This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED							
payments made	OMB NO. 0938-0050						
				EXPIRES 05-31-2019			
HOSPITAL AND H AND SETTLEMENT	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provi der CCN: 15-0058	Peri od: From 01/01/2017 To 12/31/2017				
PART I - COST	REPORT STATUS						
Provi der	1. [X] Electronically filed cost report		Date: 5/25/20	18 Time: 4:03 pm			
use only	2. [] Manually submitted cost report						
	3. [0] If this is an amended report enter the number 4. [F] Medicare Utilization. Enter "F" for full or "L		resubmitted this co	ost report			
Contractor use only	5. [1] Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. (9. [N] Initial Report for [N] Final Report for (5) Amended	or this Provider CCN 12					
DART II CERT	TIFICATION						

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL OF SOUTH BEND, INC (15-0058) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)
Officer or Administrator of Provider(s)
Ti tl e
Dato

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	527, 803	128, 720	0	0	1. 00
2.00	Subprovi der - IPF	0	11, 381	0		0	2. 00
3.00	Subprovi der - IRF	0	-29, 032	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	510, 152	128, 720	0	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 Provider CCN: 15-0058 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/25/2018 3:56 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 615 N MI CHI GAN 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 PSYCHIATRIC UNIT Subprovider - IPF Р 4.00 15S058 43780 04/07/2011 Р 4 00 4 Ν 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: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2017 12/31/2017 20.00 21.00 Type of Control (see instructions) 21.00 2 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 §412.106(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 unpai d el i gi bl e 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 16, 755 2, 544 5. 094 9. 984 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 26 542 0 0 160 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.

	.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								
59. 00	2.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.								59.00
				NAHE 413.85	Worksheet		Pass-Th		
				Y/N	Line #		Qualific		
						1	Cri teri o	n Code	
				1. 00	2.00		3. 0	0	
60. 00	Are you claiming nursing and allied health education			Y					60.00
	any programs that meet the criteria under §413.85? (
60. 01	If line 60 is yes, complete columns 2 and 3 for each instructions)	program	. (see		23	3. 00	1		60. 01
	ITISTI ucti ons)	Y/N	IME	Direct GME	IME		Di rect	GMF	
		.,		511 00 C 02			2	02	
		1.00	2. 00	3. 00	4. 00		5. 0	0	
61.00	Did your hospital receive FTE slots under ACA	Υ				3. 00		3.00	61.00
	section 5503? Enter "Y" for yes or "N" for no in								
(4.04	column 1. (see instructions)								(4.04
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports								61. 01
	ending and submitted before March 23, 2010. (see								
	instructions)								
61. 02	Enter the current year total unweighted primary care					İ			61. 02
	FTE count (excluding OB/GYN, general surgery FTEs,								
	and primary care FTEs added under section 5503 of								
	ACA). (see instructions)								
61.03	Enter the base line FTE count for primary care								61. 03
	and/or general surgery residents, which is used for								
	determining compliance with the 75% test. (see								
	i nstructi ons)								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ΓΑ	Provider C		Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prep 5/25/2018 3:50	pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4. 00	5. 00	
Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the 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						61. 04
61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
	Pro	ogram Name	Ů		Direct GME FTE Count	
		1. 00	2. 00	3. 00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61. 10
					1.00	1
ACA Provisions Affecting the Health Resources and Ser 62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc 62.01 Enter the number of FTE residents that rotated from a	trai ned ti ons) Teachi	lin this cost ng Health Cer	reporting penter (THC) int			62. 00
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide			ns)			1
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this c			N	63. 00
, ,	2	2. 2 33gH	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3. 00	

0. 00

Unwei ghted

FTEs

Nonprovi der

Si te

3.00

2.00

0. 00

Unwei ghted

FTEs in

Hospi tal

4.00

0.000000 64.00

Ratio (col. 3/ (col. 3 + col. 4))

5.00

period that begins on or after July 1, 2009 and before June 30, 2010.

64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care

resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

Program Name Program Code

1.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0058 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/25/2018 3:56 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 0.000000 65.00 0. 00 0. 00 65.00 Enter in column 1, if line 63 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs 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) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν O N 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

	Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0058	Peri od:	worksheet S	
		From 01/01/2017 To 12/31/2017	Part I	repared:
			1.00	
	Long Term Care Hospital PPS		1.00	
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no. TEFRA Providers	ng period? Enter	N N	80. 00 81. 00
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for year Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for year Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i) TEFRA?		N	85. 00 86. 00
87. 00	\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 100(4)(1)(1)(1)(1)(2) For "Y" for passing the section 100(4)(1)(1)(1)(1)(2) For "Y" for passing the section 100(4)(1)(1)(1)(1)(2) For "Y" for passing the section 100(4)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	1	N	87. 00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	V	XI X	
	Title Wand VIV Comittee	1. 00	2. 00	
90. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Υ	90.00
91. 00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91. 00
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92. 00
93. 00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93. 00
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94. 00
	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0. 00 N	0. 00 N	95. 00 96. 00
97. 00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column.	0. 00	0.00	97. 00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98. 00
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wks C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for		Y	98. 01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	Y	Y	98. 02
98. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH), reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column		N	98. 03
98. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	N N	N	98. 04
98. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance of Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and i		Y	98. 05
98. 06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98. 06
405 00	Rural Provi ders			
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive method of paymen	nt N		105. 00 106. 00
	for outpatient services? (see instructions)			
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cos	st		107. 00

	yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N					108. 00
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
		Physi cal	Occupati onal	Speech	Respi ratory	
		1. 00	2.00	3. 00	4. 00	
-	109.00 If this hospital qualifies as a CAH or a cost provider, are	N	N	N	N	109. 00
	therapy services provided by outside supplier? Enter "Y"					
	for yes or "N" for no for each therapy.					
						1

	1.00	
110.00Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110. 00
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
appl i cabl e.		

ealth Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO	I NC CN: 15-0058	Peri od:		u of Form Workshee		
OSTITAL AND HOSTITAL HEALTH CARL COMPLEX TOLINTITICATION DATA		From 01/01/ To 12/31/		Part I Date/Tir 5/25/20	me Pre	epare
		1. 00		2. 0	n	+
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, of integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	period? Enter enter the column 2.	N		2.0		111.
			1. 00	2.00	3.00	
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no ir is yes, enter the method used (A, B, or E only) in column 2. If column 2 is a either "93" percent for short term hospital or "98" percent for long term psychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1.	s "E", enter rm care (incl ne definition	in column udes	N		0	115.
16.00 s this facility classified as a referral center? Enter "Y" for yes or "N' 17.00 s this facility legally-required to carry malpractice insurance? Enter "\ no.		"N" for	N Y			116. 117.
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 i claim-made. Enter 2 if the policy is occurrence.	f the policy	/ is	1			118.
erariii iiidae. Effer 2 11 the porrey 13 occurrence.	Premi ums	Losse	S	Insura	ance	
	1.00	2.00)	3.0	0	+
18.01 List amounts of malpractice premiums and paid losses:	1, 129, 6	571 45	3, 207		(0 118.
		1. 00		2. 0	0	+
18.02 Are malpractice premiums and paid losses reported in a cost center other of Administrative and General? If yes, submit supporting schedule listing column and amounts contained therein.		N		2.0	<u> </u>	118.
9.00 DO NOT USE THIS LINE 10.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y' "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	' for yes or ne Outpatien			N		119. 120.
21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.	s charged to	Y				121.
22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.						122
Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N				125
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the certified in column 1 and termination date, if applicable, in column 2.	fication date	e				126
7.00 f this is a Medicare certified heart transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.	cation date					127
8.00 If this is a Medicare certified liver transplant center, enter the certified in column 1 and termination date, if applicable, in column 2.	cation date					128
9.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.	cation date i	n				129
0.00 If this is a Medicare certified pancreas transplant center, enter the certal date in column 1 and termination date, if applicable, in column 2.						130
1.00 If this is a Medicare certified intestinal transplant center, enter the condate in column 1 and termination date, if applicable, in column 2.						131
2.00 f this is a Medicare certified islet transplant center, enter the certifing column 1 and termination date, if applicable, in column 2.						132
3.00 f this is a Medicare certified other transplant center, enter the certifing column 1 and termination date, if applicable, in column 2.						133
44.00 f this is an organ procurement organization (0P0), enter the 0P0 number i and termination date, if applicable, in column 2.	n corumn I					134
All Providers 10.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home		Y		15H0	13	140

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0058 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/25/2018 3:56 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number

Name: BEACON HEALTH SYSTEM | Contractor's Name: WI PHYS SVCS Contractor's Number: 08001 141 00 Name: BEACON HEALTH SYSTEM 141 00 142.00 Street: 615 N MICHIGAN ST PO Box: 142.00 143.00 City: SOUTH BEND 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00|If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no N 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99169. 00 transition factor. (see instructions) Begi nni ng Endi ng 1. 00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 01/01/2016 12/31/2016 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 0171.00 N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

JSPI I	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider	CCN: 15-0058	Peri od: From 01/01/2017 To 12/31/2017		epare
			Y/N	Date	
			1. 00	2. 00	4
	General Instruction: Enter Y for all YES responses. Enter N for all NO rmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	responses. Ento	er all dates in	the	
00	Has the provider changed ownership immediately prior to the beginning of reporting period? If yes, enter the date of the change in column 2. (see) Y	12/01/2011	1
		Y/N	Date	V/I	
	In	1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2
00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3
		Y/N	Type	Date	
		1.00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4
00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5
			Y/N	Legal Oper.	
	la let le la company		1. 00	2. 00	_
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the legal operator of the program?	the provider is	s N		- 6
00 00	Are costs claimed for Allied Health Programs? If "Y" see instructions. Were nursing school and/or allied health programs approved and/or renewed	ed during the	Y N		8
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education y program in the current cost report? If yes, see instructions.				ç
. 00	Was an approved Intern and Resident GME program initiated or renewed in cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Internal		N		10
. 00	Teaching Program on Worksheet A? If yes, see instructions.	proved	Y	Y/N	11
	Bad Debts			1.00	
. 00	Is the provider seeking reimbursement for bad debts? If yes, see instruc	ctions.		Υ	12
	, ,		ost reporting	N N	13
3. 00	If line 12 is yes, did the provider's bad debt collection policy change period? If yes, submit copy.	during this c	. 3	N	
00	If line 12 is yes, were patient deductibles and/or co-payments waived? I Bed Complement	i yes, see in:	STI UCTI OIIS.	N	_ 1

		L Pa	rt A	Pa	art B	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
<u></u>	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	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 Report for	Y	05/11/2017	Υ	05/11/2017	17. 00
	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 made to PS&R	Y		Υ		18. 00
	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	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

Heal th	Financial Systems MEMORIAL HOSPITAL OF	F SOUTH BEND,	INC	In Lie	u of Form CMS-	-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0058	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Pre 5/25/2018 3:5	epared:		
			i pti on	Y/N	Y/N	p		
20. 00			0	1. 00 N	3. 00 N	20. 00		
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date			
		1.00	2.00	3. 00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)		1.00			
	Capital Related Cost							
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		sale mada duri	ing the cost	N N	22. 00 23. 00		
23.00	reporting period? If yes, see instructions.	due to apprais	sars made dur	ing the cost	IN	23.00		
24. 00	Were new leases and/or amendments to existing leases entere lf yes, see instructions	d into during	this cost re	porting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see	N	25. 00		
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	e cost reporti	ng period? I	f yes, see	N	26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportir	ng period? If	yes, submit	N	27. 00		
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	tered into dur	ing the cost	reporting	N	28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service R	eserve Fund)	N	29. 00		
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu instructions.		debt? If yes	, see	N	30. 00		
31. 00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	, see	N	31. 00		
	Purchased Services							
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through co	ntractual	N	32. 00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	lied pertainir	ng to competi	tive bidding? If	N	33. 00		
04.00	Provi der-Based Physi ci ans							
34. 00	If yes, see instructions.	0		. ,	Y	34.00		
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		its with the	provi der-based	N	35. 00		
				Y/N	Date			
	Home Office Costs			1. 00	2.00			
36. 00	Were home office costs claimed on the cost report?			Υ		36.00		
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	epared by the	home office?			37. 00		
38. 00				N		38. 00		
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	r chain compor	nents? If yes	, N		39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00		
	1.00 2.0							
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JEREMY		KUSKYE		41. 00		
42. 00	respectively. Enter the employer/company name of the cost report preparer.	BEACON HEALTH	SYSTEM			42. 00		
43. 00		574-647-1144		JKUSKYE@BEACONI RG	HEALTHSYSTEM. O	43. 00		

Health Financial Systems	MEMORIAL HOSPITAL OF	SOUTH BEND,	INC	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMEN	IT QUESTI ONNAI RE	Provider C		Peri od:	Worksheet S-2	
				From 01/01/2017 To 12/31/2017		narodi
				10 12/31/201/	5/25/2018 3:5	6 pm
		3.	00			
Cost Report Preparer Contact Informatio	n					
41.00 Enter the first name, last name and the	title/position R	REIMBURSEMENT	ANALYST			41.00
held by the cost report preparer in col	umns 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 ad						43. 00
report preparer in columns 1 and 2, res	pecti vel y.					

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | Peri od: | Peri od Health Financial Systems MEMORIAL HOSE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0058

				11	0 12/31/2017	5/25/2018 3:50	
	·					I/P Days / 0/P	J pili
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	No. of beas	Avai I abl e	CAIT HOURS	TI LIC V	
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		110, 595	0.00	0.00	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 IRF Subprovider						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		303	110, 595	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00		16, 790	0. 00	0	8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT	31. 01	30	10, 950	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						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY	43. 00				0	13. 00
14. 00	Total (see instructions)		379	138, 335	0. 00	0	14. 00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		8, 760		0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00	20	7, 300		0	17. 00
18.00	SUBPROVI DER						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	HOSPICE	20.00					24. 00 24. 10
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00					24. 10 25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 00	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	
27. 00	Total (sum of lines 14-26)	69. 00	423			U	20. 23
28. 00	Observation Bed Days		423			0	
29. 00	Ambulance Trips					U	29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days (see Fristruction)						31. 00
32.00	Labor & delivery days (see instructions)		9	3, 285			32.00
32. 00	Total ancillary labor & delivery room		7	5, 205			32. 00
JZ. UI	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days						33. 00
	LTCH site neutral days and discharges						33. 01
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		'		ı	'	

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

Provider CCN: 15-0058

Period: Worksheet S-3
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/25/2018 3:56 pm

						5/25/2018 3:5	6 pm
		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	21, 975	2, 982	70, 182			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)	10, 345	28, 835				2. 00
3.00	HMO IPF Subprovider	0	205				3. 00
4.00	HMO IRF Subprovider	0	702				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	21, 975	2, 982	70, 182			7. 00
8. 00	INTENSIVE CARE UNIT	2, 035	0	8, 042			8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT	2,033	1, 666	9, 755			8. 01
9. 00	CORONARY CARE UNIT	٩	1,000	7, 755			9.00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		379	4, 431			13.00
14. 00	Total (see instructions)	24, 010	5, 027	92, 410		2, 253. 50	1
15. 00	CAH visits	24,010	3, 027	72, 410		2, 255. 50	15.00
16. 00	SUBPROVIDER - IPF	1, 362	106	3, 716		25. 13	
17. 00	SUBPROVIDER - IRF	1, 051	26	3, 475		19. 94	17. 00
18. 00	SUBPROVI DER	1,031	20	3, 473	0.00	17. 74	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	٩	Ĭ	· ·			25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	اه	0	0	0.00	0.00	1
27. 00	Total (sum of lines 14-26)	٩	Ĭ	· ·	27. 80	2, 298. 57	27. 00
28. 00	Observation Bed Days		0	9, 999		2,2,0.0,	28. 00
29. 00	Ambul ance Trips	اه	Ĭ	****			29. 00
30. 00	Employee discount days (see instruction)	٩		1, 312			30.00
31. 00	Employee discount days - IRF			145			31.00
32. 00	Labor & delivery days (see instructions)	0	515	941			32.00
32. 01	Total ancillary labor & delivery room		313	741			32. 01
52. 51	outpatient days (see instructions)			O			32.01
33. 00		o					33. 00
	LTCH site neutral days and discharges	l ol					33. 01
	1 J	-1	'		'		

 Heal th Financial
 Systems
 MEMORIAL HOSF

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provi der CCN: 15-0058

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | Date/Time Prepared: |

					12/31/201/	5/25/2018 3:50	
		Full Time	<u>'</u>	Di sch	arges		
		Equi val ents			ŭ		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	4, 730	602	18, 202	1. 00
2.00	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			1 000	4 700		2 00
2.00	HMO and other (see instructions)			1, 980	4, 700		2.00
3.00	HMO I PF Subprovi der			•	28		3.00
4. 00 5. 00	HMO IRF Subprovider				43		4. 00 5. 00
6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
8. 01 9. 00	NEONATAL INTENSIVE CARE UNIT			•			8. 01 9. 00
	CORONARY CARE UNIT						
10.00	BURN INTENSIVE CARE UNIT			•			10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00 12. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						
13. 00 14. 00	NURSERY Total (see instructions)	0. 00	0	4, 730	602	18, 202	13. 00 14. 00
15. 00	CAH visits	0.00	U	4, 730	002	10, 202	15. 00
16. 00	SUBPROVIDER - IPF	0.00	0	127	10	361	16. 00
17. 00	SUBPROVI DER - I RF	0.00	0	1	3	253	17. 00
18. 00	SUBPROVI DER	0.00	0	73	3	255	18. 00
19. 00	SKILLED NURSING FACILITY			1			19. 00
20. 00	NURSING FACILITY			1			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)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0.00		•			27. 00
28. 00	Observation Bed Days	0.00		•			28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
02.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			0			33. 01

