVE CARE UNIT 31.01 22, 305, 434 22, 305, 434 31.01 04000 SUBPROVIDER - IPF 40.00 4, 892, 279 4, 892, 279 40.00 04100 SUBPROVI DER - I RF 41.00 9, 678, 074 9.678.074 41.00 43.00 04300 NURSERY 3, 866, 514 3, 866, 514 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50. 973. 871 58, 320, 694 109, 294, 565 0.308653 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 18, 303, 481 1, 633, 297 19, 936, 778 0.482838 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 31, 714, 102 71, 081, 936 102, 796, 038 0.203584 0.000000 54.00 57.00 05700 CT SCAN 17, 837, 387 36, 523, 068 54, 360, 455 0.040015 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 199, 371 1, 539, 204 0.000000 58.00 339, 833 0.614195 58.00 05900 CARDIAC CATHETERIZATION 59.00 18, 517, 516 26, 473, 406 44, 990, 922 0.079676 0.000000 59.00 06000 LABORATORY 68, 933, 793 33, 456, 807 102, 390, 600 0. 152589 0.000000 60.00 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 06500 RESPIRATORY THERAPY 34.567.674 3, 268, 248 37, 835, 922 0.143042 65.00 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 7,664,936 4, 339, 845 12, 004, 781 0.438146 0.000000 66.00 06602 PHYSI CAL THERAPY EAST BANK 4, 519, 948 4, 523, 020 0.346268 0.000000 66, 01 3,072 66.01 06601 PHYSICAL THERAPY LIVING CENTER 1, 271, 957 1, 274, 346 0.352323 0.000000 2.389 66.10 66.10 06700 OCCUPATI ONAL THERAPY 67.00 4, 596, 730 1, 671, 884 6, 268, 614 0.415990 0.000000 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 735 888, 891 889, 626 0.328546 0.000000 67.10 68.00 06800 SPEECH PATHOLOGY 2, 031, 551 1, 990, 895 4, 022, 446 0.322824 0.000000 68.00 791, 730 791, 911 06801 SPEECH THERAPY LIVING CENTER 0 283010 0.000000 68 10 181 68 10 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 55, 223, 906 19, 890, 796 75, 114, 702 0.270146 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 104, 239, 657 48, 845, 725 153, 085, 382 0.245517 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 92, 028, 976 148, 349, 610 73.00 56, 320, 634 0.224692 0.000000 73.00 76.00 03020 CARDI OLOGY 6, 142, 904 5, 506, 768 11, 649, 672 0.360750 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 0.000000 0.000000 90 00 09001 FAMILY PRACTICE CLINIC 90.10 0.000000 0.000000 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 52, 997 1, 297, 814 1, 350, 811 1.357438 0.000000 90.30 90.30 90. 50 09004 SLEEP DISORDERS CLINIC 6,764 3, 897, 828 3, 904, 592 0.250094 0.000000 90.50 09100 EMERGENCY 12, 980, 145 30, 697, 825 43, 677, 970 91 00 91 00 0 480931 0.000000 09200 OBSERVATION BEDS (NON-DISTINCT PART) 16, 207, 399 92.00 16, 207, 399 0.443478 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 429, 237, 228 1, 182, 949, 103 753, 711, 875 200. 00 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 753, 711, 875 429, 237, 228 1, 182, 949, 103 202.00

| Period: | Worksheet C | From 01/01/2014 | Part | Date/Time Prepared: | 5/29/2015 9: 20 am

					5/29/2015 9:20 am
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT				31. 01
40.00	04000 SUBPROVI DER - I PF				40.00
41.00	04100 SUBPROVI DER - I RF				41.00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS	<u>'</u>			
50.00	05000 OPERATI NG ROOM	0. 308864			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 482838			52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 203985			54.00
57. 00	05700 CT SCAN	0. 040015			57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 614195			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 079738			59. 00
60.00	06000 LABORATORY	0. 152589			60.00
60. 01	06001 BLOOD LABORATORY	0. 000000			60. 01
65. 00	06500 RESPIRATORY THERAPY	0. 143042			65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 440394			66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0. 346268			66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0. 352323			66. 10
67. 00	06700 OCCUPATI ONAL THERAPY	0. 415990			67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0. 328546			67. 10
68.00	06800 SPEECH PATHOLOGY	0. 322824			68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0. 283010			68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 270146			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 245517			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 224692			73.00
76.00	03020 CARDI OLOGY	0. 362665			76. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0. 000000			90.00
90. 10	09001 FAMILY PRACTICE CLINIC	0. 000000			90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	1. 357438			90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	0. 251808			90. 50
91.00	09100 EMERGENCY	0. 492328			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 443478			92. 00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE				113. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202. 00

Total Cost   Cost Center Description   Total Cost   From Wkst. B, Part I, col. 26   Disallowance   Disallowan
Part I, col. 26)   1.00   2.00   3.00   4.00   5.00
1,00   2,00   3,00   4,00   5,00   3,00   4,00   5,00   3,00   4,00   5,00   3,00   4,00   5,00   3,00   4,00   5,00   3,00   4,00   5,00   3,00   4,00   5,00   3,00   4,00   5,00   3,00   4,00   5,00   3,00   4,00   5,00   3,00   4,00   5,00   4,00   5,00   4,00   5,00   4,00   5,00
1.00   2.00   3.00   4.00   5.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00   3000   ADULTS & PEDI ATRI CS   74,887,763   74,887,763   30.00   31.00   31.00   31.00   10.00   31.00   10.00   11,868,509   31.00   31
30. 00
31. 00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT 9, 138, 991 9, 138, 991 12, 069 9, 151, 060 31. 01 40. 00 04000 SUBPROVI DER - I PF 4, 084, 928 40. 00 44. 084, 928 0 4, 084, 928 40. 00 04100 SUBPROVI DER - I RF 3, 716, 843 3, 716, 843 0 3, 716, 843 41. 00 04300 NURSERY 2, 348, 558 0 2, 348, 558 0 2, 348, 558 0 2, 348, 558 0 2, 348, 558 0 2, 348, 558 0 2, 348, 558 0 2, 348, 558 0 0 2, 3
40. 00
41. 00
43. 00   04300   NURSERY   2, 348, 558   2, 348, 558   0   2, 348, 558   43. 00   ANCILLARY SERVICE COST CENTERS   50. 00   05000   OPERATI NG ROOM   33, 734, 091   33, 734, 091   23, 035   33, 757, 126   50. 00   52. 00   05200   DELI VERY ROOM & LABOR ROOM   9, 626, 231   9, 626, 231   0   9, 626, 231   52. 00   54. 00   05400   RADI OLOGY-DI AGNOSTI C   20, 927, 625   20, 927, 625   41, 258   20, 968, 883   54. 00   57. 00   05700   CT SCAN   2, 175, 260   2, 175, 260   0   2, 175, 260   57. 00   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   945, 372   945, 372   0   945, 372   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   3, 584, 688   3, 584, 688   2, 778   3, 587, 466   59. 00   60. 00   06000   LABORATORY   0   0   0   0   60. 01   06001   BLOOD LABORATORY   0   0   0   65. 00   06500   RESPI RATORY THERAPY   5, 412, 112   0   5, 259, 847   26, 990   5, 286, 837   66. 00   66. 01   06602   PHYSI CAL THERAPY EAST BANK   1, 566, 179   0   1, 566, 179   0   1, 566, 179   0
ANCILLARY SERVICE COST CENTERS  50. 00 05000 OPERATI NG ROOM 33, 734, 091 33, 734, 091 23, 035 33, 757, 126 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 9, 626, 231 9, 626, 231 0 9, 626, 231 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 20, 927, 625 20, 927, 625 41, 258 20, 968, 883 54. 00 57. 00 05700 CT SCAN 2, 175, 260 2, 175, 260 0 2, 175, 260 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 945, 372 945, 372 0 945, 372 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 3, 584, 688 3, 584, 688 2, 778 3, 587, 466 59. 00 60. 01 06001 BLOOD LABORATORY 0 15, 623, 669 0 0 15, 623, 669 60. 01 65. 00 06500 RESPI RATORY THERAPY 5, 412, 112 0 5, 412, 112 0 5, 412, 112 0 5, 259, 847 26, 990 5, 286, 837 66. 00 66. 01 06602 PHYSI CAL THERAPY EAST BANK 1, 566, 179 0 1, 566, 179 0 1, 566, 179 66. 01
50. 00         05000         OPERATI NG ROOM         33, 734, 091         33, 734, 091         23, 035         33, 757, 126         50. 00           52. 00         05200         DELI VERY ROOM & LABOR ROOM         9, 626, 231         9, 626, 231         0         9, 626, 231         52. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         20, 927, 625         20, 927, 625         41, 258         20, 968, 883         54. 00           57. 00         05700         CT SCAN         2, 175, 260         2, 175, 260         0         2, 175, 260         57. 00           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         945, 372         945, 372         0         945, 372         58. 00           59. 00         05900         CARDI AC CATHETERI ZATI ON         3, 584, 688         3, 584, 688         2, 778         3, 584, 468         99. 00           60. 00         06000         LABORATORY         15, 623, 669         15, 623, 669         0         15, 623, 669         0         15, 623, 669         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <t< td=""></t<>
52. 00         05200         DELI VERY ROOM & LABOR ROOM         9, 626, 231         9, 626, 231         0         9, 626, 231         52. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         20, 927, 625         20, 927, 625         41, 258         20, 968, 883         54. 00           57. 00         05700         CT SCAN         2, 175, 260         2, 175, 260         0         2, 175, 260         57. 00           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         945, 372         945, 372         0         945, 372         58. 00           59. 00         05900         CARDI AC CATHETERI ZATI ON         3, 584, 688         3, 584, 688         2, 778         3, 587, 466         59. 00           60. 00         06000         LABORATORY         15, 623, 669         0 </td
54. 00       05400       RADI OLOGY - DI AGNOSTI C       20, 927, 625       20, 927, 625       41, 258       20, 968, 883       54. 00         57. 00       05700       CT SCAN       2, 175, 260       2, 175, 260       0       2, 175, 260       57. 00         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       945, 372       945, 372       0       945, 372       58. 00         59. 00       05900       CARDI AC CATHETERI ZATI ON       3, 584, 688       3, 584, 688       2, 778       3, 587, 466       59. 00         60. 01       060.01       BLOOD LABORATORY       0
57. 00         05700         CT SCAN         2, 175, 260         2, 175, 260         0         2, 175, 260         57. 00           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         945, 372         945, 372         0         945, 372         58. 00           59. 00         05900         CARDI AC CATHETERI ZATI ON         3, 584, 688         3, 584, 688         2, 778         3, 587, 466         59. 00           60. 00         06000         LABORATORY         0
58. 00     05800     MAGNETI C RESONANCE I MAGI NG (MRI)     945, 372     945, 372     0     945, 372     58. 00       59. 00     05900     CARDI AC CATHETERI ZATI ON     3, 584, 688     3, 584, 688     2, 778     3, 587, 466     59. 00       60. 00     06000     LABORATORY     15, 623, 669     0     15, 623, 669     0     15, 623, 669     0
59. 00     05900 CARDI AC CATHETERI ZATI ON     3,584,688     3,584,688     2,778     3,587,466     59. 00       60. 00     06000 LABORATORY     15,623,669     15,623,669     0     15,623,669     0     15,623,669     0 <td< td=""></td<>
60. 00   06000   LABORATORY   15, 623, 669   0   15, 623, 669   0   0   0   0   0   0   0   0   0
60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0
65. 00   06500   RESPI RATORY THERAPY   5, 412, 112   0   5, 412, 112   0   5, 412, 112   0   5, 412, 112   0   66. 00   06600   PHYSI CAL THERAPY   5, 259, 847   0   5, 259, 847   26, 990   5, 286, 837   66. 00   66. 01   06602   PHYSI CAL THERAPY EAST BANK   1, 566, 179   0   1,
66. 00   06600   PHYSI CAL THERAPY   5, 259, 847   0   5, 259, 847   26, 990   5, 286, 837   66. 00   66. 01   06602   PHYSI CAL THERAPY EAST BANK   1, 566, 179   0   1, 566,
66. 01 06602 PHYSI CAL THERAPY EAST BANK 1, 566, 179 0 1, 566, 179 0 1, 566, 179 66. 01
66. 10   06601   PHYSI CAL THERAPY LIVING CENTER   448, 982   0   448, 982   0   448, 982   66. 10
67. 00   06700   OCCUPATI ONAL THERAPY   2,607,679   0   2,607,679   0   2,607,679   67. 00
67. 10   06701   OCCUPATI ONAL THERAPY LIVING CENTER   292, 283   0   292, 283   0   292, 283   67. 10
68. 00   06800   SPEECH PATHOLOGY   1, 298, 542   0   1, 298, 542   0   1, 298, 542   68. 00
68. 10   06801   SPEECH THERAPY LI VING CENTER   224, 119   0   224, 119   0   224, 119   68. 10
70. 00   07000   ELECTROENCEPHALOGRAPHY 0 0 0 0 70. 00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   20, 291, 947   20, 291, 947   0   20, 291, 947   71. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   37, 585, 137   37, 585, 137   0   37, 585, 137   72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   33, 332, 990   33, 332, 990   0   33, 332, 990   73. 00
76. 00   03020   CARDI OLOGY   4, 202, 618   4, 202, 618   22, 316   4, 224, 934   76. 00
OUTPATIENT SERVICE COST CENTERS
90. 00   09000   CLI NI C   0   0   0   90. 00
90. 10   09001   FAMILY PRACTICE CLINIC   0   0   90. 10
90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC   1,833,642   1,833,642   0   1,833,642   90. 30
90. 50   09004   SLEEP DI SORDERS CLINIC   976, 515   976, 515   6, 692   983, 207   90. 50
91. 00   09100   EMERGENCY   21,006,105   21,006,105   497,787   21,503,892   91.00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   7, 187, 626   7, 187, 626   7, 187, 626   92. 00
SPECIAL PURPOSE COST CENTERS
113. 00 11300 I NTEREST EXPENSE 113. 00
200.00 Subtotal (see instructions) 336, 188, 851 0 336, 188, 851 632, 925 336, 821, 776 200.00
201. 00 Less Observation Beds 7, 187, 626 7, 187, 626 7, 187, 626 201. 00
202.00 Total (see instructions) 329,001,225 0 329,001,225 632,925 329,634,150 202.00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150058 Peri od: Worksheet C From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 9:20 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 156, 111, 351 156, 111, 351 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 29, 836, 085 29, 836, 085 31.00 02060 NEONATAL INTENSIVE CARE UNIT 31.01 22, 305, 434 22, 305, 434 31.01 04000 SUBPROVIDER - IPF 40.00 4, 892, 279 4, 892, 279 40.00 04100 SUBPROVI DER - I RF 41.00 9, 678, 074 9.678.074 41.00 43.00 04300 NURSERY 3, 866, 514 3, 866, 514 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50. 973. 871 58, 320, 694 109, 294, 565 0.308653 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 18, 303, 481 1, 633, 297 19, 936, 778 0.482838 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 31, 714, 102 71, 081, 936 102, 796, 038 0.203584 0.000000 54.00 57.00 05700 CT SCAN 17, 837, 387 36, 523, 068 54, 360, 455 0.040015 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 199, 371 1, 539, 204 0.000000 58.00 339, 833 0.614195 58.00 05900 CARDIAC CATHETERIZATION 59.00 18, 517, 516 26, 473, 406 44, 990, 922 0.079676 0.000000 59.00 06000 LABORATORY 68, 933, 793 33, 456, 807 102, 390, 600 0. 152589 0.000000 60.00 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 06500 RESPIRATORY THERAPY 34.567.674 3, 268, 248 37, 835, 922 0.143042 65.00 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 7,664,936 4, 339, 845 12, 004, 781 0.438146 0.000000 66.00 06602 PHYSI CAL THERAPY EAST BANK 4, 519, 948 4, 523, 020 0.346268 0.000000 66, 01 3,072 66.01 06601 PHYSICAL THERAPY LIVING CENTER 1, 271, 957 1, 274, 346 0.352323 0.000000 2.389 66.10 66.10 06700 OCCUPATI ONAL THERAPY 67.00 4, 596, 730 1, 671, 884 6, 268, 614 0.415990 0.000000 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 735 888, 891 889, 626 0.328546 0.000000 67.10 68.00 06800 SPEECH PATHOLOGY 2, 031, 551 1, 990, 895 4, 022, 446 0.322824 0.000000 68.00 791, 730 791, 911 06801 SPEECH THERAPY LIVING CENTER 0 283010 0.000000 68 10 181 68 10 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 55, 223, 906 19, 890, 796 75, 114, 702 0.270146 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 104, 239, 657 48, 845, 725 153, 085, 382 0.245517 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 92, 028, 976 148, 349, 610 73.00 56, 320, 634 0.224692 0.000000 73.00 76.00 03020 CARDI OLOGY 6, 142, 904 5, 506, 768 11, 649, 672 0.360750 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 0.000000 0.000000 90 00 09001 FAMILY PRACTICE CLINIC 90.10 0.000000 0.000000 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 52, 997 1, 297, 814 1, 350, 811 1.357438 0.000000 90.30 90.30 90. 50 09004 SLEEP DISORDERS CLINIC 6,764 3, 897, 828 3, 904, 592 0.250094 0.000000 90.50 09100 EMERGENCY 12, 980, 145 30, 697, 825 43, 677, 970 91 00 91 00 0 480931 0.000000 09200 OBSERVATION BEDS (NON-DISTINCT PART) 16, 207, 399 92.00 16, 207, 399 0.443478 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 429, 237, 228 1, 182, 949, 103 753, 711, 875 200. 00 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 201.00

753, 711, 875

429, 237, 228 1, 182, 949, 103

202.00

Total (see instructions)

| Period: | Worksheet C | From 01/01/2014 | Part | Date/Time Prepared: | 5/29/2015 9: 20 am

					5/29/2015 9:20 am
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	NPATIENT ROUTINE SERVICE COST CENTERS				
	3000 ADULTS & PEDI ATRI CS				30.00
	3100 INTENSIVE CARE UNIT				31.00
31. 01 0	2060 NEONATAL INTENSIVE CARE UNIT				31. 01
	4000 SUBPROVI DER - I PF				40. 00
	4100 SUBPROVI DER - I RF				41.00
	14300 NURSERY				43. 00
A	NCILLARY SERVICE COST CENTERS				
50.00 0	5000 OPERATING ROOM	0. 308864			50. 00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	0. 482838			52. 00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	0. 203985			54. 00
57.00 0	5700 CT SCAN	0. 040015			57. 00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 614195			58. 00
59.00 0	5900 CARDI AC CATHETERI ZATI ON	0. 079738			59. 00
60.00 0	6000 LABORATORY	0. 152589			60.00
60. 01 0	6001 BLOOD LABORATORY	0. 000000			60. 01
65.00 0	6500 RESPI RATORY THERAPY	0. 143042			65. 00
	16600 PHYSI CAL THERAPY	0. 440394			66. 00
1	6602 PHYSI CAL THERAPY EAST BANK	0. 346268			66. 01
	6601 PHYSICAL THERAPY LIVING CENTER	0. 352323			66. 10
	6700 OCCUPATI ONAL THERAPY	0. 415990			67. 00
	6701 OCCUPATIONAL THERAPY LIVING CENTER	0. 328546			67. 10
	6800 SPEECH PATHOLOGY	0. 322824			68. 00
	6801 SPEECH THERAPY LIVING CENTER	0. 283010			68. 10
	7000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 270146			71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 245517			72. 00
	7300 DRUGS CHARGED TO PATIENTS	0. 224692			73. 00
	3020 CARDI OLOGY	0. 362665			76. 00
	UTPATIENT SERVICE COST CENTERS				
	9000 CLI NI C	0. 000000			90.00
	9001 FAMILY PRACTICE CLINIC	0. 000000			90. 10
	19002 HEMATOLOGY ONCOLOGY CLINIC	1. 357438			90. 30
	19004 SLEEP DISORDERS CLINIC	0. 251808			90. 50
	9100 EMERGENCY	0. 492328			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 443478			92.00
	PECIAL PURPOSE COST CENTERS	2: 110170			72.00
	1300 I NTEREST EXPENSE				113. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00
	,	1			1202.00

Heal th Financial Systems MEMORIAL HOSPITA CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provi der CCN: 150058

					o 12/31/2014	Date/lime Pre 5/29/2015 9:20	
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part		Net of Capital		Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS				1		
	05000 OPERATI NG ROOM	33, 734, 091	3, 921, 849			_	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9, 626, 231	1, 418, 594			ı	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 927, 625				0	54.00
57. 00	05700  CT SCAN	2, 175, 260				0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	945, 372		· ·		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 584, 688				0	59. 00
60.00	06000 LABORATORY	15, 623, 669	554, 780	15, 068, 889	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	1		0	60. 01
65.00	06500 RESPI RATORY THERAPY	5, 412, 112				0	65. 00
66. 00	06600 PHYSI CAL THERAPY	5, 259, 847				0	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	1, 566, 179				0	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	448, 982				0	66. 10
67. 00	06700 OCCUPATI ONAL THERAPY	2, 607, 679				0	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	292, 283				0	67. 10
68. 00	06800 SPEECH PATHOLOGY	1, 298, 542				0	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	224, 119	2, 154	221, 965	0	0	68. 10
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1		0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 291, 947				0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	37, 585, 137				0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	33, 332, 990				0	73. 00
76.00	03020 CARDI OLOGY	4, 202, 618	314, 755	3, 887, 863	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS				1		
	09000 CLI NI C	0	0	) c		_	
90. 10	09001 FAMILY PRACTICE CLINIC	0	0	C		0	90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	1, 833, 642				0	90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	976, 515				0	90. 50
91. 00	09100 EMERGENCY	21, 006, 105				0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 187, 626	942, 873	6, 244, 753	0	0	92.00
	SPECIAL PURPOSE COST CENTERS	T	ı	T	T		
	11300 INTEREST EXPENSE						113. 00
200.00		230, 143, 259					200. 00
201.00	I I	7, 187, 626					201. 00
202.00	Total (line 200 minus line 201)	222, 955, 633	14, 817, 643	208, 137, 990	0	0	202. 00

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCN: REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | 5/29/2015 9:20 am Provi der CCN: 150058

						5/29/2015 9:20 am
				le XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges			
		Capital and	(Worksheet C,			
		Operating Cost			)	
		Reduction	8)	/ col. 7)		
		6. 00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	33, 734, 091	109, 294, 565	0. 30865	3	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9, 626, 231	19, 936, 778	0. 48283	8	52. 00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	20, 927, 625	102, 796, 038	0. 20358	4	54. 00
57.00	D5700 CT SCAN	2, 175, 260	54, 360, 455	0. 04001	5	57. 00
58. 00	D5800 MAGNETIC RESONANCE IMAGING (MRI)	945, 372	1, 539, 204	0. 61419	5	58.00
59.00	05900 CARDIAC CATHETERIZATION	3, 584, 688	44, 990, 922	0. 07967	6	59.00
60.00	06000 LABORATORY	15, 623, 669	102, 390, 600	0. 15258	9	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0. 00000	o	60. 01
65.00	06500 RESPI RATORY THERAPY	5, 412, 112	37, 835, 922	0. 14304:	2	65. 00
66.00	06600 PHYSI CAL THERAPY	5, 259, 847	12, 004, 781	0. 43814	6	66. 00
66. 01	06602 PHYSICAL THERAPY EAST BANK	1, 566, 179	4, 523, 020	0. 34626	8	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	448, 982	1, 274, 346	0. 35232	3	66. 10
	06700 OCCUPATI ONAL THERAPY	2, 607, 679				67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	292, 283				67. 10
68. 00	06800 SPEECH PATHOLOGY	1, 298, 542	4, 022, 446	0. 32282	4	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	224, 119		0. 283010	0	68. 10
	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 291, 947	75, 114, 702			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	37, 585, 137		0. 24551	7	72. 00
	07300 DRUGS CHARGED TO PATIENTS	33, 332, 990				73. 00
	03020 CARDI OLOGY	4, 202, 618				76. 00
	OUTPATIENT SERVICE COST CENTERS	., ., ., .	, , , , ,			
	09000 CLI NI C	0	0	0.00000	o	90. 00
	09001 FAMILY PRACTICE CLINIC	0	0	1		90. 10
	09002 HEMATOLOGY ONCOLOGY CLINIC	1, 833, 642	1, 350, 811			90. 30
	09004 SLEEP DISORDERS CLINIC	976, 515				90. 50
	09100 EMERGENCY	21, 006, 105				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 187, 626				92.00
	SPECIAL PURPOSE COST CENTERS	,,,,,,,,,,		2	=	72.00
	11300 I NTEREST EXPENSE					113. 00
200.00	Subtotal (sum of lines 50 thru 199)	230, 143, 259	956, 259, 366			200. 00
201.00	Less Observation Beds	7, 187, 626				201.00
202.00	Total (line 200 minus line 201)	222, 955, 633				202. 00
202.00	110tai (1110 200 millius 1110 201)	1 222, 755, 055	, , , , , , , , , , , , , , , , , , , ,	I	I	1202.00

Health Financial Systems MEMC	RIAL HOSPITAL C	OF SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	9, 823, 812	0	9, 823, 81	2 84, 081	116. 84	30.00
31.00 INTENSIVE CARE UNIT	852, 983		852, 98	7, 156	119. 20	31.00
31. 01 NEONATAL INTENSIVE CARE UNIT	442, 503		442, 50	7, 978	55. 47	31. 01
40. 00 SUBPROVI DER - I PF	541, 120	0	541, 12	5, 041	107. 34	40.00
41. 00 SUBPROVI DER - I RF	526, 755	0	526, 75	5 4, 212	125.06	41.00
43. 00 NURSERY	210, 700		210, 70	4, 725	44. 59	43.00
200.00 Total (lines 30-199)	12, 397, 873		12, 397, 87	3 113, 193		200.00
Cost Center Description	Inpatient	Inpati ent		•		
· ·	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 ADULTS & PEDIATRICS	24, 387	2, 849, 377				30.00
31. 00 INTENSIVE CARE UNIT	3, 055	364, 156	,			31.00
31. 01 NEONATAL INTENSIVE CARE UNIT	0	0	)			31. 01
40. 00 SUBPROVI DER - I PF	3, 418	366, 888	1			40.00
41. 00 SUBPROVI DER - I RF	1, 424	178, 085				41.00
43. 00 NURSERY	0	l ·	1			43.00
200.00 Total (lines 30-199)	32, 284	3, 758, 506				200. 00

Health Financial Systems MEMO	RIAL HOSPITAL C	F SOUTH BEND,	I NC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	narod:
				10 12/31/2014	5/29/2015 9: 2	pareu. O am
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T	T				
50. 00   05000   OPERATI NG ROOM	3, 921, 849					
52. 00   05200   DELI VERY ROOM & LABOR ROOM	1, 418, 594					52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 363, 648				-	54.00
57. 00   05700   CT   SCAN	121, 172				13, 269	57. 00
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	159, 299				65, 822	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	649, 560				67, 488	59. 00
60. 00 06000 LABORATORY	554, 780				125, 644	60.00
60. 01 06001 BLOOD LABORATORY	0	_	0.00000		0	60. 01
65. 00 06500 RESPIRATORY THERAPY	407, 767				103, 847	65. 00
66. 00 06600 PHYSI CAL THERAPY	496, 037				· ·	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	15, 200				5	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	4, 322				6	66. 10
67. 00 06700 OCCUPATIONAL THERAPY	302, 875					67.00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	2, 842				2	67. 10
68. 00 06800 SPEECH PATHOLOGY	29, 597				2, 721	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	2, 154				0	68. 10
70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	1 222 (07	-	0.00000			70. 00 71. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 222, 687				365, 711 71, 183	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	280, 585 651, 938					72.00
73. 00   07300  DRUGS CHARGED TO PATTENTS  76. 00   03020  CARDI OLOGY	314, 755					76.00
OUTPATIENT SERVICE COST CENTERS	314,733	11,049,072	0.02701	0 2,000,910	/1,039	76.00
90. 00   09000   CLINIC	0		0.00000	0	0	90.00
90. 10   09001 FAMILY PRACTICE CLINIC			0.00000		0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	361, 769				4	90. 30
90. 50   09004 SLEEP DI SORDERS CLINIC	9, 272				0	90. 50
91. 00   09100   EMERGENCY	1, 526, 941				_	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	942, 873				214, 037	92.00
200.00 Total (lines 50-199)	15, 760, 516			179, 818, 584	_	
	.0,,00,010	, , , , , , , , , , , , , , , , , , , ,	1	, 5.5, 661	2,000,720	

lealth Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of Form CMS-2552-

Health Financial Systems MEMO	ORIAL HOSPITAL (	OF SOUTH BEND,	INC	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS			Period: From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS	C	) c		0 0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	C	) c	)	0	0	31. 00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	C	) c	)	0	0	31. 01
40. 00   04000   SUBPROVI DER - I PF	C	) c	)	0 0	0	40.00
41. 00   04100   SUBPROVI DER -   RF	C	) c		0 0	0	41.00
43. 00   04300   NURSERY	C	) c		0	0	43.00
200.00 Total (lines 30-199)	C	) c		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	84, 081	0.00	24, 38	7 0		30.00
31. 00   03100   I NTENSI VE CARE UNIT	7, 156	0.00	3, 05	5 0	,	31. 00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	7, 978	0.00		0 0		31. 01
40. 00   04000   SUBPROVI DER - 1 PF	5, 041	0.00	3, 41	8 0	,	40.00
41. 00   04100   SUBPROVI DER -   RF	4, 212	0.00	1, 42	4 0		41.00
43. 00   04300 NURSERY	4, 725	0.00		0 0		43.00
200.00 Total (lines 30-199)	113, 193	8	32, 28	4 0		200. 00