Provider CCN: 15-0058

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Peri od: | Peri

3.00 Non-physician anesthetist Part 4.00 Non-physician anesthetist Part 4.00 Non-physician anesthetist Part 4.00 Non-physician Part A — 4.00 Non-physician Part A — 4.00 Non-physician Part A — 4.01 Nysician						To	12/31/2017	Date/Time Pre 5/25/2018 3:5	
PART 1 - MORE DATA 1 - M								Average Hourly	
PART 1			Number	керогтеа					
SALAMETER SALA			1 00	2.00				4.00	
1.00		PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	0.00	
2. 00 Non-physic ian anesthetist Part	1 00		202 00	120 001 720		120 001 720	4 701 022 00	20.00	1 00
3.00 Non-physician anesthetist Part	1.00		200.00	138, 801, 720	0	138, 801, 720	4, 781, 032. 00	29.03	1.00
3.00 Non-physic clan anescherits Fart	2. 00			0	0	0	0. 00	0. 00	2. 00
Amin Instrative	3. 00	1		0	О	О	0.00	0. 00	3. 00
Amin Instrative	4 00	B Bhysisian Bant A		074 003		074 002	E 401 00	150 (2	4 00
5.00 Physician and ken 0 0 0 0 0 0 0 0 0	4.00			874, 903		874, 903	5, 481.00	159. 62	4.00
Physician-Part B		9		2, 602, 245	0	2, 602, 245			4. 01
Nospit Call - Laised RRC and Fölle	5.00			U	0	U	0.00	0.00	5.00
7. 00 Interns. & residents (in an approved program) 1,908,503 1,908,503 55,122,85 34,62 7,00 1,908,503 1,908,503 55,122,85 34,62 7,00 1,908,503 1,908,503 1,908,503 55,122,85 34,62 7,00 1,908,503 1	6. 00			0	0	0	0. 00	0. 00	6. 00
7. of Contracted interns and residents (in an approved program) 8.00 New office and/or related programs on these office and of the second of t									
Contracted interns and proved programs) 8.00 Home office and/or related programs and proved provided proved provided proved p	7. 00		21. 00	0	1, 908, 503	1, 908, 503	55, 122. 85	34. 62	7. 00
B. 00	7. 01			0	О	0	0.00	0. 00	7. 01
1.00 1.00 1.00 1.00 1.00 0 0 0 0 0 0 0 0 0		` ''							
9.00 Sex 44.00 0 0 0 0 0 0 0 0 0	8. 00			0	О	0	0.00	0. 00	8. 00
10.00 Excluded area salaries (see 6,471,163 0 6,471,163 289,904.00 22.32 10.00	0.00	organization personnel	44.00	0		0	0.00	0.00	0.00
OTHER WAGES & RELATED COSTS			44.00	6, 471, 163	0	6, 471, 163			
11.00 Contract labor: Direct Patient Care Care Care Care Care Care Care Care									
12.00 Contract labor: Top level management and other management and administrative services 13.00 Contract labor: Physician-Pert 276,760 0 276,760 1,550.00 178.55 13.00 14.00 14.00 14.00 15.00 178.55 13.00 178.55 13.00 14.00	11. 00			3, 721, 598	0	3, 721, 598	57, 445. 00	64. 79	11. 00
management and other	12.00			0		0	0.00	0.00	12.00
Services 276, 760 276, 760 1,550.00 178.55 13.00 14.00 4	12.00			U	0	U	0.00	0.00	12.00
13.00 Contract Labor: Physician=Part 276,760 0 276,760 1,550.00 178.55 13.00 14.00 Home office and/or related organization sal aries and wage-related costs 13,612,241 0 13,612,241 405,473.00 33.57 14.01 14.00 67fice sal aries 13,612,241 0 13,612,241 405,473.00 33.57 14.01 14.00 15.00 16.00 15.00									
14. 00	13. 00			276, 760	О	276, 760	1, 550. 00	178. 55	13. 00
orgal nzation sal aries and wage-rel ated costs 13,612,241 0 13,612,241 405,473.00 33.57 14.01 14.02 Rel ated organization sal aries 0 0 0 0 0.00 0.00 14.02 15.00 Home office: Physician Part A 0 0 0 0 0.00 0.00 15.00 15.00 Home office and Contract 0 0 0 0 0 0.00 0.00 15.00 15.00 Home office and Contract 0 0 0 0 0 0 0.00 15.00 15.00 Home office and Contract 0 0 0 0 0 0 0 0 0	14 00			0	0	0	0.00	0.00	14 00
14. 01 Home office salaries 13,612,241 0 13,612,241 405,473.00 33.57 14.01 14. 02 Related organization salaries 0 0 0 0 0.00 0.00 15. 00 Home office: Physician Part A 0 0 0 0 0.00 0.00 16. 00 Home office office: Physician Part A 0 0 0 0 0.00 16. 00 Home office office: Physician Part A 0 0 0 0 0.00 16. 00 Home office office: Physician Part A 0 0 0 0 0.00 16. 00 Home office office: Physician Part A Teaching 0 0 0 0 0.00 17. 00 Wage-related costs (core) (see 49,267,284 0 49,267,284 0 49,267,284 18.00 19. 00 Excluded areas 2,456,766 0 2,456,766 19.00 19. 00 Excluded areas 2,456,766 0 2,456,766 19.00 19. 00 Excluded areas 2,456,766 0 2,456,766 19.00 19. 00 Non-physician anesthetist Part 0 0 0 0 19. 00 Physician Part A 0 0 0 0 19. 00 Physician Part A 0 0 0 0 19. 00 Physician Part A 0 0 0 0 19. 00 Physician Part A 0 0 0 0 19. 00 Physician Part A 0 0 0 0 22. 00 Physician Part A 0 0 0 0 23. 00 Physician Part B 0 0 0 0 24. 00 Wage-related costs (RHC/FOHC) 0 0 0 0 25. 00 Interns & residents (in an another and another and another anot	14.00			O			0.00	0.00	14.00
14. 02 Related organization salaries 0 0 0 0 0 0 0 0 0	14 01			13 612 241	0	13 612 241	405 473 00	33 57	14 01
16.00 Home office and Contract Home office		Related organization salaries		13, 012, 241	ő	0			
Home office and Contract Physicians Part A - Teaching Wage-related costs (core) (see instructions) Physicians an anesthetist Part A	15. 00			0	0	0	0. 00	0. 00	15. 00
WAGE-RELATED COSTS Wage-rel ated costs (core) (see instructions) 17.00 Wage-rel ated costs (other) (see instructions) 246,727 0 246,727 18.00 246,727 (see instructions) 19.00 246,727 0 246,727 0 246,727 18.00 20.00 2	16. 00	Home office and Contract		0	0	0	0.00	0. 00	16. 00
17. 00 Wage-rel ated costs (core) (see instructions) 18. 00									
18. 00 Wage-related costs (other) (see instructions) 246,727 0 246,727 19. 00 246,727 19. 00 246,727 19. 00 246,727 19. 00 2456,766 19. 00 20. 0	17. 00	Wage-related costs (core) (see		49, 267, 284	0	49, 267, 284			17. 00
See instructions Case	18 00			246 727	0	246 727			18 00
20. 00 Non-physician anesthetist Part A Non-physician anesthetist Part B Do		(see instructions)							
21.00 Non-physician anesthetist Part B				2, 456, 766 0	0	2, 456, 766 0			
Section Physician Part A - Administrative Physician Part A - Teaching 328,145 0 328,145 22.01		A		-	_				
Administrative	21.00	Non-physician anesthetist Part B		0	0	0			21.00
22. 01 Physician Part A - Teaching 328, 145 0 328, 145 22. 01 23. 00 Physician Part B 0 0 0 0 23. 00 24. 00 Wage-related costs (RHC/FOHC) 0 0 0 0 24. 00 25. 00 Interns & residents (in an approved program) 396, 902 0 396, 902 25. 00 25. 50 Home office wage-related (core) 5, 823, 692 0 5, 823, 692 25. 50 25. 51 Related organization wage-related (core) 0 0 0 0 25. 51 4. Mome office: Physician Part A - Administrative - wage-related (core) 0 0 0 0 25. 52 4. Home office & Contract Physicians Part A - Teaching - wage-related (core) 0 0 0 0 25. 53 25. 53 Physicians Part A - Teaching - wage-related (core) 0 0 0 0 25. 53 26. 00 Employee Benefits Department 4. 00 138, 883 0 138, 883 2, 080. 00 66. 77 26. 00	22. 00			0	0	0			22. 00
23. 00 Physician Part B	22. 01	1		328, 145	o	328, 145			22. 01
25. 00 Interns & residents (in an approved program) 25. 00 396, 902 25. 00 25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) Home office: Physician Part A 0 0 0 25. 52 - Administrative - wage-related (core) Home office & Contract 0 0 0 0 25. 53 Physicians Part A - Teaching - wage-related (core) 0 0 0 0 0 0 0 0 0	23.00	Physician Part B		0	0	0			23. 00
approved program Approved pr				396 902	0	396 902			
Core		approved program)							
25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A	25. 50			5, 823, 692	0	5, 823, 692			25. 50
25. 52 Home office: Physician Part A 0 0 0 25. 52 Administrative - wage-rel ated (core) 4.00 138,883 0 138,883 2,080.00 66. 77 26. 00 25. 52 25. 52 25. 53 25.	25. 51	Related organization		0	0	О			25. 51
- Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department	25, 52	, ,		n	0	n			25 52
25. 53 Home office & Contract 0 0 0 0 25. 53 Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department 4. 00 138, 883 0 138, 883 2, 080. 00 66. 77 26. 00	20.02	- Administrative -		O					20.02
Physicians Part A - Teaching -	25. 53			n	0	n			25. 53
OVERHEAD COSTS - DIRECT SALARIES 26. 00 Empl oyee Benefits Department 4. 00 138, 883 0 138, 883 2, 080. 00 66. 77 26. 00		Physicians Part A - Teaching -		· ·					
26. 00 Employee Benefits Department 4. 00 138, 883 0 138, 883 2, 080. 00 66. 77 26. 00			ES						
27. UU Administrative & General 5.00 5,390,776 0 5,390,776 190,410.00 28.31 27.00		Employee Benefits Department	4. 00						
	27.00	Administrative & General	5. 00	5, 390, 776	0	5, 390, 776	190, 410. 00	28. 31	27.00

HOSPITAL WAGE INDEX INFORMATION

Provi der CCN: 15-0058

Peri od: Worksheet S-3 From 01/01/2017 Part II To 12/31/2017 Date/Time Prepared:

5/25/2018 3:56 pm Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. $(col.2 \pm col.$ Salaries in col. 4 A-6)3) 1.00 5.00 2.00 6.00 3.00 4.00 28.00 Administrative & General under 140, 646 140, 646 452.00 311. 16 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 570, 958 570, 958 17, 392. 00 29.00 32. 83 Operation of Plant 30.00 7.00 2, 452, 715 0 2, 452, 715 106, 063. 00 23. 13 30.00 31.00 Laundry & Linen Service 8.00 0.00 0. 00 31.00 32.00 Housekeepi ng 9.00 3, 335, 430 0 3, 335, 430 210, 600. 00 15. 84 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 17. 50 34. 00 34.00 10.00 3, 072, 021 -1, 279, 991 1, 792, 030 102, 416. 00 Di etary 35.00 Di etary under contract (see 0.00 0.00 35.00 instructions) Cafeteri a 11.00 1, 279, 991 1, 279, 991 73, 164. 00 17. 49 36.00 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 38.00 Nursing Administration 13.00 2, 265, 618 2, 265, 618 108, 325. 00 20. 92 38.00 39.00 Central Services and Supply 14.00 1, 878, 316 1, 878, 316 94, 019. 00 19. 98 39.00 Pharmacy 2, 080. 00 79. 21 40.00 15.00 6, 277, 453 -6, 112, 703 164, 750 40.00 Medical Records & Medical 41.00 16.00 0.00 0.00 41.00 Records Library 99, 441. 00 27. 87 42. 00 42.00 Social Service 17.00 2, 771, 399 0 2, 771, 399 43.00 Other General Service 18.00 0.00 0.00 43.00 instructions)

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0058 Worksheet S-3 Peri od: From 01/01/2017 To 12/31/2017 Part III Date/Time Prepared: 5/25/2018 3:56 pm 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 . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 2.00 5.00 6.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 136, 340, 121 -1, 908, 503 134, 431, 618 4, 705, 154. 15 28. 57 1.00 instructions) 2.00 289, 904. 00 22. 32 2.00 Excluded area salaries (see 6, 471, 163 6, 471, 163 instructions) 3.00 Subtotal salaries (line 1 129, 868, 958 -1, 908, 503 127, 960, 455 4, 415, 250. 15 28.98 3.00 minus line 2) 4.00 Subtotal other wages & related 17, 610, 599 17, 610, 599 464, 468. 00 37.92 4.00 costs (see inst.) Subtotal wage-related costs 5.00 55, 337, 703 C 55, 337, 703 0.00 43. 25 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 202, 817, 260 -1, 908, 503 200, 908, 757 4, 879, 718. 15 41 17 7.00 Total overhead cost (see 28, 294, 215 -6, 112, 703 22, 181, 512 1, 006, 442. 00 22.04 7.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: | From CMS-2552-10 | Prepared: | Prepar Health Financial Systems
HOSPITAL WAGE RELATED COSTS Provider CCN: 15-0058

	10 12/31/2017	5/25/2018 3:50	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	4, 477, 601	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	15, 478, 858	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
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		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	21, 602, 361	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	358, 809	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	111, 877	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)	347, 311	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	120, 474	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumul ative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	9, 878, 100	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	73, 707	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))		
	Day Care Cost and Allowances	0	22. 00
23. 00		0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	52, 449, 098	24. 00
	Part B - Other than Core Related Cost		
25. 00	SERVICE AWARDS, ST DISABILITY	246, 727	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: 15-0	058 Peri od:	Worksheet S-3

PART V - Contract Labor and Benefit Cost 1.00 2.00	HOSFIT	AL CONTRACT LABOR AND BENEFFT COST	Frovider CCN. 13-0038	From 01/01/2017 To 12/31/2017	Part V Date/Time Pre 5/25/2018 3:5	pared:
PART V - Contract Labor and Benefit Cost Hospital and Hospital -Based Component I dentification:		Cost Center Description		Contract Labor		
Hospital and Hospital-Based Component Identification:				1. 00	2. 00	
1.00 Total facility's contract labor and benefit cost 0 0 0 0 0 0 0 0 0		PART V - Contract Labor and Benefit Cost				
2. 00 Hospi tal		Hospital and Hospital-Based Component Identification:				
3.00 Subprovi der - I PF 4.00 Subprovi der - I RF 5.00 Subprovi der - (Other) 6.00 Swi ng Beds - SNF 7.00 Swi ng Beds - NF 8.00 Hospi tal - Based SNF 9.00 Hospi tal - Based NF 10.00 Hospi tal - Based HHA 12.00 Separatel y Certi fied ASC 13.00 Hospi tal - Based Heal th Clinic RHC 15.00 Hospi tal - Based Heal th Clinic RHC 16.00 Hospi tal - Based Heal th Clinic FQHC 17.00 Renal Dialysis	1.00	Total facility's contract labor and benefit cost		0	0	1. 00
4. 00 Subprovi der - IRF 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 0 0 7. 00 9. 00 Hospi tal - Based NF 9. 00 9. 00 10. 00 Hospi tal - Based OLTC 10. 00 11. 00 12. 00 Separatel y Certi fied ASC 12. 00 12. 00 13. 00 Hospi tal - Based Heal th Clinic RHC 13. 00 14. 00 15. 00 Hospi tal - Based Heal th Clinic FQHC 15. 00 16. 00 19. 00 17. 00 17. 00 Renal Dialysis 17. 00	2.00	Hospi tal		0	0	2. 00
5. 00 Subprovi der - (Other) 0 0 5. 00 6. 00 Swi ng Beds - SNF 0 0 6. 00 7. 00 Swi ng Beds - NF 0 0 7. 00 8. 00 Hospi tal - Based SNF 9. 00 8. 00 9. 00 Hospi tal - Based NF 9. 00 10. 00 10. 00 Hospi tal - Based OLTC 10. 00 11. 00 12. 00 Separatel y Certi fied ASC 12. 00 12. 00 13. 00 Hospi tal - Based Heal th Clinic RHC 13. 00 14. 00 15. 00 Hospi tal - Based Heal th Clinic FQHC 15. 00 16. 00 16. 00 17. 00 17. 00	3.00	Subprovi der - IPF		0	0	3. 00
6. 00 Swing Beds - SNF 0 0 0 6. 00 7. 00 Swing Beds - NF 0 0 7. 00 8. 00 Hospi tal -Based SNF 8. 00 10. 00 Hospi tal -Based OLTC 10. 00 11. 00 Hospi tal -Based HHA 11. 00 12. 00 Separatel y Certified ASC 11. 00 14. 00 Hospi tal -Based Heal th Clinic RHC 15. 00 Hospi tal -Based Heal th Clinic FQHC 15. 00 16. 00 Hospi tal -Based-CMHC 17. 00 17. 00 Renal Dialysis 17. 00	4.00	Subprovi der - I RF		0	0	4. 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 Separatel y Certified ASC 12. 00 13. 00 Hospi tal -Based Hospi ce 13. 00 14. 00 Hospi tal -Based Heal th Clinic RHC 14. 00 15. 00 Hospi tal -Based Heal th Clinic FQHC 15. 00 16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	5.00	Subprovider - (Other)		0	0	5. 00
8.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA Separatel y Certi fi ed ASC 13.00 Hospi tal -Based Hospi ce 14.00 Hospi tal -Based Heal th Clinic RHC 15.00 Hospi tal -Based Heal th Clinic FOHC 16.00 Hospi tal -Based-CMHC 17.00 Renal Dialysis	6.00	Swing Beds - SNF		0	0	6. 00
9. 00 Hospi tal -Based NF Hospi tal -Based OLTC Hospi tal -Based HHA 11. 00 Separatel y Certified ASC Hospi tal -Based Hospi ce Hospi tal -Based Heal th Clinic RHC 15. 00 Hospi tal -Based Heal th Clinic RHC Hospi tal -Based Hospi ce Hospi tal -Based Tollinic FOHC 15. 00 Hospi tal -Based CMHC 16. 00 Tr. 00 Renal Dialysis	7.00	Swing Beds - NF		0	0	7. 00
10. 00 Hospi tal -Based OLTC 10. 00 11. 00 Hospi tal -Based HHA 11. 00 12. 00 Separatel y Certi fi ed ASC 12. 00 13. 00 Hospi tal -Based Hospi ce 13. 00 14. 00 Hospi tal -Based Heal th Clinic RHC 14. 00 15. 00 Hospi tal -Based Heal th Clinic FQHC 15. 00 16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	8.00	Hospi tal -Based SNF				8. 00
11. 00 Hospi tal -Based HHA 11. 00 12. 00 Separatel y Certified ASC 12. 00 13. 00 Hospi tal -Based Hospi ce 13. 00 14. 00 Hospi tal -Based Heal th Clinic RHC 14. 00 15. 00 Hospi tal -Based Heal th Clinic FQHC 15. 00 16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	9.00	Hospi tal -Based NF				9. 00
12. 00 Separatel y Certified ASC 12. 00 13. 00 Hospital - Based Hospice 13. 00 14. 00 Hospital - Based Health Clinic RHC 14. 00 15. 00 Hospital - Based Health Clinic FQHC 15. 00 16. 00 Hospital - Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	10.00	Hospi tal -Based OLTC				10.00
13. 00 Hospi tal -Based Hospi ce 13. 00 14. 00 Hospi tal -Based Heal th Clinic RHC 14. 00 15. 00 Hospi tal -Based Heal th Clinic FQHC 15. 00 16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	11. 00	Hospi tal -Based HHA				11. 00
14. 00 Hospital -Based Health Clinic RHC 14. 00 15. 00 Hospital -Based Health Clinic FQHC 15. 00 16. 00 Hospital -Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	12.00	Separately Certified ASC				12.00
15. 00 Hospital -Based Health Clinic FQHC 15. 00 16. 00 Hospital -Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	13.00	Hospi tal -Based Hospi ce				13. 00
16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	14.00	Hospital-Based Health Clinic RHC				14. 00
17. 00 Renal Dialysis 17. 00	15. 00	Hospital-Based Health Clinic FQHC				15. 00
	16. 00	Hospi tal -Based-CMHC				16. 00
18.00 l0ther	17. 00	Renal Dialysis				17. 00
10.00 0110.00	18. 00	Other		0	0	18. 00

		Provider CC	IN: 15-0058	Period: From 01/01/2017 To 12/31/2017		pared:
					5/25/2018 3: 50	6 pm
	Uncompensated and indigent care cost computation				1. 00	
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 colum	n 8)	0. 263059	1.0
	Medicaid (see instructions for each line)					
	Net revenue from Medicaid				83, 172, 471	2.0
	Did you receive DSH or supplemental payments from Medicaid?				Y	3. 0
	If line 3 is yes, does line 2 include all DSH and/or supplemen	, ,		ai d?	N	4. (
	If line 4 is no, then enter DSH and/or supplemental payments f	from Medicai	d		9, 905, 223	•
	Medicaid charges				279, 676, 568	•
	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program	(line 7 min	us sum of Li	noc 2 and E. if	73, 571, 438 0	•
00	<pre></pre>	(TITIE / IIITII	us suii oi ii	iles 2 and 5, 11	١	0. (
	Children's Health Insurance Program (CHIP) (see instructions f	for each line	e)			
	Net revenue from stand-alone CHIP		- /		2, 601	9.
	Stand-alone CHIP charges				32, 280	1
	Stand-alone CHIP cost (line 1 times line 10)				8, 492	11.
. 00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9;	if < zero then	5, 891	12.
	enter zero)					
	Other state or local government indigent care program (see ins					
	Net revenue from state or local indigent care program (Not inc				191, 449	1
1. 00	Charges for patients covered under state or local indigent car 10)	re program (i	Not included	in lines 6 or	866, 357	14.
5. 00	IO) State or local indigent care program cost (line 1 times line 1	14)			227, 903	15.
	Difference between net revenue and costs for state or local in		program (Li	ne 15 minus line	36, 454	1
	13; if < zero then enter zero)	iai goire oar o	pi ogi am (i i		1	
	Grants, donations and total unreimbursed cost for Medicaid, CH	HIP and state	e/Local indi	gent care program	ns (see	
	instructions for each line)					
	Private grants, donations, or endowment income restricted to f				0	1
	Government grants, appropriations or transfers for support of				0	
	Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)	al indigent o	care program	s (sum of lines	42, 345	19.
	0, 12 and 10)		Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
			1.00	2.00	3. 00	
	Uncompensated Care (see instructions for each line)					
0. 00	Charity care charges and uninsured discounts for the entire fa (see instructions)	acility	8, 685, 3	06 2, 665, 752	11, 351, 058	20.
. 00	Cost of patients approved for charity care and uninsured disco	ounts (see	2, 284, 7	48 2, 665, 752	4, 950, 500	21.
	instructions)		70.4	102 77	2/5 2/4	22
00	Payments received from patients for amounts previously writter	n off as	72, 4	85 192, 776	265, 261	22.
. 00	shori tu soro			1		1
	charity care (line 21 minus line 22)		ງ ງ1ງ ງ	63 2 172 074	4 685 220	23
	charity care Cost of charity care (line 21 minus line 22)		2, 212, 2	63 2, 472, 976	4, 685, 239	23.
			2, 212, 2	2, 472, 976	4, 685, 239 1. 00	23.