Health Financial Systems	MEMORIAL HOSPITAL OF SOU	ITH BEND, INC		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LNDATLENT (OUTDAT)	ENT ANGLE ADV CEDVICE OTHER DACC	D: -I CON 150050	D!I	W

Period: From 01/01/2014 To 12/31/2014 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Worksheet D Part IV Provider CCN: 150058 THROUGH COSTS Date/Time Prepared: 5/29/2015 9:20 am Title XVIII Hospi tal PPS Non Physician Nursing School Allied Health All Other Total Cost Cost Center Description Anestheti st Medi cal (sum of col 1 Education Cost through col. Cost 4) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 0 50.00 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05700 CT SCAN 0 0 57.00 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 58.00 0 05900 CARDIAC CATHETERIZATION 0 59.00 0 59.00 60.00 06000 LABORATORY 0 0 0 60.00 06001 BLOOD LABORATORY 0 60.01 60.01 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 Λ 0 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 66.01 06602 PHYSI CAL THERAPY EAST BANK 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0 0 66.10 0 66.10 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 0 67.10 06800 SPEECH PATHOLOGY 0 68.00 68.00 0 06801 SPEECH THERAPY LIVING CENTER 0 68 10 0 68 10 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 Ω Ω 73 00 03020 CARDI OLOGY 76.00 0 0 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 O 0 n 90.00 0 0 0 0 0 09001 FAMILY PRACTICE CLINIC 0 0 90.10 90.10 0 0 90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC 0 0 90.30 0 09004 SLEEP DISORDERS CLINIC 0 90.50 0 0 90.50 91. 00 09100 EMERGENCY 0 371, 984 371, 984 91 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00

0

0

371, 984

0

371, 984 200. 00

Не

200.00

Total (lines 50-199)

In Lieu of Form CMS-2552-10 Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 150058 Peri od: Worksheet D From 01/01/2014 To 12/31/2014 THROUGH COSTS Part IV Date/Time Prepared: 5/29/2015 9:20 am Title XVIII Hospi tal PPS Total Charges Ratio of Cost Cost Center Description Total Outpati ent I npati ent (from Wkst. C, to Charges Outpati ent Ratio of Cost Program Cost (sum of (col. 5 ÷ col to Charges Part I, col. Charges 7) col. 2, 3 and 8)  $(col. 6 \div col$ 4) 7) 6.00 7.00 8.00 9.00 10.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 109, 294, 565 0.000000 0.000000 19, 628, 039 50.00 52.00 | 05200 | DELIVERY ROOM & LABOR ROOM 0 19, 936, 778 0.000000 0.000000 121, 738 52.00 05400 RADI OLOGY-DI AGNOSTI C 102, 796, 038 0.000000 0.000000 12, 292, 679 54.00 000000000000 54.00 05700 CT SCAN 54, 360, 455 0.000000 0.000000 57.00 5, 953, 075 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 1, 539, 204 0.000000 0.000000 635, 996 58.00 59.00 05900 CARDIAC CATHETERIZATION 44, 990, 922 0.000000 0.000000 4, 674, 303 59.00 60.00 06000 LABORATORY 102, 390, 600 0.000000 0.000000 23, 190, 095 60.00 06001 BLOOD LABORATORY 0.000000 0.000000 60 01 Ω 60 01 06500 RESPIRATORY THERAPY 37, 835, 922 9, 635, 955 65.00 0.000000 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 12,004,781 0.000000 0.000000 2, 457, 658 66.01 06602 PHYSICAL THERAPY EAST BANK 4, 523, 020 0.000000 0.000000 1,620 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0.000000 0.000000 1, 274, 346 1.683 66 10 66 10 67.00 06700 OCCUPATIONAL THERAPY 6, 268, 614 0.000000 0.000000 1, 047, 678 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 000000 889, 626 0.000000 67.10 0.000000 518 67.10 68. 00 06800 SPEECH PATHOLOGY 4, 022, 446 0.000000 0.000000 369, 821 68 00 68. 10 06801 SPEECH THERAPY LIVING CENTER 791, 911 0.000000 0.000000 128 68.10 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 75, 114, 702 0.000000 0.000000 22, 466, 551 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 153, 085, 382 72 00 0.000000 0.000000 38, 833, 902 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 148, 349, 610 0.000000 0.000000 29, 702, 828 73.00 03020 CARDI OLOGY 11, 649, 672 0.000000 0.000000 2, 658, 915 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 0.000000 0.000000 90 00 0 90. 10 09001 FAMILY PRACTICE CLINIC 0 0.000000 0.000000 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 0 1, 350, 811 0.000000 0.000000 90.30 14 09004 SLEEP DISORDERS CLINIC 0.000000 90. 50 0 3, 904, 592 0.000000 0 90.50

371, 984

371, 984

43, 677, 970

16, 207, 399

956, 259, 366

0.008517

0.000000

0.008517

0.000000

6. 145. 388

0 92.00

179, 818, 584 200. 00

91.00

91. 00 09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50-199)

92.00

| Period: | Worksheet D | From 01/01/2014 | Part IV | Date/Time Prepared: | 5/29/2015 9: 20 am | Provi der CCN: 150058 THROUGH COSTS

					5/29/2015 9: 2	<u>0 am</u>
			e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12. 00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATI NG ROOM	0	12, 535, 493	[ C	)		50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	9, 207	0			52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	19, 783, 296	C			54.00
57.00  05700 CT SCAN	0	7, 820, 704	0			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	47, 673	C	)		58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	6, 250, 778	C	)		59. 00
60. 00   06000   LABORATORY	0	6, 838, 613	C			60.00
60. 01   06001   BLOOD   LABORATORY	0	0	C	)		60. 01
65. 00 06500 RESPIRATORY THERAPY	0	657, 345	C	)		65. 00
66. 00 06600 PHYSI CAL THERAPY	o	1, 226, 047	l c	)		66. 00
66.01 06602 PHYSICAL THERAPY EAST BANK	o	837, 000	C	)		66. 01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	o	374, 151	l c	)		66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	o	117, 379	C	)		67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENT	ER O	203, 474		)		67. 10
68.00 06800 SPEECH PATHOLOGY	o	93, 784		)		68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	o	172, 158	l c	)		68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	. 0		)		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	ENTS O	7, 696, 005	l c	)		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	16, 417, 796		)		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	13, 983, 307		)		73. 00
76. 00 03020 CARDI OLOGY	o	1, 396, 321	l c	)		76. 00
OUTPATIENT SERVICE COST CENTERS	'					
90. 00 09000 CLI NI C	0	C	C			90.00
90.10 09001 FAMILY PRACTICE CLINIC	l ol	0		)		90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	ol	O	l c	)		90. 30
90. 50 09004 SLEEP DISORDERS CLINIC	o	682, 288	l c	)		90. 50
91. 00 09100 EMERGENCY	52, 340	6, 538, 925	•			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT P		2, 109, 780		)		92.00
200.00 Total (lines 50-199)	52, 340	105, 791, 524				200.00
			•	•		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 150058 Peri od: Worksheet D From 01/01/2014 Part V Date/Time Prepared: 12/31/2014 5/29/2015 9:20 am Title XVIII Hospi tal **PPS** Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 308653 12, 535, 493 8, 112 3, 869, 118 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 482838 9, 207 0 4, 445 52.00 05400 RADI OLOGY-DI AGNOSTI C 19, 783, 296 0 4, 027, 563 54 00 0 203584 12 801 54 00 0 57.00 05700 CT SCAN 0.040015 7, 820, 704 5,061 312, 945 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 614195 47, 673 31 29, 281 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.079676 6, 250, 778 0 498, 037 59.00 4 045 06000 LABORATORY 60.00 0.152589 6, 838, 613 4, 425 1, 043, 497 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 0 60.01 06500 RESPIRATORY THERAPY 65.00 0.143042 657, 345 425 0 94,028 65.00 06600 PHYSI CAL THERAPY 537, 188 0 438146 793 66 00 1, 226, 047 66 00 06602 PHYSICAL THERAPY EAST BANK 66.01 0.346268 837,000 542 289, 826 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0. 352323 374, 151 242 131, 822 66.10 0 0 0 0 0 0 66.10 06700 OCCUPATIONAL THERAPY 67.00 0.415990 117, 379 67.00 76 48,828 06701 OCCUPATIONAL THERAPY LIVING CENTER 67. 10 0.328546 203, 474 132 66, 851 67.10 68.00 06800 SPEECH PATHOLOGY 0. 322824 93, 784 61 30, 276 68.00 06801 SPEECH THERAPY LIVING CENTER 0. 283010 68.10 172, 158 111 48, 722 68.10 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 C 2, 079, 045 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7, 696, 005 4.980 71 00 0.270146 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 245517 16, 417, 796 10, 624 4, 030, 848 72.00 07300 DRUGS CHARGED TO PATIENTS 0 3, 141, 937 73.00 0. 224692 13, 983, 307 9,048 73.00 503, 723 03020 CARDI OLOGY 76.00 0.360750 1, 396, 321 904 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 90.00 C 0 09001 FAMILY PRACTICE CLINIC 0.000000 90. 10 0 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 1. 357438 90.30 0 90.30 0 09004 SLEEP DISORDERS CLINIC 90.50 0.250094 682, 288 441 170, 636 90.50 91.00 09100 EMERGENCY 0.480931 6, 538, 925 4, 231 0 3, 144, 772 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.443478 2, 109, 780 1, 365 0 935, 641 92.00 200.00 Subtotal (see instructions) 200. 00 105, 791, 524 68, 456 25, 039, 029 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 105, 791, 524 68, 456 25, 039, 029 202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 150058 Peri od: Worksheet D From 01/01/2014 Part V 12/31/2014 Date/Time Prepared: 5/29/2015 9:20 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 504 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 2 606 0 57.00 05700 CT SCAN 203 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 19 58.00 05900 CARDIAC CATHETERIZATION 59.00 322 0 59.00 06000 LABORATORY 0 60.00 675 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06500 RESPIRATORY THERAPY 0 65.00 61 65.00 06600 PHYSI CAL THERAPY 0 66 00 347 66 00 06602 PHYSI CAL THERAPY EAST BANK 66.01 188 0 66.01 66. 10 06601 PHYSICAL THERAPY LIVING CENTER 85 0 66. 10 06700 OCCUPATIONAL THERAPY 67.00 32 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 0 67. 10 43 67.10 68.00 06800 SPEECH PATHOLOGY 20 0 68.00 06801 SPEECH THERAPY LIVING CENTER 31 68. 10 68. 10 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 1, 345 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2,608 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 2,033 73.00 03020 CARDI OLOGY 76.00 326 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09001 FAMILY PRACTICE CLINIC 0 0 90. 10 90.10 90.30 09002 HEMATOLOGY ONCOLOGY CLINIC 0 90.30 0 09004 SLEEP DISORDERS CLINIC 0 90.50 110 90.50 91.00 09100 EMERGENCY 2,035 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 605 92.00 200.00 Subtotal (see instructions) 0 200. 00 16, 201 Less PBP Clinic Lab. Services-Program 201.00 0 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 16, 201 0 202.00

Health Financial Systems MEMO	RIAL HOSPITAL (	OF SOUTH BEND,	INC	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150058	Peri od:	Worksheet D	
		Component	t CCN: 15S058	From 01/01/2014 To 12/31/2014		pared: O am
		Ti tl	e XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	F 00	
ANCILLARY SERVICE COST CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
50, 00 O5000 OPERATING ROOM	3, 921, 849	109, 294, 565	0. 03588	96, 832	3, 475	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	1, 418, 594				3, 473	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 363, 648					1
57. 00   05700   CT   SCAN	121, 172				32	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	159, 299					1
59. 00 05900 CARDI AC CATHETERI ZATI ON	649, 560				0	59. 00
60. 00   06000   LABORATORY	554, 780					
60. 01   06001   BLOOD   LABORATORY	001,700		0.00000		0,000	60. 01
65. 00 06500 RESPIRATORY THERAPY	407, 767	_				65. 00
66. 00 06600 PHYSI CAL THERAPY	496, 037				l e	
66. 01 06602 PHYSI CAL THERAPY EAST BANK	15, 200				0	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	4, 322		1		Ō	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	302, 875		•		5, 833	
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	2, 842		1	95 0	0	67. 10
68. 00 06800 SPEECH PATHOLOGY	29, 597	4, 022, 446	0.00735	2, 258	17	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	2, 154	791, 911	0. 00272	20 0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	00	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 222, 687	75, 114, 702	0. 01627	78 42, 976	700	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	280, 585	153, 085, 382	0. 00183	4, 875	9	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	651, 938	148, 349, 610			5, 690	73. 00
76. 00 03020 CARDI OLOGY	314, 755	11, 649, 672	0. 0270	18 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	_				
90. 10 09001 FAMILY PRACTICE CLINIC	0	_			0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	361, 769				0	90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	9, 272				0	90. 50
91. 00   09100   EMERGENCY	1, 526, 941				l e	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	14 017 (42		•		0	
200.00   Total (lines 50-199)	14, 817, 643	956, 259, 366	Pl	2, 191, 261	29, 441	200. 00

	<i>J</i>	RIAL HOSPITAL (				eu of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	RVICE OTHER PAS		CCN: 150058 t CCN: 15S058	Peri od: From 01/01/2014 To 12/31/2014		pared: O am
			Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Healt		4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	C		)	0 0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM			)	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C			2	0	0	54.00
57. 00	05700 CT SCAN			2	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)			2	0	0	
	05900 CARDI AC CATHETERI ZATI ON			2		0	
60.00	06000 LABORATORY				0	0	
60. 01	06001 BLOOD LABORATORY					0	60. 01
65. 00	06500 RESPI RATORY THERAPY					0	65. 00
66. 00	06600 PHYSI CAL THERAPY					0	66.00
66. 01	06602 PHYSI CAL THERAPY EAST BANK					0	66. 01
	06601 PHYSI CAL THERAPY LIVING CENTER			(		0	
67. 00	O6700   OCCUPATIONAL THERAPY   O6701   OCCUPATIONAL THERAPY LIVING CENTER					0	
68. 00	06800 SPEECH PATHOLOGY					0	67. 10 68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER					0	68. 10
	07000 ELECTROENCEPHALOGRAPHY					0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					0	
	107200 I MPL. DEV. CHARGED TO PATIENTS					0	1
	07300 DRUGS CHARGED TO PATIENTS					0	
	03020 CARDI OLOGY					_	1
70.00	OUTPATIENT SERVICE COST CENTERS		,	4	0 0	0	70.00
90.00	09000 CLINIC		) (	ol	0 0	0	90.00
90. 10	09001 FAMILY PRACTICE CLINIC			á	0	o o	1
	09002 HEMATOLOGY ONCOLOGY CLINIC			ol .	o o	0	1
	09004 SLEEP DI SORDERS CLINIC				0	ő	1
	09100 EMERGENCY			371 0	84	371 984	1

371, 984 91. 00 0 92. 00 371, 984 200. 00

90. 50 | 09004 | SLEEP DI SORDERS CLINIC 91. 00 | 09100 | EMERGENCY 92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (Lines 50-199)

	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	RVICE OTHER PAS		CCN: 150058 t CCN: 15S058	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/29/2015 9:2	
			Ti t	e XVIII	Subprovi der  - I PF	PPS	
	Cost Center Description	Total		Ratio of Cos		I npati ent	
		Outpati ent	(from Wkst. C		Ratio of Cost	Program	
		Cost (sum of	Part I, col.			Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
	ANOLILIARY OF BUILDE COOT OF STEED	6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS		100 004 54	-1		0, 000	
50. 00	05000 OPERATING ROOM	0	, ,			96, 832	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0				0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0				32, 464	
57. 00	05700 CT SCAN	0	, ,			14, 521	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	.,, =-			1, 066	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	,			0	
60.00	06000 LABORATORY	0	, ,			304, 614	
60.01	06001 BLOOD LABORATORY	0		0.00000		0	
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0				5, 837	65. 00
66.00		0		1		261, 258	1
66. 01 66. 10	06602 PHYSICAL THERAPY EAST BANK 06601 PHYSICAL THERAPY LIVING CENTER	0	.,,			0	66. 01 66. 10
67. 00	06700 OCCUPATIONAL THERAPY		6, 268, 61	1		120, 724	67.00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER			1		120, 724	
68. 00	06800 SPEECH PATHOLOGY		1	1		_	68.00
68. 10	06801 SPEECH THERAPY LIVING CENTER					2, 250	1
70.00	07000 ELECTROENCEPHALOGRAPHY			0.00000		0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			1		42, 976	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS					4, 875	
73.00	07300 DRUGS CHARGED TO PATIENTS					1, 294, 661	73.00
	03020 CARDI OLOGY			1		0	
70.00	OUTPATIENT SERVICE COST CENTERS		11,017,07	0.0000	0.00000	<u> </u>	70.00
90.00	09000 CLINIC	1 0		0.00000	0.000000	0	90.00
90. 10	09001 FAMILY PRACTICE CLINIC			0.00000		0	1
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC					0	1
90. 50	09004 SLEEP DI SORDERS CLINIC		.,,			0	90. 50
91. 00	09100 EMERGENCY	371, 984				9, 175	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,1,751				0	
200.00	,	371, 984		1	2.22000	2, 191, 261	

Health Financial Systems	MEMORI AL	HOSPITAL OF S	SOUTH BEND,	I NC		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE	OTHER PASS	Provi der		F	Period: From 01/01/2014	
			Component	: CCN: 159	S058   1	To 12/31/2014	Date/Time Prepared: 5/29/2015 9:20 am
			Ti tl	e XVIII		Subprovi der -	PPS

		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Inpatient	Outpati ent	Outpati ent	111		
oost outter boser per on	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8	9	Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C	)	0		50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	)	0		52. 00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
57. 00   05700 CT SCAN	0	C		0		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	)	0		58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	C	)	0		59. 00
60. 00   06000   LABORATORY	0	C	)	0		60.00
60. 01   06001   BLOOD LABORATORY	0	C	)	0		60. 01
65. 00 06500 RESPIRATORY THERAPY	0	C	)	0		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C	)	0		66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0	C	)	0		66. 01
66. 10   06601 PHYSI CAL THERAPY LIVING CENTER	0	C	)	0		66. 10
67. 00  06700 OCCUPATI ONAL THERAPY	0	C	)	0		67. 00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	C	)	0		67. 10
68. 00   06800   SPEECH PATHOLOGY	0	C	)	0		68. 00
68. 10   06801   SPEECH THERAPY LIVING CENTER	0	C	)	0		68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C	)	0		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	)	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	)	0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	)	0		73. 00
76. 00 03020 CARDI OLOGY	0	C	)  (	0		76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	C	1	0		90. 00
90. 10 09001 FAMILY PRACTICE CLINIC	0	C		0		90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	C		0		90. 30
90. 50 09004 SLEEP DISORDERS CLINIC	0	C		0		90. 50
91. 00   09100   EMERGENCY	78	C	1	0		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0		92. 00
200.00   Total (lines 50-199)	78	C	)  (	0		200. 00

Health Financial Systems MEMO	RIAL HOSPITAL C	DE SOUTH BEND	LNC	In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150058	Peri od:	Worksheet D	2002 10
			45TOFO	From 01/01/2014	Part II	
		Component	t CCN: 15T058	To 12/31/2014	Date/Time Pre 5/29/2015 9:2	parea: O am
		Ti tl	e XVIII	Subprovi der -	PPS	
				. I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26) 1. 00	2.00	2.00	4.00	Г 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
50. 00 05000 OPERATING ROOM	3, 921, 849	109, 294, 565	0. 03588	12, 719	456	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	1, 418, 594			· ·	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 363, 648				2, 469	54.00
57. 00   05700 CT SCAN	121, 172				127	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	159, 299				816	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	649, 560				0.0	59.00
60. 00   06000   LABORATORY	554, 780		1		1, 398	
60. 01 06001 BLOOD LABORATORY	0		0.00000		0	60. 01
65. 00 06500 RESPIRATORY THERAPY	407, 767	37, 835, 922	1		1, 215	65. 00
66. 00 06600 PHYSI CAL THERAPY	496, 037	12, 004, 781	0. 04132		24, 592	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	15, 200	4, 523, 020	0.00336		0	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	4, 322	1, 274, 346	0.00339	92 0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	302, 875	6, 268, 614	0. 04831	584, 174	28, 225	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	2, 842	889, 626	0.00319	95 0	0	67. 10
68. 00 06800 SPEECH PATHOLOGY	29, 597	4, 022, 446	0. 00735	338, 093	2, 488	68. 00
68. 10   06801   SPEECH THERAPY LIVING CENTER	2, 154	791, 911	0. 00272	20 0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	_			0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 222, 687				2, 037	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	280, 585					1
73.00 07300 DRUGS CHARGED TO PATIENTS	651, 938					
76. 00 03020 CARDI OLOGY	314, 755	11, 649, 672	0. 02701	11, 315	306	76. 00
OUTPATIENT SERVICE COST CENTERS	_	_	1	1		
90. 00 09000 CLI NI C	0	_			0	
90. 10 09001 FAMILY PRACTICE CLINIC	0	_			0	90. 10
90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC	361, 769				0	
90. 50 09004 SLEEP DISORDERS CLINIC	9, 272				0	70.00
91.00   09100   EMERGENCY 92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	1, 526, 941				34	91. 00 92. 00
200.00 Total (lines 50-199)	14, 817, 643			3, 002, 478		
200.00    10tal (1111es 50-177)	14,017,043	750, 257, 300	11	3,002,470	07,022	<sub>1</sub> 200.00

Health Financial Systems MEMC	ORIAL HOSPITAL C	NE SOUTH REND	LNC	In lie	eu of Form CMS-	2552_10
	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS			Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV	pared:
		Ti tl	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Anesthetist Cost	Nursi ng School		Medical Education Cost	4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	_	1	.1		_	
50. 00 05000 OPERATING ROOM	0		1	0 0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	(		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0	0	
57. 00 05700 CT SCAN	0			0	0	
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI) 59. 00   05900   CARDIAC CATHETERIZATION	0			0	0	
60. 00   06000   LABORATORY	0			0		
60. 01   06000   LABORATORY				0	0	
65. 00 06500 RESPIRATORY THERAPY				0	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	0			0		1
66. 01 06602 PHYSI CAL THERAPY EAST BANK					0	
66. 10 06601 PHYSICAL THERAPY LIVING CENTER					0	
67. 00 06700 OCCUPATI ONAL THERAPY					0	
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0				l ő	1
68. 00 06800 SPEECH PATHOLOGY	0				0	1
68. 10 06801 SPEECH THERAPY LIVING CENTER	0			0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	o o	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	l o	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	73. 00
76. 00 03020 CARDI OLOGY	0		ol	0 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS	*		•	<u> </u>		
90. 00 09000 CLI NI C	0	(		0 0	0	90. 00
90.10 09001 FAMILY PRACTICE CLINIC	0	(		0 0	0	90. 10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	(		0 0	0	90. 30
90. 50   09004   SLEEP DI SORDERS CLINIC	0	(		0 0	0	90. 50
91. 00   09100   EMERGENCY	0	(	371, 9		371, 984	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(		0 0	0	
200.00   Total (lines 50-199)	0	(	371, 9	84 0	371, 984	200. 00

	RIAL HOSPITAL C				u of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der	CCN: 150058	Peri od:	Worksheet D	
THROUGH COSTS		Componen-	t CCN: 15T058	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre 5/29/2015 9:2	
		Ti tl	e XVIII	Subprovi der -	PPS	
			,	I RF		
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00		7)	10.00	
ANOLIL ARV OFRIGE COOT OFFITERS	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS		400 004 5/5		0.00000	40.740	
50. 00   05000   OPERATI NG   ROOM	0		l		12, 719	
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0				0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0				107, 370	
57. 00   05700   CT   SCAN	0	, ,			56, 890	
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0	.,,			7, 885	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0				0	
60. 00   06000   LABORATORY	0	, ,			258, 080	
60. 01   06001   BLOOD LABORATORY	0				0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0				112, 703	1
66. 00 06600 PHYSI CAL THERAPY	0				595, 171	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0	1,020,020			0	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	0	.,,			0	
67. 00   06700   OCCUPATI ONAL THERAPY	0	6, 268, 614			584, 174	1
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	007,020	•		0	67. 10
68. 00 06800 SPEECH PATHOLOGY	0	.,,			338, 093	
68. 10 06801 SPEECH THERAPY LIVING CENTER	0				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	_	1 0.0000		125 127	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0				125, 137	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				8, 385	72. 00 73. 00
73.00   07300   DRUGS CHARGED TO PATLENTS 76.00   03020   CARDI OLOGY					783, 584	
76. 00 03020 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS	0	11, 649, 672	0.00000	0. 000000	11, 315	76. 00
			0.00000	0. 000000	0	90.00
	0					
90. 10   09001   FAMILY PRACTICE CLINIC 90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC	0	_	1		0	90. 10 90. 30
90. 50   09002   HEMATOLOGY ONCOLOGY CLINIC 90. 50   09004   SLEEP DI SORDERS CLINIC			1		_	1
	1	-, ,				
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	371, 984				972 0	
200.00 Total (lines 50-199)	371, 984			0.000000	3, 002, 478	
200.00 [10tal (11165 30-177)	3/1,904	750, 257, 300	'I	[	3,002,470	1200.00

Health Financial Systems	MEMORIAL HOSPI	TAL OF SOUT	TH BEND, I	I NC	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER	R PASS	Provi der	CCN: 150058	Peri od: From 01/01/2014	Worksheet D Part IV
Tilkoodii 60313			Component	CCN: 15T058		Date/Time Prepared: 5/29/2015 9:20 am
			Ti tl e	e XVIII	Subprovi der -	PPS

			Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent	TIXI		
	oost center bescriptron	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	onal goo	Costs (col. 9			
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATING ROOM	0	C	)	0		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	C		0		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	C		0		54.00
57.00	05700 CT SCAN	o	C		0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	C		0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	C		0		59. 00
60.00	06000 LABORATORY	o	C		0		60.00
60. 01	06001 BLOOD LABORATORY	0	C		o		60. 01
65.00	06500 RESPI RATORY THERAPY	o	C		0		65. 00
66.00	06600 PHYSI CAL THERAPY	o	C		0		66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	o	C		0		66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	o	C		0		66. 10
67.00	06700 OCCUPATI ONAL THERAPY	o	C		0		67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	o	C		0		67. 10
68.00	06800 SPEECH PATHOLOGY	o	C		0		68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	o	C		0		68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	o	C		0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	C		0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	C		0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	C		0		73. 00
76.00	03020 CARDI OLOGY	0	C		0		76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	C		0		90. 00
90. 10	09001 FAMILY PRACTICE CLINIC	0	C		0		90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	C		0		90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	0	C		0		90. 50
91.00	09100 EMERGENCY	8	C		0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	C		0		92. 00
200.00	Total (lines 50-199)	8	C		0		200. 00

Health Financial Systems MEMO	RIAL HOSPITAL O	F SOUTH BEND,	INC	In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost	Swing Bed Adjustment	Reduced Capi tal	Total Patient Days	Per Diem (col. 3 / col. 4)	
	(from Wkst. B,	.,	Related Cost		,	
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	9, 823, 812	0	9, 823, 81	2 84, 081		
31.00 INTENSIVE CARE UNIT	852, 983		852, 98			
31.01 NEONATAL INTENSIVE CARE UNIT	442, 503		442, 50	7, 978		
40. 00 SUBPROVI DER - I PF	541, 120					
41. 00 SUBPROVI DER - I RF	526, 755	0	526, 75	5 4, 212	125.06	41.00
43. 00 NURSERY	210, 700		210, 70			43.00
200.00 Total (lines 30-199)	12, 397, 873		12, 397, 87	3 113, 193		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	11 701					
30. 00 ADULTS & PEDI ATRI CS	11, 784	1, 376, 843				30.00
31. 00   INTENSIVE CARE UNIT	0	0	1			31.00
31. 01 NEONATAL INTENSIVE CARE UNIT	0	450 (04	1			31. 01
40. 00   SUBPROVI DER - I PF	1, 431	· ·				40.00
41. 00 SUBPROVI DER - I RF	625	1	1			41.00
43. 00 NURSERY	0	1	1			43. 00
200.00 Total (lines 30-199)	13, 840	1, 608, 610	1			200. 00

	RIAL HOSPITAL C	OF SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014	Part II	
				To 12/31/2014	Date/Time Pre 5/29/2015 9: 2	parea: O am
-		Ti t	le XIX	Hospi tal	PPS	o alli
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	Ŭ		
	26)	, and the second second	,			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	3, 921, 849	109, 294, 565	0. 03588	3 11, 027, 857	395, 713	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 418, 594	19, 936, 778	0. 07115	5 10, 625, 363	756, 048	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 363, 648	102, 796, 038	0. 02299	4 5, 625, 865	129, 361	54.00
57.00   05700   CT SCAN	121, 172	54, 360, 455	0. 00222	9 2, 529, 357	5, 638	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	159, 299	1, 539, 204	0. 10349	4 205, 128	21, 230	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	649, 560	44, 990, 922	0. 01443	8 1, 375, 372	19, 858	59. 00
60. 00   06000   LABORATORY	554, 780	102, 390, 600	0. 00541	8 13, 463, 212	72, 944	60.00
60. 01   06001   BL00D   LABORATORY	0	0	0. 00000	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	407, 767	37, 835, 922	0. 01077	7 10, 951, 926	118, 029	65. 00
66. 00 06600 PHYSI CAL THERAPY	496, 037	12, 004, 781	0. 04132	0 665, 970	27, 518	66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	15, 200	4, 523, 020	0. 00336	1 352	1	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	4, 322	1, 274, 346	0. 00339	2 0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	302, 875				19, 071	67.00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	2, 842				. 0	67. 10
68. 00 06800 SPEECH PATHOLOGY	29, 597				1, 434	
68. 10 06801 SPEECH THERAPY LIVING CENTER	2, 154				0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	_,		0.00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 222, 687	75, 114, 702			2, 758	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	280, 585				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	651, 938				76, 147	
76. 00 03020 CARDI OLOGY	314, 755				20, 209	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	) 0	0.00000	0 0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC	0		0.00000		0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	361, 769	1, 350, 811			12, 946	
90. 50 09004 SLEEP DISORDERS CLINIC	9, 272				. 8	90. 50
91. 00 09100 EMERGENCY	1, 526, 941				99, 567	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	942, 873				0	92.00
200.00 Total (lines 50-199)	15, 760, 516			78, 202, 975	1, 778, 480	
			'		, .,	

Health Financial Systems MEMC	RIAL HOSPITAL C	F SOUTH BEND,	I NC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 01/01/2014	Part III	
				Γο 12/31/2014	Date/Time Pre 5/29/2015 9: 2	parea: O am
		Ti t	le XIX	Hospi tal	PPS	O dili
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
5551 5511151 B5551   p11511	indicating control	Cost	Medi cal	Adjustment	(sum of cols.	
		1 1 1 1	Education Cost		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	(		0	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0	(		0	31. 01
40. 00   04000   SUBPROVI DER - 1 PF	0	0	(	0	0	40. 00
41. 00   04100   SUBPROVI DER - I RF	0	0	(	0	0	41.00
43. 00   04300   NURSERY	0	0	(	D	0	43.00
200.00 Total (lines 30-199)	0	0	(	)	0	200. 00
Cost Center Description		Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
	/ 00	7.00	0.00	col . 8)		
INDATI ENT DOUTINE CEDVICE COCT CENTEDO	6. 00	7. 00	8. 00	9. 00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	84, 081	0.00	11, 784	1 0		30.00
31. 00   03100   NTENSI VE CARE UNI T	7, 156			0		31.00
31. 00   03100   INTENSIVE CARE UNIT	7, 150	l .		0		31.00
40. 00   04000   SUBPROVI DER -   PF	5, 041					40.00
41. 00   04100   SUBPROVI DER - 1 PF						41.00
41.00   04100   SUBPROVIDER - TRF 43.00   04300   NURSERY	4, 212 4, 725					43.00
200.00 Total (lines 30-199)	113, 193		13, 840			200.00
200.00   10tal (11les 30-199)	113, 193	1	13, 040	ار ا		<sub>1</sub> 200.00

Health Financial Systems	MEMORIAL HOSPITAL OF SOU	ITH BEND, INC		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LNDATLENT (OUTDAT)	ENT ANGLE ADV CEDVICE OTHER DACC	D: -I CON 150050	D!I	W

Period: From 01/01/2014 To 12/31/2014 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Worksheet D Part IV Provider CCN: 150058 THROUGH COSTS Date/Time Prepared: 5/29/2015 9:20 am Title XIX Hospi tal PPS Non Physician Nursing School Allied Health All Other Total Cost Cost Center Description Anestheti st Medi cal (sum of col 1 Education Cost through col. Cost 4) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 0 50.00 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05700 CT SCAN 0 0 57.00 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 58.00 0 05900 CARDIAC CATHETERIZATION 0 59.00 0 59.00 60.00 06000 LABORATORY 0 0 0 60.00 06001 BLOOD LABORATORY 0 60.01 60.01 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 Λ 0 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 66.01 06602 PHYSI CAL THERAPY EAST BANK 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0 0 66.10 0 66.10 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER 0 67.10 06800 SPEECH PATHOLOGY 0 68.00 68.00 0 06801 SPEECH THERAPY LIVING CENTER 0 68 10 0 68 10 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 Ω Ω 73 00 03020 CARDI OLOGY 76.00 0 0 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 O 0 n 90.00 0 0 0 0 0 09001 FAMILY PRACTICE CLINIC 0 0 90.10 90.10 0 0 90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC 0 0 90.30 0 09004 SLEEP DISORDERS CLINIC 0 90.50 0 0 90.50 91. 00 09100 EMERGENCY 0 371, 984 371, 984 91 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00

0

0

371, 984

0

371, 984 200. 00

Не

200.00

Total (lines 50-199)

In Lieu of Form CMS-2552-10 Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 150058 Peri od: Worksheet D From 01/01/2014 To 12/31/2014 THROUGH COSTS Part IV Date/Time Prepared: 5/29/2015 9:20 am Title XIX Hospi tal PPS Total Charges Ratio of Cost Cost Center Description Total Outpati ent I npati ent (from Wkst. C, to Charges Outpati ent Ratio of Cost Program Cost (sum of (col. 5 ÷ col to Charges Part I, col. Charges 7) col. 2, 3 and 8)  $(col. 6 \div col$ 4) 7) 6.00 7.00 8.00 9.00 10.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 109, 294, 565 0.000000 0.000000 11, 027, 857 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 19, 936, 778 0.000000 0.000000 10, 625, 363 52.00 05400 RADI OLOGY-DI AGNOSTI C 102, 796, 038 0.000000 0.000000 5, 625, 865 54.00 000000000000 54.00 05700 CT SCAN 54, 360, 455 0.000000 0.000000 2, 529, 357 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 1, 539, 204 0.000000 0.000000 205, 128 58.00 59.00 05900 CARDIAC CATHETERIZATION 44, 990, 922 0.000000 0.000000 1, 375, 372 59.00 60.00 06000 LABORATORY 102, 390, 600 0.000000 0.000000 13, 463, 212 60.00 06001 BLOOD LABORATORY 0.000000 0.000000 60 01 Ω 60 01 06500 RESPIRATORY THERAPY 37, 835, 922 10, 951, 926 65.00 0.000000 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 12,004,781 0.000000 0.000000 665, 970 66.01 06602 PHYSICAL THERAPY EAST BANK 4, 523, 020 0.000000 0.000000 352 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0.000000 0.000000 1, 274, 346 66 10 66 10 0 67.00 06700 OCCUPATIONAL THERAPY 6, 268, 614 0.000000 0.000000 394, 711 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 000000 889, 626 0.000000 67.10 0.000000 0 67.10 06800 SPEECH PATHOLOGY 68 00 4, 022, 446 0.000000 0.000000 194, 925 68 00 68. 10 06801 SPEECH THERAPY LIVING CENTER 791, 911 0.000000 0.000000 0 68.10 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 0 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 75, 114, 702 0.000000 0.000000 169, 440 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 153, 085, 382 0.000000 0.000000 72.00 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 148, 349, 610 0.000000 0.000000 17, 325, 881 73.00 03020 CARDI OLOGY 11, 649, 672 0.000000 0.000000 76.00 748, 001 76.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 0.000000 0.000000 90 00 0 90. 10 09001 FAMILY PRACTICE CLINIC 0 0.000000 0.000000 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 0 1, 350, 811 0.000000 0.000000 48, 338 90.30 09004 SLEEP DISORDERS CLINIC 0.000000 90. 50 90. 50 0 3, 904, 592 0.000000 3. 158 91. 00 09100 EMERGENCY 43, 677, 970 0.008517 0.008517 91.00 371, 984 2, 848, 119

371, 984

16, 207, 399

956, 259, 366

0.000000

0.000000

0 92.00

78, 202, 975 200. 00

92.00

200.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50-199)

Provi der CCN: 150058 THROUGH COSTS

Title XIX   Hospital   PPS
Program   Program   Program   Program   Program   Pass-Through   Costs (col. 8   x col. 10)   x col. 12)
Pass-Through   Costs (col. 8   x col. 10)   x col. 12)
Costs (col . 8   Costs (col . 9   x col . 12)
X COI . 10   X COI . 12
11.00   12.00   13.00
ANCI LLARY SERVI CE COST CENTERS
50. 00   05000   OPERATI NG ROOM   0 0 0 0 52. 00   05200   DELI VERY ROOM & LABOR ROOM   0 0 0 0 52. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   0   0   52. 00
EA OO OEAOO BADLOLOCY DIACNOSTIC
54. 00   05400  KADI 0E001-DI AGNOSTI C   0 0 0 0 1 54. 00
57. 00   05700   CT SCAN   0   0   0   57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)   0   0   58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON 0 0 59. 00
60. 00   06000   LABORATORY   0   0   60. 00
60. 01   06001   BLOOD LABORATORY   0   0   0   60. 01
65. 00   06500   RESPI RATORY THERAPY   0   0   65. 00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 66. 00
66. 01 06602 PHYSICAL THERAPY EAST BANK 0 0 0 66. 01
66. 10   06601   PHYSI CAL THERAPY LIVING CENTER   0   0   0   66. 10
67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER 0 0 0 67. 10
68. 00   06800   SPEECH PATHOLOGY   0   0   68. 00
68. 10   06801  SPEECH THERAPY LIVING CENTER   0   0   0   68. 10
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00
72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   73. 00
76. 00   03020  CARDI OLGGY
OUTPATIENT SERVICE COST CENTERS
90. 00   09000  CLI NI C   0   0   90. 00
90. 10   09001  FAMILY PRACTICE CLINIC   0   0   90. 10
90. 30   09002  HEMATOLOGY ONCOLOGY CLINIC   0   0   90. 30
90. 50   09004   SLEEP DI SORDERS CLINI C
91. 00   09100   EMERGENCY   24, 257   0   0   91. 00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   92. 00
200.00   Total (lines 50-199)   24,257   0   0   200.00

Health Financial Systems MEMO	RIAL HOSPITAL C	IF SOUTH REND	LNC	In lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150058	Peri od:	Worksheet D	2332 10
				From 01/01/2014 To 12/31/2014	Part II Date/Time Pre 5/29/2015 9:2	pared: O am
		Ti t	le XIX	Subprovi der  - I PF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		1	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
ANOLILIADY CEDITION OF COST OFNITEDS	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS  50. 00 05000 OPERATING ROOM	2 021 040	100 204 5/5	0. 03588	12	0	F0 00
	3, 921, 849				· -	
52. 00   05200   DELIVERY ROOM & LABOR ROOM 54. 00   05400   RADIOLOGY-DIAGNOSTIC	1, 418, 594				0 31	52. 00 54. 00
· ·	2, 363, 648 121, 172				0	
57.00   05700   CT SCAN 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	159, 299		1		0	58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	649, 560				0	
60. 00   06000   LABORATORY	554, 780					
60. 01   06001   BLOOD LABORATORY	334, 700		1		0	1
65. 00 06500 RESPIRATORY THERAPY	407, 767	1			0	
66. 00 06600 PHYSI CAL THERAPY	496, 037				347	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	15, 200				0.7	1
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	4, 322		1		0	
67. 00 06700 OCCUPATI ONAL THERAPY	302, 875				224	1
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	2, 842			05	0	67. 10
68.00 06800 SPEECH PATHOLOGY	29, 597	4, 022, 446	0.00735	0 8	0	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	2, 154	791, 911	0. 00272	.0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 222, 687			78 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	280, 585				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	651, 938				178	
76. 00 03020 CARDI OLOGY	314, 755	11, 649, 672	0. 02701	8 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLI NI C	0				0	
90. 10 09001 FAMILY PRACTICE CLINIC	0	1			0	
90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC	361, 769				0	
90. 50 09004 SLEEP DI SORDERS CLINIC	9, 272				0	
91. 00 09100 EMERGENCY	1, 526, 941				88 0	
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART) 200.00   Total (lines 50-199)	14, 817, 643	10,20,,0,,		71, 019	ı	92. 00 200. 00
200.00      10tai (111les 50-199)	14,017,043	1 700, 207, 300	"I	/1,019	1 941	1200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA THROUGH COSTS	RY SERVICE OTHER PASS	Component	I NC CCN: 150058 CCN: 15S058	Peri od: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/29/2015 9:2	pared:
		Ti t	le XIX	Subprovi der - I PF	PPS	
Cost Center Description	Non Physician Anesthetist	Nursing School	Allied Healt		Total Cost	
	Cost			Medical Education Cost		
	1.00	2.00	3.00	4. 00	4) 5. 00	
ANCILLARY SERVICE COST CENTERS					3. 55	
50. 00 05000 OPERATI NG ROOM	0	C		0 0	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	0	
57. 00  05700 CT SCAN	0	0		0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	00.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	1 0 / 1 0 0
60. 00   06000   LABORATORY	0	0		0	0	
60. 01   06001   BLOOD LABORATORY	0	0		0	0	
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	0			0	0	
66. 00   06600   PHYSI CAL THERAPY 66. 01   06602   PHYSI CAL THERAPY EAST BANK				0	0	1
66. 10 06601 PHYSICAL THERAPY LIVING CENTER				0	0	1
67. 00 06700 OCCUPATIONAL THERAPY					0	
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTE	R				0	
68. 00 06800 SPEECH PATHOLOGY	,   0				0	
68. 10 06801 SPEECH THERAPY LIVING CENTER	0			0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	O	l o		o o	l o	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NTS O	l c		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
76. 00 03020 CARDI OLOGY	0	0		0 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	0	0		0	0	
90. 10 09001 FAMILY PRACTICE CLINIC	0	0		0	0	
90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC	0	0		0	0	
90. 50 09004 SLEEP DI SORDERS CLINIC	0	0	074 0	0	0	
91. 00   09100   EMERGENCY 92. 00   09200   0BSERVATION   BEDS (NON-DISTINCT   PA	DT) 0		371, 9		371, 984	
47. OO OASOO OBSEKVATION BEDS (NON-DISTINCT PA	KI)   U	1 0	1	0 0	0	92.00

Health Financial Systems MEMOF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RLAL HOSPLTAL ( VLCE OTHER PAS			Peri od:	u of Form CMS-2 Worksheet D	2332-10
THROUGH COSTS	VIOL OTHER TAG			From 01/01/2014	Part IV	
		Componen	t CCN: 15S058	To 12/31/2014	Date/Time Pre 5/29/2015 9:2	pared: 0 am
		Ti 1	ile XIX	Subprovi der -	PPS	
	<b>-</b>	I = 1 01	15 6.0 .	IPF		
Cost Center Description	Total Outpati ent	(from Wkst. C,	Ratio of Cost to Charges	Outpatient Ratio of Cost	I npati ent	
	Cost (sum of				Program Charges	
	col. 2, 3 and		7)	(col. 6 ÷ col.	chai ges	
	4)	0)	')	7)		
	6.00	7. 00	8.00	9, 00	10.00	
ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
50. 00 05000 OPERATING ROOM	C	109, 294, 565	0.00000	0. 000000	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM					0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C				1, 347	
57. 00   05700   CT   SCAN	C	54, 360, 455			0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	l c	1, 539, 204		0. 000000	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	44, 990, 922	0.00000	0. 000000	0	59.00
60. 00   06000   LABORATORY	C	102, 390, 600	0.00000	0. 000000	13, 546	60.00
60. 01   06001   BL00D   LABORATORY	C	(	0.00000	0. 000000	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	C	37, 835, 922	0.00000	0. 000000	0	65.00
66. 00   06600 PHYSI CAL THERAPY	C	12, 004, 781			8, 395	
66. 01 06602 PHYSI CAL THERAPY EAST BANK	C	4, 523, 020	1		0	66. 01
66. 10   06601 PHYSI CAL THERAPY LIVING CENTER	C	1, 274, 346			0	66. 10
67. 00  06700 OCCUPATI ONAL THERAPY	C	6, 268, 614			4, 629	
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	C	889, 626			0	
68. 00 06800 SPEECH PATHOLOGY	C	4, 022, 446			0	
68. 10   06801   SPEECH THERAPY LIVING CENTER	C	791, 911			0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	C	(	0.00000		0	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	C				0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	C	153, 085, 382			0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	C	, ,			40, 583	
76. 00 03020 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS		11, 649, 672	0.00000	0. 000000	0	76. 00
90. 00 09000 CLINIC			0.00000	0. 000000	0	90.00
90. 10   09000  CELINIC 90. 10   09001  FAMILY PRACTICE CLINIC			1		0	
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC		1, 350, 811			0	90. 10
90. 50   09004 SLEEP DI SORDERS CLINIC		3, 904, 592			0	90. 50
91. 00   09100   EMERGENCY	371, 984		1		2, 519	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	371, 704				2, 317	1
200. 00 Total (lines 50-199)	371, 984			0.000000		200. 00

Health Financial Systems	MEMORI AL	HOSPITAL OF S	SOUTH BEND, I	INC	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE	OTHER PASS	Provi der	CCN: 150058	Peri od: From 01/01/2014	Worksheet D
THROUGH COSTS			Component			Date/Time Prepared: 5/29/2015 9:20 am
-			Ti ti	le XIX	Subprovi der -	PPS

			Ti	tle XIX	Subprovi der - I PF	PPS	
Cost	t Center Description	Inpati ent	Outpati ent	Outpati ent	IPF		
0031	t denter beschiptron	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	onal goo	Costs (col.			
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
ANCI LLARY	SERVICE COST CENTERS						
50.00 05000 OPER	RATING ROOM	0	(	0	0		50. 00
52. 00 05200 DELI	VERY ROOM & LABOR ROOM	0	(	o	0		52. 00
54. 00 05400 RADI	OLOGY-DI AGNOSTI C	0	(	o	0		54. 00
57.00 05700 CT S	SCAN	0	(	o	0		57.00
58. 00   05800 MAGN	NETIC RESONANCE IMAGING (MRI)	O	(	o	0		58. 00
59. 00 05900 CARD	DIAC CATHETERIZATION	O	(	o	0		59. 00
60. 00 06000 LABO	DRATORY	0	(	o	0		60.00
60. 01 06001 BL00	DD LABORATORY	0	(	o	0		60. 01
65. 00 06500 RESP	PIRATORY THERAPY	0	(	o	0		65. 00
66. 00 06600 PHYS	SI CAL THERAPY	0	(	o	0		66. 00
66. 01 06602 PHYS	SICAL THERAPY EAST BANK	0	(	o	0		66. 01
66. 10 06601 PHYS	SICAL THERAPY LIVING CENTER	0	(	o	0		66. 10
67. 00 06700 0CCL	JPATI ONAL THERAPY	0	(	o	0		67. 00
67. 10 06701 0CCL	JPATIONAL THERAPY LIVING CENTER	0	(	o	0		67. 10
68. 00 06800 SPEE	ECH PATHOLOGY	0	(	o	0		68. 00
68. 10   06801   SPEE	ECH THERAPY LIVING CENTER	0	(	o	0		68. 10
70.00 07000 ELEC	CTROENCEPHALOGRAPHY	0	(	o	0		70. 00
71. 00 07100 MEDI	CAL SUPPLIES CHARGED TO PATIENTS	0	(	0	0		71. 00
72. 00 07200 I MPL	DEV. CHARGED TO PATIENTS	0	(	0	0		72. 00
73. 00 07300 DRUG	GS CHARGED TO PATIENTS	0	(	0	0		73. 00
76. 00 03020 CARD	OI OLOGY	0	(	0	0		76. 00
	T SERVICE COST CENTERS						
90. 00 09000 CLI N	VI C	0	(	0	0		90. 00
	LY PRACTICE CLINIC	0	(	0	0		90. 10
	ATOLOGY ONCOLOGY CLINIC	0	(	0	0		90. 30
90. 50   09004   SLEE	EP DISORDERS CLINIC	0	(	0	0		90. 50
91.00 09100 EMER	RGENCY	21	(	0	0		91. 00
92. 00 09200 OBSE	ERVATION BEDS (NON-DISTINCT PART)	0	(	0	0		92.00
200.00 Tota	al (lines 50-199)	21	(	o	0		200. 00