25. 00

26.00

27.00

27. 01

28.00

29.00

30.00

28, 872, 158

966, 614

1, 487, 098

27, 385, 060

7, 724, 370

12, 409, 609

12, 451, 954 31. 00

25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

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

28.00 Non-Medicare bad debt expense (see instructions)

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

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

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

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

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)

stay limit

26.00

	Financial Systems MEMOR SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	IAL HOSPITAL OF FXPENSES	SOUTH BEND, Provi der CO		In Lie Period:	u of Form CMS-: Worksheet A	2552-10
11202710		EM EMBES	, rowadi d	1	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/25/2018 3:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	O piii
		1.00	2. 00	3. 00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		0		20, 515, 452	20, 515, 452	
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	(19, 168, 011	19, 168, 011	
3. 00 4. 00	00300 OTHER CAPITAL RELATED COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	138, 883	0 391, 064	529, 94	7 770, 116	0 1, 300, 063	
5. 00	00500 ADMINISTRATIVE & GENERAL	5, 390, 776	102, 222, 132	'	· ·	70, 987, 715	
6.00	00600 MAINTENANCE & REPAIRS	570, 958	4, 423, 432		0	4, 994, 390	
7.00	00700 OPERATION OF PLANT	2, 452, 715	7, 035, 357			9, 467, 815	
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0 3, 335, 430	1, 634, 631 2, 270, 075	1, 634, 63° 5, 605, 50!		1, 634, 631 5, 605, 505	1
10. 00	01000 DI ETARY	3, 072, 021	3, 062, 400				1
11. 00	01100 CAFETERI A	0	0		2, 555, 974	2, 555, 974	1
13. 00	01300 NURSING ADMINISTRATION	2, 265, 618	1, 063, 936			3, 329, 554	
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	1, 878, 316	6, 702, 834			8, 422, 600	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	6, 277, 453 0	27, 865, 154 1, 968			7, 113, 384 1, 968	
17. 00	01700 SOCIAL SERVICE	2, 771, 399	994, 447	3, 765, 846		3, 765, 846	
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		1, 908, 503	1, 908, 503	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	5, 146, 504	2, 338, 318			5, 557, 119	1
23. 00 23. 01	02300 PARAMED ED PRGM-(SPECIFY) 02301 PARAMED ED	90, 229	51, 765 0		4 0 0 0	141, 994 0	1
23.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	٥	0		5 0	0	23.01
30.00	03000 ADULTS & PEDIATRICS	31, 025, 103	15, 064, 645	46, 089, 748	-377, 161	45, 712, 587	30. 00
31. 00	03100 I NTENSI VE CARE UNIT	5, 674, 903	4, 243, 193			9, 805, 555	
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	6, 096, 691	1, 997, 656			8, 086, 925	1
40. 00 41. 00	04000 SUBPROVI DER	1, 200, 601 1, 208, 485	427, 168 423, 824			1, 627, 769 1, 630, 806	
43. 00	04300 NURSERY	1, 415, 426	393, 023			1, 807, 720	1
	ANCILLARY SERVICE COST CENTERS						
50.00	O5000 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM	13, 628, 033	40, 505, 673			31, 043, 054	1
52. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 031, 167 8, 342, 191	3, 642, 189 11, 275, 799			7, 536, 589 13, 471, 245	1
57. 00	05700 CT SCAN	1, 057, 364	554, 550			1, 611, 914	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	513, 533	513, 53		513, 533	
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 041, 209	7, 576, 791	8, 618, 000		1, 609, 448	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	2, 358, 976	9, 809, 588 0	12, 168, 56	-175, 620 0	11, 992, 944 0	1
65. 00	06500 RESPI RATORY THERAPY	3, 139, 890	1, 862, 697	5, 002, 58	-164, 227	4, 838, 360	1
66. 00	06600 PHYSI CAL THERAPY	2, 569, 356	982, 334			3, 525, 258	1
66. 01	06602 PHYSI CAL THERAPY EAST BANK	979, 856	285, 181			1, 265, 037	
66. 10 67. 00	06601 PHYSICAL THERAPY LIVING CENTER 06700 OCCUPATIONAL THERAPY	392, 659 1, 659, 223	95, 212 436, 609	'		487, 871 2, 095, 832	•
	06701 OCCUPATIONAL THERAPY LIVING CENTER	235, 492	73, 954				
	06800 SPEECH PATHOLOGY	928, 723	229, 834			1, 158, 557	
68. 10	06801 SPEECH THERAPY LIVING CENTER	178, 042	40, 022	218, 06,	4 0	218, 064	•
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		10, 817, 377	0 10, 817, 377	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0		24, 059, 019	24, 059, 019	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		27, 029, 217	27, 029, 217	73. 00
76. 00	03020 CARDI OLOGY	2, 366, 830	1, 168, 885	3, 535, 71!	5 -5	3, 535, 710	76. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0	,	0	0	90.00
90. 10	09001 FAMILY PRACTICE CLINIC	o	0			0	1
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	771, 877	219, 460	991, 33	-534	990, 803	90. 30
	09004 SLEEP DI SORDERS CLINIC	683, 549	434, 537			944, 146	1
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 453, 924	17, 448, 340	27, 902, 26	-103, 105	27, 799, 159	91. 00 92. 00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
113.00	11300 INTEREST EXPENSE		0	(0		113. 00
118.00		134, 829, 872	279, 762, 210	414, 592, 082	980, 442	415, 572, 524	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	٥	0	Ι ,		0	190. 00
	19300 NONPALD WORKERS	301, 981	381, 558	683, 539	-31, 893	651, 646	1
	19301 HEALTH PROPERTIES	1, 790, 364	1, 989, 696			3, 854, 754	193. 10
	19303 LEI GHTON CENTER	0	0	(0 0		193. 40
	19305 WELLNESS CENTER 19308 UNUSED SPACE	1, 664, 095	2, 211, 686	3, 875, 78°	1 -1, 023, 243	2, 852, 538 0	193. 50 193. 80
	19308 UNUSED SPACE 19309 OCCUPATIONAL HEALTH	0	0			0	193. 80
193. 91	19310 RESEARCH AND PROTOCOL	ō	Ō		o o	0	193. 91
	19311 CCOP	0	0	(0		193. 92
193. 93 200. 00	19312 REASEARCH ADMIN TOTAL (SUM OF LINES 118 through 199)	215, 408 138, 801, 720	72, 603 284, 417, 753			288, 011 423, 219, 473	
200.00	TOTAL (SOW OF LINES TO HILOUGH 199)	130, 001, 720	204, 417, 703	1 423, 217, 47.	S ₁ U	423, 217, 4/3	1200.00

Peri od: From 01/01/2017 To 12/31/2017

Worksheet A Date/Time Prepared: 5/25/2018 3:56 pm

In Lieu of Form CMS-2552-10

			5/25/2018 3:50	5 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	or Allocation		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS	0.00	7.00		
	202 10/	20 707 (20		1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	282, 186	20, 797, 638		1.00
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP	617, 704	19, 785, 715		2.00
3.00 00300 OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-43, 330	1, 256, 733		4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	-19, 852, 882	51, 134, 833		5. 00
	1			
6. 00 00600 MAI NTENANCE & REPAI RS	-146, 397	4, 847, 993		6. 00
7.00 O0700 OPERATION OF PLANT	-221, 943	9, 245, 872		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	1, 634, 631		8.00
9. 00 00900 HOUSEKEEPI NG	l ol	5, 605, 505		9.00
10. 00 01000 DI ETARY	-181, 821	3, 396, 234		10.00
	1 1			
11. 00 01100 CAFETERI A	-1, 631, 827	924, 147		11. 00
13. 00 01300 NURSI NG ADMINI STRATI ON	-26, 295	3, 303, 259		13.00
14.00 O1400 CENTRAL SERVICES & SUPPLY	-112, 343	8, 310, 257		14.00
15. 00 01500 PHARMACY	-697, 377	6, 416, 007		15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	1, 968		16. 00
17. 00 01700 SOCIAL SERVICE	60	3, 765, 906		17. 00
21.00 02100 1 &R SERVICES-SALARY & FRINGES APPRVD	0	1, 908, 503		21.00
22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRVD	-400	5, 556, 719		22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	-30, 964	111, 030		23.00
23. 01 02301 PARAMED ED	0	0		23. 01
	ı U	U		∠3. ∪1
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	-32, 063	45, 680, 524		30.00
31.00 03100 INTENSIVE CARE UNIT	-1, 139, 142	8, 666, 413		31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	-87, 464	7, 999, 461		31. 01
40. 00 04000 SUBPROVI DER - 1 PF	0	1, 627, 769		40.00
41. 00 04100 SUBPROVI DER - I RF	0	1, 630, 806		41. 00
43. 00 04300 NURSERY	0	1, 807, 720		43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	-1, 982, 347	29, 060, 707		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	-1, 389, 582	6, 147, 007		52. 00
	1			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-350, 110	13, 121, 135		54. 00
57.00 05700 CT SCAN	-5, 925	1, 605, 989		57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	513, 533		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	-24, 430	1, 585, 018		59.00
60. 00 06000 LABORATORY	0	11, 992, 944		60.00
60. 01 06001 BL00D LABORATORY	0	0		60. 01
65. 00 06500 RESPI RATORY THERAPY	0	4, 838, 360		65. 00
66. 00 06600 PHYSI CAL THERAPY	-238, 337	3, 286, 921		66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	o	1, 265, 037		66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER		487, 871		66. 10
	1 -1			
67. 00 06700 OCCUPATI ONAL THERAPY	-90, 125	2, 005, 707		67. 00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	309, 446		67. 10
68. 00 06800 SPEECH PATHOLOGY	0	1, 158, 557		68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	l ol	218, 064		68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0		70. 00
	0	10, 817, 377		71.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	24, 059, 019		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	-44, 843	26, 984, 374		73.00
76. 00 03020 CARDI OLOGY	-119, 681	3, 416, 029		76.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	n n	0		90. 00
90. 10 09001 FAMILY PRACTICE CLINIC		0		90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	-12, 273	978, 530		90. 30
90.50 09004 SLEEP DISORDERS CLINIC	-19, 973	924, 173		90. 50
91. 00 09100 EMERGENCY	-8, 425, 834	19, 373, 325		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, .20, 004	, 5.5, 525		92. 00
				92.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 I NTEREST EXPENSE	0	0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-36, 007, 758	379, 564, 766		118. 00
NONREI MBURSABLE COST CENTERS				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ام	0		190. 00
		-1		
193. 00 19300 NONPALD WORKERS	0	651, 646		193. 00
193. 10 19301 HEALTH PROPERTI ES	0	3, 854, 754		193. 10
193. 40 19303 LEI GHTON CENTER	o	ol		193. 40
193. 50 19305 WELLNESS CENTER	ام	2, 852, 538		193. 50
193. 80 19308 UNUSED SPACE		2,002,000		193. 80
	ا ا	0		
193. 90 19309 OCCUPATI ONAL HEALTH	0	0		193. 90
193. 91 19310 RESEARCH AND PROTOCOL	0	0		193. 91
193. 92 19311 CCOP	o	ol		193. 92
193. 93 19312 REASEARCH ADMIN	l ol	288, 011		193. 93
1 I				200. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-36, 007, 758	387, 211, 715		∠UU. UU

Provider CCN: 15-0058

| Period: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/25/2018 3:56 pm

					3/23/201	8 3:56 pm
		Increases				
	Cost Center	Li ne #	Salary	0ther		
	2. 00 A - DRUGS CHARGED TO PATIENTS	3.00	4. 00	5. 00		
1. 00	DRUGS CHARGED TO PATTENTS	73.00	0	20, 916, 514		1.0
1.00	O PATTEINTS	73.00		20, 916, 514		1.0
	B - SUPPLIES CHARGED TO PATIE	INTS	<u> </u>	20, 710, 314		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	34, 672, 801		1.0
	PATI ENTS		1	.,,		
2.00		0.00	0	0		2. 0
3.00		0.00	0	0		3. 0
4.00		0.00	0	0		4. 0
5.00		0. 00	0	0		5. 0
6.00		0.00	0	0		6. 0
7.00		0.00	0	0		7. 0
8.00		0.00	0	0		8. 0
9. 00 10. 00		0. 00 0. 00	0	0		9.0
11. 00		0.00	0	0		10. 0 11. 0
12. 00		0.00	0	0		12. 0
13. 00		0.00	o	0		13. 0
14. 00		0.00	Ö	0		14. 0
15. 00		0.00	o	Ö		15. 0
16.00		0.00	0	0		16. 0
	0 = = = = =			34, 672, 801		
	C - AMORTIZATION TO CAPITAL					
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	80, 245		1. 0
	FIXT	+	+			
	0		0	80, 245		
1 00	D - INTEREST TO CAPITAL	1 00	ما	E EE2 2E0		
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	5, 552, 358		1.0
	FIXT	+		5, 552, 358		
	H - EE UTILIZATION OF H&L		<u> </u>	3, 332, 330		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	669, 398		1.0
	0			669, 398		
	L - LAB		·,			
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	144, 705		1.0
	EQUI P					
	TOTALS		0	144, 705		
4 00	O - CAFETERIA FROM DIET SALAR		4 070 004			
1. 00	CAFETERI A	11.00	<u>1, 279, 991</u> 1, 279, 991	0		1.0
	V - MEDICAL DIRECTOR RECLASS		1, 279, 991	U		
1.00	ADULTS & PEDIATRICS	30.00	0	23, 125		1.0
1.00	0		 	23, 125		'
	W - WORKERS COMP EH&W		<u> </u>	20, 120		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	100, 718		1.0
	0 — — — — —			100, 718		
	X - PROPERTY INSURANCE TO CAP	PI TAL				
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	333, 308		1. 0
	FIXT					
	O CARACE TO ASC		0	333, 308		
1 00	Y - GARAGE TO A&G	F 00	<u></u>	1/5 050		1.0
1.00	ADMI NI STRATI VE & GENERAL		0	16 <u>5, 0</u> 59 165, 059		1.0
	AB - DEPRECIATION TO CAPITAL		U	100, 009		
1. 00	NEW CAP REL COSTS-BLDG &	1.00	0	14, 850, 394		1.0
1.00	FIXT	1.00	٩	17,000,074		1.0
2.00	NEW CAP REL COSTS-MVBLE	2. 00	0	15, 350, 132		2.0
	EQUI P			., ,		
	0		o	30, 200, 526		
	BA - IMPLANTS CHARGED TO PATI					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	24, 059, 019		1. 0
2 00	PATI ENTS	2 22	_ [
2.00		0.00	0	0		2. 0
3. 00 4. 00		0. 00 0. 00	0	0		3.0
4. UU				<u></u> 0 24, 059, 019		4.0
	DA - DACC TP CAPITAL		<u> </u>	24, 007, 019		
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	499, 972		1.0
00	EQUI P	2. 55	9	,, ,, 2		
2.00	NEW CAP REL COSTS-MVBLE	2. 00	О	20, 257		2. 0
	EQUI P	1	1			
	NEW CAR DEL COCTO MURIE	2 00	ol	392		3.0
3.00	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	Ч	372		0.0

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/25/2018 3:56 pm Provider CCN: 15-0058

5. 00 NE EC 6. 00 NE EC 7. 00 NE	Cost Center 2.00 EW CAP REL COSTS-MVBLE QUI P EW CAP REL COSTS-MVBLE QUI P EW CAP REL COSTS-MVBLE QUI P EW CAP REL COSTS-MVBLE	1 ncreases Li ne # 3.00 2.00 2.00 2.00	Sal ary 4.00 0	0ther 5.00 146,937	4.00
5. 00 NE EC 6. 00 NE EC 7. 00 NE	2.00 EW CAP REL COSTS-MVBLE QUI P EW CAP REL COSTS-MVBLE QUI P EW CAP REL COSTS-MVBLE QUI P	3. 00 2. 00 2. 00	4.00	5. 00 146, 937	4.00
5. 00 NE EC 6. 00 NE EC 7. 00 NE	EW CAP REL COSTS-MVBLE QUIP EW CAP REL COSTS-MVBLE QUIP EW CAP REL COSTS-MVBLE QUIP	2.00	0	146, 937	4.00
5. 00 NE EC 6. 00 NE EC 7. 00 NE	QUIP EW CAP REL COSTS-MVBLE QUIP EW CAP REL COSTS-MVBLE QUIP	2.00	0		4.00
6. 00 NE EC 7. 00 NE	QUIP EW CAP REL COSTS-MVBLE QUIP		0	446	
6. 00 NE EC 7. 00 NE	EW CAP REL COSTS-MVBLE QUIP	2.00			5. 00
7. 00 NE			O	2, 206, 195	6. 00
	QUI P	2. 00	0	66, 673	7. 00
8. 00 NE	EW CAP REL COSTS-MVBLE	2. 00	0	30, 915	8. 00
9. 00 NE	QUIP EW CAP REL COSTS-MVBLE	2.00	0	7, 865	9. 00
10.00 NE	QUIP EW CAP REL COSTS-MVBLE	2.00	0	173, 940	10. 00
11. 00 NE	QUIP EW CAP REL COSTS-MVBLE	2. 00	0	51, 277	11. 00
12.00 NE	QUIP EW CAP REL COSTS-MVBLE QUIP	2. 00	0	31, 893	12. 00
13. 00 NE	EW CAP REL COSTS-MVBLE	2. 00	0	61, 100	13. 00
14. 00 NE	EW CAP REL COSTS-MVBLE	2. 00	0	353, 845	14. 00
15. 00 NE	EW CAP REL COSTS-MVBLE	2. 00	0	19, 200	15. 00
16. 00 NE	EW CAP REL COSTS-MVBLE	2. 00	0	2, 267	16. 00
0				3, 673, 174	
	D - INTEREST EXPENSE				
1.00	NTEREST EXPENSE	113.00	0_	<u>5, 552, 3</u> 58	1. 00
0			0	5, 552, 358	
	R - INTERNS SALARY FROM LN 2				
	&R SERVICES-SALARY & RINGES APPRVD	21.00	1, 908, 503	0	1.00
0			1, 908, 503	0	
OC	O - CAFETERIA FROM DIET NON-	SALARI ES			
1.00 CA	AFETERI A	1100	0	<u>1, 275, 983</u> 1, 275, 983	1. 00
DI	H - PHARMACY		<u> </u>	1, 273, 703	
	RUGS CHARGED TO PATIENTS	73.00	6, 112, 703	0	1.00
0	V DDODEDTI EC		6, 112, 703	U	
	Y - PROPERTIES	400 40		200 653	
0	EALTH PROPERTIES	1 <u>93.</u> 10	0	30 <u>0, 8</u> 53 300, 853	1.00
500. 00 Gr	rand Total: Increases		9, 301, 197	127, 720, 144	500.00

RECLASSI FI CATIONS

Provider CCN: 15-0058

Period: Worksheet A-6 From 01/01/2017

Date/Time Prepared:

12/31/2017

5/25/2018 3:56 pm 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 20, 916, 514 0 1.00 20, 916, 514 SUPPLIES CHARGED TO PATIENTS 1.00 CENTRAL SERVICES & SUPPLY 14.00 11,613 0 1.00 0 398, 019 0 2.00 ADULTS & PEDIATRICS 30.00 2.00 3.00 INTENSIVE CARE UNIT 31.00 ol 112, 541 0 3.00 NEONATAL INTENSIVE CARE UNIT 0 0 4.00 31.01 7, 422 4.00 5.00 SUBPROVIDER - IRF 41.00 0 1,503 0 5.00 6.00 NURSERY 43.00 729 0 6.00 7 00 OPERATING ROOM 50 00 o 23, 090, 206 0 7 00 DELIVERY ROOM & LABOR ROOM 0 8.00 52.00 0 136, 767 8.00 9.00 RADI OLOGY-DI AGNOSTI C 54.00 3, 933, 609 0 9.00 10.00 CARDIAC CATHETERIZATION 59.00 6, 751, 835 0 10.00 RESPIRATORY THERAPY 0 65.00 11 00 156, 362 11 00 0 12.00 PHYSICAL THERAPY 66.00 0 19,822 12.00 13.00 CARDI OLOGY 76.00 o 0 13.00 14.00 HEMATOLOGY ONCOLOGY CLINIC 90.30 0 534 0 14.00 0 EMERGENCY 91.00 0 15.00 51, 828 15.00 16.00 PHARMACY 15.00 0 16.00 ō 34, 672, 801 C - AMORTIZATION TO CAPITAL 1.00 ADMINISTRATIVE & GENERAL 5.00 80, 245 11 1.00 80, 245 D - INTEREST TO CAPITAL 1.00 INTEREST EXPENSE 113.00 0 5, 552, 358 11 1.00 5, 552, 358 H - EE UTILIZATION OF H&L 669, 398 WELLNESS CENTER 193.50 1.00 0 1.00 669, 398 LAB 1.00 LABORATORY 60.00 144, 705 1.00 14 ō 144, 705 TOTALS O - CAFETERIA FROM DIET SALARIES 1, 279, 991 1.00 DI ETARY 10.00 0 1.00 1, 279, 991 V - MEDICAL DIRECTOR RECLASS 1.00 ADMINISTRATIVE & GENERAL 5.00 23, 125 0 1.00 O 23, 125 W - WORKERS COMP EH&W ADMINISTRATIVE & GENERAL 1.00 5.00 100, 718 0 1.00 100, 718 X - PROPERTY INSURANCE TO CAPITAL 5.00 0 333, 308 1.00 ADMINISTRATIVE & GENERAL 1.00 12 333, 308 Y - GARAGE TO A&G 1.00 HEALTH PROPERTIES 165, 059 193.10 0 1.00 165, 059 AB - DEPRECIATION TO CAPITAL 1.00 ADMINISTRATIVE & GENERAL 5.00 0 30, 200, 526 1.00 2 00 0.00 0 2 00 30, 200, 526 BA - IMPLANTS CHARGED TO PATIENTS 1.00 RADI OLOGY-DI AGNOSTI C 54.00 6, 941 0 1.00 o 2 00 CARDIAC CATHETERIZATION 190, 044 0 59 00 2.00 3.00 PHYSICAL THERAPY 66.00 0 6,610 0 3.00 4.00 MEDICAL SUPPLIES CHARGED TO o 23, 855, 424 0 4.00 71.00 PATI ENTS 24, 059, 019 ō DA - DACC TP CAPITAL 1.00 ADMINISTRATIVE & GENERAL 5.00 0 499, 972 10 1.00 2.00 OPERATION OF PLANT 7.00 0 20, 257 10 2.00 3.00 DI ETARY 10.00 0 392 10 3.00 CENTRAL SERVICES & SUPPLY 4.00 14.00 0 146, 937 10 4.00 OPERATING ROOM 50.00 446 5.00 10 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 2, 206, 195 10 6.00 CARDIAC CATHETERIZATION 59.00 0 10 7.00 66, 673 7.00 8.00 LABORATORY 60.00 0 30, 915 10 8.00 RESPIRATORY THERAPY o 10 9. 00 9.00 65.00 7,865 0 10.00 SLEEP DISORDERS CLINIC 90.50 173, 940 10 10.00 EMERGENCY 91.00 0 10 11.00 51, 277 11.00 12.00 NONPALD WORKERS 193.00 0 31, 893 10 12.00 HEALTH PROPERTIES 13.00 193.10 0 61, 100 10 13.00 WELLNESS CENTER 14 00 193 50 353 845 10 14 00

Health Financial Systems RECLASSIFICATIONS MEMORIAL HOSPITAL OF SOUTH BEND, INC
Provider CCN: 15-0058 Period: Worksheet A-6 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/25/2018 3:56 pm

						5/25/2018 3:5	6 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
15. 00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22. 00	0	19, 200	10		15. 00
16.00	ADULTS & PEDIATRICS	30.00	0	2, 267	10		16. 00
				3, 673, 174			
	DD - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	5, 552, 358	0		1. 00
	0			5, 552, 358			
	IR - INTERNS SALARY FROM LN 2	22 TO LN 21					
1.00	I&R SERVICES-OTHER PRGM	22. 00	1, 908, 503	0	0		1. 00
	COSTS APPRVD						
	0		1, 908, 503	0			
	00 - CAFETERIA FROM DIET NON-	SALARI ES					
1.00	DI ETARY	1000	0_	<u>1, 275, 9</u> 83			1. 00
	0		0	1, 275, 983			
	PH - PHARMACY						
1.00	PHARMACY	15. 00	<u>6, 112, 7</u> 03	0	0		1. 00
	0		6, 112, 703	0			
	YY - PROPERTIES						
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	300, 853	14		1. 00
	FI XT						
	0		0	300, 853			
500.00	Grand Total: Decreases		9, 301, 197	127, 720, 144			500.00

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10 RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0058 Peri od: Worksheet A-7 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/25/2018 3:56 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 21, 318, 068 0 1.00 3, 055, 282 0 2.00 Land Improvements 371, 586 371, 586 0 2.00 0 3.00 429, 186, 207 62, 071, 491 62, 071, 491 4, 387, 070 3 00 Buildings and Fixtures 0 4.00 Building Improvements 851, 999 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 284, 145, 586 16, 453, 698 16, 453, 698 7, 246, 815 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 738, 557, 142 78, 896, 775 78, 896, 775 11, 633, 885 8.00 9.00 Reconciling Items 0 9.00 738, 557, 142 Total (line 8 minus line 9) 78, 896, 775 10.00 78, 896, 775 0 11, 633, 885 10.00 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, 318, 068 1.00 2.00 Land Improvements 3, 426, 868 1, 992, 768 2.00 486, 870, 628 3.00 Buildings and Fixtures 46, 362, 502 3.00 4.00 Building Improvements 851, 999 851, 999 4.00

293, 352, 469

805, 820, 032

805, 820, 032

187, 910, 780

237, 118, 049

237, 118, 049

5.00

6.00

7.00

8.00

9.00

10.00

5.00

6.00

7.00

8.00

9.00

Fi xed Equipment

Movable Equipment

Reconciling Items

HIT designated Assets

10.00 Total (line 8 minus line 9)

Subtotal (sum of lines 1-7)

			Т	o 12/31/2017	Date/Time Pre 5/25/2018 3:5		
		Sl	JMMARY OF CAPI	ΓAL			
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see		
oost oonter bescriptron	Deprese at ron	Louse	Tittel est	,	instructions)		
	9. 00	10.00	11. 00	12.00	13. 00		
PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUN	MN 2, LINES 1 a	nd 2				
1.00 NEW CAP REL COSTS-BLDG & FLXT	C	0	C	0	0	1. 00	
2.00 NEW CAP REL COSTS-MVBLE EQUIP	C	0	(0	0	2. 00	
3.00 Total (sum of lines 1-2)	C	0	(0	0	3. 00	
SUMMARY OF CAPITAL							
		-					
Cost Center Description		Total (1) (sum					
	Capi tal -Rel ate						
	d Costs (see	through 14)					
	instructions)						
	14. 00	15. 00					
PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUN	MN 2, LINES 1 a	nd 2				
1.00 NEW CAP REL COSTS-BLDG & FLXT	C	0				1.00	
2.00 NEW CAP REL COSTS-MVBLE EQUIP	C	0				2.00	
3.00 Total (sum of lines 1-2)	c) o				3. 00	

Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0058	From 01/01/2017	Worksheet A-7 Part III Date/Time Prepared:		

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider Co	F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet A-/ Part III Date/Time Prep 5/25/2018 3:56		
	COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL		
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance		
			(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 & FIXT	512, 467, 564		512, 467, 564			1.00	
2. 00 NEW CAP REL COSTS-MVBLE EQUIP	293, 352, 469					2.00	
3.00 Total (sum of lines 1-2)	805, 820, 033					3. 00	
	ALLUCA	ALLOCATION OF OTHER CAPITAL SUMMARY OF CA					
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease		
		Capi tal -Relate					
		d Costs	through 7)	0.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CE	6. 00	7. 00	8. 00	9. 00	10.00		
1.00 NEW CAP REL COSTS-BLDG & FLXT	INTERS			14 050 204	491, 721	1. 00	
2.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		14, 850, 394 15, 350, 132		2. 00	
3.00 Total (sum of lines 1-2)	0	0		30, 200, 526		3. 00	
3.00 Total (Suill Of Titles 1-2)	U	SI	<u>l </u>		0, 224, 732	3.00	
Cost Center Description	Interest	Insurance (see			Total (2) (sum		
		instructions)	instructions)	Capi tal -Rel ate			
				d Costs (see	through 14)		
	44.00	40.00	10.00	instructions)	45.00		
DADT III DECONCILIATION OF CADITAL COCTO OF	11.00	12. 00	13. 00	14. 00	15. 00		
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 NEW CAP REL COSTS-BLDG & FIXT	5, 632, 603	333, 308	0	-510, 388	20, 797, 638	1. 00	
2.00 NEW CAP REL COSTS-BLDG & FIXT	-1, 442, 333		1 0	1		2. 00	
3.00 Total (sum of lines 1-2)	4, 190, 270	1	·	1		3. 00	
5. 00 Total (Suil Of Titles 1-2)	4, 170, 270	1 333, 300	٠ -	- 303, 003	40, 303, 333	3.00	

Health Financial Systems

MEMORIAL HOSPITAL OF SOUTH BEND, INC

In Lieu of Form CMS-2552-10

Provider CCN: 15-0058

Period:
From 01/01/2017
To 12/31/2017
Pate/Time Prepared:
5/25/2018 3:56 pm

Expense Classification on Worksheet A
To/From Which the Amount is to be Adjusted

					0 12/31/2017	5/25/2018 3:56	
				Expense Classification on			•
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	T	1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Investment income - NEW CAP		0	NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	1. 00
	REL COSTS-BLDG & FLXT (chapter 2)						
2. 00	Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2.00	ol	2. 00
	REL COSTS-MVBLE EQUIP (chapter			EQUI P			
	2)						
3.00	Investment income - other		0		0. 00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time	В	_51_505	ADMINISTRATIVE & GENERAL	5. 00	0	4. 00
4.00	di scounts (chapter 8)		-31, 373	ADMINISTRATIVE & GENERAL	3.00	j Y	4.00
5.00	Refunds and rebates of	В	-1, 220, 953	ADMINISTRATIVE & GENERAL	5. 00	o	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
7.00	stations excluded) (chapter		Ü		0.00	١	7.00
	21)						
8.00	Television and radio service		0		0.00	o	8.00
	(chapter 21)						
9.00	Parking lot (chapter 21)		0		0. 00		9. 00
10. 00	Provider-based physician adjustment	A-8-2	-13, 546, 265			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	o	11. 00
11.00	(chapter 23)		O		0.00	Ĭ	11.00
12. 00	Related organization	A-8-1	3, 612, 340			o	12.00
	transactions (chapter 10)						
13.00	Laundry and linen service		0	OAFETERIA	0.00		
14. 00 15. 00	Cafeteria-employees and guests		-1, 367, 322	CAFETERIA	11. 00 0. 00		14. 00 15. 00
15.00	Rental of quarters to employee and others		U		0.00	١	15.00
16. 00	Sale of medical and surgical		0		0.00	ol	16. 00
	supplies to other than						
	patients						
17. 00	Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
10.00	abstracts		Ü		0.00	l	10.00
19. 00	Nursing and allied health		0		0.00	o	19. 00
	education (tuition, fees,						
	books, etc.)						
20.00	Vending machines		0		0.00		20.00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	О	22. 00
	overpayments and borrowings to						
00	repay Medicare overpayments			DECDI DATODY TUESAS:			00.5-
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
	therapy costs in excess of						
	limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1. 00	o	26. 00
20.00	COSTS-BLDG & FIXT			FIXT	1.00	Ĭ	20.00
27. 00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2.00	o	27.00
0-	COSTS-MVBLE EQUIP			EQUI P	_		
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00		29. 00 30. 00
30.00	therapy costs in excess of	A-0-3	0		67.00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)	, -		 	_		
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
	Trimitation (Gnapter 14)	1		I	ı	ı I	

Health Financial Systems
ADJUSTMENTS TO EXPENSES MEMORIAL HOSPITAL OF SOUTH BEND, INC
Provider CCN: 15-0058