Heal th Financial   Systems   MEMORIAL HOSPITAL OCSTS   Provider   Cox   150058   Provider   150058	Health Financial Systems MEMO	DIAL HOSDITAL C	NE SOUTH REND	LNC	In lie	eu of Form CMS-2	2552_10
Component CCN: 15T058   To   1273/12014   Date/Time Prepared: 5/29/2015 9:20 am   Date/Time Prepared: 5/29/2016 am   Date/Time Prepared: 5/29/2018 am   Date/Time Prepared: 5/29/2018 am   Date/Time Prepared: 5/							2552-10
Cost Center Description	7. T. G.K.T. GILMENT GET THE PARTY ENTER THE GET THE GET THE FOREST CONTROL OF THE PARTY ENTER THE GET	000.0			From 01/01/2014	Part II	
Capital Related Cost (From Wisst. B)			Component	t CCN: 15T058	To 12/31/2014	Date/Time Pre	pared:
Capital Related Cost (From Wkst. B, Part II, col.   Related Cost (From Wkst. C, Part II, col.   Related Cost (Col. 1 + col.   Related Col.   Related Cost (Col. 1 + col.   R			Ti t	le XIX	Subprovi der -		U alli
Related Cost   Grom Wisst.   Col.   Col.   1, etc.   col.   Col.   1, etc.   col.   2, etc.   col.   1, etc.   col.   2, etc.   col.   1, etc.   col.   2, etc.   col.   col.   1, etc.   col.   col			11.0	I C XIX	I RF	113	
Claim   Col.   Charges   Col.   Col.   Col.   Col.   Col.   Col.   Charges   Col.	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
Part II							
ANCILLARY SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00		(from Wkst. B,	Part I, col.		. Charges	column 4)	
NOTE			8)	2)			
ANCILLARY SERVICE COST CENTERS							
50. 00		1. 00	2. 00	3. 00	4. 00	5. 00	
52.00   05200   DELIVERY ROOM & LABOR ROOM   1, 418, 594   19, 936, 778   0, 071155   0   0   52.00		2 224 242	100 004 545			4 470	
54.00   05400   RADI OLOGY-DI AGNOSTI C   2, 363, 648   102, 796, 038   0.022994   53, 642   1, 233   54.00   57.00   05700   CT SCAN   121, 172   54, 360, 455   0.002229   36, 805   82   57.00   05900   05900   CARDI AC CATHETERI ZATI ON   649, 560   44, 990, 922   0.014438   0   0   59.00   05900   CARDI AC CATHETERI ZATI ON   649, 560   44, 990, 922   0.014438   0   0   0   59.00   05900   CARDI AC CATHETERI ZATI ON   649, 560   44, 990, 922   0.014438   0   0   0   0.00000   0   0   0.00000   0						· ·	
57. 00   05700   CT SCAN   121, 172   54, 360, 455   0. 002229   36, 805   82   57. 00   58. 00   05800   MAGNETI C RESONANCE IMAGING (MRI )   159, 299   1, 539, 204   0. 103494   3, 730   386   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   649, 560   44, 990, 922   0. 014438   0   0   59. 00   06.							
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   159, 299   1, 539, 204   0. 103494   3, 730   386   58. 00   59. 00   05900   CARDI AC CATHETERIZATION   649, 560   44, 990, 922   0. 014438   0   0   59. 00   0. 000000   0. 005418   102, 712   556   60. 00   60. 01   06001   BLOOD LABORATORY   0   0   0. 000000   0   0. 005418   102, 712   556   60. 00   60. 01   60. 01   60. 00   06000   RESPI RATORY THERAPY   407, 767   37, 835, 922   0. 010777   3, 101   33   65. 00   66. 01   06600   PHYSI CAL THERAPY   496, 037   12, 004, 781   0. 041320   358, 584   14, 817   66. 00   66. 01   06600   PHYSI CAL THERAPY   LIVING CENTER   4, 322   1, 274, 346   0. 003392   0   0   66. 11   06601   06601   PHYSI CAL THERAPY LIVING CENTER   4, 322   1, 274, 346   0. 003392   0   0   66. 11   06701   0CCUPATI ONAL THERAPY LIVING CENTER   2, 842   889, 626   0. 003195   0   0   67. 10   06701   0CCUPATI ONAL THERAPY LIVING CENTER   2, 842   889, 626   0. 003195   0   0   67. 10   06801   SPEECH PATHOLOGY   29, 597   4, 022, 446   0. 007358   219, 751   1, 617   68. 00   06801   SPEECH THERAPY LIVING CENTER   2, 154   791, 911   0. 002720   0   0   68. 10   0. 000000   0   0   70. 00   0. 000000   0   0   70. 00   0. 000000   0   0   0. 000000   0							
59. 00 05900 CARDI AC CATHETERI ZATI ON 649, 560 44, 990, 922 0. 0.014438 0 0 59. 00 60. 00 06000 LABORATORY 554, 780 102, 390, 600 0. 005418 102, 712 556 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0. 0.000000 0 0 60. 01 65. 00 06500 RESPI RATORY THERAPY 407, 767 37, 835, 922 0. 0.01777 3, 101 33 65. 00 66. 00 06600 PHYSI CAL THERAPY 496, 037 12, 004, 781 0. 041320 358, 584 14, 817 66. 00 66. 01 06602 PHYSI CAL THERAPY EAST BANK 15, 200 4, 523, 020 0. 003361 0 0 66. 10 66. 10 06601 PHYSI CAL THERAPY LIVING CENTER 4, 322 1, 274, 346 0. 003392 0 0 66. 10 67. 10 06700 0CCUPATI ONAL THERAPY LIVING CENTER 2, 842 889, 626 0. 003195 0 0 67. 10 06701 0CCUPATI ONAL THERAPY LIVING CENTER 2, 842 889, 626 0. 003195 0 0 67. 10 06801 SPEECH PATHOLOGY 29, 597 4, 022, 446 0. 007358 219, 751 1, 617 68. 00 06801 SPEECH PATHOLOGY 29, 597 4, 022, 446 0. 007358 219, 751 1, 617 68. 00 0700 0 ELECTROENCEPHALOGRAPHY 0 0 0. 000000 0 0 0 0 0. 000000 0 0 0							
60. 00   06000   LABORATORY   554, 780   102, 390, 600   0.005418   102, 712   556   60. 00   60. 01   60. 01   60. 001   60.						l e	
60. 01 06001 BL00D LABORATORY 0 0 0.000000 0 0.000000 0 0 65. 00 65. 00 06500 RESPIRATORY THERAPY 407, 767 37, 835, 922 0.010777 3, 101 33 65. 00 06600 PHYSI CAL THERAPY EAST BANK 15, 200 4, 523, 020 0.003361 0 0 66. 01 06601 PHYSI CAL THERAPY EAST BANK 15, 200 4, 523, 020 0.003361 0 0 66. 01 06601 PHYSI CAL THERAPY LIVING CENTER 4, 322 1, 274, 346 0.003392 0 0 0 66. 10 06601 PHYSI CAL THERAPY LIVING CENTER 4, 322 1, 274, 346 0.003392 0 0 0 66. 10 06. 10 06001 PHYSI CAL THERAPY LIVING CENTER 2, 842 889, 626 0.003195 0 0 0 67. 10 06701 0CCUPATI ONAL THERAPY LIVING CENTER 2, 842 889, 626 0.003195 0 0 0 67. 10 06801 SPEECH PATHOLOGY 29, 597 4, 022, 446 0.007358 219, 751 1, 617 68. 00 06801 SPEECH PATHOLOGY 29, 597 4, 022, 446 0.007358 219, 751 1, 617 68. 00 06801 SPEECH THERAPY LIVING CENTER 2, 154 791, 911 0.002720 0 0 68. 10 06801 SPEECH THERAPY LIVING CENTER 2, 154 791, 911 0.002720 0 0 68. 10 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0.000000 0 0 0 0.000000 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0.000000 0 0 0 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 280, 585 153, 085, 382 0.001833 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 280, 585 153, 085, 382 0.001833 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 280, 585 153, 085, 382 0.001833 0 0 0 72. 00 07200 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0 0 0 0 000000 0 0 0 0 000000		1		1		"	
65. 00		1				l	
66. 00   06600   PHYSI CAL THERAPY   496, 037   12, 004, 781   0. 041320   358, 584   14, 817   66. 00   66. 01   06602   PHYSI CAL THERAPY EAST BANK   15, 200   4, 523, 020   0. 003361   0   0   66. 01   66. 10   06601   PHYSI CAL THERAPY LIVING CENTER   4, 322   1, 274, 346   0. 003392   0   0   66. 10   67. 00   06700   0CCUPATI ONAL THERAPY LIVING CENTER   4, 322   1, 274, 346   0. 003392   0   0   66. 10   67. 10   06701   0CCUPATI ONAL THERAPY LIVING CENTER   2, 842   889, 626   0. 003195   0   0   67. 10   68. 00   06800   SPEECH PATHOLOGY   29, 597   4, 022, 446   0. 007358   219, 751   1, 617   68. 00   68. 10   06801   SPEECH THERAPY LIVING CENTER   2, 154   791, 911   0. 002720   0   0   68. 10   0. 000000   0   0. 000000   0   0. 000000   0		1	-	1		·	
66. 01 06602 PHYSI CAL THERAPY EAST BANK 15, 200 4, 523, 020 0.003361 0 0 66. 01 66. 10 06601 PHYSI CAL THERAPY LIVING CENTER 4, 322 1, 274, 346 0.003392 0 0 66. 10 67. 10 06700 0CCUPATI ONAL THERAPY LIVING CENTER 2, 842 889, 626 0.003195 0 0 67. 10 06701 0CCUPATI ONAL THERAPY LIVING CENTER 2, 842 889, 626 0.003195 0 0 67. 10 0680. SPEECH PATHOLOGY 29, 597 4, 022, 446 0.007358 219, 751 1, 617 68. 00 0680. SPEECH PATHOLOGY 29, 597 4, 022, 446 0.007358 219, 751 1, 617 68. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0 0 0 68. 10 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0 0 0 0.000000 0 0 0 0.000000							
66. 10							1
67. 00		1				· -	
67. 10						"	
68. 00   06800   SPEECH PATHOLOGY   29, 597   4, 022, 446   0. 007358   219, 751   1, 617   68. 00   68. 10   06801   SPEECH THERAPY LIVING CENTER   2, 154   791, 911   0. 002720   0   0   68. 10   0. 000000   0   0   0. 000000   0		1				15, 532	1
68. 10	· · · · · · · · · · · · · · · · · · ·	1		1		1	
70. 00         07000         ELECTROENCEPHALOGRAPHY         0         0         0.000000         0         0         70. 00           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         1, 222, 687         75, 114, 702         0.016278         65, 090         1, 060         71. 00           72. 00         07200         IMPL. DEV. CHARGED TO PATI ENTS         280, 585         153, 085, 382         0.001833         0         0         72. 00           73. 00         07300         DRUGS CHARGED TO PATI ENTS         651, 938         148, 349, 610         0.004395         502, 113         2, 207         73. 00           76. 00         03020         CARDI OLOGY         314, 755         11, 649, 672         0.027018         4, 806         130         76. 00           0VIDATI ENT SERVI CE COST CENTERS         0         0         0.000000         0         0.000000         0         0         90. 00           90. 10         09001         FAMILLY PRACTICE CLINIC         0         0         0.000000         0         0         90. 10           90. 50         09004         SLEEP DI SORDERS CLINIC         361, 769         1, 350, 811         0.267816         0         0         90. 50           91. 00						1, 617	
71. 00		1	1			0	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   280, 585   153, 085, 382   0.001833   0   0   72. 00   73. 00   74. 00			ı	1			
73. 00   07300   DRUGS CHARGED TO PATIENTS   651, 938   148, 349, 610   0.004395   502, 113   2, 207   73. 00   76. 00   03020   CARDI OLOGY   0.0027018   4, 806   130   76. 00   000000   000000   000000   0000000							
76. 00   03020   CARDI OLOGY   314,755   11,649,672   0.027018   4,806   130   76.00		1					
OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE CLINIC   OUTPATIENT SERVICE COST COUNTY SERVICE CLINIC   OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST COUNTY SERVICE COUNTY SERVICE CLINIC   OUTPATIENT SERVICE COST COUNTY SERVICE COUNTY							
90. 00   09000   CLINIC   0   0.000000   0   0   90. 00   90. 00   90. 10   90. 10   90. 10   90. 10   90. 10   90. 20   FAMILY PRACTICE CLINIC   0   0   0.000000   0   90. 10   90. 30   90. 50   90. 50   90. 4   SLEEP DISORDERS CLINIC   9, 272   3, 904, 592   0.002375   0   90. 50   91. 00   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   16, 207, 399   0.000000   0   92. 00   92. 00   92. 00   0000000   0   0   92. 00   0000000   0   0   92. 00   0000000   0   0   92. 00   0000000   0   0   92. 00   0000000   0   0   92. 00   0000000   0   0   92. 00   00000000   0   0   92. 00   00000000   0   0   92. 00   00000000   0   0   92. 00   00000000   0   0   92. 00   00000000000   0   0   0000000000		314, 755	11, 649, 672	0. 02701	8 4, 806	130	76. 00
90. 10   09001   FAMILY PRACTICE CLINIC   0   0.000000   0   90. 10   90. 30   90. 30   90. 50   90. 50   91. 00   91. 00   91. 00   92. 00   92. 00   08SERVATION BEDS (NON-DISTINCT PART)   0   0.000000   0   0.000000   0   0.000000   0							
90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC   361, 769   1, 350, 811   0. 267816   0   90. 30   90. 50   90. 50   91. 00   09100   EMERGENCY   1, 526, 941   43, 677, 970   0. 034959   0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   16, 207, 399   0. 000000   0   92. 00   92. 00   0000000   0   0   92. 00   0000000   0   0   0   0000000   0		1	1	1			,
90. 50   09004   SLEEP DI SORDERS CLINIC   9, 272   3, 904, 592   0. 002375   0   90. 50   91. 00   91.00   09100   EMERGENCY   1, 526, 941   43, 677, 970   0. 034959   0   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)   0   16, 207, 399   0. 000000   0   92. 00   92. 00   0000000   0   0   92. 00   0000000   0   0   92. 00   0000000   0   0   0   0000000   0   0   0   000000		_	_			· -	
91. 00   09100   EMERGENCY   1,526,941   43,677,970   0.034959   0   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0   16,207,399   0.000000   0   92. 00		1				0	
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   16, 207, 399   0.000000   0   92. 00		1		l .		0	
						ľ	
200. 00   Total (lines 50-199)   14, 817, 643  956, 259, 366    1, 713, 019  39, 132   200. 00	1 1	_					
	200.00   Total (lines 50-199)	14, 817, 643	956, 259, 366	·	1, 713, 019	39, 132	200. 00

Health Financial Systems MEMC	ORIAL HOSPITAL O	F SOUTH BEND.	INC	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CCN: 150058	Peri od:	Worksheet D	
THROUGH COSTS		Componen	t CCN: 15T058	From 01/01/2014 To 12/31/2014		narodi
		Componen	t CCN. 131036	10 12/31/2014	5/29/2015 9: 2	epareu. 20 am
		Ti ·	tle XIX	Subprovi der -	PPS	
	1		1	IRF		
Cost Center Description	Non Physician Anesthetist	Nursing School	Allied Heal	th All Other Medical	Total Cost	
	Cost			Medical Education Cost	(sum of col 1	
	COST			Education Cost	through col. 4)	
	1.00	2.00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	(	D	0 0	0	50. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	(	o	0 0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	(	0	0 0	0	
57. 00  05700 CT SCAN	0	(	0	0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(	)	0 0	0	
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	(	O	0 0	0	
60. 00   06000   LABORATORY	0	(	P	0 0	0	
60. 01   06001   BLOOD   LABORATORY	0	(	P	0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	(		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0	(		0	0	
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0	(		0	0	
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	0	(		0	0	000
67. 00   06700   OCCUPATI ONAL THERAPY	0	(		0	0	
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER 68. 00 06800 SPEECH PATHOLOGY	0			0	0	
68. 10   06800   SPEECH PATHOLOGY 68. 10   06801   SPEECH THERAPY LIVING CENTER	0			0	0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY				0 0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	ì			0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	Ö	
76. 00   03020   CARDI OLOGY	0		ő	0 0	l ő	1
OUTPATIENT SERVICE COST CENTERS			-1			
90. 00 09000 CLI NI C	0	(		0 0	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	(	o	0 0	0	90. 10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	(	o l	0 0	0	90. 30
90. 50 09004 SLEEP DISORDERS CLINIC	0	(	o l	0 0	0	90. 50
91. 00   09100   EMERGENCY	0		371, 9		371, 984	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(	0	0 0	0	1 - 1 - 2 - 2
200.00 Total (lines 50-199)	0	(	371, 9	84 0	371, 984	1200.00

Heal th Financ		RLAL HOSPLTAL C				eu of Form CMS-2	2552-10
	T OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der	CCN: 150058	Peri od:	Worksheet D	
THROUGH COSTS	5		Componen	t CCN: 15T058	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre 5/29/2015 9:20	
•			Ti ·	tle XIX	Subprovi der -	PPS	
					I RF		
(	Cost Center Description	Total		Ratio of Cos		Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col . 5 ÷ col		Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)	7.00	0.00	7)	10.00	
ANGLIL	ARY SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10.00	
	OPERATING ROOM	1 0	109, 294, 56	0.00000	0. 000000	41, 219	50.00
1 1							1
	DELIVERY ROOM & LABOR ROOM	0					52.00
	RADI OLOGY-DI AGNOSTI C	0					
1 1	CT SCAN	0	, ,				
	MAGNETIC RESONANCE IMAGING (MRI)	0	1,007,20				
	CARDI AC CATHETERI ZATI ON	0	,	1			
	_ABORATORY	0	, ,				
	BLOOD LABORATORY	0		0.00000			60. 01 65. 00
	RESPI RATORY THERAPY PHYSI CAL THERAPY	1					
	PHYSICAL THERAPY PHYSICAL THERAPY EAST BANK	0					66. 00 66. 01
	PHYSICAL THERAPY EAST BANK PHYSICAL THERAPY LIVING CENTER						66. 10
	OCCUPATIONAL THERAPY		1, 274, 346 6, 268, 614				
	OCCUPATIONAL THERAPY DISCUPATIONAL THERAPY LIVING CENTER	0	889, 620				1
	SPEECH PATHOLOGY			1			68.00
	SPEECH THERAPY LIVING CENTER						68. 10
1 1	ELECTROENCEPHALOGRAPHY			0.00000			70.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS		`			•	
	IMPL. DEV. CHARGED TO PATIENTS		, ,				1
	DRUGS CHARGED TO PATTENTS						
	CARDI OLOGY			1			1
	IENT SERVICE COST CENTERS		11,047,072	2, 0.00000	0.00000	4, 000	70.00
90. 00 09000 0		0	1	0.00000	0. 000000	0	90.00
	FAMILY PRACTICE CLINIC	0		0.00000		0	90. 10
	HEMATOLOGY ONCOLOGY CLINIC	0	1			_	
	SLEEP DISORDERS CLINIC	0					90. 50
	EMERGENCY	371, 984				o o	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	0,11,704		1			
	Total (lines 50-199)	371, 984		1	0.00000	1, 713, 019	
		37.7701	, , , , , , , , , , , , , , , , , , , ,	-1	1	.,	,_ 30. 00

Health Financial Systems	MEMORIAL HOSPITAL OF SO	OUTH BEND, INC	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150058	Peri od: From 01/01/2014	Worksheet D
Inkough COSTS		Component CCN: 15T058		
		Title XIX	Subprovi der -	PPS

		Ti t	le XIX	Subprovi der - I RF	PPS	
Cost Center Description	Inpatient	Outpati ent	Outpati ent	110		
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through	1		
	Costs (col. 8	3	Costs (col.			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS			•			
50. 00 05000 OPERATING ROOM	0	C	)	0	50	0. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	O	1	0	52	2. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	O	1	0	54	4. 00
57. 00  05700 CT SCAN	o	O	1	0	57	7. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	o	0	)	0	58	8. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	0	)	0	59	9. 00
60. 00 06000 LABORATORY	o	0	)	0	60	0. 00
60. 01 06001 BLOOD LABORATORY	o	0	)	0	60	0. 01
65. 00 06500 RESPIRATORY THERAPY	o	0	)	0		5. 00
66. 00 06600 PHYSI CAL THERAPY	o	0	,	0	l l	6. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	o	0	,	0	l l	6. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	o	0	,	0		6. 10
67. 00 06700 OCCUPATI ONAL THERAPY	o	0	,	0	67	7. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	,	0		7. 10
68. 00 06800 SPEECH PATHOLOGY	0	0	,	0		8. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0	0	,	0	l l	8. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	,	0		0. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	,	0	71	1. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	,	0	72	2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0	,	0	l l	3. 00
76. 00 03020 CARDI OLOGY	o	0	,	0	76	6. 00
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
90. 00 09000 CLI NI C	0	C		0	90	0. 00
90. 10 09001 FAMILY PRACTICE CLINIC	0	0	)	0	90	0. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	o	O		0	I	0. 30
90. 50 09004 SLEEP DISORDERS CLINIC	0	0	)	0	90	0. 50
91. 00 09100 EMERGENCY	ol	0	,	0		1. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	,	0		2. 00
200.00 Total (lines 50-199)	0	O		0		0. 00

COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 150058 Period: Worksheet D-1	
From 01/01/2014	ocod.
To 12/31/2014 Date/Time Prepa 5/29/2015 9:20	
Title XVIII Hospital PPS	

		Title XVIII	Hospi tal	5/29/2015 9: 2 PPS	<u>0 am</u>
	Cost Center Description	THE AVITT	позрі саі	113	
	DART I ALL PROVIDED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		84, 081	1. 00
2.00	Inpatient days (including private room days, excluding swing-be			84, 081	2.00
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.	). If you have only pri	vate room days,	44, 365	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed	days)		31, 646	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December (	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	uays) arter becember .	or or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room o	Have) after December 2	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	days) at ter becember 3	i or the cost	O	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	24, 387	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	, (i noludi na privoto r	oom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruction)		Juli days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	y (including private ro	oom days) after	0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, ento Swing-bed NF type inpatient days applicable to titles V or XIX		s soom dovo)	0	12.00
12. 00	through December 31 of the cost reporting period	only (including private	e room days)	U	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14.00	after December 31 of the cost reporting period (if calendar yea				14.00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed (	iays)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	ne cost	0.00	20.00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	74, 887, 763 0	21. 00 22. 00
22.00	5 x line 17)	31 of the cost reporti	ng perrod (Trile	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December:	21 of the cost reportion	ag ported (Line	0	24. 00
24.00	7 x line 19)	or the cost reporting	ig perrou (Trile	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting $% \label{eq:cost_reporting} % % \label{eq:cost_reporting} % \label{eq:cost_reporting} % \label{eq:cost_reporting} % % \label{eq:cost_report} % % eq:cost_report$	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	ne 21 minus line 26)		74, 887, 763	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	191, 029, 679	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			130, 491, 049 60, 538, 630	1
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	ine 28)		0. 392022	ı
32. 00	Average private room per diem charge (line 29 ÷ line 3)	20)		2, 941. 31	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			1, 912. 99	
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruc	tions)	1, 028. 32	1
35. 00	Average per diem private room cost differential (line 34 x line			403. 12	
36. 00	Private room cost differential adjustment (line 3 x line 35)			17, 884, 419	
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost di	fferential (line	57, 003, 344	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			890. 66	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3			21, 720, 525	39. 00
40. 00	Medically necessary private room cost applicable to the Program			0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		21, 720, 525	41. 00

Heal th	Financial Systems MEMOD	RIAL HOSPITAL O	NE SOUTH REND	LNC	In lie	eu of Form CMS-	2552_10
	TATION OF INPATIENT OPERATING COST	THE HOST TIME C		CCN: 150058	Peri od:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
			T: ±1	- 20/111		5/29/2015 9: 2	0 am
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	, , , , , , , , , , , , , , , , , , ,		Inpatient Days	Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1.00					42. 00
40.00	Intensive Care Type Inpatient Hospital Units		7.454	1 4 (50 5	- 4		40.00
43. 00 43. 01	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	11, 868, 509 9, 151, 060	•	1		_	
44. 00	CORONARY CARE UNIT	7, 101, 000	, , , , ,	1, 11, 1			44. 00
45. 00	BURN INTENSIVE CARE UNIT						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
171.00	Cost Center Description						171.00
49.00	Program inpatient ancillary service cost (Wk	ct D 2 col 1	2 Line 200)			1.00	48. 00
48. 00 49. 00	Total Program inpatient costs (sum of lines			ons)		42, 453, 544 64, 174, 069	
	PASS THROUGH COST ADJUSTMENTS	<b>Y</b> ,	•				
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sun	n of Parts I and	3, 213, 533	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	ry services (fr	rom Wkst. D, s	sum of Parts II	2, 433, 065	51. 00
52. 00	Total Program excludable cost (sum of lines					5, 646, 598	
53. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		elated, non-phy	ysician anesth	netist, and	58, 527, 471	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)				1	
54.00	Program di scharges					0.00	
55. 00 56. 00							55. 00 56. 00
57. 00							57.00
58. 00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996, t	updated and co	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	odated by the r	market basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		ts (Titles 54 X	60), Of 1% Of	the target		
62. 00	Relief payment (see instructions)	•				0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decemb	per 31 of the o	cost reportino	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	65)(title XVII	I only). For	0	66. 00
<b>.</b>	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31 d	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [	December 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil						70. 00
71. 00 72. 00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72.00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	m (line 14 x li	ne 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ice costs (line	e 72 + line 73)	)			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from V	Worksheet B, F	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00	Inpatient routine service cost (line 74 minu	siine //)					78. 00

79.00 Aggregate charges to beneficiaries for excess costs (from provider records)
 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)

Inpatient routine service cost per diem limitation

Inpatient routine service cost limitation (line 9 x line 81)

Program inpatient ancillary services (see instructions)

89.00 Observation bed cost (line 87 x line 88) (see instructions)

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)

88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

Reasonable inpatient routine service costs (see instructions)

Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)

79. 00 80. 00

81.00

82.00

83.00

84. 00 85. 00

86.00

8, 070 87. 00

890. 66 88. 00

7, 187, 626 89. 00

81.00

82.00

83.00

84.00

85.00

86.00

Health Financial Systems MEMO	RIAL HOSPITAL C	F SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/29/2015 9: 20	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	9, 823, 812	74, 887, 763	0. 131180	7, 187, 626	942, 873	90.00
91.00 Nursing School cost	0	74, 887, 763	0. 000000	7, 187, 626	0	91. 00
92.00 Allied health cost	0	74, 887, 763	0. 000000	7, 187, 626	0	92. 00
93.00 All other Medical Education	0	74, 887, 763	0. 000000	7, 187, 626	0	93. 00

Health Financial Systems	MEMORIAL HOSPITAL OF SOL	UTH BEND, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150058	Peri od: From 01/01/2014	Worksheet D-1
		Component CCN: 15S058		
		Title XVIII	Subprovi der -	PPS

		litie XVIII	Supprovider -	PPS	
	Cost Center Description			L	
	T			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		5, 041	1. 00
2. 00	Inpatient days (including private room days, excluding swing-bed			5, 041	2. 00
3.00	Private room days (excluding swing-bed and observation bed days)		ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation bed		21 -6 -1	5, 041	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through beceinbe	1 31 01 the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	-			
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room of	Have) after December 2	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	days) at tel December 3	TOT THE COST	U	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	3, 418	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
00	December 31 of the cost reporting period (if calendar year, ento		com dayo, area	· ·	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period			0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of after December 31 of the cost reporting period (if calendar year			0	13. 00
14. 00	Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(	,	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWI NG BED ADJUSTMENT	II	6.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 o	T the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services a	after December 31 of t	he cost	0.00	20. 00
20.00	reporting period	arter becember 51 or t	ne cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)			4, 084, 928	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	a period (line 6	0	23. 00
23.00	x line 18)	i or the cost reportin	g perrod (Trile o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December 3	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (1)	ne 21 minus line 26)		4, 084, 928	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ 1	ine 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 minus		tions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31)		0.00	35. 00 36. 00
36.00	General inpatient routine service cost net of swing-bed cost and	d private room cost di	fferential (line	4, 084, 928	36.00
200	27 minus line 36)			., 551, 720	27.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST			010.04	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see in Program general inpatient routine service cost (line 9 x line 3)			810. 34 2, 769, 742	
40.00	Medically necessary private room cost applicable to the Program			2, 709, 742	
	Total Program general inpatient routine service cost (line 39 +	,		2, 769, 742	
			•		

01	Financial Systems MEMOF ATION OF INPATIENT OPERATING COST	RIAL HOSPITAL OF		CCN: 150058	Period:	u of Form CMS-2 Worksheet D-1	
	ATTOM OF THE ATTENT OF ENATING COST			CCN: 15S058	From 01/01/2014	Date/Time Pre	
			· ·	e XVIII	Subprovi der -	5/29/2015 9: 2 PPS	
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
	cost center bescription	Inpatient Cost				(col. 3 x col.	
		1.00	2. 00	3. 00	4. 00	5. 00	
12. 00	NURSERY (title V & XIX only)	0	0	0.0	00 0	0	42.0
13. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	0	0.0	0 00	0	43.0
13. 01	NEONATAL INTENSIVE CARE UNIT	o	Ō	l .		0	43.0
14. 00	CORONARY CARE UNIT						44. C
15.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. C
	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description						
10.00	D	1 0 1 0	1. 200)			1.00	40.0
8.00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ine)		559, 311 3, 329, 053	1
7. 00	PASS THROUGH COST ADJUSTMENTS	+1 till ough 40) (3	ee mstructro	113)		3, 327, 033	47.0
0.00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sur	m of Parts I and	366, 888	50.0
1 00	Describerand seets applicable to Dragger inn	ationt andillows	comileos (fr	om Wko+ D k	oum of Donto II	20 510	E1 0
51. 00	Pass through costs applicable to Program inpa and IV)	апентансттагу	services (Fr	Om WKSt. D, S	sum or PartS II	29, 519	51.0
2. 00	Total Program excludable cost (sum of lines!	50 and 51)				396, 407	52.0
3. 00	Total Program inpatient operating cost exclude		ated, non-phy	sician anesth	netist, and	2, 932, 646	53.0
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
4. 00	Program di scharges					0	54.0
5. 00	Target amount per discharge						55.0
6. 00 7. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and tar	get amount (1	ine 56 minus	line 53)	0 0	56. 0 57. 0
8. 00	Bonus payment (see instructions)	ng cost and tai	get amount (i	THE 50 IIITHUS	111le 53)	0	58. (
9. 00	Lesser of lines 53/54 or 55 from the cost re	oorting period e	ndi ng 1996, u	pdated and co	ompounded by the	0. 00	59. (
0. 00	market basket Lesser of lines 53/54 or 55 from prior year (	cost roport und	atod by the m	arkot baskot		0.00	60.0
51. 00	If line 53/54 is less than the lower of lines				the amount by	0.00	1
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% of	f the target ´		
52.00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62. 0
	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	1
	PROGRAM INPATIENT ROUTINE SWING BED COST	•	,				
4. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64.0
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reportino	g period (See	0	65.0
	instructions)(title XVIII only)			=> <			
6.00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line 6	4 plus line 6	5)(TITIE XVII	i only). For	0	66. 0
57. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost re	eporting period	0	67.0
0.00	(line 12 x line 19)	t£t D-	21	*b			/ , ,
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs arter be	cember 31 or	the cost repo	orting period	0	68. 0
9. 00	Total title V or XIX swing-bed NF inpatient (					0	69.0
70 00	PART III - SKILLED NURSING FACILITY, OTHER NU						70.0
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70. 0 71. 0
2. 00	Program routine service cost (line 9 x line	71)					72.0
3.00	Medically necessary private room cost applica						73.0
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient				Part II column		74. 0 75. 0
2. 00	26, line 45)				, Goranii		
6.00	Per diem capital-related costs (line 75 ÷ li	,					76.0
7. 00 8. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. C
9. 00	Aggregate charges to beneficiaries for excess		ovi der record	s)			79.0
7. 00	Total Program routine service costs for compa		st limitation	(line 78 mir	nus line 79)		80.0
80.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li						81. C
80. 00 81. 00	Reasonable inpatient routine service cost it militation (if	,					83.0
30. 00 31. 00 32. 00			•				84.0
30. 00 31. 00 32. 00 33. 00 34. 00	Program inpatient ancillary services (see in		_				
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Program inpatient ancillary services (see in Utilization review - physician compensation	(see instruction					85.0
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation Total Program inpatient operating costs (sum	(see instruction of lines 83 thr					85. 0 86. 0
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Program inpatient ancillary services (see in Utilization review - physician compensation	(see instruction of lines 83 thr 5 THROUGH COST )	ough 85)			0	86. 0

Health Financial Systems MEMO	RIAL HOSPITAL C	F SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 01/01/2014 To 12/31/2014		
		T: +1	e XVIII	Cubaravidas	5/29/2015 9: 2 PPS	o am
		11 (1)	e XVIII	Subprovider - IPF	PP3	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	541, 120	4, 084, 928	0. 13246	7 0	0	90. 00
91.00 Nursing School cost	0	4, 084, 928	0.00000	0	0	91. 00
92.00 Allied health cost	0	4, 084, 928	0.00000	0	0	92.00
93.00 All other Medical Education	0	4, 084, 928	0.00000	0 0	0	93. 00

Health Financial Systems	MEMORIAL HOSPITAL OF SOL	JTH BEND, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150058	Peri od: From 01/01/2014	Worksheet D-1
		Component CCN: 15T058		
		Title XVIII	Subprovi der -	PPS