33.01 OTHER REVENUE - NED STAFF B -25,596/MONIN STRATIVE & CERERAL 5.00 3.					To	om 01/01/2017 12/31/2017		
COST Center Description Basis Actode (2) Aeount Cost Center Line # 864. A.7 Ber. 2-20. Oarl HUT Adjustment for Description Basis Actode (2) Aeount Cost Center Line # 800. 5.00 \$2.00 \$3.00 \$3.00 \$0.00 \$3.								э рііі
2.00 CAH HIT Adjustment For					To/From Which the Amount is	to be Adjusted		
2.00 CAH HIT Adjustment For								
2.00 CAH HIT Adjustment For								
20.00 CARL HILL ADJUSTMENT FOR 0 0 0 32.00		Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
Depreciation and interest	22.00	CAULIUT Additional for	1.00					22.00
0.00 0.33.00 0.00	32.00			0		0.00	0	32.00
OFFICE STATE STA		OTHER ADJUSTMENTS (SPECIFY)		0				33. 00
33.02 OTHER REVENUE - PEDS B	33. 01		В	-25, 596	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33.14 OTHER REVENUE - CRID 8	33. 02		В	0	ADULTS & PEDIATRICS	30.00	o	33. 02
1. TOPHICAL SALES - FORCE 6					1		1	33. 03
33 0.0 OTHER REVENUE - BCK SOLIC APPLIES					1		0	
33.09 OHER REVENUE - CARD NAS AMIN B -2,866/CARDIOLOGY 76.00 0 33.00					ł		Ö	33. 06
ABOUND A					1			33. 07
33.10 ONTRACTED SERVICES B -3-47, 991 ADMINISTRATIVE & GENERAL 5.00 0 33.10 CAPITAL 5.00 CAPIT					1		1	
CAPITAL CAPITAL CAPITAL CAPITAL COUPT CAPITAL CAP					1		1	33. 10
33.12 OTHER REVENUE - DISTRIBUTION B OCCHITAL SERVICES & SUPPLY 14.00 0.31.13	33. 11		В	-61, 408		2. 00	11	33. 11
33.14 OTHER REVENUE - BIOMED B	33. 12		В	0	1	14.00	0	33. 12
33.16 VISITOR MEAL OFFSET B			В		1		l	33. 14
33.19 OTHER REVENUE - ENGINEERING B -221, 943 OPERATION OF PLANT 66.00 0 33.15 33.20 OTHER REVENUE - ELAIDA BADMIN B -635 EMPLOYEE BENEFITS 6.00 0 33.25 33.20 OTHER REVENUE - ADDIOLOGY B ORADIOLOGY-DI AGNOSTIC 54.00 0 33.22 33.21 OTHER REVENUE - MCD LD B ORADIOLOGY-DI AGNOSTIC 54.00 0 33.22 33.22 OTHER REVENUE - MICL B ONEONATAL INTENSIVE CARE UNIT 31.01 0 33.24 33.25 OTHER REVENUE - NICU B ONEONATAL INTENSIVE CARE UNIT 31.01 0 33.24 33.26 OTHER REVENUE - MCD LD B ONEONATAL INTENSIVE CARE UNIT 31.01 0 33.24 33.26 OTHER REVENUE - MCD LD B ONEONATAL INTENSIVE CARE UNIT 31.01 0 33.24 33.26 OTHER REVENUE - MCD LD B ONEONATAL INTENSIVE CARE UNIT 31.01 0 33.24 33.27 TRANSPORT TRANS					1		1	33. 15
33. 10 OTHER REVENUE - REHAB AMMIN B 25PHYSICAL THERAPY 66. 00 0 33. 15					1		1	33. 16
BENEFITS 3. 20 THER REVENUE - RADIOLOGY					1			33. 19
33 22 OTHER REVENUE - RADIOLOGY B ORADIOLOGY-DIAGNOSTIC 54,00 0 33,22	33. 20		В	-635	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 20
DIAGN OTHER REVENUE - NED ED B -64ADMINISTRATIVE & GENERAL 5.00 O 33.23 33.24 OTHER REVENUE - NICU B ONEOMATAL INTERSIVE CARE UNIT 31.01 O 33.24 OTHER REVENUE - NICU B ONEOMATAL INTERSIVE CARE UNIT 31.01 O 33.24 OTHER REVENUE - NEONATAL SERVICES GIRL 32.20 OTHER REVENUE - OF COUND TRANSPORT TRANS	33. 22	•	В	0	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 22
33. 26 OTHER REVENUE - NICU B ONEONATAL INTENSIVE CARE UNIT 31. 01 0 33. 25 OTHER REVENUE - MRIN B ONEONATAL INTENSIVE CARE UNIT 31. 01 0 33. 25 OTHER REVENUE - NEONATAL B ONEONATAL INTENSIVE CARE UNIT 31. 01 0 33. 25 OTHER REVENUE - REVUNUE - RE		DI AGN	_					
33. 25 OTHER REVENUE - NEONATAL SERVICES 33. 26 OTHER REVENUE - PRONATAL SERVICES 33. 27 OTHER REVENUE - GROUND SERVICES 33. 27 OTHER REVENUE - GROUND SERVICES 33. 28 PACE CONSULTING AMORTIZATION A 1, 350/NEW CAP REL COSTS-BLDG & 1, 00 10 33, 26 (20 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0					1		0	
SERVICES					1		0	33. 25
SERVICES 33. 27 THER REVENUE - GROUND TRANSPORT 33. 28 -107, 905 EMERGENCY 91. 00 10 33. 27 33. 28 -107, 905 EMERGENCY 91. 00 10 33. 28 33. 30 OTHER REVENUE - DRIVER'S ED B -10, 915 OCCUPATIONAL THERAPY 67. 00 0 33. 33 33. 30 OTHER REVENUE - RAD ADMIN B -3, 320 RADIOLOGY-DIAGNOSTIC 54. 00 10 33. 35 33. 35 NONALLOWABLE CAPITALIZED A -13, 123 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 35 33. 36 OTHER REVENUE - MAIN STREET PT B OPHYSICAL THERAPY 66. 00 0 33. 35 33. 46 ALLOWABLE CAPITALIZED INTEREST A -9, 762 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 46 33. 48 NONALLOWABLE CAPITALIZED INTEREST A -9, 762 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 46 33. 48 NONALLOWABLE CAPITALIZED INTEREST A -9, 762 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 46 33. 48 NONALLOWABLE CAPITALIZED A -3, 092 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 46 33. 49 NONALLOWABLE CAPITALIZED A -3, 092 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 46 33. 50 OTHER REVENUE RENT B -230, 879 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 50 33. 50 OTHER REVENUE B -14, 540 ADMIN INSTRATIVE & GENERAL 5. 00 0 33. 56 33. 59 SENDAN REVENUE B -7, 204 ADMIN INSTRATIVE & GENERAL 5. 00 0 33. 56 33. 60 OTHER REVENUE B -4, 428 DELIVERY ROOM & LABOR ROOM 52. 00 0 33. 56 33. 60 OTHER REVENUE SPICE S			_		(MRI)			
33. 26 TARRASPORT PACE CONSULTING AMORTIZATION A 1,350 NEW CAP REL COSTS-BLDG & 1.00 10 33. 26 1.00 10 33. 26 1.00 10 33. 26 1.00 10 33. 26 1.00 10 33. 26 1.00 10 33. 26 1.00 10 33. 26 1.00 10 33. 26 1.00 10 33. 26 1.00 10 33. 36 1.0	33. 26		В	-10, 053	NEONATAL INTENSIVE CARE UNIT	31. 01	0	33. 26
33. 28 PACE CONSULTING AMORTIZATION A 1,350NEW CAP REL COSTS-BLDG & 1.00 10 33. 28	33. 27		В	-107, 905	EMERGENCY	91.00	o	33. 27
STATE STAT	22 20			1 250	NEW CAR REL COSTS BLDC 0	1 00	10	22 20
CON 33. 33 33 33 34 34 35 35 36 36 37 38 38 38 38 38 38 38	33. 28	PACE CONSULTING AMORTIZATION	A	1, 350		1.00	10	33. 28
33. 33 OTHER REVENUE - RAD ADMIN B -3, 320 RADI OLOGY-DI AGNOSTIC 54. 00 0 33. 33 33. 35 NONALLOWABLE CAPITALIZED A -13, 123 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 35 33. 36 OTHER REVENUE - MAIN STREET PT B OPHYSICAL THERAPY 66. 00 0 33. 35 33. 39 OTHER REVENUE - PAC OTHER REVENUE A ONEW CAP REL COSTS-BLDG & 1. 00 10 33. 35 33. 42 EXCESS CAPITALIZED INTEREST A -9, 762 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 46 33. 48 NONALLOWABLE CAPITALIZED A -3, 092 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 46 33. 48 NONALLOWABLE CAPITALIZED A -3, 092 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 46 1 INCORRECT LIFING ON ASBESTOS A 1, 121 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 50 33. 50 OTHER REVENUE - RENT B -230, 879 NEW CAP REL COSTS-BLDG & 1. 00 14 33. 55 33. 50 OTHER REVENUE - RENT B -230, 879 NEW CAP REL COSTS-BLDG & 1. 00 14 33. 55 33. 51 SPECIAL PROGRAM REVENUE B -14, 504 DAMIN INSTRATIVE & GENERAL 5. 00 0 33. 56 33. 63 STERILIZATION REVENUE B -7, 204 ADMIN INSTRATIVE & GENERAL 5. 00 0 33. 56 33. 64 OTHER REVENUE - NUTRITIONAL B -4, 289 DELIVERY ROOM & LABOR ROOM 52. 00 0 33. 66 33. 65 OTHER REVENUE - SDECC PT B -232, 312 PHYSICAL THERAPY 66. 00 0 33. 69 33. 96 PARKING GARAGE - OPERATING A -49, 032 ADMIN ISTRATIVE & GENERAL 5. 00 0 33. 96 33. 97 PARKING GARAGE - OPERATING A -49, 032 ADMIN ISTRATIVE & GENERAL 5. 00 0 33. 97 34. 03 NON ALLOWABLE 1999 INTEREST A -1, 380, 925 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 97 34. 03 NON ALLOWABLE 1999 INTEREST A -1, 380, 925 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 97 34. 03 NON ALLOWABLE 1999 INTEREST A -1, 380, 925 NEW CAP REL COSTS-BLDG & 1. 00 11 34. 03 34. 04 DUCKNOWABLE 1999 INTEREST A -1, 380, 925 NEW CAP REL COSTS-BLDG & 1. 00 11 34. 03 34. 05 DECEMBER 1 10 10 10 10	33. 30		В	-10, 915	OCCUPATIONAL THERAPY	67. 00	o	33. 30
33. 35 NONALLOWABLE CAPITALIZED A -13, 123 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 35 33. 36 OTHER REVENUE - MAIN STREET PT B OPHYSICAL THERAPY 66. 00 0 33. 36 33. 39 PACE COMPONENT DEPREC 29 V 23 A ONEW CAP REL COSTS-BLDG & 1. 00 10 33. 35 33. 42 EXCESS CAPITALIZED INTEREST A -9, 762 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 42 33. 46 ALLOWABLE CAPITALIZED INTEREST A 10, 626 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 46 33. 48 NONALLOWABLE CAPITALIZED A -3, 092 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 46 1	33 33		B	-3 320	RADI OLOGY-DI AGNOSTI C	54 00	0	33 33
33. 36 OTHER REVENUE - MAIN STREET PT B OPHYSICAL THERAPY PAC COMPONENT DEPREC 29 V 23 A ONEW CAP REL COSTS-BLDG & 1.00 10 33. 36			1					
33. 39 PACE COMPONENT DEPREC 29 V 23 A ONEW CAP REL COSTS-BLDG & 1.00 10 33. 35 33. 42 EXCESS CAPITALIZED INTEREST A -9,762 NEW CAP REL COSTS-BLDG & 1.00 10 33. 42 33. 48 ALLOWABLE CAPITALIZED INTEREST A -10,626 NEW CAP REL COSTS-BLDG & 1.00 10 33. 46 33. 48 NONALLOWABLE CAPITALIZED A -3,092 NEW CAP REL COSTS-BLDG & 1.00 10 33. 46 1	00.07				i i			00.07
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33. 48 NONALLOWABLE CAPITALIZED A -3,092 NEW CAP REL COSTS-BLDG & 1.00 10 33. 48 FIXT 1.00 11 33. 48 FIXT 1.00 11 33. 48 FIXT 1.00 11 33. 50 INCORRECT LIFING ON ASBESTOS AN 1.121 NEW CAP REL COSTS-BLDG & 1.00 10 33. 50 AN 1.00 11 33. 40 AN 1.00 11 34. 03 AN 1.00	33. 46		A		i I	1. 00	10	33. 46
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33. 55 OTHER REVENUE - RENT B	33. 50		A	1, 121		1. 00	10	33. 50
STATE STATE STATE STATE STATE STAT	22 EE	1	D D		1	1 00	1.4	22 EE
33. 58 SPECIAL PROGRAM REVENUE B -7, 204 ADMINISTRATIVE & GENERAL 5. 00 0 33. 58 33. 59 SEMINAR REVENUE B -36, 797 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 59 33. 63 STERILIZATION REVENUE B -4, 428 DELIVERY ROOM & LABOR ROOM 52. 00 0 33. 63 33. 66 OTHER REVENUE - NUTRITIONAL SERVENUE CATHLER REVENUE CATHLE REVENUE CATHL	33. 33	OTHER REVENUE - RENT	Б			1.00	14	33. 33
33. 59 SEMI NAR REVENUE B -36, 797 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 59 33. 63 STERILIZATION REVENUE B -4, 428 DELIVERY ROOM & LABOR ROOM 52. 00 0 33. 63 33. 66 OTHER REVENUE - NUTRITIONAL B -14, 808 DI ETARY 10. 00 0 33. 66 33. 76 OTHER REVENUE - CATH LAB B -968 CARDI AC CATHETERIZATION 59. 00 0 33. 76 33. 88 OTHER REVENUE - SBCSC PT B -232, 312 PHYSI CAL THERAPY 66. 00 0 33. 88 33. 94 EDUC SERVI CES EMS B -30, 964 PARAMED ED PRGM-(SPECIFY) 23. 00 0 33. 94 33. 96 PARKING GARAGE - OPERATING A -49, 032 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 96 33. 97 PARKING GARAGE - CAPITAL A -29, 790 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 97 34. 03 NON ALLOWABLE 1999 INTEREST A -1, 380, 925 NEW CAP REL COSTS-MVBLE 2. 00 11 34. 03				•	i I		1	
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33. 88 OTHER REVENUE - SBCSC PT B -232, 312 PHYSICAL THERAPY 66. 00 0 33. 88 33. 94 EDUC SERVICES EMS B -30, 964 PARAMED ED PRGM-(SPECIFY) 23. 00 0 33. 94 33. 96 PARKING GARAGE - OPERATING A -49, 032 ADMINISTRATIVE & GENERAL 5. 00 0 33. 96 33. 97 PARKING GARAGE - CAPITAL A -29, 790 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 97 34. 03 NON ALLOWABLE 1999 INTEREST A -1, 380, 925 NEW CAP REL COSTS-MVBLE 2. 00 11 34. 03	22 74		D. D.	040	CARDIAC CATHETEDIZATION	50 00		32 74
33. 94 BDUC SERVICES EMS 33. 96 PARKING GARAGE - OPERATING 33. 97 PARKING GARAGE - CAPITAL A -49, 032 ADMINISTRATIVE & GENERAL 5. 00 0 33. 96 PARKING GARAGE - CAPITAL A -29, 790 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 97 FIXT 34. 03 NON ALLOWABLE 1999 INTEREST A -1, 380, 925 NEW CAP REL COSTS-MVBLE EQUIP					1		1	33. 88
33. 97 PARKING GARAGE - CAPITAL A -29, 790 NEW CAP REL COSTS-BLDG & 1. 00 10 33. 97 FLXT 34. 03 NON ALLOWABLE 1999 INTEREST A -1, 380, 925 NEW CAP REL COSTS-MVBLE 2. 00 11 34. 03		•			i i		1	33. 94
34. 03 NON ALLOWABLE 1999 INTEREST A -1, 380, 925 NEW CAP REL COSTS-MVBLE 2. 00 11 34. 03 EQUI P		•			i l		1	
34. 03 NON ALLOWABLE 1999 INTEREST A -1, 380, 925 NEW CAP REL COSTS-MVBLE 2. 00 11 34. 03 EQUI P	33. 97	PARKING GARAGE - CAPITAL	A			1. 00	10	33. 97
	34. 03	NON ALLOWABLE 1999 INTEREST	А		1	2. 00	11	34. 03
34. 23 ADMI 331 ON REVENUE D -32, 049 ADMI NI STRATI VE & GENERAL 3. UU U 34. 23	24 22	ADMISSION DEVENUE	P	22 440	1	E 00		24 22
	34. 23	MUMI 331 ON KEVENUE	10	-32, 649	MUNITINI STRATT VE & GENERAL	5.00	ı ^O l	J4. ∠3

Health Financial Systems
ADJUSTMENTS TO EXPENSES Peri od: Provi der CCN: 15-0058 Worksheet A-8 From 01/01/2017 | Worksheet A-8 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

					0 12/31/2017	5/25/2018 3:50	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
34. 31	SKYWAY INTEREST AMORTIZATION	A	3, 580	NEW CAP REL COSTS-BLDG &	1.00	10	34. 31
				FIXT			
34. 36	OLD CAPITAL - BUILDING	A	26, 887	NEW CAP REL COSTS-BLDG &	1.00	14	34. 36
				FLXT			
34. 37	NEW CAPITAL BUILDING	A	-5, 543	NEW CAP REL COSTS-BLDG &	1.00	14	34. 37
				FI XT			
35. 02	OTHER REVENUE - AMBULANCE	В	-112, 343	CENTRAL SERVICES & SUPPLY	14.00	0	35. 02
	SUPPL		•				
36. 01	LOBBY EXPENSE	A	-12, 808	ADMINISTRATIVE & GENERAL	5. 00	0	36. 01
36. 05	HAF EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	36. 05
36. 18	TRUSTEE FEES	A		ADMINISTRATIVE & GENERAL	5. 00		36. 18
36. 23	CONTRI BUTI ONS	A		ADMI NI STRATI VE & GENERAL	5. 00		36. 23
36. 25	NON-ALLOWED EXPENSES	A		ADMI NI STRATI VE & GENERAL	5. 00	o o	36. 25
36. 26	ENTRY FEES	B		ADMINISTRATIVE & GENERAL	5. 00	Ĭ	36. 26
37. 00	OTHER REVENUE - MATERNAL CHILD		· ·	ADULTS & PEDIATRICS	30.00	0	37. 00
37.00	ADMIN	D	-10, 313	ADULTS & PEDIATRICS	30.00	U	37.00
37. 01	OTHER REVENUE - OSTC	В	11 122	NURSING ADMINISTRATION	13.00	0	37. 01
37. 01	OTHER REV - TRAUMA SVCS	В	· ·	EMERGENCY	91.00		37. 01
37. 03	OTHER REVENUE - TEAM PHARMACY	В	· ·				39.00
	II .	В		PHARMACY	15.00		
40.00	OTHER REVENUE - PEDS REHAB OT		· ·	OCCUPATI ONAL THERAPY	67.00	0	40.00
41.00	OTHER REVENUE - FCMC	В	· ·	ADULTS & PEDIATRICS	30.00		41.00
42. 00	OTHER REVENUE - PULMONARY	В	-160	ADULTS & PEDIATRICS	30.00	0	42. 00
	MED/SURG	_				_	
44. 00	OTHER REVENUE - CARDI AC REHAB	В		CARDI OLOGY	76.00		44. 00
44. 01	OTHER REVENUE - OSTC	В		PHYSICAL THERAPY EAST BANK	66. 01	0	44. 01
44. 02	OTHER REVENUE - SAFETY	В		NURSING ADMINISTRATION	13. 00	0	44. 02
44. 03	OTHER REVENUE - 11 SOUTH	В		ADULTS & PEDIATRICS	30.00	0	44. 03
44. 04	OTHER REVENUE - 12 SOUTH	В		ADULTS & PEDIATRICS	30.00		44. 04
44. 05	OTHER REVENUE - SOCIAL	В	0	SOCI AL SERVI CE	17. 00	0	44. 05
	SERVI CES						
44.06	OTHER REVENUE - PHARMACY	В	-44, 843	DRUGS CHARGED TO PATIENTS	73.00	0	44.06
44.07	OTHER REVENUE - FPC	В	-400	I&R SERVICES-OTHER PRGM	22. 00	0	44.07
				COSTS APPRVD			
44.08	OTHER REVENUE - ICU	В	-1, 999	INTENSIVE CARE UNIT	31.00	0	44. 08
44.09	OTHER REVENUE - INDIGENT CARE	В	0	SOCIAL SERVICE	17. 00	0	44.09
44. 10	OTHER REVENUE - ORNISH CARDIAC	В	-2, 530	CARDI OLOGY	76. 00	0	44. 10
	REHAB						
44. 11	OTHER REVENUE - RES SVCS	В	-1, 378	NURSING ADMINISTRATION	13.00	0	44. 11
44. 12	OTHER REVENUE - 8 SOUTH	В	-140	ADULTS & PEDIATRICS	30.00	0	44. 12
44. 13	OTHER REVENUE - SOCIAL SVCS	В		SOCIAL SERVICE	17. 00	0	44. 13
50. 00	TOTAL (sum of lines 1 thru 49)		-36, 007, 758]	50.00
-	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) Do	scrintion - all chanter referen	oces in this col	umn nortain to	CMS Dub 15_1	1		

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

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0058 | Period: From 01/01/2017 | Worksheet A-8-1 | Provider CCN: 15-0058 | Period: From 01/01/2017 | Provider CCN: 15-0058 | Provider CCN: 15-0058 | Period: From 01/01/2017 | Provider CCN: 15-0058 | Provider CCN:

							5/25/2018 3:5	6 pm
	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 ADJUST	MENTS REQUIRED AS A RESULT OF	TRAN	SACTIONS WITH RELA	ATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:							
1.00	0.00		HOME	OFFICE OLD CAP-BUI	I LD	0	0	1.00
2.00	0.00		HOME	OFFICE OLD CAP-EQU	UIP	0	0	2.00
3.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME	OFFICE NEW CAP-BUI	I LD	530, 811	0	3.00
4.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	HOME	OFFICE NEW CAP-EQU	UIP	2, 060, 037	O	4.00
4.01	5. 00	ADMINISTRATIVE & GENERAL	HOME	OFFICE NON-CAPITAL	L	35, 495, 247	O	4. 01
4.02	5. 00	ADMINISTRATIVE & GENERAL	HOME	OFFICE NON-ALLOWAR	BLE	0	34, 473, 755	4. 02
5.00	TOTALS (sum of lines 1-4).					38, 086, 095	34, 473, 755	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 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.

6.00	В	100.00 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.

Heal th	Financial Syste	ems		MEMORIAL I	HOSPITAL OF	SOUTH BEND,	INC		In Lie	u of Form CM:	S-2552-10
	NT OF COSTS OF	SERVICES FROM	RELATED C	RGANI ZATI ON	IS AND HOME	Provi der	CCN: 15-0058	Peri		Worksheet A	-8-1
OFFICE	COSTS							To	01/01/2017 12/31/2017	Date/Time P	
	N	W . A 7 D C								5/25/2018 3	: 56 pm
		Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQL	JIRED AS A R	RESULT OF TR	RANSACTI ONS	WITH RELATED (ORGANI	ZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:									
1.00	0	C									1.00
2.00	1 0										2.00

* 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.

3.00

4.00

4.01

4 02

5.00

nas no	been posted to norksheet A,	cordinate transfer 2, the amount arrowable should be mareated in cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	FED 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:
- 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.

3.00

4.00

4.01

4 02

5.00

530, 811

2,060,037

35, 495, 247

-34, 473, 755

3, 612, 340

10

10

0

0

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0058

Period: Worksheet A-8-2 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/25/2018 3:56 pm

In Lieu of Form CMS-2552-10

						10 12/31/2017	5/25/2018 3:5	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component Hours	
	1. 00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	
1. 00		DR. S	6, 000	0		211, 500	1	1. 00
2.00	5. 00	DR. AN	209, 125	0	209, 125	181, 300	1, 195	2. 00
3.00	5. 00	DR. W	23, 750	0	23, 750	211, 500	360	3.00
4.00	13. 00	DR. H	3, 900	0	3, 900	211, 500	50	4.00
5.00	13. 00	DR. D	44, 910	0	44, 910	211, 500	306	5.00
6.00		DR. DU	11, 213	0	11, 213	211, 500	1	6.00
7.00		DR. DE	53, 632		,	211, 500	1	7. 00
8.00		DR. AW	27, 975					8.00
9. 00		DR. K	164, 675		,	211, 500	1	9. 00
10. 00	31. 00	AGGREGATE-INTENSIVE CARE	992, 950	992, 950	0	0	0	10. 00
11 00	21 01	UNI T	70.000	70.000				11 00
11.00		DR. L	70, 000		12 412	140 700	0	11. 00
12. 00	31.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	12, 413	0	12, 413	169, 700	83	12. 00
13. 00	31 01	AGGREGATE-NEONATAL INTENSIVE	2, 423	0	2, 423	169, 700	8	13. 00
13.00	31.01	CARE UN	2, 423		2,423	107, 700		13.00
14. 00	50.00	DR. C	30, 000	0	30, 000	246, 400	200	14. 00
15. 00		AGGREGATE-OPERATING ROOM	1, 969, 952			0	O	15. 00
16.00		DR. H	28, 950		28, 950	246, 400	193	16.00
17.00	52. 00	AGGREGATE-DELIVERY ROOM &	1, 346, 475	1, 346, 475	0	0	o	17.00
		LABOR ROOM						
18. 00		DR. DU	30, 150	0	30, 150	237, 100	1	18. 00
19. 00		DR. D	1, 000					19. 00
20. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST	48, 000	0	48, 000	271, 900	240	20. 00
04 00	F4 00	I C	075 400	075 400				04.00
21. 00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	275, 100	275, 100	0	0	0	21. 00
22. 00	54 00	AGGREGATE-RADI OLOGY-DI AGNOST	4, 800	0	4, 800	271, 900	24	22. 00
22.00	34.00	I C	4, 000		4,000	271,700	27	22.00
23. 00	54. 00	DR. R	50, 625	0	50, 625	211, 500	1	23. 00
24. 00		AGGREGATE-RADI OLOGY-DI AGNOST	2, 150			0	ol	24. 00
		I C	·	·				
25.00	57. 00	AGGREGATE-CT SCAN	5, 925	5, 925	0	0	0	25.00
26.00	59. 00	DR. A	25, 500	0	25, 500	211, 500	1	26.00
27.00		DR. P	24, 760		24, 760	211, 500	184	27.00
28. 00		DR. A	900		900	211, 500	1	28. 00
29. 00		DR. F	250			211, 500	1	29. 00
30.00		AGGREGATE-CARDI OLOGY	4, 370			0	0	30. 00
31. 00		DR. F	8, 450		8, 450		1	31. 00
32. 00		DR. S	1, 800	0			1	32. 00
33. 00		DR. M	21, 700				1	33. 00
34. 00		DR. S	4, 000					34. 00
35. 00 36. 00		DR. D DR. S	1, 150 10, 200					35. 00
37. 00		DR. L	62, 500					36. 00 37. 00
38. 00		DR. M	12, 375				1	38. 00
39. 00		DR. F	49, 425				393	39. 00
40. 00		DR. A	31, 950		31, 950			
41. 00		DR. B	100, 000					41. 00
42.00		AGGREGATE-EMERGENCY	7, 744, 507			1	0	42. 00
43.00	91.00	DR. R	7, 625	0	7, 625	211, 500	61	43.00
44.00	91. 00	DR. S	336, 983	0	336, 983	211, 500	1, 995	44.00
45.00	91. 00	DR. T	379, 891	0	379, 891	211, 500	1	45.00
200.00			14, 244, 429				7, 052	200. 00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng Educati on	Share of col. 12	Insurance	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		DR. S	102	5	0		0	1. 00
2.00		DR. AN	104, 160	5, 208			Ö	2. 00
3.00	5. 00	DR. W	36, 606			o	0	3.00
4.00	13. 00	DR. H	5, 084	254	0	0	0	4. 00
5.00		DR. D	31, 115			· ·	0	5. 00
6.00		DR. DU	102	5	0		0	6.00
7.00		DR. DE	102	5	0	-	0	7. 00
8.00		DR. AW	6, 609			이	0	8. 00
9.00		DR. K	95, 378	4, 769		0	0	9. 00
10. 00	31.00	AGGREGATE-INTENSIVE CARE UNIT		0	0	⁰	0	10. 00
11. 00	31 ∩1	DR. L	_	0	0	0	o	11. 00
12. 00		AGGREGATE-NEONATAL INTENSIVE	6, 772					12. 00
50		CARE UN]				l	50
		•	•		•	. '	'	

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0058

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/25/2018 3:56 pm

						0 12/31/201/	5/25/2018 3:5	
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit		Cost of		Physician Cost	
		rdentiffer	LIIIII	Unadjusted RCE Limit	Continuing	Component Share of col.	of Malpractice Insurance	
					Educati on	12		
13. 00	1. 00	2. 00 AGGREGATE-NEONATAL INTENSIVE	8. 00 653	9.00	12. 00	13.00	14.00	13. 00
13.00	31.01	CARE UN	003	33	U	0	0	13.00
14.00		DR. C	23, 692	1, 185		0	0	14. 00
15.00		AGGREGATE-OPERATING ROOM	0	0	0	0	0	15. 00
16. 00 17. 00		DR. H AGGREGATE-DELIVERY ROOM &	22, 863	1, 143	0	0	0	16. 00 17. 00
	32.33	LABOR ROOM						
18.00		DR. DU	114	6	0	0	0	18.00
19. 00 20. 00	•	DR. D AGGREGATE-RADI OLOGY-DI AGNOST	125 31, 373		0	0	0	19. 00 20. 00
20.00	34.00	I C	31, 373	1, 307	0	0		20.00
21. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST I C	0	0	0	0	0	21. 00
22. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST I C	3, 137	157	0	0	0	22. 00
23.00	•	DR. R	102	5	-	0	0	23. 00
24. 00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST I C	0	0	0	0	0	24. 00
25. 00		AGGREGATE-CT SCAN	0	0	0	0	0	25. 00
26. 00		DR. A	102	5	0	0	0	26. 00
27. 00 28. 00		DR. P DR. A	18, 710 102	936 5		0	0	27. 00 28. 00
29. 00		DR. F	102	5	-	0	Ö	29. 00
30.00		AGGREGATE-CARDI OLOGY	0	0	0	0	0	30. 00
31. 00 32. 00	76.00	DR. F DR. S	102	5	0	0	0	31. 00 32. 00
32.00		DR. M	102 102) 5 5	0	0	0	32.00
34. 00		DR. S	119	6	0	0	Ö	34. 00
35. 00		76. 00 DR. D		5	0	0	0	35. 00
36. 00 37. 00		DR. S	102 102	5	0	0	0	36. 00 37. 00
38. 00	•	76.00 DR. L 90.30 DR. M		5	0	0	0	38. 00
39. 00	90. 50	DR. F	102 39, 961	1, 998		0	0	39. 00
40.00	•	DR. A	21, 455	1, 073		0	0	40.00
41. 00 42. 00	•	DR. B AGGREGATE-EMERGENCY	53, 688 0	2, 684 0	0	0	0	41. 00 42. 00
43. 00	•	DR. R	6, 203	310	0	0	Ö	43. 00
44. 00	•	DR. S	202, 857	10, 143		0	0	44. 00
45. 00 200. 00		DR. T	102 712, 204	5 35, 610	0	0	0	45. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
		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		
1.00		DR. S	0			5, 898		1.00
2. 00 3. 00		DR. AN DR. W		104, 160 36, 606		104, 965 0		2. 00 3. 00
4.00	13. 00		Ö	1		Ö		4. 00
5.00		DR. D	0			13, 795		5. 00
6. 00 7. 00		DR. DU DR. DE	0 0	102 102		11, 111 53, 530		6. 00 7. 00
8. 00		DR. AW	0	6, 609		21, 366		8. 00
9.00	31. 00	DR. K	0			69, 297		9. 00
10. 00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	992, 950		10. 00
11. 00 12. 00	•	DR. L AGGREGATE-NEONATAL INTENSIVE	0		0 5, 641	70, 000 5, 641		11. 00 12. 00
13. 00	31. 01	CARE UN AGGREGATE-NEONATAL INTENSIVE	0			1, 770		13. 00
		CARE UN DR. C	0					14. 00
14. 00 15. 00	•	AGGREGATE-OPERATING ROOM		- / -	6, 308 0	6, 308 1, 969, 952		14. 00 15. 00
16.00	50.00	DR. H	Ö		6, 087	6, 087		16. 00
17. 00	52. 00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	1, 346, 475		17. 00
18. 00	52.00	DR. DU	0	114	30, 036	30, 036		18. 00
19. 00	54. 00	DR. D	0	125	875	875		19. 00
20. 00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST I C	0	31, 373	16, 627	16, 627		20. 00
21. 00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	О	О	0	275, 100		21. 00
		IC	l					

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0058

							5/25/2018 3:5	
	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		
22. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST	0	3, 137	1, 663	1, 663		22. 00
		I C	_					
23. 00		DR. R	0	102	50, 523			23. 00
24.00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	0	0	0	2, 150		24. 00
05.00		I C						
25. 00	l .	AGGREGATE-CT SCAN	0	0	0	5, 925		25. 00
26. 00		DR. A	0	102				26. 00
27. 00	l .	DR. P	0	18, 710				27. 00
28. 00		DR. A	0	102	798	798		28. 00
29. 00	l .	DR. F	0	102	148			29. 00
30.00		AGGREGATE - CARDI OLOGY	0	0	0	4, 370		30.00
31.00		DR. F	0	102	8, 348			31. 00
32. 00		DR. S	0	102	1, 698			32. 00
33. 00		DR. M	0	102				33. 00
34.00		DR. S	0	119		3, 881		34. 00
35. 00		DR. D	0	102	1, 048			35. 00
36. 00		DR. S	0	102	· ·			36. 00
37. 00		DR. L	0	102				37. 00
38. 00	l .	DR. M	0	102	12, 273			38. 00
39. 00		DR. F	0	39, 961	9, 464			39. 00
40.00		DR. A	0	21, 455	· ·			40.00
41. 00		DR. B	0	53, 688		46, 312		41. 00
42. 00		AGGREGATE - EMERGENCY	0	0	0	7, 744, 507		42.00
43.00		DR. R	0	6, 203		1, 422		43. 00
44.00		DR. S	0	202, 857	134, 126			44. 00
45.00	91.00	DR. T	0	102	379, 789			45.00
200.00			0	712, 204	1, 134, 836	13, 546, 265		200.00

| Period: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0058

					o 12/31/2017	Date/Time Pre	pared:
			CAPI TAL REI	ATED COSTS		5/25/2018 3:5	6 pm
	Cook Control 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	00 707 (00	00 707 (00				4 00
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	20, 797, 638 19, 785, 715	20, 797, 638	19, 785, 715			1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 256, 733	55, 816				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	51, 134, 833	967, 347			53, 075, 554	5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	4, 847, 993 9, 245, 872	48, 702 3, 296, 628			4, 948, 650 15, 702, 885	6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 634, 631	2, 436			1, 639, 384	8. 00
9.00	00900 HOUSEKEEPI NG	5, 605, 505	352, 239			6, 325, 696	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	3, 396, 234 924, 147	438, 722 74, 868			4, 269, 982 1, 082, 847	10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	3, 303, 259	179, 483			3, 675, 806	1
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 310, 257	518, 865			9, 341, 242	1
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	6, 416, 007 1, 968	175, 853 80, 304			6, 760, 780 158, 669	
17. 00	01700 SOCIAL SERVICE	3, 765, 906	139, 428			4, 065, 274	1
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD	1, 908, 503	0	1	- '	1, 927, 300	
22. 00 23. 00	02200 &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	5, 556, 719 111, 030	257, 852 60, 027			6, 091, 768 229, 052	1
23. 01	02301 PARAMED ED	0	0			0	1
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	45 (00 504	2 202 207	0 (00 450	205 504	F0 FF0 400	00.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	45, 680, 524 8, 666, 413	3, 880, 987 459, 855			53, 559, 190 9, 619, 640	1
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	7, 999, 461	466, 356			8, 969, 528	
40.00	04000 SUBPROVI DER - I PF	1, 627, 769	204, 600			2, 038, 839	1
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	1, 630, 806 1, 807, 720	189, 195 74, 287			2, 011, 892 1, 966, 621	41. 00 43. 00
10. 00	ANCILLARY SERVICE COST CENTERS	1,007,720	7 1, 207	, 0, 0, 0	10, 711	1, 700, 021	10.00
50.00	05000 OPERATING ROOM	29, 060, 707	1, 733, 176			32, 576, 952	1
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	6, 147, 007 13, 121, 135	590, 781 881, 171			7, 339, 527 14, 922, 765	52. 00 54. 00
57. 00	05700 CT SCAN	1, 605, 989	46, 186			1, 706, 527	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	513, 533	69, 916			649, 963	1
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 585, 018 11, 992, 944	274, 339 177, 918			2, 130, 602 12, 363, 358	1
60. 01	06001 BLOOD LABORATORY	0	0			0	60. 01
65. 00	06500 RESPIRATORY THERAPY	4, 838, 360	118, 876			5, 101, 253	1
66. 00 66. 01	06600 PHYSI CAL THERAPY 06602 PHYSI CAL THERAPY EAST BANK	3, 286, 921 1, 265, 037	209, 553 0			3, 721, 137 1, 274, 688	1
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	487, 871	0			491, 738	
67.00	06700 OCCUPATI ONAL THERAPY	2, 005, 707	103, 696			2, 224, 395	1
67. 10 68. 00	06701 OCCUPATIONAL THERAPY LIVING CENTER 06800 SPEECH PATHOLOGY	309, 446 1, 158, 557	0 6, 372		, ,	311, 765 1, 180, 138	1
68. 10	06801 SPEECH THERAPY LIVING CENTER	218, 064	0, 372			219, 818	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C		0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 817, 377 24, 059, 019	0		-	10, 817, 377 24, 059, 019	
73. 00	07300 DRUGS CHARGED TO PATIENTS	26, 984, 374	0	Č		27, 044, 578	73. 00
76. 00	03020 CARDI OLOGY	3, 416, 029	121, 844	115, 916	23, 311	3, 677, 100	76. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	O	0		ol	0	90.00
90. 10	09001 FAMILY PRACTICE CLINIC	o o	0	C		0	
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	978, 530	162, 932			1, 304, 068	
90. 50 91. 00	09004 SLEEP DI SORDERS CLINIC 09100 EMERGENCY	924, 173 19, 373, 325	0 571, 004	543, 221		930, 905 20, 590, 511	90. 50 91. 00
92. 00		17, 070, 020	071,001	010,221	102, 701	0	1
440.00	SPECIAL PURPOSE COST CENTERS	1					1440 00
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	379, 564, 766	16, 991, 614	16, 164, 875	1, 326, 530	372, 098, 783	113.00
110.00	NONREI MBURSABLE COST CENTERS	077,001,700	10, 771, 011	10, 101, 070	1, 020, 000	072, 070, 100	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	76, 804			149, 871	1
	19300 NONPALD WORKERS 19301 HEALTH PROPERTIES	651, 646 3, 854, 754	3, 627, 557 0	3, 451, 056		7, 733, 233 3, 872, 387	
	19303 LEIGHTON CENTER	0,004,734	101, 663	1		198, 380	193. 40
	19305 WELLNESS CENTER	2, 852, 538	0	C		2, 868, 928	
	19308 UNUSED SPACE 19309 OCCUPATIONAL HEALTH	0	0		0		193. 80 193. 90
	19310 RESEARCH AND PROTOCOL		0		0	0	193. 91
193. 92	2 19311 CCOP	o	0	l c	o	0	193. 92

Health Financial Systems	MEMORIAL HOSPITAL O	F SOUTH BEND,	I NC	In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Period: From 01/01/2017	Worksheet B Part I		
				To 12/31/2017	Date/Time Pre 5/25/2018 3:5	pared: <u>6 pm</u>	
		CAPI TAL REI	LATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
	0	1. 00	2.00	4. 00	4A		
193. 93 19312 REASEARCH ADMIN	288, 011	0		0 2, 122	290, 133	193. 93	
200.00 Cross Foot Adjustments					0	200. 00	
201.00 Negative Cost Centers		0		0	0	201. 00	
202.00 TOTAL (sum lines 118 through 201)	387, 211, 715	20, 797, 638	19, 785, 71	5 1, 365, 649	387, 211, 715	202. 00	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: | 5/25/2018 3:56 pm

						5/25/2018 3:5	6 pm
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	OFNEDAL CERVILOE COCT CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
4 00	GENERAL SERVICE COST CENTERS			I			4 00
1.00	00100 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 ADMINISTRATIVE & GENERAL	53, 075, 554					5. 00
6.00	00600 MAINTENANCE & REPAIRS	786, 063	5, 734, 713				6. 00
7.00	00700 OPERATION OF PLANT	2, 494, 309	958, 402	19, 155, 596			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	260, 406	708				8. 00
9. 00	00900 HOUSEKEEPI NG	1, 004, 799	102, 404			7, 843, 593	9. 00
10. 00	01000 DI ETARY	678, 261	127, 546			182, 167	10.00
11. 00	01100 CAFETERI A	172, 004	21, 766			0	11.00
						9. 498	
13.00	01300 NURSI NG ADMI NI STRATI ON	583, 880	52, 180				13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY	1, 483, 800	150, 845			220, 754	14.00
15. 00	01500 PHARMACY	1, 073, 909	51, 124		0	20, 184	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	25, 204	23, 346		0	46, 135	16. 00
	01700 SOCIAL SERVICE	645, 744	40, 535		0	15, 011	17. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	306, 140	0	0	0	0	21. 00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	967, 641	74, 963	300, 643	0	0	22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	36, 384	17, 451	69, 988	105, 992	0	23. 00
23. 01	02301 PARAMED ED	o	0	0	0	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>					
30.00	03000 ADULTS & PEDIATRICS	8, 507, 586	1, 128, 285	4, 525, 047	564, 151	3, 453, 362	30.00
31. 00	03100 NTENSI VE CARE UNI T	1, 528, 022	133, 690				31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	1, 424, 756	135, 580			133, 317	31. 01
40. 00	04000 SUBPROVI DER - I PF	323, 857	59, 482			257, 221	
41. 00	l i	1				265, 872	
	04100 SUBPROVI DER - I RF	319, 577	55, 003				41.00
43. 00	04300 NURSERY	312, 386	21, 597	86, 615	1, 365	89, 048	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	5, 174, 653	503, 872			1, 044, 913	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 165, 840	171, 753		· ·		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 370, 392	256, 176	1, 027, 403	13, 790	405, 804	54.00
57.00	05700 CT SCAN	271, 072	13, 427	53, 850	90, 082	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	103, 243	20, 326	81, 518	6, 852	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	338, 433	79, 756			264, 599	59. 00
60.00	06000 LABORATORY	1, 963, 845	51, 725			89, 218	
60. 01	06001 BLOOD LABORATORY	0	0.,,20	0		0	60. 01
65. 00	06500 RESPIRATORY THERAPY	810, 303	34, 560	1	_	_	65. 00
		1	60, 922				
66.00	06600 PHYSI CAL THERAPY	591, 080				62, 334	66.00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	202, 477	0	0	0	0	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	78, 110	0	0	0	0	66. 10
67. 00	06700 OCCUPATI ONAL THERAPY	353, 332	30, 147	120, 904	0	16, 792	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	49, 522	0	0	0	0	67. 10
68.00	06800 SPEECH PATHOLOGY	187, 458	1, 853	7, 430	0	2, 629	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	34, 917	0	0	0	0	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 718, 275	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 821, 631	0	٥	0	Ö	72. 00
	07300 DRUGS CHARGED TO PATIENTS	4, 295, 869	0	Ö	0	Ö	73. 00
	03020 CARDI OLOGY	584, 085	35, 423				76.00
76.00		304, 003	30, 423	142, 004	U	0	76.00
00.00	OUTPATIENT SERVICE COST CENTERS			1 0			00.00
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	207, 143	47, 368	189, 971	707	108, 130	90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	147, 869	0	0	714	0	90. 50
91.00	09100 EMERGENCY	3, 270, 679	166, 003	665, 763	260, 761	336, 601	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			•		
113.00	11300 NTEREST EXPENSE						113. 00
118.00		50, 674, 956	4, 628, 218	14, 717, 955	1, 902, 854	7, 580, 435	
	NONREI MBURSABLE COST CENTERS	00/07/1/700	1,020,210	1 17 1 17 7 5 5	177027001	7,000,100	1.10.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	23, 806	22, 329	89, 550	0	0	190. 00
	19300 NONPALD WORKERS	1, 228, 378	1, 054, 610	4, 229, 557	445	263, 158	
	19301 HEALTH PROPERTIES	615, 105	0	0	0		193. 10
	19303 LEI GHTON CENTER	31, 511	29, 556	118, 534			193. 40
193. 50	19305 WELLNESS CENTER	455, 712	0	0	39	0	193. 50
193. 80	19308 UNUSED SPACE	0	0	0	0	0	193. 80
193. 90	19309 OCCUPATI ONAL HEALTH	0	0	0	0	0	193. 90
	19310 RESEARCH AND PROTOCOL	l ol	0	0	0	0	193. 91
	19311 CCOP		0	n	n		193. 92
	19312 REASEARCH ADMIN	46, 086	n	l n	n		193. 93
200.00		15, 500	O				200. 00
201.00			^	^	^	^	200.00
		52 075 554	U 5 721 712	10 155 504	1 000 220		
202. 00	TOTAL (sum lines 118 through 201)	53, 075, 554	5, 734, 713	19, 155, 596	1, 903, 338	7, 843, 593	₁ 202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