PART   ALL PROPRIETS			TI LIE AVIII	I RF	FF3		
MART   - ALL PROVIDER COMPONENTS   MARTINE		Cost Center Description			1.00		
INVARIENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00		
Impatient days (including private room days, excluding saing-bed and nekeror days)							
Drivate room days (excluding swing-bed and observation bed days). If you have only private room days do all complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days) through December 31 of the cost 5.00 Total swing-bed SNF type inputient days (including private room days) after December 31 of the cost 7.00 Total swing-bed SNF type inputient days (including private room days) after December 31 of the cost 7.00 Total swing-bed SNF type inputient days (including private room days) after December 31 of the cost 7.00 Total swing-bed NF type inputient days (including private room days) after December 31 of the cost 7.00 reporting period (if call-endar-year, enter 0 on this line)  1.01 Total swing-bed NF type inputient days (including private room days) after December 31 of the cost 7.00 reporting period (if call-endar-year, enter 0 on this line)  1.02 Swing-bed SNF type inputient days applicable to the Program (excluding swing-bed and 7.00 period days) after 1.00 Swing-bed SNF type inputient days applicable to the Itle XVIII only (including private room days) after 1.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) after 1.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) after 1.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) after 1.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) after 1.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) after 1.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) after 1.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) after 1.00 Swing-bed SNF type inputient applicable to title XVIII only (including private room days) after 1.00 Swing-becember 31 of the cost reporting period (including XVIIII only 1.00 Swing-bed							
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10tal swingh-ed SNF type Inpatient days (Including private room days) after December 31 of the cost reporting period (I're calendar year, enter 0 on this line)   7.00	5.00		days) through December	31 of the cost	0	5.00	
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x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (see instructions) 0 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3,716,843 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 0 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room per diem charge (line 29 + line 3) 0 20.00 Semi-private room per diem charge (line 30 + line 4) 0 20.00 Semi-private room cost differential (line 32 minus line 33) (see instructions) 0 20.00 Semi-private room cost differential (line 32 minus line 33) (see instructions) 0 20.00 Semi-private room cost differential (line 32 minus line 35) 0 20.00 Semi-private room cost differential (line 32 minus line 35) 0 20.00 Semi-private room cost differential (line 32 minus line 35) 0 20.00 Semi-private room cost differential (line 32 minus line 35) 0 20.00 Semi-private room cost differential (line 32 minus line 35) 0 20.00 Semi-private room cost differential (line 32 minus line 35) 0 20.00 Semi-private	23. 00	1	of the cost reporting	period (line 6	0	23. 00	
7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) RRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  29.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843)  38.00 Average per diem private room cost differential (line 3 x line 35) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00		x line 18)		, , ,			
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 0 26.00 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3, 716, 843 27.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 29.00 Pri vate room charges (excluding swing-bed charges) 0 29.00 30.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.00 Average private room per diem charge (line 29 ÷ line 3) 0.00 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 33.00 Average per diem private room cost differential (line 32 x line 31) 0.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843) 0.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843) 0.00 38.00 Agiusted general inpatient routine service cost per diem (see instructions) 882.44 38.00 Adjusted general inpatient routine service cost line 9 x line 38) 1, 256, 595 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	24. 00	] 31	31 of the cost reportin	ng period (line	0	24. 00	
x line 20)  26. 00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 32 minus line 33)(see instructions) Ceneral inpatient routine service cost differential (line 34 x line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem charge (line 21 minus line 26) Ce	25 00	1	of the cost reporting	period (line 8	0	25 00	
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30. 00 Average private room per diem charge (line 29 + line 3)  30. 00 Average semi-private room per diem charge (line 30 + line 4)  30. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem pri	20.00		or the cost reperting	por rod (11110 0		20.00	
PRI VATE ROOM DIFFERENTI AL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-pri vate room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average pri vate room per diem charge (line 29 ÷ line 3)  32.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4)  33.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem pri vate room cost differential (line 34 x line 31)  36.00 Pri vate room cost differential djustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843)  37.00 FART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00  29.00 29.00  29.00 20.00  30.00			04 ' '' 04)				
28. 00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  O 29. 00  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 28. 00  29. 00  29. 00  20. 00  30. 00  0 .00  30. 00  0 .00  30. 00  0 .00  30. 00  0 .00  30. 00  0 .00  31. 00  0 .00  32. 00  34. 00  35. 00  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  O .00  36. 00  37. 00  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843)  O .00  37. 00  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  O .00  O .00	27.00		ne 21 minus iine 26)		3, 716, 843	27.00	
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 ÷ line 3)  31.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00  29.00  29.00  20.00  30.00  0.00  31.00  0.00  32.00  33.00  40.00  40.00	28. 00		and observation bed cha	arges)	0	28. 00	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.0000000000000000000000000000000000	29. 00	Private room charges (excluding swing-bed charges)					
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 37.00 Program general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 36.00 0.00			ino 20)		-		
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  0.00 34.00  37.00 35.00  38.00 36.00  37.10 37.00  38.00 37.00  39.00 Average per diem private room cost differential (line 3, 716, 843)  37.00 36.00  37.00 Average per diem private room cost differential (line 3, 716, 843)  37.00 Beer all inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 Average per diem private room private room cost differential (line 3, 700)  38.00 Average per diem private room cost differential (line 3, 716, 843)  39.00 Average per diem private room cost differential (line 3, 716, 843)  39.00 Average per diem private room cost differential (line 3, 716, 843)  39.00 Average per diem private room cost differential (line 3, 716, 843)  39.00 Average per diem private room cost differential (line 3, 716, 843)  39.00 Average per diem private room cost differential (line 3, 716, 843)  39.00 Average per diem private room cost differential (line 3, 716, 843)  39.00 Average per diem private room cost differential (line 3, 716, 843)  39.00 Average per diem private room cost differential (line 3, 716, 843)  39.00 Average per diem private room cost differential (line 3, 716, 843)  39.00 Average per diem private r		,	The 28)				
35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,					
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3,716,843 37.00 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00  37.00 Addivide the service cost differential (line 3, 716,843 37.00			, ,	i ons)			
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 716, 843 27. 00 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00		,	31)				
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  882.44 38.00 Program general inpatient routine service cost (line 9 x line 38)  1, 256, 595 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			d private room cost dif	ferential (line	-		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  882.44 38.00  97.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00							
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  882.44 38.00  97.00 Program general inpatient routine service cost (line 9 x line 38)  1, 256, 595 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY					
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1, 256, 595 39.00 40.00	38 00				882 44	38 00	
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,					
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   1,256,595   41.00	40. 00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40.00	
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		1, 256, 595	41. 00	

UMPITE	Financial Systems MEMOF ATION OF INPATIENT OPERATING COST	RIAL HOSPITAL OF		CCN: 150058	Period:	u of Form CMS-2 Worksheet D-1	
COMPUTATION OF INPATIENT OPERATING COST				CCN: 15T058	From 01/01/2014	Date/Time Pre	pared:
			Ti tl	e XVIII	Subprovi der -	5/29/2015 9: 20 PPS	0 am
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		Inpatient Cost In	patient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. (	00 0	0	42.0
3. 00	INTENSIVE CARE UNIT	0	0			0	
3. 01 4. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0. (	00	0	43.0
5. 00	BURN INTENSIVE CARE UNIT						45. 0
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 0 47. 0
7.00	Cost Center Description						47.0
8. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	line 200)			1. 00 919, 228	48. (
	Total Program inpatient costs (sum of lines			ns)		2, 175, 823	1
0. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpa	atient routine se	rvices (from	Wkst. D. sur	m of Parts I and	178, 085	   50. 0
	III)		•				
1. 00	Pass through costs applicable to Program inpa and IV)	attent ancillary	services (fr	un wkst. D, s	SUM OF PARTS II	67, 630	51.0
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		ited non nhi	sician anoc+	natist and	245, 715 1, 930, 108	1
3.00	medical education costs (line 49 minus line !		rtea, non-pny	si ci ali aliesti	letist, and	1, 930, 106	] 55. (
4. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. (
5. 00	Target amount per discharge					0.00	
6. 00 7. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and targ	iot amount (1	ino 56 minus	lino 52)	0	56. 57.
7. 00 8. 00	Bonus payment (see instructions)	0	58.				
9. 00	Lesser of lines 53/54 or 55 from the cost representations	0.00	59.				
0. 00	market basket Lesser of lines 53/54 or 55 from prior year (	cost report, upda	ted by the m	arket basket		0.00	60.
1. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61. (
	Relief payment (see instructions)	0					
	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						63. (
4. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decemb	er 31 of the	cost reporti	ng period (See	0	64. (
5. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See						65.
6. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For						66. (
7. 00	CAH (see instructions)						67. (
	(line 12 x line 19)						
8. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68. (
9. 00	Total title V or XIX swing-bed NF inpatient   PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. (
0. 00	Skilled nursing facility/other nursing facility						70. (
1. 00 2. 00	Adjusted general inpatient routine service of		e 70 ÷ line	2)			71.
2. 00 3. 00	Program routine service cost (line 9 x line medically necessary private room cost applications)		line 14 x li	ne 35)			72. (
4. 00	Total Program general inpatient routine servi	ce costs (line 7	2 + line 73)		Domt II'		74. (
5. 00	Capital-related cost allocated to inpatient ( 26, line 45)	outine service c	usis (Trom W	urksneet B, F	art II, COLUMN		75. (
6. 00	Per diem capital related costs (line 75 ÷ line	,					76. ( 77. (
7. 00 8. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 78.
9. 00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.
0. 00 1. 00	,						80. 81.
2. 00	Inpatient routine service cost limitation (li	ne 9 x line 81)					82.
3.00	Reasonable inpatient routine service costs (						83. 84.
	Program inpatient ancillary services (see ins Utilization review - physician compensation		5)				85.
5. 00	Total Program inpatient operating costs (sum						86. (
5. 00			ugii 03)				1 00. 1
5. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)	S THROUGH COST	agii 65)			0	

Health Financial Systems MEMOR	RIAL HOSPITAL C	F SOUTH BEND,	I NC	In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1		
		Component		From 01/01/2014 To 12/31/2014		narod:	
		Component	. CCN. 131030	10 12/31/2014	5/29/2015 9: 20		
		Ti tl	e XVIII	Subprovi der -	PPS		
				I RF			
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2. 00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00 Capital-related cost	526, 755	3, 716, 843	0. 14172	1 0	0	90. 00	
91.00 Nursing School cost	0	3, 716, 843	0.00000	0	0	91.00	
92.00 Allied health cost	0	3, 716, 843	0.00000	0	0	92.00	
93.00 All other Medical Education	0	3, 716, 843	0.00000	0 0	0	93. 00	

Health Financial Systems	MEMORIAL HOSPITAL OF SO	UTH BEND, INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150058	Peri od: From 01/01/2014	Worksheet D-1	
			To 12/31/2014	Date/Time Pre 5/29/2015 9: 2	
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	

		Title XIX	Hospi tal	5/29/2015 9: 2 PPS	0 am
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			84, 081 84, 081	1.00
2. 00 3. 00	Private room days (excluding swing-bed and observation bed days	<i>y</i> ,	vate room days	84, 081	2. 00 3. 00
0.00	do not complete this line.	). It you have only pri	vate room days,	Ŭ	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed			76, 011	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through December	r 31 or the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3°	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	<b>3</b> .			
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	11, 784	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instructi	ons)	,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
.2.00	through December 31 of the cost reporting period	om y (mor dam ng pri var	o i com dayo)	, and the second	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(exciduling swilling bed to	ady3)	4, 725	
16.00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT	through Docombon 21 or	f the cost	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through becember 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
40.00	reporting period			0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	tne cost	0.00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
04 00	reporting period			74 007 740	04.00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	na period (line	74, 887, 763 0	21. 00 22. 00
22.00	5 x line 17)	or the cost reports	riig perroa (irric	Ü	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportino	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportion	na period (line	0	24. 00
24.00	7 x line 19)	or or the cost reporter	ig perrod (Trie		24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		74, 887, 763	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	arges)	0	
29. 00 30. 00	Semi-private room charges (excluding swing-bed charges)			0	•
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0. 00 0. 00	1
35. 00	Average per diem private room cost differential (line 34 x line		5115)	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	d private room cost di	fferential (line	74, 887, 763	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
38. 00	Adjusted general inpatient routine service cost per diem (see i			890.66	•
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	,		10, 495, 537 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 +			10, 495, 537	•

111 45-	Figure 1 Contains	NAL HOCDITAL O	E COUTU DEND	LNC	1 1:-	£ F CMC	DEED 40
	Financial Systems MEMOR ATION OF INPATIENT OPERATING COST	RIAL HOSPITAL O			Period:	eu of Form CMS-: Worksheet D-1	2552-10
					From 01/01/2014		narad:
					To 12/31/2014	Date/Time Pre 5/29/2015 9:2	
		<b>.</b>		le XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Davs	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
				col . 2)		4)	
12.00	NUDCEDY (+:+1 - V 0 VIV1.)	1.00	2.00	3.00	4.00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	2, 348, 558	4, 725	9 497.0	5 0	0	42. 00
43.00	INTENSIVE CARE UNIT	11, 868, 509	7, 156	1, 658. 5	4 0	0	43. 00
43. 01	NEONATAL INTENSIVE CARE UNIT	9, 151, 060	7, 978	1, 147. 0	4 0	0	43. 01
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	line 200)			1. 00 19, 841, 010	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)		30, 336, 547	49. 00
EO 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	ationt routing	sorul cos (from	wkst D sum	of Parts L and	1 274 042	50. 00
50. 00			•	•		1, 376, 843 1, 802, 737	
51. 00	.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51. 00
52.00	2.00 Total Program excludable cost (sum of lines 50 and 51)						
53. 00	3.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges	0	54.00				
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	57. 00
58. 00	Bonus payment (see instructions)	· ·			•	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost repmarket basket	porting period	endi ng 1996, ι	updated and co	mpounded by the	0.00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the m	narket basket		0.00	60.00
61.00	If line 53/54 is less than the lower of lines				the amount by	0	61. 00
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			Ö	63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST					_	
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the d	cost reporting	period (See	0	65. 00
	instructions)(title XVIII only)					_	
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line 6	55)(title XVII	l only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
	(line 13 x line 20)			·			
69. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/MR C	NLY		0	69. 00
70.00	Skilled nursing facility/other nursing facili						70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ine /u ÷ line	۷)			71. 00 72. 00
73. 00	Medically necessary private room cost applica	,	(line 14 x li	ne 35)			73. 00
74.00	Total Program general inpatient routine servi	ce costs (line	72 + line 73)	)			74. 00
75. 00	Capital-related cost allocated to inpatient i	routine service	costs (from V	Vorksheet B, P	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00

Program capital -related costs (line 9 x line 76) 78.00 | Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records)
Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 79.00 80.00 80.00 81.00 Inpatient routine service cost per diem limitation 81.00 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 84.00 85.00 85.00 Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 8, 070 87. 00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 890. 66 88. 00 89.00 |Observation bed cost (line 87 x line 88) (see instructions) 7, 187, 626 89. 00

Health Financial Systems MEMO	RIAL HOSPITAL C	F SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/29/2015 9: 20	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	9, 823, 812	74, 887, 763	0. 131180	7, 187, 626	942, 873	90.00
91.00 Nursing School cost	0	74, 887, 763	0.00000	7, 187, 626	0	91.00
92.00 Allied health cost	0	74, 887, 763	0.00000	7, 187, 626	0	92.00
93.00 All other Medical Education	0	74, 887, 763	0. 000000	7, 187, 626	0	93. 00

Health Financial Systems	MEMORIAL HOSPITAL OF SOL	JTH BEND, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150058	Peri od: From 01/01/2014	Worksheet D-1
		Component CCN: 15S058		
		Title XIX	Subprovi der -	PPS

		litle XIX	I PF	PPS	
	Cost Center Description			L	
	T			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		5, 041	1. 00
2. 00	Inpatient days (including private room days, excluding swing-bed			5, 041	2. 00
3.00	Private room days (excluding swing-bed and observation bed days)		ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation bed		. 21 -6 -1	5, 041	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through beceinbe	1 31 01 the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	-			
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room of	Have) after December 2	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	days) at tel December 3	Tor the cost	U	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 431	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		nom days) after	0	11. 00
00	December 31 of the cost reporting period (if calendar year, ento		days) ares	· ·	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period			0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of after December 31 of the cost reporting period (if calendar year			0	13. 00
14. 00	Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(	,	4, 725	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWI NG BED ADJUSTMENT	II	6.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 o	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services a	after December 31 of t	he cost	0.00	20. 00
20.00	reporting period	arter becember 51 or t	ne cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)			4, 084, 928	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	a period (line 6	0	23. 00
23.00	x line 18)	i or the cost reportin	g perrod (Trile o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December 3	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (1)	ne 21 minus line 26)		4, 084, 928	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ 1	ine 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 minus	, ,	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31)		0.00	35. 00 36. 00
36. 00 37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost di	fferential (line	4, 084, 928	37.00
200	27 minus line 36)			., 551, 720	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST			010 04	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see in Program general inpatient routine service cost (line 9 x line 3)			810. 34 1, 159, 597	
40.00	Medically necessary private room cost applicable to the Program			1, 139, 397	
	Total Program general inpatient routine service cost (line 39 +	,		1, 159, 597	
			•		

OMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 150058	Peri od: From 01/01/2014	worksheet D-1	
			Component	CCN: 15S058			
			Title	e XIX	Subprovi der - I PF	PPS	
	Cost Center Description	Total		Average Per	Program Days	Program Cost	
		Inpatient CostInp	patient DaysD	col. 1	÷	(col. 3 x col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. (	00 0	0	42. 0
3. 00	INTENSIVE CARE UNIT	O	0	0. 0	00 00	0	43. 0
3. 01	NEONATAL INTENSIVE CARE UNIT	0	0	0. 0		0	
4. 00	CORONARY CARE UNIT						44.0
5. 00 6. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 0 46. 0
	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description						
8. 00	Program inpatient ancillary service cost (Wks	st D_3 col 3 l	ine 200)			1. 00 18, 324	48. C
9. 00	Total Program inpatient costs (sum of lines 4			s)		1, 177, 921	1
	PASS THROUGH COST ADJUSTMENTS					1	
0. 00	Pass through costs applicable to Program inpa	atient routine ser	rvices (from N	Vkst. D, sun	n of Parts I and	153, 604	50.0
1. 00	Pass through costs applicable to Program inpa	atient ancillary s	services (fro	n Wkst. D, s	sum of Parts II	962	51.0
	and IV)	•	•				
2. 00 3. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud	,	ted non-nhyei	cian anos+l	netist and	154, 566 1, 023, 355	1
3. 00	medical education costs (line 49 minus line 5		teu, non-physi	crair anesti	letist, and	1,023,333	33.0
	TARGET AMOUNT AND LIMIT COMPUTATION					T .	
4. 00 5. 00	Program discharges Target amount per discharge						54. C
	Target amount (line 54 x line 55)					0.00	1
7. 00	Difference between adjusted inpatient operati	ng cost and targe	et amount (li	ne 56 minus	line 53)	0	
8. 00 9. 00							
7. 00	market basket						
0.00	Lesser of lines 53/54 or 55 from prior year					0.00	1
1.00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61.0
	amount (line 56), otherwise enter zero (see i		(	.,,	g		
2.00							
3. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instructi	OHS)				63.0
4. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decembe	er 31 of the d	cost reporti	ng period (See	0	64.0
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Necember	31 of the co	st reporting	n neriod (See	0	65. 0
3. 00	instructions)(title XVIII only)	ts at ter becember	31 Of the co.	st reporting	g perrou (see		05.0
6. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 64	plus line 65)	(title XVII	I only). For	0	66.0
7 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through De	ecember 31 of	the cost re	eporting period	0	67. 0
7.00	(line 12 x line 19)	s costs through be		the cost re	sporting period		07.0
8. 00	Title V or XIX swing-bed NF inpatient routine	e costs after Dece	ember 31 of t	ne cost repo	orting period	0	68. 0
9. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	outine costs (lir	ne 67 + line (	58)		0	69. 0
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY, A	AND ICF/MR ONL	_Y			
0. 00 1. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	-					70. 0 71. 0
2. 00	Program routine service cost (line 9 x line 3	•	2 10 ÷ 11110 Z	"			72.0
3. 00	Medically necessary private room cost applica	abĺe to Program (I		e 35)			73.0
4.00	Total Program general inpatient routine servi	•	,	akabaat D. I	Don't II oolumn		74.0
5. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service co	osts (from wo	KSneet B, F	Part II, column		75.0
6. 00	Per diem capital-related costs (line 75 ÷ lin						76.0
7. 00 8. 00	Program capital -related costs (line 9 x line						77. 0 78. 0
9. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		vi den ineconds	)			79.0
0. 00	Total Program routine service costs for compa	arison to the cost			nus line 79)		80.0
1.00	'						81.0
2. 00 3. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s	· · · · · · · · · · · · · · · · · · ·					82. 0 83. 0
J. UU	Program inpatient ancillary services (see ins	structions)					84. 0
4. 00	Utilization review - physician compensation						85. 0 86. 0
4. 00 5. 00	Total Drogram inpationt approxima costs (						. an ()
4. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ugn 85)				30.0
4. 00 5. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions) Adjusted general inpatient routine cost per o	THROUGH COST				0	

Health Financial Systems MEMOR	RIAL HOSPITAL C	F SOUTH BEND,	I NC	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 01/01/2014 To 12/31/2014		nared:
		Component	CON. 155050	10 12/31/2014	5/29/2015 9: 20	
		Ti t	le XIX	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	541, 120	4, 084, 928	0. 13246	7 0	0	90. 00
91.00 Nursing School cost	0	4, 084, 928	0.00000	0 0	0	91. 00
92.00 Allied health cost	0	4, 084, 928	0.00000	0	0	92.00
93.00 All other Medical Education	0	4, 084, 928	0. 00000	0 0	0	93. 00

Health Financial Systems	MEMORIAL HOSPITAL OF SO	JTH BEND, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150058	Peri od: From 01/01/2014	Worksheet D-1
		Component CCN: 15T058	To 12/31/2014	Date/Time Prepared: 5/29/2015 9:20 am
		Title XIX	Subprovi der -	PPS

		TI LIE XIX	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			4, 212	1. 00
2.00	Inpatient days (including private room days, excluding swing-be			4, 212	
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.	). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		4, 212	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0	5. 00
, 00	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember s	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 31	l of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	625	9. 00
7.00	newborn days)	the riegiam (exerauring	oming boar and	020	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enti-	er 0 on this line)	Join days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13. 00
14. 00	Medically necessary private room days applicable to the Program	-	· .	0	14. 00
15. 00	Total nursery days (title V or XIX only)	Control of the contro		4, 725	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services	through Docombor 21 of	f the cost	0.00	17. 00
17.00	reporting period	till odgir becelliber 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of t	the cost	0. 00	18. 00
40.00	reporting period			0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	inrough December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)	21 of the cost managet	na noried (line	3, 716, 843	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ line 17)	31 of the cost reporti	ng perrod (irne	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	l of the cost reporting	period (line 6	0	23. 00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	31 of the cost reportir	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)	04 1 11 0()		0	
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus line 26)		3, 716, 843	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3 ,	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	i ne 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruct	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line		,	0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost dif	ferential (line	3, 716, 843	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i	nstructi ons)		882. 44	
39. 00	Program general inpatient routine service cost (line 9 x line 3)			551, 525	
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	•		551, 525	40.00
41.00	Tiotai irogram generai impatrent routine service cost (IIIIe 39 +	11116 40)	I	331, 323	41.00

OMPUT	Financial Systems MEMOF ATION OF INPATIENT OPERATING COST	RIAL HOSPITAL OF		CCN: 150058	Period:	u of Form CMS-2 Worksheet D-1	
o o .				CCN: 15T058	From 01/01/2014	Date/Time Pre	pared
			Ti t	le XIX	Subprovi der - I RF	5/29/2015 9: 2 PPS	∪ am
	Cost Center Description	Total Inpatient Costlr	Total npatient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
2. 00	NURSERY (title V & XIX only)	0	0	0. (			42. C
	Intensive Care Type Inpatient Hospital Units						
3.00	INTENSIVE CARE UNIT	0	0	0. (		0	
3. 01 4. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	U	U	0. (	00 0	Ü	43. C
5. 00	BURN INTENSIVE CARE UNIT						45. 0
	SURGICAL INTENSIVE CARE UNIT						46.0
7. 00	OTHER SPECIAL CARE (SPECIFY)						47. C
	Cost Center Description					1. 00	
8. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			538, 288	48. 0
9. 00	Total Program inpatient costs (sum of lines			ns)		1, 089, 813	49. 0
	PASS THROUGH COST ADJUSTMENTS					70.1/0	
0. 00	Pass through costs applicable to Program inpa	atient routine se	ervices (from	WKSt. D, Sur	m of Parts I and	78, 163	50.0
1. 00	Pass through costs applicable to Program inpa	atient ancillarv	services (fr	om Wkst. D. s	sum of Parts II	39, 132	51.0
	and IV)		(1)				
2. 00	Total Program excludable cost (sum of lines!					117, 295	
3. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		ated, non-phy	sician anesti	netist, and	972, 518	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
4. 00	Program di scharges						54. (
5.00	Target amount per discharge						55. (
6. 00 7. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and targ	net amount (	ine 56 minus	line 53)	0	1
8. 00	Bonus payment (see instructions)	ing cost and tary	get amount (i	THE 50 III HUS	11110 33)	Ö	
9. 00	Lesser of lines 53/54 or 55 from the cost rep	oorting period er	nding 1996, u	pdated and co	ompounded by the	0. 00	59. (
0.00	market basket						
0. 00 1. 00							60. 0
2. 00	Relief payment (see instructions)					0	62.0
3. 00	00 Allowable Inpatient cost plus incentive payment (see instructions)						63.0
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cost	ts through Docomb	oor 21 of the	cost roporti	ng poriod (Soc	0	64. (
4.00	instructions)(title XVIII only)	ts through becenik	ser 31 or the	cost reporti	ng perrou (see		04.
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after December	r 31 of the c	ost reportino	g period (See	0	65. (
, 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costo (lino (	1 plucii po (	E) (+: +1 o V)/II	l anly) Fan	0	66.0
6. 00	CAH (see instructions)	ie costs (Title 64	4 prus rine o	b)(title XVII	i oniy). For	0	00.0
7. 00		e costs through [	December 31 o	f the cost re	eporting period	0	67. (
0 00	(line 12 x line 19)						
8. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after Dec	cember 31 of	the cost repo	orting period	0	68.0
9. 00	Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	68)		0	69. (
	PART III - SKILLED NURSING FACILITY, OTHER NU						
0.00	Skilled nursing facility/other nursing facili						70.0
1. 00 2. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		ie /u - IIIIe	<b>4</b> )			71. (
3. 00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73.
4. 00	Total Program general inpatient routine servi	ce costs (line l	72 + line 73)				74.
5. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service (	costs (from W	orksheet B, F	Part II, column		75. (
6. 00	20, 1110 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)					76. (
7. 00	Program capital-related costs (line 9 x line	,					77. (
	Inpatient routine service cost (line 74 minus			->			78.
9. 00 0. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			*.	nus line 70)		79. 80.
1. 00	Inpatient routine service costs for compa		st irmitation	(11116 /0 11111	143 TITE /1)		81.
2. 00	Inpatient routine service cost limitation (li						82. (
3.00	Reasonable inpatient routine service costs (		)				83.
4.00	Program inpatient ancillary services (see insultilization review - physician compensation		s)				84. (
	Total Program inpatient operating costs (sum						86. (
5. 00							1
5. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
5. 00		THROUGH COST	i 0)			0	87. ( 88. (

Health Financial Systems MEMOR	RIAL HOSPITAL (	OF SOUTH BEND,	INC	In Lie	eu of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi de		Peri od:	Worksheet D-1	
		Componer		From 01/01/2014 To 12/31/2014		
		Ti	tle XIX	Subprovi der – I RF	PPS	
Cost Center Description	Cost	Routine Cost		Total Observation	Observation Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	526, 755	3, 716, 84	3 0. 14172	1 0	0	90.00
91.00 Nursing School cost	C	3, 716, 84	3 0.00000	0 0	0	91. 00
92.00 Allied health cost	C	3, 716, 84	3 0.00000	0 0	0	92.00
93.00 All other Medical Education	(	3, 716, 84	3 0.00000	0 0	0	93. 00

Health Financial Systems MEMORIAL HOSPITAL OF SO	UTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
I NPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Pre 5/29/2015 9:2	pared:
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			59, 015, 606		30. 00
31.00  03100 INTENSIVE CARE UNIT			8, 414, 243		31. 00
31.01   02060   NEONATAL INTENSIVE CARE UNIT			0		31. 01
40. 00   04000   SUBPROVI DER - 1 PF			0		40. 00
41. 00   04100   SUBPROVI DER - I RF			51, 523		41. 00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00   05000   OPERATING ROOM		0. 30886	19, 628, 039	6, 062, 395	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 48283	121, 738	58, 780	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 20398	12, 292, 679	2, 507, 522	54.00
57. 00  05700 CT SCAN		0. 04001	5, 953, 075	238, 212	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0. 61419	635, 996	390, 626	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.07973	4, 674, 303	372, 720	59. 00
60. 00 06000 LABORATORY		0. 15258	23, 190, 095	3, 538, 553	60.00
60. 01   06001   BLOOD LABORATORY		0.00000	00	0	60. 01
65. 00 06500 RESPI RATORY THERAPY		0. 14304	9, 635, 955	1, 378, 346	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 44039		1, 082, 338	66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK		0. 34626	1, 620	561	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER		0. 35232		593	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY		0. 41599		435, 824	67.00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 32854		170	67. 10
68. 00   06800   SPEECH PATHOLOGY		0. 32282		119, 387	68. 00
68. 10   06801   SPEECH THERAPY LIVING CENTER		0. 28301		36	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 27014		6, 069, 249	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 24551		9, 534, 383	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 22469		6, 673, 988	
76. 00   03020   CARDI OLOGY		0. 36266		964, 295	76.00
OUTPATIENT SERVICE COST CENTERS		0.00200	2,000,7.0	7017270	70.00
90. 00 09000 CLI NI C		0.00000	00	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC		0.00000		0	90. 10
90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC		1. 35743		19	90. 30
90. 50   09004   SLEEP DI SORDERS CLINI C		0. 25180		0	90. 50
91. 00   09100   EMERGENCY		0. 49232		_	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 44347		0,023,347	92. 00
200.00 Total (sum of lines 50-94 and 96-98)		0. 14547	179, 818, 584	42, 453, 544	
201.00 Less PBP Clinic Laboratory Services-Program only charges (	(line 61)		1,7,010,004	12, 100, 044	201.00
202.00 Net Charges (line 200 minus line 201)	(		179, 818, 584		202.00
[1.52 onar 955 (11116 200 million 201)		1	177,010,004	l	1-52. 00

	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	MEMORIAL HOSPITAL OF SOU		CCN: 150058	Peri od:	eu of Form CMS-2 Worksheet D-3	
			Componen	CCN: 15S058	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/29/2015 9:2	pared: 0 am
			Ti tl	e XVIII	Subprovi der - I PF	PPS	<u> </u>
	Cost Center Description			Ratio of Cos		Inpati ent	
				To Charges		Program Costs	
					Charges	(col. 1 x col.	
				1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS				0		30.00
31. 00	03100 I NTENSI VE CARE UNI T				0		31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT				0		31. 01
40.00	04000 SUBPROVI DER - I PF				3, 325, 945		40.00
41.00	04100 SUBPROVI DER - I RF				0		41.00
43.00	04300 NURSERY						43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM			0. 3088		29, 908	
52.00	05200 DELIVERY ROOM & LABOR ROOM			0. 4828		1	
54.00	05400 RADI OLOGY-DI AGNOSTI C			0. 2039			
57. 00	05700 CT SCAN			0. 0400		581	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)			0. 6141			
59. 00	05900 CARDI AC CATHETERI ZATI ON			0. 0797		0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY			0. 1525 0. 0000			1
65. 00	06500 RESPIRATORY THERAPY			0.0000		0 835	
66. 00	06600 PHYSI CAL THERAPY			0. 1430			
66. 01	06602 PHYSI CAL THERAPY EAST BANK			0. 3462		0	1
66. 10	06601 PHYSI CAL THERAPY LIVING CENTER			0. 3523		Ö	1
67. 00	06700 OCCUPATI ONAL THERAPY			0. 4159			1
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER			0. 3285		0	1
68.00	06800 SPEECH PATHOLOGY			0. 3228		729	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER			0. 2830	10 0	0	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY			0.0000	00 0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIEN	TS		0. 2701			
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS			0. 2455			
73. 00	07300 DRUGS CHARGED TO PATIENTS			0. 2246		290, 900	
76. 00	03020 CARDI OLOGY			0. 3626	65 0	0	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS			0.0000	00		00.00
90. 00	09000 CLINIC 09001 FAMILY PRACTICE CLINIC			0. 0000 0. 0000			
	09001 FAMILY PRACTICE CLINIC			1. 3574		1	
	00004 CLEEP DISORDERS CLINIC			0.3574			

0. 492328 0. 443478

90. 50

91.00

201. 00

202. 00

4, 517

0 92.00

559, 311 200. 00

90. 50 09004 SLEEP DISORDERS CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50-94 and 96-98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

91. 00 09100 EMERGENCY

200.00

201.00

	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	MEMORIAL HOSPITAL OF SOU		CCN: 150058	Peri od:	eu of Form CMS-2 Worksheet D-3	
			Componen	t CCN: 15T058	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/29/2015 9:20	pared:
			Ti tI	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description			Ratio of Cos		Inpati ent	
				To Charges		Program Costs	
					Charges	(col. 1 x col. 2)	
				1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
30.00	03000 ADULTS & PEDIATRICS				0		30.00
31.00	03100 INTENSIVE CARE UNIT				0		31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT				0		31. 01
40.00	04000 SUBPROVI DER - I PF				0		40. 00
41.00	04100 SUBPROVI DER - I RF				3, 296, 480		41. 00
43.00	04300 NURSERY						43. 00
	ANCILLARY SERVICE COST CENTERS			1	1		
50.00	05000 OPERATING ROOM			0. 3088			
52.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC			0. 4828 0. 2039		0	
54. 00 57. 00	05700 CT SCAN			0. 2039			
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)			0. 6141			
59.00	05900 CARDI AC CATHETERI ZATI ON			0.0797		0	1
60.00	06000 LABORATORY			0. 1525		_	
60. 01	06001 BLOOD LABORATORY			0.0000		0	1
65.00	06500 RESPI RATORY THERAPY			0. 1430	42 112, 703	16, 121	65. 00
66.00	06600 PHYSI CAL THERAPY			0. 4403	94 595, 171	262, 110	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK			0. 3462		0	
66. 10	06601 PHYSICAL THERAPY LIVING CENTER			0. 3523		0	
67. 00	06700 OCCUPATI ONAL THERAPY			0. 4159			67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER			0. 3285		0	
68. 00	06800 SPEECH PATHOLOGY			0. 3228			
68. 10 70. 00	06801 SPEECH THERAPY LIVING CENTER 07000 ELECTROENCEPHALOGRAPHY			0. 2830 0. 0000		0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	тс		0.0000		1	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13		0. 2455			
73. 00	07300 DRUGS CHARGED TO PATIENTS			0. 2246			
	03020 CARDI OLOGY			0. 3626			
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C			0.0000	00 0	0	90. 00
90. 10				0.0000		1	
	09002 HEMATOLOGY ONCOLOGY CLINIC			1. 3574			
00 E0	00004 SLEED DISODDEDS CLINIC			0.0510	ΛOI Λ		00 50

479

0 92.00

919, 228 200. 00

90. 50

91.00

201. 00

202. 00

0. 251808

0. 492328 0. 443478

3, 002, 478

90. 50 09004 SLEEP DISORDERS CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50-94 and 96-98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

91. 00 09100 EMERGENCY

200.00

201.00

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH	BEND, INC	In Lie	u of Form CMS-2552-10
				(

Health Financial Systems MEMORIAL HOSPITAL OF SOUT	H BEND,	INC	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150058	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Pre	pared:
	T' 1	1 7/17/		5/29/2015 9: 2	0 am
Cook Cooker Doorsinking	111	le XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient Program	Inpatient Program Costs	
		To Charges			
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			28, 395, 864		30.00
31. 00 03100 INTENSIVE CARE UNIT			7, 629, 190		31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT			15, 249, 178		31. 01
40. 00   04000   SUBPROVI DER - 1 PF			0		40.00
41. 00   04100   SUBPROVI DER -   RF			0		41.00
43. 00   04300   NURSERY			2, 186, 781		43.00
ANCI LLARY SERVI CE COST CENTERS		1			
50. 00 05000 OPERATI NG ROOM		0. 30886	11, 027, 857	3, 406, 108	50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 48283	10, 625, 363	5, 130, 329	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 20398	5, 625, 865	1, 147, 592	54.00
57. 00   05700   CT   SCAN		0. 0400		101, 212	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 61419		125, 989	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 07973	1, 375, 372	109, 669	59. 00
60. 00   06000   LABORATORY		0. 15258	13, 463, 212	2, 054, 338	60.00
60. 01   06001   BL00D   LABORATORY		0.00000	00	0	60. 01
65. 00 06500 RESPI RATORY THERAPY		0. 14304	10, 951, 926	1, 566, 585	65. 00
66. 00   06600   PHYSI CAL THERAPY		0. 44039	665, 970	293, 289	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK		0. 34626	352	122	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER		0. 35232	23 0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY		0. 41599	394, 711	164, 196	67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 32854		0	67. 10
68. 00 06800 SPEECH PATHOLOGY		0. 32282		62, 926	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER		0. 2830		0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 27014	169, 440	45, 774	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2455	7 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 22469	17, 325, 881	3, 892, 987	73. 00
76. 00   03020   CARDI 0L0GY		0. 36266	748, 001	271, 274	76. 00
OUTPATIENT SERVICE COST CENTERS		•			
90. 00 09000 CLI NI C		0.00000	00	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC		0.00000	00	0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC		1. 35743	48, 338	65, 616	90. 30
90. 50   09004   SLEEP DI SORDERS CLINIC		0. 25180	3, 158	795	90. 50
91. 00   09100   EMERGENCY		0. 49232	2, 848, 119	1, 402, 209	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 44347	78 0	0	92. 00
200.00 Total (sum of lines 50-94 and 96-98)			78, 202, 975	19, 841, 010	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (I	ne 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)			78, 202, 975		202. 00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150058	Peri od:	Worksheet D-3	
		Component	CCN: 15S058	From 01/01/2014 To 12/31/2014	Date/Time Prep 5/29/2015 9:20	
		Ti t	le XIX	Subprovi der  - I PF	PPS	
	Cost Center Description	·	Ratio of Cos	The state of the s	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
	INDATION DOUTING CEDVICE COCT CENTERS		1.00	2. 00	3. 00	
0. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS  03000 ADULTS & PEDI ATRI CS		I	0		30.00
1. 00	03100 INTENSIVE CARE UNIT			0		31.0
. 00	02060 NEONATAL INTENSIVE CARE UNIT			0		31.0
. 00	04000 SUBPROVI DER - I PF			107, 230		40.0
. 00	04100 SUBPROVI DER - I RF			107, 230		41. 0
	04300 NURSERY			0		43. 0
	ANCI LLARY SERVI CE COST CENTERS					10.0
0. 00	05000 OPERATING ROOM		0. 30886	54 0	0	50.00
. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 48283		0	52.00
. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 20398	1, 347	275	54.0
. 00	05700 CT SCAN		0.04001	15 0	0	57.0
. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 61419	95 0	0	58.0
. 00	05900 CARDI AC CATHETERI ZATI ON		0. 07973	88 0	0	59.0
. 00	06000 LABORATORY		0. 15258		2, 067	60.0
. 01	06001 BLOOD LABORATORY		0.00000		0	60.0
. 00	06500 RESPI RATORY THERAPY		0. 14304		0	65.0
. 00	06600 PHYSI CAL THERAPY		0. 44039		3, 697	66.0
. 01	06602 PHYSI CAL THERAPY EAST BANK		0. 34626		0	
. 10	06601 PHYSI CAL THERAPY LIVING CENTER		0. 35232		0	66. 1
. 00	06700   OCCUPATIONAL THERAPY   06701   OCCUPATIONAL THERAPY LIVING CENTER		0. 41599		1, 926	
. 10	06800 SPEECH PATHOLOGY		0. 3285 <sup>4</sup> 0. 32282		0	67. 1 68. 0
. 10	06801 SPEECH THERAPY LIVING CENTER		0. 32262		0	68. 1
. 00	07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 27014		0	
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2455		0	72. 0
. 00	07300 DRUGS CHARGED TO PATIENTS		0. 22469		9, 119	
	03020 CARDI OLOGY		0. 36266		0	
	OUTPATIENT SERVICE COST CENTERS					
. 00	09000 CLI NI C		0.00000	00 0	0	90.0
. 10	09001 FAMILY PRACTICE CLINIC		0. 00000	00	0	
	09002 HEMATOLOGY ONCOLOGY CLINIC		1. 35743		0	
0 50	00004 SLEED DISODDEDS CLINIC		0 25100	no n	ام	00 50

0. 492328 0. 443478

90. 50

91.00

201. 00

202. 00

1, 240

0 92.00

18, 324 200. 00

90. 50 09004 SLEEP DISORDERS CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50-94 and 96-98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

91. 00 09100 EMERGENCY

200.00

201.00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150058 t CCN: 15T058	Period: From 01/01/2014 To 12/31/2014		
		Ti t	le XIX	Subprovi der -	5/29/2015 9: 2 PPS	0 am
				I RF		
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
0. 00	03000 ADULTS & PEDIATRICS		I	0		30. (
	03100 INTENSIVE CARE UNIT					31.
I. 00	02060 NEONATAL INTENSIVE CARE UNIT			0		31.
	04000 SUBPROVI DER - I PF			0		40.
. 00	04100 SUBPROVI DER - I RF			1, 917, 284		41.
	04300 NURSERY			1, 917, 204		43.
. 00	ANCI LLARY SERVI CE COST CENTERS		1			45.
0. 00	05000 OPERATING ROOM		0. 3088	64 41, 219	12, 731	50.
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 4828			
1. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 2039		1	
7. 00	05700 CT SCAN		0. 0400			
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 6141		1	
9. 00	05900 CARDI AC CATHETERI ZATI ON		0. 0797		0	59.
	06000 LABORATORY		0. 1525		15, 673	
). 01	06001 BLOOD LABORATORY		0.0000		0	60.
5. 00	06500 RESPI RATORY THERAPY		0. 1430		444	
5. 00	06600 PHYSI CAL THERAPY		0. 4403			
o. 01	06602 PHYSI CAL THERAPY EAST BANK		0. 3462	68 0	0	66.
5. 10	06601 PHYSICAL THERAPY LIVING CENTER		0. 3523	23 0	0	66.
. 00	06700 OCCUPATI ONAL THERAPY		0. 4159	90 321, 466	133, 727	67.
7. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 3285	46 0	0	67.
3. 00	06800 SPEECH PATHOLOGY		0. 3228	24 219, 751	70, 941	68.
3. 10	06801 SPEECH THERAPY LIVING CENTER		0. 2830	10 0	0	68.
. 00	07000 ELECTROENCEPHALOGRAPHY		0.0000	00	0	70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2701		17, 584	71.
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2455		0	72.
	07300 DRUGS CHARGED TO PATIENTS		0. 2246			73.
. 00	03020 CARDI OLOGY		0. 3626	4, 806	1, 743	76.
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		0.0000			90.
	09001 FAMILY PRACTICE CLINIC		0.0000		0	90.
). 30	09002 HEMATOLOGY ONCOLOGY CLINIC		1. 3574		0	90.
			0 0540			

0. 492328 0. 443478

1, 713, 019

0

0 92.00

538, 288 200. 00

90. 50

0 91.00

201. 00

202. 00

90. 50 09004 SLEEP DISORDERS CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50-94 and 96-98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

91. 00 09100 EMERGENCY

200.00

201.00

From 01/01/2014   Part A Date/Time Prepared: 5/29/2015 9: 20 am   Title XVIII   Hospital   PPS		ATION OF REIMBURSEMENT SETTLEMENT		CCN: 150058	Peri od:	Worksheet E	2332-10
MRICA - INVALIDED HOSPITAL SURVICES UNDER LIPPS	CALCOL	ATTON OF RETWINDORSEMENT SETTEEMENT	T T OVI GET	CCN. 130030	From 01/01/2014	Part A Date/Time Pre	
Name			Ti tl	e XVIII	Hospi tal		T T
1.00   NOR Amounts Other than Outlier Payments   0   1.0				0	1. 00	2. 00	
1.01   RGC amounts other than outlier enyments for discharges occurring prior to Corboral 1 (see instructions) progress for discharges occurring on or 11,339,293   1.02   1.02   1.03   1.03   1.03   1.04   1.05   1.03   1.04   1.05   1.03   1.04   1.03   1.04   1.05   1.04   1.05	1.00						1 00
1.02   BRG amounts other than outlier payments for discharges occurring on or   11,339,293   1.02		,	prior		_		
1.03   Ref for Tederal Specific Coperating payment for Model 4 RPCI For   1.03   Ref for Federal Specific Coperating payment for Model 4 RPCI For   1.04	1 00				11 220 202		1 00
discharges occurring prior to October 1 (see Instructions)	1.02		g on or		11, 339, 293		1.02
1.04   BBC for Federal specific operating payment for Model 4 BPCI for discharges occurring on a rather October 1 (see instructions)   1,934,596   2.00   0.01   1.01   0.01	1.03				0		1. 03
2.00   Outlier payments for discharges. (see instructions)   1.934,996   2.00   Outlier payment for discharges for Model 4 BPCI (see instructions)   0   2.01	1. 04				0		1. 04
2.01   Dutiler reconciliation amount   0   2.01	2 00				1 024 504		2 00
		, , ,			1, 934, 596		
Bed days, avail able of vided by number of days in the cost reporting   period (see instructions)		, , ,	ns)		15 542 227		2. 02
period (see Instructions)			ng				
FTE count for all opathic and osteopathic programs for the most recent cost prepriting period ending on or before 12/31/1996. (see instructions)   5.00   6.00							
Cost reporting period ending on or before 12/31/1996, (see Instructions)   Count for all opathic and osteopathic programs with on meet the control of count for all opathic and osteopathic programs with accordance with 42 (CRR 431-376)2   Production amount to the IME cap as specified under 42   CRR 431-376(2)   CRR 5412-105(f)(1)(1)(9)(9)   CRR 5412-105(f)(1)(1)(1)(9)   CRR 5412-105(f)(1)(1)(1)(9)   CRR 5412-105(f)(1)(1)(1)(1)(1)(1)   CRR 5412-105(f)(1)(1)(1)(1)(1)(1)   CRR 5412-105(f)(1)(1)(1)(1)(1)(1)   CRR 5412-105(f)(1)(1)(1)(1)(1)(1)(1)   CRR 5412-105(f)(1)(1)(1)(1)(1)(1)   CRR 5412-105(f)(1)(1)(1)(1)(1)(1)   CRR 5412-105(f)(1)(1)(1)(1)(1)(1)(1)   CRR 5412-105(f)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	5. 00		ecent		16. 76		5.00
criteria for an add-on to the cap for new programs in accordance with 42 CR 43.79(e) 7.00 MMA Section 42? reduction amount to the IME cap as specified under 42 0.00 7.00 CRT \$421.05(f)(1)(i)(i)(B)(2) If the cap as specified under 42 0.00 7.00 CRT \$421.05(f)(1)(i)(i)(B)(2) If the cast report straddles July 1. 2011 then see instructions 6.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00		cost reporting period ending on or before 12/31/1996. (see instru	uctions)		0.00		, ,,
CRR 413.79(e)   CRR 413.79(e)   7.00   MAX Section #22 reduction amount to the IME cap as specified under 42   0.00   7.00   7.01   ACA Section #503 reduction amount to the IME cap as specified under 42   0.00   7.01   ACA Section #503 reduction amount to the IME cap as specified under 42   0.00   7.01   ACA Section #503 reduction amount to the IME cap as specified under 42   0.00   7.01   ACA Section #503 reduction amount to the IME cap as specified under 42   0.00   7.01   ACA Section #503 reduction #503 of the ACA If the cost report straddles July 1, 2011, see Instructions.   8.01	6.00				0.00		6.00
CRR \$412.105(f)(1)(1)(8)(8)(1)	7.00	CFR 413.79(e)			0.00		7.00
7.01 ACA Section 5503 reduction amount to the IME cap as specified under 42 CR \$412.105(Pf(1)(Iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.  8.00 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), 4 of RF 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002).  8.01 The amount of increase if the hospital was awarded FTE cap slots under section 550s of the ACA. If the cost report straddles July 1, 2011, see closed toaching hospital under section 550s of the ACA. If the cost report straddles July 1, 2011, see closed toaching hospital under section 550s of ACA. (see instructions)  8.02 Cost tractions.  8.03 Losed toaching hospital under section 550s of ACA. (see instructions)  8.04 Justice of Lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see instructions)  8.05 Losed toaching hospital under section 550s of ACA. (see instructions)  8.06 PTE count for residents in dental and podiatric programs in the current year from your records  11.00 FTE count for residents in dental and podiatric programs.  12.00 Current year allowable FTE (see instructions)  13.00 Total allowable FTE count for the prior year.  14.00 FTE count for residents in individent year or a first september 30, 1997, otherwise enter zero.  15.00 Sum of Lines 12 through 14 divided by 3.  15.00 Sum of Lines 12 through 14 divided by 3.  15.00 Sum of Lines 12 through 14 divided by 3.  15.00 Current year resident to bed ratio (line 18 divided by line 4).  16.00 Adjusment for residents in individent year of the program 0.00 17.00  17.00 Current year resident to bed ratio (see instructions)  18.00 Current year resident to bed ratio (see instructions)  19.00 Current year resident to bed ratio (see instructions)  19.00 Current year resident to bed ratio (see instructions)  19.00 Current year resident to bed ratio (see instructions)  19.01 Individent 47 See See All 20 Co (70 (10) (V) (V	7.00		der 42		0.00		7.00
then see instructions.  0.0 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)(v), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).  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.  8.02 Instructions.  8.02 Instructions, Instructions of the ACA if the cost report straddles July 1, 2011, see Instructions of Closed teaching hospital under section 5506 of ACA. (see instructions)  9.00 (closed teaching hospital under section 5506 of ACA. (see instructions)  9.01 (closed teaching hospital under section 5506 of ACA. (see instructions)  9.02 (closed teaching hospital under section 5506 of ACA. (see instructions)  10.03 (closed teaching hospital under section 5506 of ACA. (see instructions)  10.04 (see instructions)  10.05 (see instructions)  10.06 (see instructions)  11.07 (see instructions)  11.08 (see instructions)  12.00 (current year all owable FTE (see instructions)  12.00 (current year all owable FTE (see instructions)  13.00 (oral allowable FTE count for the prior year.  14.00 (current year allowable FTE count for the prior year.  15.00 (substant for residents in individed by 3.  15.00 (substant for residents in individed by 3.  16.00 (adjustment for residents in individed by 3.  17.00 (adjustment for residents in individed by 3.  18.00 (adjustment for residents individed by 3.  18.00 (adjustme	7. 01	ACA Section 5503 reduction amount to the IME cap as specified ur			0.00		7. 01
Osteopathic programs for affiliated programs in accordance with 42 CFR   413.75(b), 41			1, 2011				
### ### ### ### ### ### ### ### ### ##	8.00				0.00		8. 00
1.0   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.							
Section 5503 of the ACA. If the cost report straddles July 1, 2011, see Instructions.	0.01		. undon		2 00		0.01
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)   Common 19.76   Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)   Common 19.76   Com	8.01	· ·			3.00		8.01
closed teaching hospital under section 5506 of ACA. (see instructions)   9.00	0 02		from a		0.00		0.02
and 8,02) (see instructions)   10.00	8.02				0.00		8.02
10.00   FTE count for allopathic and osteopathic programs in the current year from your records   11.00   FTE count for residents in dental and podiatric programs.   0.00   11.00	9.00		(8, 8,01		19. 76		9. 00
11.00   FTE count for residents in dental and podiatric programs.   0.00   11.00   Current year allowable FTE (see instructions)   19.76   12.00   13.00   Total allowable FTE count for the prior year.   19.76   13.00   14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.   15.00   Sum of lines 12 through 14 divided by 3.   19.26   15.00   16.00   16.00   17.00   17.00   17.00   18.00   19.26   19.26   18.00   19.26	10. 00		t year		27. 17		10.00
12.00   Current year allowable FTE (see instructions)   19.76   13.00   10.76   13.00   10.76   13.00   10.76   13.00   10.76   13.00   10.76   13.00   10.76   13.00   10.76   13.00   10.76   13.00   10.76   13.00   10.76   13.00   10.76   13.00   10.76   13.00   10.76   13.00   10.76   13.00   10.76   13.00   10.77   10.76   13.00   10.77   10.7	11 00	1			0.00		11 00
14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.   18.26   14.00   or after September 30, 1997, otherwise enter zero.   15.00   Sum of I lines 12 through 14 divided by 3.   19.26   15.00   16.00   Adjustment for residents in initial years of the program   0.00   16.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjusted rolling average FTE count   19.26   18.00   19.26   18.00   19.00   19.26   18.00   19.00   19.26   18.00   19		, , , ,					
or after September 30, 1997, otherwise enter zero.  Sum of lines 12 through 14 divided by 3.  15.00  Maj ustment for residents in initial years of the program  0.00  16.00  Adj ustment for residents displaced by program or hospital closure  0.00  17.00  Adj usted rolling average FTE count  19.26  18.00  Current year resident to bed ratio (line 18 divided by line 4).  0.050833  19.00  Prior year resident to bed ratio (see instructions)  0.044966  20.00  Interet the lesser of lines 19 or 20 (see instructions)  10.44966  21.00  IME payment adj ustment (see instructions)  10.476,515  22.00  IME payment adj ustment - Managed Care (see instructions)  10.00			andad an				
16.00	14.00	,	ended on		10. 20		14.00
17.00		,					
19.00   Current year resident to bed ratio (line 18 divided by line 4).   0.050833   19.00   20.00   Prior year resident to bed ratio (see instructions)   0.044966   20.00   21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.044966   21.00   22.00   IME payment adjustment (see instructions)   1,476,515   22.00   IME payment adjustment - Managed Care (see instructions)   1,476,515   22.00   IME payment adjustment - Managed Care (see instructions)   1,476,515   22.00   IME payment adjustment for the Add-on for Section 422 of the MMA			Э				1
20.00   Prior year resident to bed ratio (see instructions)   0.044966   20.00   21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.044966   21.00   22.00   IME payment adjustment (see instructions)   1,476,515   22.00   IME payment adjustment - Managed Care (see instructions)   0   22.01   IME payment adjustment - Managed Care (see instructions)   0   22.01   IME payment adjustment - Managed Care (see instructions)   0   22.01   IME payment adjustment for the Add-on for Section 422 of the MMA   23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).   24.00   IME FTE Resident Count Over Cap (see instructions)   7.41   24.00   25.00   If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)   26.00   Resident to bed ratio (divide line 25 by line 4)   0.000000   25.00   26.00   IME payments adjustment factor. (see instructions)   0.000000   27.00   28.00   IME add-on adjustment amount (see instructions)   0.000000   28.00   IME add-on adjustment amount - Managed Care (see instructions)   0.000000   28.00   29.00		, ,					1
21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.044966   21.00   22.00   IME payment adjustment (see instructions)   1 IME payment adjustment - Managed Care (see instructions)   22.01   1 IME payment adjustment - Managed Care (see instructions)   22.01   1 Imigrate Medical Education Adjustment for the Add-on for Section 422 of the MMA   23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).   24.00   IME FTE Resident Count Over Cap (see instructions)   7.41   24.00   25.00   If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)   25.00   IME payments adjustment factor. (see instructions)   0.000000   26.00   27.00   IME payments adjustment factor. (see instructions)   0.000000   27.00   28.00   IME add-on adjustment amount (see instructions)   0.000000   28.00   1 IME add-on adjustment amount - Managed Care (see instructions)   0.000000   28.00   29.00   10 IME payment (sum of lines 22 and 28)   1,476,515   29.00   29.01   29		,		•			
22.00   IME payment adjustment (see instructions)   1,476,515   22.00     IME payment adjustment - Managed Care (see instructions)   1,476,515   0     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).     24.00   IME FTE Resident Count Over Cap (see instructions)   7.41   24.00     25.00   If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)   0.000   25.00     26.00   Resident to bed ratio (divide line 25 by line 4)   0.000000   27.00     28.00   IME payments adjustment factor. (see instructions)   0.000000   27.00     28.01   IME add-on adjustment amount (see instructions)   0   28.01     29.00   Total IME payment (sum of lines 22 and 28)   1,476,515   29.00     29.01   Total IME payment - Managed Care (sum of lines 22.01 and 28.01)   0   29.01     Disproportionate Share Adjustment   7.00   7.00     30.00   Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)   31.21   31.00     31.00   Sum of lines 30 and 31   37.75   32.00     32.00   Sum of lines 30 and 31   37.75   32.00     33.00   Allowable disproportionate share percentage (see instructions)   20.36   33.00		1 '					1
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	22. 00	1					
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME payments adjustment amount (see instructions)  29.00 IME add-on adjustment amount (see instructions)  20.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sem of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Sum of lines 30 and 31  31.00 Allowable disproportionate share percentage (see instructions)  23.00 Allowable disproportionate share percentage (see instructions)  20.00 Conditional allowable disproportionate share percentage (see instructions)  20.00 Sum of lines 30 and 31  20.00 Allowable disproportionate share percentage (see instructions)	22. 01				0		22. 01
Slots under 42 Sec. 412.105 (f)(1)(iv)(C).	23. 00			he MMA	0.00		23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.01 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medical d patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  25.00  26.00  27.00  28.00  28.01  29.01  29.01  29.01  30.00  31.01  31.21  31.00  32.00  33.00  33.00		slots under 42 Sec. 412.105 (f)(1)(iv)(C).					
Line 23 or line 24 (see instructions)		·	ver of				
27. 00       IME payments adjustment factor. (see instructions)       0.000000       27. 00         28. 00       IME add-on adjustment amount (see instructions)       0       28. 00         28. 01       IME add-on adjustment amount - Managed Care (see instructions)       0       28. 01         29. 00       Total IME payment (sum of lines 22 and 28)       1, 476, 515       29. 00         29. 01       Disproportionate Share Adjustment       0       29. 01         30. 00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       6. 54       30. 00         31. 00       Percentage of Medicaid patient days (see instructions)       31. 21       31. 00         32. 00       Sum of lines 30 and 31       37. 75       32. 00         33. 00       Allowable disproportionate share percentage (see instructions)       20. 36       33. 00		line 23 or line 24 (see instructions)					
28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  31.00 Sum of lines 30 and 31  32.00 Allowable disproportionate share percentage (see instructions)  32.00 Allowable disproportionate share percentage (see instructions)  28.00 28.00 29.01 29.00 29.01							
29.00 Total IME payment (sum of lines 22 and 28) 1,476,515 29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment  30.00 Percentage of SI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 31.21 31.00 32.00 Sum of lines 30 and 31 37.75 32.00 Allowable disproportionate share percentage (see instructions) 20.36 33.00					0		1
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  30. 00 Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  29. 01  30. 00  31. 21  31. 20  32. 00  33. 00  33. 00					0		
Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  31.00 Sum of lines 30 and 31  31.00 Allowable disproportionate share percentage (see instructions)  32.00 Allowable disproportionate share percentage (see instructions)  33.00 Allowable disproportionate share percentage (see instructions)		, , ,			1, 476, 515		1
(see instructions)31.0031.00 Percentage of Medicaid patient days (see instructions)31.2132.00 Sum of lines 30 and 3137.7533.00 Allowable disproportionate share percentage (see instructions)20.36		Di sproporti onate Share Adjustment					
31.00 Percentage of Medicaid patient days (see instructions) 31.21 31.00 32.00 Sum of lines 30 and 31 32.00 33.00 Allowable disproportionate share percentage (see instructions) 20.36 33.00	30. 00		ent days		6. 54		30.00
33.00 Allowable disproportionate share percentage (see instructions) 20.36 33.00	31. 00				31. 21		31.00
[ 1		, , , , , , , , , , , , , , , , , , , ,					
		, , , , , , , , , , , , , , , , , , ,		1	_,,,	ı	