					72/31/2017	5/25/2018 3:5	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI ON	SERVICES &		
		10.00	44.00	10.00	SUPPLY	45.00	
CEN	EDAL CEDULCE COCT CENTEDO	10. 00	11. 00	13. 00	14. 00	15. 00	
	ERAL SERVICE COST CENTERS OO NEW CAP REL COSTS-BLDG & FIXT						1.00
	00 NEW CAP REL COSTS-BEDG & TTXT						2.00
	OO EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00 ADMINISTRATIVE & GENERAL						5. 00
	00 MAI NTENANCE & REPAIRS						6. 00
	OO OPERATION OF PLANT						7. 00
	00 LAUNDRY & LINEN SERVICE						8.00
	00 HOUSEKEEPI NG						9. 00
	00 DI ETARY	5, 769, 485					10.00
	00 CAFETERI A	0, 707, 409	1, 363, 909			•	11.00
	OO NURSI NG ADMI NI STRATI ON	o	36, 207			•	13. 00
	00 CENTRAL SERVICES & SUPPLY	0	31, 404		11, 840, 968		14. 00
1	OO PHARMACY	0	50, 937		0.1,0.10,700	8, 161, 971	1
1	00 MEDICAL RECORDS & LIBRARY	o	00, 707		0	0	1
	00 SOCIAL SERVICE	0	33, 241	15, 897	0	Ō	1
	00 I&R SERVICES-SALARY & FRINGES APPRVD	o	C C		0	ō	
	00 I&R SERVICES-OTHER PRGM COSTS APPRVD	o	36, 998	sl ol	0	Ō	1
	00 PARAMED ED PRGM-(SPECIFY)	o	2, 519		0	ō	1
	01 PARAMED ED	o	_, C	ol ol	0	Ō	1
	ATIENT ROUTINE SERVICE COST CENTERS	-1					
	00 ADULTS & PEDIATRICS	4, 748, 657	390, 132	1, 936, 305	0	367	30.00
31. 00 031	OO INTENSIVE CARE UNIT	537, 783	62, 783		0	87	31.00
	60 NEONATAL INTENSIVE CARE UNIT	0	58, 656		0	58	31. 01
40.00 040	00 SUBPROVIDER - IPF	244, 668	17, 463		0	0	1
	00 SUBPROVIDER - IRF	238, 377	13, 851		0	313	41.00
	00 NURSERY	0	14, 132		0	0	43.00
ANC	ILLARY SERVICE COST CENTERS						1
50. 00 050	OO OPERATING ROOM	0	134, 221	626, 642	0	6, 345	50.00
52. 00 052	OO DELIVERY ROOM & LABOR ROOM	0	42, 747	264, 060	0	0	52. 00
54.00 054	00 RADI OLOGY-DI AGNOSTI C	O	88, 501	115, 889	0	1, 921	54.00
57. 00 057	00 CT SCAN	o	10, 105	o o	0	0	57. 00
58. 00 058	OO MAGNETIC RESONANCE IMAGING (MRI)	O	C	o	0	14	58. 00
59. 00 059	OO CARDI AC CATHETERI ZATI ON	0	9, 999	36, 541	0	356	59.00
60.00 060	00 LABORATORY	0	37, 486	o	0	0	60.00
60. 01 060	01 BLOOD LABORATORY	O	C	o	0	0	60. 01
65. 00 065	00 RESPI RATORY THERAPY	O	34, 495	18	0	1, 841	65.00
66. 00 066	00 PHYSI CAL THERAPY	o	23, 242	13, 880	0	193	66.00
66. 01 066	02 PHYSI CAL THERAPY EAST BANK	o	10, 534	l o	0	0	66. 01
66. 10 066	01 PHYSICAL THERAPY LIVING CENTER	o	3, 721	0	0	0	66. 10
67. 00 067	00 OCCUPATIONAL THERAPY	o	16, 625	o	0	0	67. 00
67. 10 067	01 OCCUPATIONAL THERAPY LIVING CENTER	o	2, 650	o	0	0	67. 10
68. 00 068	00 SPEECH PATHOLOGY	o	8, 381	0	0	29	68. 00
68. 10 068	01 SPEECH THERAPY LIVING CENTER	o	1, 528	8 o	0	0	68. 10
70. 00 070	00 ELECTROENCEPHALOGRAPHY	o	C	o	0	0	70.00
71. 00 071	OO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0	6, 986, 171		71. 00
72. 00 072	OO IMPL. DEV. CHARGED TO PATIENTS	0	C	0	4, 854, 797	0	72. 00
	OO DRUGS CHARGED TO PATIENTS	0	C	0	0	8, 145, 064	73. 00
76. 00 030	20 CARDI OLOGY	0	16, 955	29, 525	0	106	76. 00
	PATIENT SERVICE COST CENTERS						
	00 CLINIC	0	C	0	0	0	1
	01 FAMILY PRACTICE CLINIC	0	C	0	0	0	
	02 HEMATOLOGY ONCOLOGY CLINIC	0	7, 025		0	71	1
	04 SLEEP DISORDERS CLINIC	0	6, 751		0	0	1
	OO EMERGENCY	0	96, 134	422, 979	0	5, 206	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	CLAL PURPOSE COST CENTERS						4
	00 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 769, 485	1, 299, 423	4, 534, 793	11, 840, 968	8, 161, 971	118. 00
	REIMBURSABLE COST CENTERS						4
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0		190. 00
	00 NONPALD WORKERS	0	4, 069		0		193. 00
193. 10 193	01 HEALTH PROPERTIES	0	28, 200	20, 084	0		193. 10
	03 LEI GHTON CENTER	0	C	0	0		193. 40
	05 WELLNESS CENTER	0	29, 978	0	0		193. 50
	08 UNUSED SPACE	0	C	0	0		193. 80
	09 OCCUPATI ONAL HEALTH	0	C	0	0		193. 90
	10 RESEARCH AND PROTOCOL	0	C	0	0		193. 91
193. 92 193		0	C	0	0		193. 92
	12 REASEARCH ADMIN	0	2, 239	7, 198	0	0	193. 93
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	C	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	5, 769, 485	1, 363, 909	4, 566, 840	11, 840, 968	8, 161, 971	<u> </u> 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

| Period: | Worksheet B | From 01/01/2017 | Part | | Part | | | Date/Time Prepared: | 5/25/2018 3:56 pm

			LUTERNO	DECLESIVE 1	5/25/2018 3:5	
			INTERNS &	RESIDENTS		
Cost Center Description		SOCIAL SERVICE	SERVI CES-SALAR		PARAMED ED	
	RECORDS & LI BRARY		Y & FRINGES	PRGM COSTS	PRGM	
	16.00	17. 00	21.00	22. 00	23. 00	
GENERAL SERVI CE COST CENTERS				T		4 00
1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT 2.00 OO200 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 MAI NTENANCE & REPAI RS						6.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A						11. 00
13. 00 O1300 NURSI NG ADMINI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00 01500 PHARMACY						15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	346, 985					16. 00
17. 00 01700 SOCI AL SERVI CE	0	4, 978, 268				17. 00
21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 22. 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	2, 233, 440	7 472 012		21. 00 22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		7, 472, 013	461, 386	23. 00
23. 01 02301 PARAMED ED	0	0			,	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 NTENSI VE CARE UNI T	56, 799 4, 344	3, 260, 752 235, 731	1, 476, 885 6, 740	4, 940, 941 22, 549	0	30. 00 31. 00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	1, 520	129, 346		22, 549	0	31.00
40. 00 04000 SUBPROVI DER - I PF	3, 041	461, 716	Ö	Ö	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	1, 412	116, 792	0	o	0	41. 00
43. 00 04300 NURSERY	1, 086	0	0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 O5000 OPERATING ROOM	79, 715	1, 322	103, 626	346, 683	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	12, 224	0	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	59, 949	131, 824	10, 110	33, 823	0	54.00
57. 00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 O5900 CARDIAC CATHETERIZATION	0) 0	0	0	0	58. 00 59. 00
60. 00 06000 LABORATORY	26, 933	0	Ö	o	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	o	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0	29, 487	98, 650	0	65. 00
66. 00 06600 PHYSI CAL THERAPY 66. 01 06602 PHYSI CAL THERAPY EAST BANK	37, 468 0) 0	0	0	0	66. 00 66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	o	0	Ö	o	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	9, 231	0	0	o	0	67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67. 10
68. 00 06800 SPEECH PATHOLOGY 68. 10 06801 SPEECH THERAPY LIVING CENTER	4, 235 0	0	0	0	0	68. 00 68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	Ö	0	o o	o	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	О	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATLENTS 76. 00 03020 CARDI OLOGY	25, 087	0	58, 132	194, 481	0	73. 00 76. 00
OUTPATIENT SERVICE COST CENTERS	23,007		30, 132	174, 401		70.00
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 10 09001 FAMILY PRACTICE CLINIC	0	110 020	422, 087	1, 412, 101	0	90. 10
90.30 O9002 HEMATOLOGY ONCOLOGY CLINIC 90.50 O9004 SLEEP DISORDERS CLINIC	0	118, 939 0	3, 370	11, 274	0	90. 30 90. 50
91. 00 09100 EMERGENCY	36, 165	509, 622	106, 996	357, 958	461, 386	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	-		·	·		92. 00
SPECIAL PURPOSE COST CENTERS			Г			
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	346, 985	4, 978, 268	2, 217, 433	7, 418, 460	461, 386	113.00
NONREI MBURSABLE COST CENTERS	340, 763	4, 970, 200	2, 217, 433	7, 418, 400	401, 300	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
193. 00 19300 NONPAI D WORKERS	0	0	16, 007	53, 553		193. 00
193. 10 19301 HEALTH PROPERTIES	0	0	0	0		193. 10
193. 40 19303 LEI GHTON CENTER 193. 50 19305 WELLNESS CENTER	0) 	0	0		193. 40 193. 50
193. 80 19308 UNUSED SPACE	Ö	Ö	Ö	o		193. 80
193. 90 19309 OCCUPATI ONAL HEALTH	0	0	0	О		193. 90
193. 91 19310 RESEARCH AND PROTOCOL	0	0	0	0		193. 91
193. 92 19311 CCOP 193. 93 19312 REASEARCH ADMIN	0	0 	0	0		193. 92 193. 93
200.00 Cross Foot Adjustments			0	o		200. 00
	•	-		-1		

Health Financial Systems	MEMORIAL HOSPITAL C	OF SOUTH BEND,	INC	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
				From 01/01/2017	Part	
			-	Γo 12/31/2017	Date/Time Pre	
					5/25/2018 3:5	6 pm
			INTERNS 8	RESI DENTS		
Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALA	SERVI CES-OTHER	PARAMED ED	
	RECORDS &		Y & FRINGES	PRGM COSTS	PRGM	
	LI BRARY					
	16.00	17. 00	21.00	22. 00	23. 00	

0 346, 985

4, 978, 268

0 2, 233, 440

7, 472, 013

0 201. 00 461, 386 202. 00

201. 00 202. 00

Negative Cost Centers TOTAL (sum lines 118 through 201)

| Period: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0058

				To	12/31/2017	Date/Time Prepared:
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	5/25/2018 3:56 pm
				Residents Cost		
				& Post Stepdown		
				Adjustments		
	GENERAL SERVICE COST CENTERS	23. 01	24. 00	25. 00	26. 00	
1.00	00100 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 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS					5. 00 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
11. 00	01100 CAFETERI A					11. 00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD					21.00
22. 00 23. 00	02200 1 &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)					22.00
23. 01	02301 PARAMED ED	0				23. 01
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		00 540 450		00 400 (00	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	88, 548, 459 13, 327, 049		82, 130, 633 13, 297, 760	30.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	o	11, 795, 621	1	11, 795, 621	31. 01
40.00	04000 SUBPROVI DER - I PF	0	3, 707, 625	1	3, 707, 625	40.00
41. 00	04100 SUBPROVI DER - I RF	0	3, 374, 253	i I	3, 374, 253	41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	<u> </u>	2, 574, 852	<u> </u>	2, 574, 852	43. 00
50.00	05000 OPERATING ROOM	0	43, 261, 755	-450, 309	42, 811, 446	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	10, 158, 614	1	10, 158, 614	52.00
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	0	19, 438, 347 2, 145, 063	1	19, 394, 414 2, 145, 063	54. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	861, 916	l l	861, 916	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	3, 180, 152		3, 180, 152	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	14, 740, 009	0	14, 740, 009 0	60.00
65. 00	06500 RESPIRATORY THERAPY	0	6, 258, 624	-	6, 130, 487	65. 00
66.00	06600 PHYSI CAL THERAPY	0	4, 754, 585		4, 754, 585	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	1, 487, 699		1, 487, 699	66. 01
66. 10 67. 00	06601 PHYSICAL THERAPY LIVING CENTER 06700 OCCUPATIONAL THERAPY	0	573, 569 2, 771, 426		573, 569 2, 771, 426	66. 10
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	Ö	363, 937	1	363, 937	67. 10
68. 00	06800 SPEECH PATHOLOGY	0	1, 392, 153	1	1, 392, 153	68. 00
68. 10 70. 00	06801 SPEECH THERAPY LIVING CENTER 07000 ELECTROENCEPHALOGRAPHY	0	256, 263	0	256, 263 0	68. 10
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	19, 521, 823	· ·	19, 521, 823	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	32, 735, 447		32, 735, 447	72. 00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 CARDI OLOGY	0	39, 485, 511 4, 762, 958		39, 485, 511 4, 510, 345	73. 00 76. 00
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	4, 702, 730	-252, 015	4, 510, 345	70.00
90.00	09000 CLI NI C	0	0	· ·	0	90.00
90. 10 90. 30	09001 FAMILY PRACTICE CLINIC 09002 HEMATOLOGY ONCOLOGY CLINIC	0	1, 834, 188 2, 039, 413		0 2, 024, 769	90. 10
90. 50	09004 SLEEP DISORDERS CLINIC	0	1, 086, 239	1	1, 086, 239	90. 50
91. 00	09100 EMERGENCY	0	27, 286, 764	1	26, 821, 810	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0		92. 00
113.00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE					113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	363, 724, 314	-9, 635, 893	354, 088, 421	118. 00
100.00	NONREI MBURSABLE COST CENTERS		205 554		205 554	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19300 NONPAID WORKERS		285, 556 14, 587, 775		285, 556 14, 518, 215	190. 00 193. 00
	19301 HEALTH PROPERTIES	o	4, 535, 776		4, 535, 776	193. 10
	19303 LEI GHTON CENTER	o	377, 981		377, 981	193. 40
	19305 WELLNESS CENTER 19308 UNUSED SPACE	0	3, 354, 657 0	1	3, 354, 657 0	193. 50 193. 80
	19308 UNUSED SPACE 19309 OCCUPATIONAL HEALTH		0	0	ol	193. 80
193. 91	19310 RESEARCH AND PROTOCOL	o	0	o	o	193. 91
	19311 CCOP	0	245 454	0	245 454	193. 92 193. 93
193. 93 200. 00	19312 REASEARCH ADMIN Cross Foot Adjustments		345, 656 0		345, 656 0	200. 00
	1 1 ray documente	, <u> </u>		, 9	٥	1200.00

Health Financial Systems	MEMORIAL HOSPITAL O	F SOUTH BEND,	I NC	In Lie	u of Form CMS-2	552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Peri od:	Worksheet B	
				From 01/01/2017 To 12/31/2017	Part Date/Time Prep	nared.
					5/25/2018 3:56	
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		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	387, 211, 715	-9, 705, 45	3 377, 506, 262	:	202. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0058

				To	12/31/2017	Date/Time Pre 5/25/2018 3:5	
			CAPI TAL REI	LATED COSTS		372372010 3.3	О рііі
	Cost Center Description	Di rectly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	cost denter bescription	Assigned New	FLXT	EQUI P	Subtotai	BENEFI TS	
		Capital Related Costs				DEPARTMENT	
		0	1.00	2.00	2A	4. 00	
1 00	GENERAL SERVICE COST CENTERS						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	0	55, 816		108, 916		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	0	967, 347		1, 887, 627	4, 232	5. 00
6. 00 7. 00	00700 OPERATION OF PLANT	0	48, 702 3, 296, 628		95, 034 6, 432, 856		6. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	2, 436	2, 317	4, 753		8. 00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	352, 239		687, 340		9.00
10. 00 11. 00	01100 CAFETERI A	0	438, 722 74, 868		856, 098 146, 093		10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	0	179, 483	170, 750	350, 233	1, 779	13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	518, 865		1, 012, 485		14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	175, 853 80, 304		343, 150 156, 701	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	139, 428		272, 072		17. 00
21. 00 22. 00	02100 &R SERVI CES-SALARY & FRINGES APPRVD 02200 &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0 257, 852	-	0 503, 158	.,	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	60, 027		117, 133		23. 00
23. 01	02301 PARAMED ED	0	0		0		23. 01
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	3, 880, 987	3, 692, 158	7, 573, 145	24, 422	30. 00
31. 00	03100 NTENSI VE CARE UNI T	0	459, 855		897, 335		31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	466, 356		910, 021	4, 786	31. 01
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	204, 600 189, 195		399, 245 369, 184		40. 00 41. 00
43. 00	04300 NURSERY	0	74, 287		144, 960		43. 00
	ANCILLARY SERVICE COST CENTERS	_					
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	1, 733, 176 590, 781		3, 382, 023 1, 152, 817		50. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	881, 171		1, 719, 468		54. 00
57. 00	05700 CT SCAN	0	46, 186		90, 124		57. 00
58. 00 59. 00	05800 MAGNETI C RESONANCE MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	69, 916 274, 339		136, 430 535, 329		58. 00 59. 00
60.00	06000 LABORATORY	0	177, 918		347, 180		60. 00
60. 01	06001 BLOOD LABORATORY	0	0	-	0	_	60. 01
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	118, 876 209, 553		231, 968 408, 910		65. 00 66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	0		0		66. 01
66. 10	06601 PHYSI CAL THERAPY LIVING CENTER	0	102 (0)	0 (50	0	308	66. 10
67. 00 67. 10	06700 OCCUPATIONAL THERAPY 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	103, 696 0	98, 650 0	202, 346 0	1, 302 185	67. 00 67. 10
68. 00	06800 SPEECH PATHOLOGY	0	6, 372	6, 062	12, 434	729	68. 00
	06801 SPEECH THERAPY LIVING CENTER	0	0	0	0	140	68. 10
71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	70. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS 03020 CARDI OLOGY	0	0 121, 844	0 115, 916	0 237, 760	4, 798 1, 858	73. 00 76. 00
70.00	OUTPATIENT SERVICE COST CENTERS	0	121, 044	113, 710	237, 700	1,030	70.00
90.00	09000 CLINIC	0	0	- 1	0	_	90.00
90. 10 90. 30	O9001 FAMILY PRACTICE CLINIC O9002 HEMATOLOGY ONCOLOGY CLINIC	0	0 162, 932	-	0 317, 936	0 606	90. 10 90. 30
90. 50	09004 SLEEP DI SORDERS CLINIC	0	0	0	0	537	90. 50
91.00	09100 EMERGENCY	0	571, 004	543, 221	1, 114, 225	8, 206	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS				O		92. 00
113.00	11300 INTEREST EXPENSE						113. 00
118.00	3 /	0	16, 991, 614	16, 164, 875	33, 156, 489	105, 799	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	76, 804	73, 067	149, 871	0	190. 00
193.00	19300 NONPALD WORKERS	0	3, 627, 557		7, 078, 613	237	193. 00
	19301 HEALTH PROPERTIES	0	0	0	0		193. 10
	19303 LEIGHTON CENTER 19305 WELLNESS CENTER	0	101, 663 0	96, 717 0	198, 380 0		193. 40 193. 50
	19308 UNUSED SPACE		0		0		193. 80
	19309 OCCUPATIONAL HEALTH	0	0	0	0		193. 90
	19310 RESEARCH AND PROTOCOL 19311 CCOP	0	0	0	0		193. 91 193. 92
	19311 REASEARCH ADMIN		0	Ö	0		193. 93
		<u>'</u>		<u> </u>	<u> </u>		