	Financial Systems MEMORIAL HOSPITAL OF			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	
		Title XVIII	Hospi tal	5/29/2015 9: 2 PPS	o am
		THE AVIII	Pri or to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
	Uncompensated Care Adjustment		1 0 044 000 440	7 / 17 / 10 105	
35. 00	Total uncompensated care amount (see instructions)			7, 647, 640, 435	•
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,		0. 000749360 6, 778, 997	0. 000952703 7, 285, 932	
33. 02	enter zero on this line) (see instructions)		0,770,777	7, 200, 702	33. 02
35. 03	Pro rata share of the hospital uncompensated care payment		5, 070, 317	1, 836, 456	35. 03
	amount (see instructions)				
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		6, 906, 773		36. 00
	Additional payment for high percentage of ESRD beneficiary of	discharges (lines 40 throug	h 46)		
40.00	Total Medicare discharges on Worksheet S-3, Part I	ar sonar gos (r r nos re em sug	0		40.00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and				
	685 (see instructions)				
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
41. 01	682, 683, 684 an 685. (see instructions) Total ESRD Medicare covered and paid discharges excluding		0		41. 01
11.01	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				''' ''
42.00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42. 00
	qualify for adjustment)				
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43. 00
44. 00	Ratio of average length of stay to one week (line 43		0. 000000		44. 00
11.00	divided by line 41 divided by 7 days)		0.00000		11.00
45.00	Average weekly cost for dialysis treatments (see		0.00		45. 00
	instructions)				
46. 00	Total additional payment (line 45 times line 44 times line 41.01)		0		46. 00
47. 00	Subtotal (see instructions)		57, 933, 992		47. 00
48. 00	Hospital specific payments (to be completed by SCH and		0,,,00,,,,2		48. 00
	MDH, small rural hospitals only. (see instructions)				
49. 00	Total payment for inpatient operating costs (see		57, 933, 992		49. 00
FO 00	instructions)		4 200 077		FO 00
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		4, 208, 066		50.00
51.00	Exception payment for inpatient program capital (Wkst. L,		0		51.00
	Pt. III, see instructions)				
52.00	Direct graduate medical education payment (from Wkst. E-4,		857, 093		52.00
53. 00	line 49 see instructions). Nursing and Allied Health Managed Care payment		190, 394		53. 00
54. 00	Special add-on payments for new technologies		18, 034		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55.00
	line 69)				
56. 00	Cost of physicians' services in a teaching hospital (see		0		56. 00
57. 00	intructions)   Routine service other pass through costs (from Wkst. D,		0		57. 00
37.00	Pt. III, column 9, lines 30 through 35).				37.00
58.00	Ancillary service other pass through costs from Wkst. D,		52, 340		58. 00
	Pt. IV, col. 11 line 200)				
59. 00	Total (sum of amounts on lines 49 through 58)		63, 259, 919		59.00
60. 00 61. 00	Primary payer payments  Total amount payable for program beneficiaries (line 59		129, 183 63, 130, 736		60. 00 61. 00
01.00	minus line 60)		03, 130, 730		01.00
62.00	Deductibles billed to program beneficiaries		4, 753, 824		62. 00
63.00	Coinsurance billed to program beneficiaries		172, 928		63. 00
	Allowable bad debts (see instructions)		323, 516		64.00
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see		210, 285 323, 516		65. 00 66. 00
00.00	instructions)		323, 310		00.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		58, 414, 269		67.00
68.00	Credits received from manufacturers for replaced devices		0		68. 00
	for applicable to MS-DRGs (see instructions)				
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69. 00
70. 00	MSP PASS THRU RECONCILIATION		-32		70. 00
70. 50	RURAL DEMONSTRATION PROJECT		0		70. 50
70. 89	Pioneer ACO demonstration payment adjustment amount (see		0		70. 89
70.00	instructions)				70.00
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
	Bundled Model 1 discount amount (see instructions)		Ö		70. 92
70. 93	HVBP payment adjustment amount (see instructions)		-56, 611		70. 93
	HRR adjustment amount (see instructions)		-1, 134		70. 94
70. 95	Recovery of accelerated depreciation		0		70. 95

ealth Financial Systems	MEMORIAL HOSPITAL OF SOUTH	H BEND,	INC	In Lie	u of Form CMS-2552-10

	Financial Systems MEMORIAL HOSPITAL OF ATION OF REIMBURSEMENT SETTLEMENT	SOUTH BEND, INC Provider CCN: 150058	Peri od:	u of Form CMS-: Worksheet E	
CALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150058	From 01/01/2014	Part A	
			To 12/31/2014	Date/Time Pre	pared:
				5/29/2015 9: 2	O am
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy)		0 0		70. 96
	(Enter in column 0 the corresponding federal year for the				
70. 97	period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy)				70.07
70. 97	(Enter in column 0 the corresponding federal year for the		0		70. 97
	period ending on or after 10/1)				
70. 98	Low Volume Payment-3		0		70. 98
	HAC adjustment amount (see instructions)		0		70. 99
70. 99	Amount due provider (line 67 minus lines 68 plus/minus		58, 356, 492		71.00
71.00	lines 69 & 70)		30, 330, 492		/ 1.00
71. 01	Sequestration adjustment (see instructions)		1, 167, 130		71. 01
	Interim payments		57, 039, 115		72. 00
	Tentative settlement (for contractor use only)		0,7,00,7,1.0		73.00
74. 00	Balance due provider (Program) (line 71 minus lines 71.01,		150, 247		74.00
, 00	72, and 73)		100/21/		/ 00
75. 00	Protested amounts (nonallowable cost report items) in		16, 787, 626		75.00
	accordance with CMS Pub. 15-2, chapter 1, §115.2				
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see		0		90.00
	instructions)				
	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92. 00	Operating outlier reconciliation adjustment amount (see		0		92.00
	instructions)				
93. 00	Capital outlier reconciliation adjustment amount (see		0		93.00
04.00	instructions)		0.00		04.00
94. 00	The rate used to calculate the time value of money (see instructions)		0.00		94. 00
95. 00	Time value of money for operating expenses (see		0		95.00
75.00	instructions)		U		95.00
96. 00	Time value of money for capital related expenses (see		0		96, 00
70. 00	instructions)				70.00
	THE COUNTY OF TH		Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
	HSP Bonus Payment Amount				
	HSP bonus amount (see instructions)		0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0. 999622	0. 999	101. 00
102.00	HVBP adjustment amount for HSP bonus payment (see instructio	ns)	0	0	102. 00
	HRR Adjustment for HSP Bonus Payment				
	HRR adjustment factor (see instructions)		1. 0000	0. 9999	
104 00	HRR adjustment amount for HSP bonus payment (see instruction	s)	0	0	104.00

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEN	D, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi	der CCN: 150058	From 01/01/2014	
			To 12/31/2014	Date/Time Prepared:

Date/Time Prepared: 5/29/2015 9:20 am Title XVIII Hospi tal PPS 1.00 PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) 16, 201 1.00 Medical and other services reimbursed under OPPS (see instructions) 24, 983, 337 2.00 2.00 21, 426, 977 3.00 PPS payments 3 00 4.00 Outlier payment (see instructions) 177, 046 4.00 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 Line 2 times line 5 6.00 0 6.00 7.00 Sum of line 3 plus line 4 divided by line 6 0.00 7.00 8.00 Transitional corridor payment (see instructions) Ω 8.00 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 55, 692 9.00 10 00 10 00 Organ acquisitions 0 11.00 Total cost (sum of lines 1 and 10) (see instructions) 16, 201 11.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12 00 12 00 68. 456 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4) 0 13.00 14.00 Total reasonable charges (sum of lines 12 and 13) 68, 456 14.00 Customary charges 15 00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15 00 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 had such payment been made in accordance with 42 CFR §413.13(e) 17 00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 68, 456 18.00 Total customary charges (see instructions) 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 52, 255 19.00 instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 20.00 0 instructions) 16, 201 21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 21.00 22.00 Interns and residents (see instructions) 0 22 00 Cost of physicians' services in a teaching hospital (see instructions) 23.00 23.00 0 Total prospective payment (sum of lines 3, 4, 8 and 9) 21, 659, 715 24.00 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 25.00 Deductibles and coinsurance (for CAH, see instructions) 12.104 25 00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 26,00 4, 148, 530 26,00 27.00 Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for 17, 515, 282 27.00 CAH. see instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 308, 719 28.00 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 0 30.00 Subtotal (sum of lines 27 through 29) 17, 824, 001 30.00 31 00 5 911 Primary payer payments 31 00 32.00 Subtotal (line 30 minus line 31) 17, 818, 090 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) 33.00 0 33.00 582, 853 34.00 Allowable bad debts (see instructions) 34 00 35.00 Adjusted reimbursable bad debts (see instructions) 378, 854 35.00 582, 853 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 36.00 37.00 Subtotal (see instructions) 18, 196, 944 37.00 38.00 MSP-LCC reconciliation amount from PS&R 273 38.00 39. 00 OTHER ADJUSTMENTS PER PS&R -429 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 39.98 0 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 Ω 18, 196, 242 40.00 Subtotal (see instructions) 40.00 40.01 363, 925 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 17, 901, 620 41.00 42.00 Tentative settlement (for contractors use only) 42.00 43 00 Balance due provider/program (see instructions) -69, 303 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 0 §115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 92 00 92 00 93.00 Time Value of Money (see instructions) 0 93.00 94.00 Total (sum of lines 91 and 93) 0 94.00

| Period: | Worksheet E-1 | From 01/01/2014 | Part | Date/Time Prepared: | 5/29/2015 9: 20 am 
 Heal th
 Financial
 Systems
 MEMORIAL F

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED
 Provi der CCN: 150058

					5/29/2015 9: 20	o am
			e XVIII	Hospi tal	PPS	
		Inpatier	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		56, 639, 515		17, 713, 320	1. 00
2.00	Interim payments payable on individual bills, either		[ C	)	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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 to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	07/17/2014	399, 600	07/17/2014	188, 300	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER	0771772014	377, 000		0	3. 02
3. 02						3. 02
3. 04						3. 03
3.05					0	3. 05
3.03	Provider to Program			1	0	3.03
3.50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51	765 THENTO TO TROOM III				0	3. 51
3. 52			ĺ		0	3. 52
3. 53			ĺ		0	3. 53
3. 54			1		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		399, 600	1	188, 300	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		57, 039, 115		17, 901, 620	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	T	1 .	П		
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			C		0	5. 02
5. 03	Describber to Describe		<u> </u>		0	5. 03
E E0	Provider to Program TENTATIVE TO PROGRAM	I	1		1 0	5. 50
5. 50 5. 51	TENTATIVE TO PROGRAM					5. 50
5. 51						5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
5. 77	5. 50-5. 98)				١	3. 77
6. 00	Determined net settlement amount (balance due) based on					6. 00
5.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		150, 247	,	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1 .55, 21,	,	69, 303	6. 02
7. 00	Total Medicare program liability (see instructions)		57, 189, 362		17, 832, 317	7. 00
7.00	The second of th		2.7.3.7002	Contractor	NPR Date	7.30
				Number	(Mo/Day/Yr)	
			)	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Health Financial Systems MEMORIAL I ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Inpatient Part A			Ti tl	e XVIII	Subprovi der  - I PF	PPS	
1.00   Total Interim payments paid to provider   2.00   3.00   4.00   1.00			I npati en	t Part A	Par	t B	
1.00   Total interim payments paid to provider   2,601,443   0   1.00   0   2.00   0   0   0   0   0   0   0   0   0			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
InterIm payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1. 00			4. 00	
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				2, 601, 443			
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	2.00			0		0	2. 00
write "NONE" or enter a zero							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  ADJUSTMENTS TO PROVIDER  ADJUSTMENTS TO PROVIDER  O	2 00						2 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	3.00						3.00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provider							
3.02   3.02   3.03   3.04   3.05   3.03   3.04   3.05   3.03   3.04   3.05							
3.03   0	3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 04   0   0   0   3. 04   3. 05   5. 05							
3.05							
Provider to Program   ADJUSTMENTS TO PROGRAM   0   0   3.50							
3.50   ADJUSTMENTS TO PROGRAM   0   0   3.50     3.51   3.52   0   0   0   3.51     3.52   3.53   0   0   0   3.53     3.54   0   0   0   3.53     3.59   3.50-3.98   0   0   0   3.59     4.00   Total interim payments (sum of lines 1, 2, and 3.99)   2,601,443   0   4.00     (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)	3.05	Drawi dan ta Draggam		0		0	3.05
3.51   3.52   3.53   3.53   3.54   3.55   3.55   3.55   3.59   3.50-3.98   3	3 50			0		0	3 50
3.52   3.53   3.54   3.99   3.50-3.98		ADJUSTIMENTS TO TROUKAM					
3.53   3.54   0							
3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09)   3.99   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   2,601,443   0   4.00   4.00   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR							
3.50-3.98    Total interim payments (sum of lines 1, 2, and 3.99)   2,601,443   0   4.00	3.54			0		0	3. 54
A. 00   Total interim payments (sum of lines 1, 2, and 3.99)   2,601,443   0   4.00	3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR							
appropriate   TO BE COMPLETED BY CONTRACTOR	4. 00			2, 601, 443		0	4. 00
TO BE COMPLETED BY CONTRACTOR							
5.00   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	5 00						5.00
Write "NONE" or enter a zero. (1)   Program to Provider	0.00						0.00
TENTATI VE TO PROVI DER							
S. 02							
Description		TENTATI VE TO PROVI DER					
Provider to Program							
TENTATI VE TO PROGRAM   0	5.03	Drawi dan ta Draggam		0		0	5.03
5.51   0	5 50			0		0	5 50
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52   0		TENTATI VE TO TROOKAW					
5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00							
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 90 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 0 6.02 7.00 Total Medicare program liability (see instructions) 2,601,533 0 7.00  Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
the cost report. (1) SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1. 00 2. 00		5. 50-5. 98)					
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)	6.00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	,			= =		_	,
7.00 Total Medicare program liability (see instructions)  2,601,533  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00							
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00				-			
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	Total medicale program Habitity (see Histructions)		2, 001, 533			7.00
0 1.00 2.00							
8.00 Name of Contractor 8.00				)			
	8.00	Name of Contractor					8. 00

Health Financial Systems MEMORIAL FAMALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Ti tl	e XVIII	Subprovi der  - I RF	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 749, 227 0		0	1. 00 2. 00
3.00	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 to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54	Cultural ( C lines - 2 01 2 40 minus		0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		Ü		U	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 749, 227		0	4. 00
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR  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. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Provider to Program		0		0	5. 03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	TENTATI VE TO TROOTONIII		0		Ö	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		22, 168		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 771, 395		0	7. 00
			1	Contractor Number	NPR Date (Mo/Day/Yr)	
8. 00	Name of Contractor	(	)	1. 00	2. 00	8. 00
0.00	Name of Contractor			l	1	0.00

Hoal th	Financial Systems MEMODIAL HOSDITAL OF S	OUTH REND INC	In lie	u of Form CMS-2	0552_10
	Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 150058   Period: From 01/01/2014   To 12/31/2014   D 5   From 01/01/2014   P 5   From 01/01/2014   P 6   From 01/01/2014   P 7   From				
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14	18, 568	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-	12		27, 442	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			8, 634	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		91, 145	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1, 182, 949, 103	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ne 20		21, 177, 615	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of ce	rtified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			1, 104, 986	8.00
9.00	9.00 Sequestration adjustment amount (see instructions)				
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					10.00
I NPATI ENT HOSPI TAL SERVI CES UNDER PPS & CAH					
30.00	30.00 Initial/interim HIT payment adjustment (see instructions) 1,146,983				
31.00	1.00 Other Adjustment (specify)				
22 00	2.00 Ralance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) -64.007				

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

-64, 097 32. 00

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150058  Component CCN: 15S058	From 01/01/2014	
- <u></u>	'		5/29/2015 9:20 am
	Title XVIII	Subprovi der -	PPS
,			

1,713   2.00   Net I PP PPS CUTIVE Payments   1,713   2.00   Net I PP PPS ECT Payments   1,713   2.00   Net I PP PPS ECT Payments   1,713   2.00   Net I PP PPS ECT Payments   1,713   2.00   1,52   2.004   (see I instructions)   2.004   1,52   2		I PF		
PART II - MEDICARE PART A SERVICES - IPF PPS			1 00	
Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		PART II - MEDICARE PART A SERVICES - IPF PPS	1.00	
12,788   3.00	1.00		2, 876, 228	1. 00
Unweighted Intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	2.00	Net IPF PPS Outlier Payments	1, 713	2. 00
15. 2004. (see instructions) 4. 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 42 CFR \$412.424(d)(i)(iii)(F)(ii) (i) (i) (i) (i) (i) (i) (i) (i) (i	3.00	Net IPF PPS ECT Payments	12, 788	3. 00
4.01   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 42 CFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	4. 00		0.00	4. 00
Current year's unweighted FTE count of 1&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	4. 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 42	0.00	4. 01
teaching program" (see Instructions)  7.00 Current year's unweighted 18k FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions)  9.00 Average Dail y Census (see instructions)  11.00 Teaching Adjustment Factor (((1 + (line 8/line 9)) raised to the power of .5150 -1).  12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  14.00 Organ acquisition (DNOT USE THIS LINE)  16.00 Subtotal (see instructions)  17.00 Primary payer payments  18.00 Subtotal (see instructions)  18.00 Subtotal (line 16 less line 17).  18.00 Subtotal (line 16 less line 17).  18.00 Subtotal (line 16 less line 17).  18.00 Subtotal (line 18 minus line 19)  19.00 Deductibles  19.00 Subtotal (line 18 minus line 19)  20.00 Subtotal (line 20 minus line 21)  21.00 Subtotal (line 20 minus line 21)  22.00 Subtotal (line 20 minus line 21)  23.00 Al Jowabile bad debts (see instructions)  24.00 Adjusted relimbursable bad debts (see instructions)  25.00 Adjusted relimbursable bad debts (see instructions)  27.054,548 22.  28.00 Oliver payse trouble said debts (see instructions)  29.00 Direct graduate medical education payments (from Wkst. E-4, line 49)  29.00 Outlier payments reconciliation  20.00 Total amount payable to the provider (see instructions)  20.00 Oliver payse through costs (see instructions)  30.00 Oliver pays through costs (see instructions)  30.00 Oliver payse through costs (see instructions)  30.00 Oliver payments reconciliation adjustment (see instructions)  30.00 Oliver payments reconciliation adjustment (see instructions)  30.00 Oliver payse through costs (see instructions)  30.00 Oliver payments reconciliation adjustment (see instructions)  30.00 Oliver payments reconciliation adjustment (see instructions)  30.00 Oliver payments reconciliation adjustment (see instructions)  30.00 Oliver payse through costs (see instruc	5.00	New Teaching program adjustment. (see instructions)	0.00	5. 00
2.00   Current 'year's unweighted I&R FTE count for residents within the new program growth period of a "new to teaching program" (see instructions)   0.00   8.0	6. 00		0.00	6. 00
8.00	7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	7. 00
9.00   Average Daily Census (see instructions)   13.810959   9.0	8.00		0.00	8. 00
10.00   Teaching Adjustment Factor {((1 + (line B/line 9)) raised to the power of .5150 -1).   0.000000   10.00   10				9. 00
11.00   Teaching Adjustment (line 1 multiplied by line 10).   0   11.00   12.00   12.00   13	10.00		0. 000000	10.00
13. 00   Nursing and Allied Health Managed Care payment (see instruction)   13. 00   Organ acquisition (D0 NOT USE THIS LINE)   14. 01   15. 00   Cost of physicians' services in a teaching hospital (see instructions)   15. 00   15. 00   Cost of physicians' services in a teaching hospital (see instructions)   2,890,729   16. 01   16. 00   Cost of physicians' services in a teaching hospital (see instructions)   2,890,729   16. 01   16. 00   Cost of physicians' services in a teaching hospital (see instructions)   2,890,729   16. 01   16. 00   Cost of physicians' services in a teaching hospital (see instructions)   2,895,220   18. 02   Cost of physicians' services (see instructions)   2,866,404   20. 00   Cost of least of the services of the	11.00		0	11. 00
13. 00   Nursing and Allied Health Managed Care payment (see instruction)   0   13. 0   0   0   0   0   0   0   0   0   0	12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2, 890, 729	12.00
15.00   Cost of physicians' services in a teaching hospital (see instructions)   2,890,729   16.00   Subtotal (see instructions)   2,890,729   16.00   16.00   Subtotal (see instructions)   5,509   17.00	13.00	Nursing and Allied Health Managed Care payment (see instruction)		13.00
16.00   Subtotal (see instructions)   2,890,729   16.00   17.00   Primary payer payments   5,509   17.00   17.00   Primary payer payments   5,509   17.00	14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
17.00   Primary payer payments   5.509   17.00   Subtotal (line 16 less line 17).   2,885,220   18.00   2,885,220   18.00   20.00   Subtotal (line 18 minus line 19)   2,666,404   20.00   2.00   Subtotal (line 20 minus line 21)   2,665,4548   22.00   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0.23.00   24.00   Adjusted reimbursable bad debts (see instructions)   0.23.00   24.00   Adjusted reimbursable bad debts (see instructions)   0.25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0.25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0.25.00   2.654,548   2.00	15.00	Cost of physicians' services in a teaching hospital (see instructions)	ol	15. 00
18.00   Subtotal (line 16 less line 17).   2,885,220   18.00   19.00   Deductibles   218,816   19.00   21.00   Coinsurance   11,856   21.00   22.00   Subtotal (line 20 minus line 21)   2,654,548   22.00   Adjusted reimbursable bad debts (exclude bad debts for professional services) (see instructions)   0.24.00   Adjusted reimbursable bad debts (see instructions)   0.25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0.25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0.27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0.27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0.27.00   Other pass through costs (see instructions)   0.27.00   Other pass through costs (see instructions)   0.29.00   Other payments (see instructi	16.00	Subtotal (see instructions)	2, 890, 729	16. 00
19.00   Deductibles   218,816   19.00   20.00   Subtotal (line 18 minus line 19)   2,666,404   20.00   20.0	17.00	Primary payer payments	5, 509	17. 00
20.00   Subtotal (line 18 minus line 19)   2, 666, 404   21.00   Coinsurance   2, 666, 404   21.00   Coinsurance   22.00   Subtotal (line 20 minus line 21)   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0 23.00   24.00   Adjusted reimbursable bad debts (see instructions)   0 24.00   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 25.00   26.00   Subtotal (sum of lines 22 and 24)   2, 654, 548   26.00   27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0 27.00   27.00   Other pass through costs (see instructions)   78 28.00   Other pass through costs (see instructions)   78 28.00   Other pass through costs (see instructions)   0 29.00   Outlier payments reconciliation   0 29.00   Outlier payments reconciliation   0 29.00   Outlier payments reconciliation   0 30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 30.50   Pioneer ACO demonstration payment adjustment (see instructions)   2, 654, 626   31.01   Sequestration adjustment (see instructions)   2, 654, 626   31.01   Sequestration adjustment (see instructions)   2, 654, 626   31.01   Sequestration adjustment (see instructions)   2, 601, 443   32.00   Interim payments   2, 601, 443   32.00   33.00   Tentative settlement (for contractor use only)   34.00   Balance due provider/program (line 31 minus lines 31.01, 32 and 33)   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 50.00   Original outlier amount from Worksheet E-3, Part II, line 2   1,713   50.00   The rate used to calculate the Time Value of Money   0.00   52.00   The rate used to calculate the Time Value of Money   0.00   52.00   Contractor use of calculate the Time Value of Money   0.00   52.00   Contractor use of calculate the Time Value of Money   0.00   52.00   Contractor use of calculate the Time Value of Money   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00	18.00	Subtotal (line 16 less line 17).	2, 885, 220	18. 00
21.00	19.00	Deducti bl es	218, 816	19. 00
22. 00       Subtotal (line 20 minus line 21)       2,654,548       22. 02         23. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       0       23. 02         24. 00       Adjusted reimbursable bad debts (see instructions)       0       24. 00         25. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       25. 02         26. 00       Subtotal (sum of lines 22 and 24)       2,654,548       26. 02         27. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27. 02         28. 00       Other pass through costs (see instructions)       78       28. 02         29. 00       Outlier payments reconciliation       0       29. 02         30. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30. 03         30. 99       Recovery of Accelerated Depreciation       0       30. 03         31. 01       Total amount payable to the provider (see instructions)       2, 654, 626       31. 03         31. 02       Total amount payments       2, 601, 443       32. 02         32. 00       Interim payments       2, 601, 443       32. 03         33. 00       Tentative settlement (for contractor use only)       30. 03       30. 03 <tr< td=""><td>20.00</td><td>Subtotal (line 18 minus line 19)</td><td>2, 666, 404</td><td>20.00</td></tr<>	20.00	Subtotal (line 18 minus line 19)	2, 666, 404	20.00
23.00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       0       23.00         24.00       Adjusted reimbursable bad debts (see instructions)       0       24.00         25.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       25.00         26.00       Subtotal (sum of lines 22 and 24)       2,654,548       26.02         27.00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27.00         28.00       Other pass through costs (see instructions)       78       28.00         29.00       Outlier payments reconciliation       0       29.00         30.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30.00         30.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30.50         30.99       Recovery of Accelerated Depreciation       0       30.90         31.01       Sequestration adjustment (see instructions)       2,654,626       31.00         32.00       Interim payments       2,601,443       32.00         33.00       Tentative settlement (for contractor use only)       0       33.00         34.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       0 <td>21.00</td> <td>Coi nsurance</td> <td>11, 856</td> <td>21.00</td>	21.00	Coi nsurance	11, 856	21.00
24.00       Adjusted reimbursable bad debts (see instructions)       0       24.00         25.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       25.00         26.00       Subtotal (sum of lines 22 and 24)       2,654,548       26.00         27.00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27.00         28.00       Other pass through costs (see instructions)       78       28.00         29.00       Outlier payments reconciliation       0       29.00         30.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30.00         30.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30.00         30.99       Recovery of Accelerated Depreciation       0       30.9         31.01       Sequestration adjustment (see instructions)       2,654,626       31.0         32.00       Interim payments       2,601,443       32.0         33.00       Tentative settlement (for contractor use only)       33.0       33.0         34.00       Balance due provider/program (line 31 minus lines 31.01, 32 and 33)       90       34.0         35.0       To BE COMPLETED BY CONTRACTOR       35.0         51.00       Outlier reconciliation adjustmen	22.00	Subtotal (line 20 minus line 21)	2, 654, 548	22. 00
25.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  26.00 Subtotal (sum of lines 22 and 24)  27.00 Direct graduate medical education payments (from Wkst. E-4, line 49)  28.00 Other pass through costs (see instructions)  29.00 Outlier payments reconciliation  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.00 Pioneer ACO demonstration payment adjustment (see instructions)  30.50 Sequestration adjustment (see instructions)  31.00 Total amount payable to the provider (see instructions)  32.00 Interim payments  33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  50.00 Original outlier amount from Worksheet E-3, Part II, line 2  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  2, 654, 548 26.00  2, 654, 548 26.00  2, 654, 548 26.00  27.00 Protest ed amounts (see instructions)  30.00 Original outlier amount from Worksheet E-3, Part II, line 2  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  0.00 52.00	23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23. 00
26.00 Subtotal (sum of lines 22 and 24) 27.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 28.00 Other pass through costs (see instructions) 29.00 Outlier payments reconciliation 30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30.50 Pioneer ACO demonstration payment adjustment (see instructions) 30.99 Recovery of Accelerated Depreciation 31.00 Total amount payable to the provider (see instructions) 32.00 Interim payments 33.00 Sequestration adjustment (see instructions) 32.00 Interim payments 33.00 Tentative settlement (for contractor use only) 34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35.00 Original outlier amount from Worksheet E-3, Part II, line 2  TO BE COMPLETED BY CONTRACTOR  50.00 Outlier reconciliation adjustment amount (see instructions) 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money  2, 654, 626 31.0 2, 654, 626 31.0 30.5 30.5 30.5 30.5 30.5 30.5 30.5 30	24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
27. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27. 00         28. 00       Other pass through costs (see instructions)       78       28. 00         29. 00       Outlier payments reconciliation       0       29. 00         30. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30. 00         30. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30. 00         30. 99       Recovery of Accelerated Depreciation       0       30. 00         31. 00       Total amount payable to the provider (see instructions)       2, 654, 626       31. 00         31. 01       Sequestration adjustment (see instructions)       53, 093       31. 00         32. 00       Interim payments       2, 601, 443       32. 00         33. 00       Tentative settlement (for contractor use only)       33. 00       90       34. 00         34. 00       Bal ance due provider/program (line 31 minus lines 31.01, 32 and 33)       90       34. 00         35. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       0       35. 00         50. 00       Original outlier amount from Worksheet E-3, Part II, line 2       1, 713       50. 00         51. 00       Outlier reconcilia	25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25. 00
27. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27. 00         28. 00       Other pass through costs (see instructions)       78       28. 00         29. 00       Outlier payments reconciliation       0       29. 00         30. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30. 00         30. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30. 00         30. 99       Recovery of Accelerated Depreciation       0       30. 00         31. 00       Total amount payable to the provider (see instructions)       2, 654, 626       31. 00         31. 01       Sequestration adjustment (see instructions)       53, 093       31. 00         32. 00       Interim payments       2, 601, 443       32. 00         33. 00       Tentative settlement (for contractor use only)       33. 00       90       34. 00         34. 00       Bal ance due provider/program (line 31 minus lines 31.01, 32 and 33)       90       34. 00         35. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       0       35. 00         50. 00       Original outlier amount from Worksheet E-3, Part II, line 2       1, 713       50. 00         51. 00       Outlier reconcilia	26.00	Subtotal (sum of lines 22 and 24)	2, 654, 548	26. 00
28.00 Other pass through costs (see instructions)  29.00 Outlier payments reconciliation  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.00 Pi oneer ACO demonstration payment adjustment (see instructions)  30.99 Recovery of Accelerated Depreciation  31.00 Total amount payable to the provider (see instructions)  31.01 Sequestration adjustment (see instructions)  32.00 Interim payments  33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 \$\frac{1}{8}\$115.2 \$\frac{1}{10}\$ BE COMPLETED BY CONTRACTOR  50.00 Outlier reconciliation adjustment amount (see instructions)  51.00 Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money  53.00 Outlier reconciliation adjustment amount (see instructions)  54.00 Outlier amount from Worksheet E-3, Part II, line 2  55.00 The rate used to calculate the Time Value of Money  55.00 Outlier reconciliation adjustment amount (see instructions)  56.00 Outlier reconciliation adjustment amount (see instructions)	27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27. 00
29.00   Outlier payments reconciliation   0   29.00	28.00		78	28. 00
30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30.00     30.50   Pi oneer ACO demonstration payment adjustment (see instructions)   0   30.50     30.99   Recovery of Accelerated Depreciation   0   30.90     31.00   Total amount payable to the provider (see instructions)   2,654,626     31.01   Sequestration adjustment (see instructions)   2,654,626     31.01   Sequestration adjustment (see instructions)   2,601,443     32.00   Interim payments   2,601,443     32.00   Sequestration adjustment (for contractor use only)   2,601,443     32.00   Sequestration adjustment (for contractor use only)   2,601,443     33.00   Balance due provider/program (line 31 minus lines 31.01, 32 and 33)   90     34.00   Sequestration adjustment (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0     51.52   To BE COMPLETED BY CONTRACTOR   1,713   50.00     50.00   Outlier reconciliation adjustment amount (see instructions)   0   51.00     51.00   Outlier reconciliation adjustment amount (see instructions)   0   51.00     52.00   The rate used to calculate the Time Value of Money   0.00   52.00	29.00	, ,	0	29. 00
30. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  30. 99 Recovery of Accelerated Depreciation  31. 00 Total amount payable to the provider (see instructions)  31. 01 Sequestration adjustment (see instructions)  32. 00 Interim payments  33. 00 Tentative settlement (for contractor use only)  34. 00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35. 0 10 BE COMPLETED BY CONTRACTOR  50. 00 Original outlier amount from Worksheet E-3, Part II, line 2  51. 00 Outlier reconciliation adjustment amount (see instructions)  52. 00 The rate used to calculate the Time Value of Money  53. 53. 54. 55. 65. 626  54. 626 31. 626  55. 64. 626 31. 626  55. 65. 626  56. 57. 67. 67. 67. 67. 67. 67. 67. 67. 67. 6	30.00		0	30. 00
30. 99 Recovery of Accelerated Depreciation  30. 99 Recovery of Accelerated Depreciation  30. 99 Total amount payable to the provider (see instructions)  31. 01 Sequestration adjustment (see instructions)  32. 00 Interim payments  33. 00 Tentative settlement (for contractor use only)  34. 00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$115.2 TO BE COMPLETED BY CONTRACTOR  50. 00 Original outlier amount from Worksheet E-3, Part II, line 2  51. 00 Outlier reconciliation adjustment amount (see instructions)  52. 00 The rate used to calculate the Time Value of Money  0 30. 9  2, 654, 626 31. 0  2, 654, 626 31. 0  31. 00  2, 654, 626 31. 0  31. 00  32. 00  33. 00  34. 00  35. 00  35. 00  36. 00  37. 00  38. 00  39. 00  39. 00  30. 00	30. 50		0	30. 50
31.00   Total amount payable to the provider (see instructions)   2,654,626   31.01   32.00   Interim payments   2,601,443   32.00   33.00   Tentative settlement (for contractor use only)   0   33.00   34.00   Balance due provider/program (line 31 minus lines 31.01, 32 and 33)   90   34.00   90   90   90   90   90   90   90			0	30. 99
31.01 Sequestration adjustment (see instructions)  32.00 Interim payments  33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  35.00 Original outlier amount from Worksheet E-3, Part II, line 2  36.00 Outlier reconciliation adjustment amount (see instructions)  37.00 Outlier reconciliation adjustment amount (see instructions)  38.00 Outlier reconciliation adjustment amount (see instructions)  39.00 Outlier reconciliation adjustment amount (see instructions)  31.00 Outlier reconciliation adjustment amount (see instructions)  32.00 Outlier reconciliation adjustment amount (see instructions)			2, 654, 626	
32.00 Interim payments  2,601,443 32.0 33.00 Tentative settlement (for contractor use only) 34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  50.00 Original outlier amount from Worksheet E-3, Part II, line 2  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  2,601,443 32.0 33.00 35.00 36.00 37.00 38.00 38.00 39.00 30.		1		
33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  35.00 Original outlier amount from Worksheet E-3, Part II, line 2  50.00 Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  30.00 33				
34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  90 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable co				33. 00
35.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$1.00 Si 15.2 TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Worksheet E-3, Part II, line 2 1, 713 50.0 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00		1		34.00
50.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money 52.00 The rate used to calculate the Time Value of Money 53.00 The rate used to calculate the Time Value of Money		Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	35. 00
51.00 Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money  0.00 52.0				
52.00 The rate used to calculate the Time Value of Money 0.00 52.0				
		, ,		51.00
53.00  Time Value of Money (see instructions) 0   53.00				
	53.00	Time Value of Money (see instructions)	0	53.00

Health Financial Systems	MEMORIAL HOSPITAL OF SOL	JTH BEND, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150058	Peri od: From 01/01/2014	Worksheet E-3
		Component CCN: 15T058		
		Title XVIII	Subprovi der -	PPS
			IRF	

	IRF			
	DADT LLL MEDICADE DADT A CEDIMORE LDE DOC		1. 00	
1. 00	PART III - MEDICARE PART A SERVICES - IRF PPS  Net Federal PPS Payment (see instructions)		1, 423, 343	1. 00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)		0. 0381	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		108, 459	3. 00
4. 00	Outlier Payments		291, 240	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or p	rior	0.00	5. 00
0.00	to November 15, 2004 (see instructions)		0.00	0.00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced	bv !	0.00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 4	2		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)			
6.00	New Teaching program adjustment. (see instructions)		0.00	6. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "	new	0. 00	7. 00
	teaching program" (see instructions)			
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "	new	0. 00	8. 00
	teaching program" (see instructions)			
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		11. 539726	
11. 00 12. 00			0. 000000 0	11. 00 12. 00
13. 00	,		1, 823, 042	13. 00
14. 00			1, 623, 042	14. 00
15. 00			U	15. 00
16. 00			0	16. 00
17. 00	J		1, 823, 042	17. 00
18. 00	· · · · · · · · · · · · · · · · · · ·		0	18. 00
19. 00	1 3 1 3 1 1 3 1 1 1		1, 823, 042	19. 00
20. 00	· · · · · · · · · · · · · · · · · · ·		0	20.00
21. 00			1, 823, 042	21. 00
22. 00			15, 504	22. 00
23.00	Subtotal (line 21 minus line 22)		1, 807, 538	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	24.00
25.00			0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27. 00	Subtotal (sum of lines 23 and 25)		1, 807, 538	27. 00
28. 00			0	28. 00
29. 00			8	29. 00
30. 00			0	30. 00
31. 00			0	31. 00
31. 50	1		0	31. 50
31. 99			0	31. 99
32.00			1, 807, 546	32.00
32. 01			36, 151	
33.00			1, 749, 227	33.00
34. 00 35. 00	, , , , , , , , , , , , , , , , , , , ,		0 22, 168	34. 00 35. 00
36. 00			2, 753, 739	36. 00
30.00	§115. 2		2, 100, 109	30.00
	TO BE COMPLETED BY CONTRACTOR			
50. 00			291, 240	50.00
51. 00		-	271, 240	51. 00
	00 The rate used to calculate the Time Value of Money			
	Time Value of Money (see instructions)		0. 00 0	52. 00 53. 00
		'	- 1	

IRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT D	I RECT Provi der	CCN: 150058	Peri od:	Worksheet E-4	
EDICAL EDUCATION COSTS			From 01/01/2014 To 12/31/2014	Date/Time Pre 5/29/2015 9:20	
	Ti tI	e XVIII	Hospi tal	PPS	.o am
				1. 00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
Unweighted resident FTE count for allopathic and oste ending on or before December 31, 1996.	eopathic programs for	cost reporti	ng periods	24. 76	1.
00 Unweighted FTE resident cap add-on for new programs p		(1) (see instr	uctions)	0. 00	2.
OO Amount of reduction to Direct GME cap under section			,	0.00	
O1 Direct GME cap reduction amount under ACA §5503 in actions for cost reporting periods straddling 7/		R 9413.79 (m).	(see	0.00	3.
00 Adjustment (plus or minus) to the FTE cap for allopat GME affiliation agreement (42 CFR §413.75(b) and § 4	thic and osteopathic	programs due	to a Medicare	0.00	4.
O1 ACA Section 5503 increase to the Direct GME FTE Cap (straddling 7/1/2011)	. , ,	cost reporti	ng periods	3. 00	4
02 ACA Section 5506 number of additional direct GME FTE periods straddling 7/1/2011)	cap slots (see inst	tructions for	cost reporting	0. 00	4
00 FTE adjusted cap (line 1 plus line 2 minus line 3 and 4.02 plus applicable subscripts	d 3.01 plus or minus	line 4 plus l	ines 4.01 and	27. 76	5
OD Unweighted resident FTE count for allopathic and oste records (see instructions)	eopathic programs for	the current	year from your	27. 17	6
00 Enter the lesser of line 5 or line 6				27. 17	7
		Pri mary Care		Total	-
00 Weighted FTE count for physicians in an allopathic ar	nd osteonathic	1.00	7 0.00	3. 00 27. 17	8
program for the current year.  Oo If line 6 is less than 5 enter the amount from line 8	•	27. 1		27. 17	
multiply line 8 times the result of line 5 divided by 6.			7	27.17	
.00 Weighted dental and podiatric resident FTE count for	the current year		0.00		10
00 Total weighted FTE count		27. 1			11
OO Total weighted resident FTE count for the prior cost	reporting year (see	25. C	0.00		12
<pre>instructions)  Total weighted resident FTE count for the penultimate year (see instructions)</pre>	e cost reporting	23. 9	0.00		13
98 (See Fistractions) 00 Rolling average FTE count (sum of lines 11 through 13	3 divided by 3).	25. 3	0.00		14
.00 Adjustment for residents in initial years of new prog		0.0			15
.00 Adjustment for residents displaced by program or hosp	oital closure	0.0			16
.00 Adjusted rolling average FTE count		25. 3			17
.00 Per resident amount		116, 765. 3		2 0/2 227	18
00 Approved amount for resident costs		2, 962, 33	[7] O	2, 962, 337	15
				1. 00	
00 Additional unweighted allopathic and osteopathic dire Sec. 413.79(c)(4)	ect GME FTE resident	cap slots rec	eived under 42	0.00	20
00 Direct GME FTE unweighted resident count over cap (se	ee instructions)			0.00	21
00 Allowable additional direct GME FTE Resident Count (s				0.00	
.00 Enter the locally adjustment national average per res	sident amount (see ir	nstructions)		0.00	
.00 Multiply line 22 time line 23				0 2, 962, 337	
00   Total direct GME amount (sum of lines 19 and 24)		Inpatient Par	t Managed care	2, 902, 337	20
		1. 00	2. 00	3. 00	
COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
Inpatient Days (see instructions)		32, 28	8, 634		26
.00 Total Inpatient Days (see instructions)		100, 87	'3 100, 873		27
.00 Ratio of inpatient days to total inpatient days		0. 32004			28
.00 Program direct GME amount		948, 08			29
0.00 Reduction for direct GME payments for Medicare Advant	tage		35, 827	1, 165, 812	30
.00 Net Program direct GME amount					

DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 150058	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2014 To 12/31/2014	Date/Time Prep 5/29/2015 9: 20	
		Title XVIII	Hospi tal	PPS	
	DUDECT MEDICAL EDUCATION COSTS FOR FORD COMPOSITE DATE. TITLE	VVIII ONLY (NUDCING CO	UOOL AND DADAMEDI	1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	XVIII UNLY (NURSING SC	HOOL AND PARAMEDI	CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, Pt	l sum of col 20 an	nd 23 lines 74	0	32. 00
02.00	and 94)	1, 3dill 01 col. 20 dil	la 20, 111105 / 1	J	02.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I,	col. 8, sum of lines	74 and 94)	0	33. 00
34.00	Ratio of direct medical education costs to total charges (line		, i	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 3	34 x line 35)		0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII C	NLY			ı
	Part A Reasonable Cost				l
	Reasonable cost (see instructions)			69, 678, 945	
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	
	Cost of physicians' services in a teaching hospital (see instru	ıctions)		0	39. 00
	Primary payer payments (see instructions)			134, 692	
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minus	line 40)		69, 544, 253	41.00
42.00	Part B Reasonable Cost			25 055 220	42.00
42. 00 43. 00	Reasonable cost (see instructions)			25, 055, 230	42.00
	Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43)			25, 049, 319	
	Total reasonable cost (sum of lines 41 and 44)			94, 593, 572	
	Ratio of Part A reasonable cost to total reasonable cost (line	41 ÷ line 45)		0. 735190	
	.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) 0.735190				
17.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART			5. 204010	17.00
48. 00	Total program GME payment (line 31)	-		1, 165, 812	48. 00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (	see instructions)		857. 093	
	5.00 Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)				

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

Provi der CCN: 150058

| Period: | Worksheet G | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: 5/29/2015 9: 20 am

					5/29/2015 9: 2	oan oan O am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1. 00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	28, 348, 000	0	0	0	1. 00
2.00	Temporary investments	51, 005, 000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	99, 561, 000	0	0	0	4. 00
5.00	Other recei vabl e	21, 189, 000		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-20, 022, 000		0	0	6. 00
7. 00	Inventory	14, 162, 000		0	0	7. 00
8. 00	Prepaid expenses	1, 559, 000		0	0	8. 00
9. 00	Other current assets	1,007,000	o o	0	0	9. 00
10.00	Due from other funds	ا	_	0	0	10. 00
11. 00				0	0	11. 00
11.00	Total current assets (sum of lines 1-10)	195, 802, 000	9, 128, 000	U	U	11.00
12 00	FIXED ASSETS	21 022 000			0	12.00
12.00	Land	21, 923, 000		0	0	
13.00	Land improvements	0	0	-	0	13.00
14. 00	Accumulated depreciation	0	0	0	0	14. 00
15. 00	Bui I di ngs	399, 389, 000	1	0	0	15. 00
16. 00	Accumul ated depreciation	0	0	0	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumulated depreciation	0	0	0	0	18. 00
19. 00	Fi xed equipment	0	0	0	0	19. 00
20.00	Accumul ated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00	Accumul ated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	273, 487, 000	0	0	0	23. 00
24.00	Accumul ated depreciation	-367, 487, 000	0	O	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26.00	Accumulated depreciation	l o	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	o o	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	1	ő	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	327, 312, 000		-	0	30.00
30. 00	OTHER ASSETS	327, 312, 000	1 0	<u> </u>	0	30.00
31. 00	Investments	0	0	0	0	31. 00
32. 00	Deposits on Leases			0	0	32. 00
33. 00	Due from owners/officers			0	0	33. 00
		01 75/ 000		0		
34. 00	Other assets	21, 756, 000		0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	21, 756, 000		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	544, 870, 000	9, 128, 000	0	0	36. 00
	CURRENT LI ABI LI TI ES		_	_	_	
37. 00	Accounts payable	51, 595, 000	1	0	0	37. 00
38. 00	Salaries, wages, and fees payable	0	0	0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	6, 107, 000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5, 900, 000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	63, 602, 000	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	l o	0	0	0	47. 00
48. 00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	204, 653, 000		0	0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49	204, 653, 000		0	0	50. 00
51. 00	Total liabilites (sum of lines 45 and 50)	268, 255, 000			0	51. 00
31.00	CAPITAL ACCOUNTS	200, 233, 000	1 0	U	U	31.00
52. 00	General fund balance	276, 615, 000				52. 00
		270,013,000				
53.00	Specific purpose fund		9, 128, 000	0		53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			이		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	276, 615, 000		0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	544, 870, 000	9, 128, 000	0	0	60. 00
	[59]	l	1			

Health Financial Systems In Lieu of Form CMS-2552-10 MEMORIAL HOSPITAL OF SOUTH BEND, INC STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 150058 Peri od: Worksheet G-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/29/2015 9:20 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 5. 00 4 00 1.00 Fund balances at beginning of period 618, 652, 000 6, 484, 000 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 96, 872, 000 2.00 Total (sum of line 1 and line 2) 3.00 715, 524, 000 6, 484, 000 3.00 4.00 NET ASSETS RELEASED FROM RESTRICTION 387,000 4.00 5.00 CAPITAL CONTRIBUTIONS 2, 644, 000 0 5.00 6.00 0 6.00 0 7.00 0 0 7.00 0 8.00 0 8.00 0 9.00 9.00 10.00 Total additions (sum of line 4-9) 387,000 2, 644, 000 10.00 Subtotal (line 3 plus line 10) 715, 911, 000 9, 128, 000 11.00 11.00 439, 296, 000 12.00 TRANFERRED TO BEACON HEALTH SYSTEM 0 12.00 13.00 13.00 14.00 14.00 0 0 0 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 439, 296, 000 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 9, 128, 000 19.00 276, 615, 000 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 NET ASSETS RELEASED FROM RESTRICTION 4.00 4.00 5.00 CAPITAL CONTRIBUTIONS 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 0 11.00 12.00 TRANFERRED TO BEACON HEALTH SYSTEM 12.00 13.00 13.00 14.00 0 14.00

0

0

0

15.00

16.00

17.00

18.00

19.00

15. 00 16. 00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Peri od:

From 01/01/2014 Parts I & II 12/31/2014 Date/Time Prepared: 5/29/2015 9:20 am Cost Center Description Inpati ent Outpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 185, 784, 289 185, 784, 289 1.00 2.00 SUBPROVIDER - IPF 4, 956, 982 4, 956, 982 2.00 SUBPROVIDER - IRF 9, 845, 650 9, 845, 650 3.00 3.00 4.00 SUBPROVI DER 4.00 Swing bed - SNF Swing bed - NF 5.00 0 5.00 6.00 0 6.00 SKILLED NURSING FACILITY 7.00 7.00 8.00 NURSING FACILITY 8.00 9.00 OTHER LONG TERM CARE 9.00 10.00 Total general inpatient care services (sum of lines 1-9) 200, 586, 921 200, 586, 921 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 33, 007, 380 33, 007, 380 11.00 11.01 NEONATAL INTENSIVE CARE UNIT 23, 571, 599 23, 571, 599 11.01 CORONARY CARE UNIT 12 00 12 00 13.00 BURN INTENSIVE CARE UNIT 13.00 14.00 SURGICAL INTENSIVE CARE UNIT 14.00 OTHER SPECIAL CARE (SPECIFY) 15.00 15.00 Total intensive care type inpatient hospital services (sum of lines 56, 578, 979 56, 578, 979 16.00 16.00 17.00 Total inpatient routine care services (sum of lines 10 and 16) 257, 165, 900 257, 165, 900 17.00 532, 400, 928 18.00 Ancillary services 532, 400, 928 18.00 Outpatient services 448, 478, 672 19.00 19.00 0 448, 478, 672 20.00 RURAL HEALTH CLINIC 0 Λ 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 21.00 HOME HEALTH AGENCY 22.00 22.00 AMBULANCE SERVICES 23.00 23.00 24.00 CMHC 24.00 AMBULATORY SURGICAL CENTER (D. P.) 25.00 25.00 26.00 26.00 HOSPI CE OTHER (SPECIFY) 27.00 27.00 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 789, 566, 828 448, 478, 672 1, 238, 045, 500 28.00 line 1) PART II - OPERATING EXPENSES 29.00 407, 968, 343 29 00 Operating expenses (per Wkst. A, column 3, line 200) 30.00 ADD (SPECIFY) 0 30.00 0 31.00 31.00 32.00 0 32.00 0 33.00 33.00 0 34.00 34.00 35.00 0 35.00 Total additions (sum of lines 30-35) 36, 00 0 36, 00 37.00 DEDUCT (SPECIFY) 37.00 38.00 0 38.00 39.00 39.00 0 40.00 40.00 0 41.00 41.00 42.00 Total deductions (sum of lines 37-41) 42.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 407, 968, 343 43.00 43.00 to Wkst. G-3, line 4)

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 150058	Peri od: Worksheet G-3

Heal th	Financial Systems MEMORIAL HOSPITAL OF SO	UTH BEND, INC	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 150058	Peri od:	Worksheet G-3	
			From 01/01/2014		
			To 12/31/2014	Date/Time Prep 5/29/2015 9:20	
				3/29/2013 9.20	J alli
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		1, 238, 045, 500	1. 00
2. 00	Less contractual allowances and discounts on patients' accounts			777, 373, 511	2. 00
3.00	Net patient revenues (line 1 minus line 2)			460, 671, 989	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43	)		407, 968, 343	
	Net income from service to patients (line 3 minus line 4)	,		52, 703, 646	5. 00
	OTHER I NCOME			22/100/210	
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			9, 455, 000	7.00
8. 00	Revenues from telephone and other miscellaneous communication s	ervi ces		0	8.00
9. 00	Revenue from television and radio service			o	9.00
10. 00	Purchase di scounts			o	10.00
11. 00	Rebates and refunds of expenses			1, 090, 602	11.00
12. 00	Parking lot receipts			214, 507	12.00
13. 00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			1, 368, 248	14.00
15. 00	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other tha	n patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			0	21. 00
	Rental of hospital space			0	22. 00
	Governmental appropriations			1, 789, 888	
	MI SC OTHER REVENUE			30, 250, 109	
	Total other income (sum of lines 6-24)			44, 168, 354	
	Total (line 5 plus line 25)			96, 872, 000	
	OTHER EXPENSES (SPECIFY)			0	27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			96, 872, 000	29. 00

	Financial Systems MEMORIAL HOSPITAL OF			u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 150058	Peri od: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Pre 5/29/2015 9:2	pared: O am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				İ
. 00	Capital DRG other than outlier			3, 600, 842	1.0
. 01	Model 4 BPCI Capital DRG other than outlier			0	
. 00	Capital DRG outlier payments			243, 899	1
. 01	Model 4 BPCI Capital DRG outlier payments	0	2.0		
. 00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	254. 92 19. 26	
. 00 . 00	Number of interns & residents (see instructions)				4. C
. 00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)				6.0
. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line				ı
. 00	30) (see instructions)	derient days (worksheet E	, part // Time	6. 54	′.、
00	Percentage of Medicaid patient days to total days (see instructions)				8. 0
. 00	Sum of lines 7 and 8				9. 0
0. 00					10.0
1. 00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)				11. C
2. 00	Total prospective capital payments (sum of lines 1, 1.01, 2,	2.01, 6 and 11)		4, 208, 066	12.0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
. 00	Program inpatient routine capital cost (see instructions)			0	1.0
. 00	Program inpatient ancillary capital cost (see instructions)			0	2.0
00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 0
. 00	Capital cost payment factor (see instructions)				4.0
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. (
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00	Program inpatient capital costs (see instructions)			0	
00	Program inpatient capital costs for extraordinary circumstances (see instructions)			0	
00	Net program inpatient capital costs (line 1 minus line 2)				3. (
00	Applicable exception percentage (see instructions)			0.00	
00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in	netructione)		0 0. 00	
00	Adjustment to capital minimum payment level for extraordinary		line 6)	0.00	
00	Capital minimum payment level (line 5 plus line 7)	Circumstances (Title 2 A	11116 0)	0	
. 00	Current year capital payments (from Part I, line 12, as appli	cable)		0	
	Current year comparison of capital minimum payment level to compare the capital minimum payment level to capital minimum payment level minimum		less line 9)	0	
	Carryover of accumulated capital minimum payment level over of			0	

Carryover of accumulated capital minimum payment level over capital payment (from prior year

12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)
13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)
14.00 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)
Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)

17.00 | Current year exception offset amount (see instructions)

0 13.00

0 14.00

0 15.00

0 16.00

0 17.00

11.00

12.00

Worksheet L, Part III, line 14)