Heal th Fin	ancial Systems ME	MORIAL HOSPITAL O	F SOUTH BEND,	I NC	In Lie	u of Form CMS-:	2552-10
ALLOCATI ON	N OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
					From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/25/2018 3:5	pared: 6 pm
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New Capital	FIXT	EQUI P		BENEFITS 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 through 201)	0	20, 797, 638	19, 785, 71	5 40, 583, 353	108, 916	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0058

Peri od: Worksheet B From 01/01/2017 Part II To 12/31/2017 Date/Time Prepared:

5/25/2018 3:56 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS **PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 1, 891, 859 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 28, 019 123, 501 6.00 00700 OPERATION OF PLANT 88, 910 7.00 20,640 6, 544, 331 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 9, 282 15 970 15, 020 8.00 2. 205 00900 HOUSEKEEPI NG 140, 310 868, 289 9.00 35, 816 9 00 2, 747 10.00 01000 DI ETARY 24, 177 174, 759 10.00 20, 166 11.00 01100 CAFETERI A 6, 131 469 29,823 0 Ω 11.00 01300 NURSING ADMINISTRATION 1, 051 20.812 71, 495 0 13 00 13 00 1.124 14.00 01400 CENTRAL SERVICES & SUPPLY 52,890 3, 249 206, 683 24, 438 14.00 15.00 01500 PHARMACY 38, 280 1, 101 70,049 0 2, 234 15.00 01600 MEDICAL RECORDS & LIBRARY 0 5, 107 16, 00 898 31, 988 503 16,00 01700 SOCIAL SERVICE 23.018 17.00 873 55, 539 1, 662 17.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 10, 912 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 102, 712 0 22.00 34, 492 1,614 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 1, 297 376 0 23.00 23.00 23, 911 836 02301 PARAMED ED 23.01 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 303, 234 24, 296 1, 545, 939 4, 452 382, 290 30.00 22, 419 03100 INTENSIVE CARE UNIT 2, 879 31.00 54, 466 183, 177 141 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 50, 785 2, 920 185, 767 52 14, 758 31.01 28, 474 40.00 04000 SUBPROVIDER - IPF 11,544 1, 281 81,500 0 40.00 04100 SUBPROVI DER - I RF 11, 391 1, 185 437 29, 432 41.00 75.363 41.00 04300 NURSERY 9, 858 43.00 11, 13₅ 465 <u>29, 59</u>1 11 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 184, 451 10, 851 690, 387 5, 064 115, 672 50.00 05200 DELIVERY ROOM & LABOR ROOM 235, 330 52.00 41, 556 3, 699 1.016 38, 182 52.00 05400 RADI OLOGY-DI AGNOSTI C 84.493 351, 003 54.00 5, 517 109 44, 923 54.00 57.00 05700 CT SCAN 9,662 289 18, 397 711 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 3,680 438 27,850 54 0 58.00 Ol 05900 CARDIAC CATHETERIZATION 59 00 12 063 1 718 109 279 29, 291 59 00 06000 LABORATORY 0 60.00 70,001 1, 114 70,871 9,876 60.00 06001 BLOOD LABORATORY 0 60.01 60.01 0 65.00 06500 RESPIRATORY THERAPY 28.883 744 47.353 1.042 65.00 06600 PHYSI CAL THERAPY 66.00 21, 069 1, 312 83, 473 6, 900 66.00 66.01 06602 PHYSICAL THERAPY EAST BANK 7, 217 C 0 0 66.01 06601 PHYSICAL THERAPY LIVING CENTER 66.10 2,784 C 0 0 66.10 67 00 06700 OCCUPATI ONAL THERAPY 12, 595 1,859 649 41, 306 67 00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 1,765 C C Ω 67.10 06800 SPEECH PATHOLOGY 2, 538 0 291 68.00 6.682 40 68.00 06801 SPEECH THERAPY LIVING CENTER 1, 245 0 0 68.10 68.10 0 0 07000 ELECTROENCEPHALOGRAPHY 70 00 0 70 00 Ω 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 61, 248 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 136, 222 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 153, 126 Λ 0 73.00 Ω 03020 CARDI OLOGY 48, 535 0 76.00 20,820 763 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09001 FAMILY PRACTICE CLINIC 90.10 0 90.10 0 C 0 90.30 09002 HEMATOLOGY ONCOLOGY CLINIC 7.384 1,020 64.902 6 11, 970 90 30 09004 SLEEP DISORDERS CLINIC 5, 271 90.50 90.50 91 00 09100 EMERGENCY 116, 583 3, 575 227, 452 2 058 37, 262 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 113.00 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 806, 289 99, 671 5, 028, 252 15, 016 839, 157 118. 00 118.00 NONREI MBURSABLE COST CENTERS

190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 849 481 30, 594 0 190, 00 193. 00 19300 NONPALD WORKERS 43, 786 22, 712 1, 444, 989 29, 132 193. 00 0 193. 10 193. 10 19301 HEALTH PROPERTIES 21, 925 0 C 193. 40 19303 LEI GHTON CENTER 1, 123 637 40, 496 0 0 193, 40 193. 50 19305 WELLNESS CENTER 0 193. 50 16, 244 0 0 0 193. 80 19308 UNUSED SPACE 0 0 0 0 193. 80 193. 90 19309 OCCUPATIONAL HEALTH 0 0 193, 90 0 C 0 193. 91 19310 RESEARCH AND PROTOCOL 0 C 0 193. 91 193. 92 19311 CCOP 0 0 0 193. 92 0 0 193. 93 19312 REASEARCH ADMIN 0 0 0 193. 93 1.643 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 1, 891, 859 123, 501 6, 544, 331 15, 020 868, 289 202. 00 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/25/2018 3:56 pm

) 12/31/201/	5/25/2018 3:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMINI STRATION	SERVICES &		
	10.00	11. 00	13. 00	SUPPLY 14. 00	15. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
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 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 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	1, 079, 354					10. 00
11. 00 01100 CAFETERI A	0	183, 521				11. 00
13. 00 O1300 NURSING ADMINISTRATION	0	4, 872				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	4, 226		1, 305, 508		14. 00
15. 00 01500 PHARMACY	0	6, 854	0	0	461, 797	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
17. 00 01700 SOCIAL SERVICE	0	4, 473	1, 571	0	0	17. 00
21. 00 02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRVD	0	4, 978		0	0	22. 00
23. 00 02300 PARAMED ED PRGM- (SPECIFY)	0	339	1	0	0	23. 00
23. 01 02301 PARAMED ED	0	0	0	0	0	23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	888, 379	E2 404	191, 374	0	21	30.00
	100, 608	52, 494 8, 448		0	5	31.00
31.00 03100 INTENSIVE CARE UNIT 31.01 02060 NEONATAL INTENSIVE CARE UNIT	100, 608	8, 448 7, 892		0	3	31.00
40. 00 04000 SUBPROVI DER - I PF	45, 772	2, 350		0	0	40.00
41. 00 04100 SUBPROVI DER - 1 RF	44, 595	1, 864		0	18	41.00
43. 00 04300 NURSERY	44, 373	1, 902		0		43.00
ANCI LLARY SERVI CE COST CENTERS	o _l	1, 702	.] 0, 103	0	0	43.00
50. 00 05000 OPERATING ROOM	O	18, 060	61, 935	0	359	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	o	5, 752		0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	11, 908		0	109	54.00
57. 00 05700 CT SCAN	0	1, 360		0	0	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 550		0	1	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	1, 345	3, 612	0	20	59.00
60. 00 06000 LABORATORY	o	5, 044		0	0	60.00
60. 01 06001 BLOOD LABORATORY	o	0	1	0	Ō	60. 01
65. 00 06500 RESPIRATORY THERAPY	o	4, 641	2	0	104	65. 00
66. 00 06600 PHYSI CAL THERAPY	o	3, 127		0	11	66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0	1, 417		0	0	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	O	501		0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	O	2, 237	0	0	0	67.00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	357	0	0	0	67. 10
68.00 06800 SPEECH PATHOLOGY	0	1, 128	0	0	2	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0	206	0	0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	770, 250		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	535, 258		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	460, 839	73. 00
76. 00 03020 CARDI OLOGY	0	2, 281	2, 918	0	6	76. 00
OUTPATIENT SERVICE COST CENTERS			J	0		00.00
90. 00 09000 CLINI C	0	0	1	0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC 90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0.45	1	0	0	90. 10
90. 50 O9004 SLEEP DI SORDERS CLINIC	0	945 908		0	4 0	90. 30
1 1	-	908 12, 935		0		90. 50
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	12, 935	41, 805	U	295	91. 00 92. 00
SPECIAL PURPOSE COST CENTERS						92.00
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 079, 354	174, 844	448, 199	1, 305, 508	461, 797	
NONREI MBURSABLE COST CENTERS	1,077,334	174, 044	440, 177	1, 303, 300	401, 777	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	o	0	0	190. 00
193. 00 19300 NONPALD WORKERS	Ö	548		0		193. 00
193. 10 19301 HEALTH PROPERTIES	0	3, 794	•	0		193. 10
193. 40 19303 LEI GHTON CENTER	0	3, 7 74	1, 705	0		193. 40
193. 50 19305 WELLNESS CENTER	0	4, 034		0		193. 50
193. 80 19308 UNUSED SPACE	0	4, US4 ∩		0		193. 80
193. 90 19309 OCCUPATI ONAL HEALTH	0	0		0		193. 90
193. 91 19310 RESEARCH AND PROTOCOL	0	0		0		193. 91
193. 92 19311 CCOP	ol ol	n	ا ما	0		193. 92
193. 93 19312 REASEARCH ADMIN	ol ol	301	711	0		193. 93
200.00 Cross Foot Adjustments	٩	30.		Ĭ		200. 00
201.00 Negative Cost Centers	o	0	ol ol	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 079, 354	183, 521	451, 366	1, 305, 508		

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

Peri od: Worksheet B From 01/01/2017 Part II To 12/31/2017 Date/Time Prepared:

5/25/2018 3:56 pm INTERNS & RESIDENTS SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER PARAMED ED MEDI CAL Cost Center Description RECORDS & Y & FRINGES PRGM COSTS PRGM LI BRARY 22.00 23.00 16.00 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 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 195, 197 16.00 01700 SOCIAL SERVICE 17.00 361, 384 17.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21 00 0 12 410 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 C 649, 496 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 143, 963 23.00 23.00 C 02301 PARAMED ED 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31, 952 236, 706 30.00 03100 INTENSIVE CARE UNIT 31.00 2,444 17, 112 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 855 9, 390 31.01 04000 SUBPROVI DER - I PF 33, 517 40.00 40.00 1.711 04100 SUBPROVI DER - I RF 41.00 794 8, 478 41.00 04300 NURSERY 43.00 611 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 44.844 96 52.00 05200 DELIVERY ROOM & LABOR ROOM 887 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 33, 724 9,569 54.00 57.00 05700 CT SCAN 57.00 C 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 0 C 58 00 05900 CARDIAC CATHETERIZATION 59.00 59.00 06000 LABORATORY 60.00 15, 151 0 60.00 06001 BLOOD LABORATORY 60.01 60.01 0 0 65.00 06500 RESPIRATORY THERAPY 65.00 66,00 06600 PHYSI CAL THERAPY 21,078 66, 00 06602 PHYSI CAL THERAPY EAST BANK 66.01 66.01 06601 PHYSICAL THERAPY LIVING CENTER 66.10 Ω 66.10 67.00 06700 OCCUPATIONAL THERAPY 5, 193 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 67.10 06800 SPEECH PATHOLOGY 68.00 2,383 68.00 68.10 06801 SPEECH THERAPY LIVING CENTER 0 68.10 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 C 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS C 73.00 03020 CARDI OLOGY 76.00 14, 113 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90 00 90.10 09001 FAMILY PRACTICE CLINIC 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 90.30 0 8,634 90.30 09004 SLEEP DISORDERS CLINIC 90.50 90.50 09100 EMERGENCY 91.00 20, 344 36, 995 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 through 117) 0 118.00 195, 197 361, 384 0 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 193. 00 19300 NONPALD WORKERS 193 00 Ω 193. 10 19301 HEALTH PROPERTIES 0 193. 10 0000 193. 40 19303 LEI GHTON CENTER 193. 40 193. 50 19305 WELLNESS CENTER 0 193. 50 193.80 19308 UNUSED SPACE 0 193.80 193. 90 19309 OCCUPATIONAL HEALTH 193. 90 0 193. 91 19310 RESEARCH AND PROTOCOL 0 193. 91 193. 92 19311 CCOP 193 92 C 193. 93 19312 REASEARCH ADMIN 193. 93 143, 963 200. 00 200.00 Cross Foot Adjustments 12, 410 649, 496

Health Financial Systems	MEMORIAL HOSPITAL C	OF SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
				From 01/01/2017		
			'	To 12/31/2017	Date/Time Pre	
					5/25/2018 3:5	5 pm
			INTERNS 8	RESIDENTS		
Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALA	R SERVI CES-OTHER	PARAMED ED	
	RECORDS &		Y & FRINGES	PRGM COSTS	PRGM	
	LI BRARY					
	1/ 00	17 00	21 00	22.00	22.00	

0 195, 197

361, 384

0 12, 410 0 649, 496 0 201. 00 143, 963 202. 00

201. 00 202. 00

Negative Cost Centers TOTAL (sum lines 118 through 201)

Un Lieu of Form CMS-2552-10
Worksheet B
Part II
B1/2017 Date/Time Prepared:
5/25/2018 3:56 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MEMORIAL HOSPITAL OF SOUTH BEND, INC Provider CCN: 15-0058 Peri od: From 01/01/2017 To 12/31/2017 Cost Center Description PARAMED ED Intern & Total Subtotal

	'			Residents Cost		
				& Post		
				Stepdown Adjustments		
		23. 01	24.00	25. 00	26.00	
	GENERAL SERVICE COST CENTERS					
1.00						1.00
2.00						2.00
4. 00 5. 00						4. 00 5. 00
6. 00						6.00
7. 00	1					7. 00
8.00						8. 00
9.00	00900 HOUSEKEEPI NG					9. 00
10. 0						10.00
11.0						11.00
13. C						13.00
14. C						14. 00 15. 00
16. 0						16. 00
17. C						17. 00
21. 0						21. 00
22.0	0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD					22. 00
23.0						23. 00
23. 0		0				23. 01
20.0	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		11 250 704		11 250 704	20.00
30. C			11, 258, 704 1, 334, 916		11, 258, 704 1, 334, 916	30. 00 31. 00
31.0			1, 226, 026		1, 226, 026	31. 01
40. 0	1		612, 541		612, 541	40.00
41. 0			551, 126	1	551, 126	41. 00
43.0	1 1		207, 749		207, 749	43. 00
	ANCILLARY SERVICE COST CENTERS					
50.0	1		4, 524, 440		4, 524, 440	50.00
52.0			1, 508, 502		1, 508, 502	52.00
54. C			2, 278, 826 121, 373		2, 278, 826 121, 373	54. 00 57. 00
58. 0			168, 453		168, 453	58.00
59. C	1 1		693, 474		693, 474	59. 00
60.0			521, 089		521, 089	60.00
60. C	1 06001 BLOOD LABORATORY		O	0	O	60. 01
65. C			317, 202		317, 202	65. 00
66.0			549, 269		549, 269	66. 00
66.0			9, 403		9, 403	66. 01
66. 1 67. 0			3, 593		3, 593	66. 10
67. C			267, 487 2, 307		267, 487 2, 307	67. 00 67. 10
68. 0			26, 227		26, 227	68. 00
68. 1			1, 591		1, 591	68. 10
70. C			0	0	o	70. 00
71. C			831, 498		831, 498	71. 00
	0 07200 IMPL. DEV. CHARGED TO PATIENTS		671, 480		671, 480	72. 00
73.0			618, 763		618, 763	73.00
76. C	0 03020 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS		329, 054	0	329, 054	76. 00
90. 0			С	ol ol	O	90.00
90. 1		•	Ö	1	o	90. 10
90. 3			417, 494	0	417, 494	90. 30
90. 5	0 09004 SLEEP DISORDERS CLINIC		6, 722	0	6, 722	90. 50
91. 0			1, 621, 735	0	1, 621, 735	91.00
92. 0				0		92. 00
110	SPECIAL PURPOSE COST CENTERS		I			112.00
113. 118.	00 11300 INTEREST EXPENSE 00 SUBTOTALS (SUM OF LINES 1 through 117)	0	30, 681, 044		30, 681, 044	113. 00 118. 00
110.	NONREI MBURSABLE COST CENTERS		30, 001, 044	· <u> </u>	30, 001, 044	118.00
190.	00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		181, 795	0	181, 795	190. 00
	00 19300 NONPALD WORKERS		8, 620, 492		8, 620, 492	193. 00
193.	10 19301 HEALTH PROPERTIES		29, 109	0	29, 109	193. 10
	40 19303 LEI GHTON CENTER		240, 636		240, 636	193. 40
	50 19305 WELLNESS CENTER		21, 584		21, 584	193. 50
	80 19308 UNUSED SPACE		0	0	0	193. 80
	90 19309 OCCUPATI ONAL HEALTH				0	193. 90
	91 19310 RESEARCH AND PROTOCOL 92 19311 CCOP				0	193. 91 193. 92
	93 19311 CCOP 93 19312 REASEARCH ADMIN		2, 824		2, 824	193. 92
200.		0	1		805, 869	200. 00
	· · · · · · · · · · · · · · · · · · ·					· · · · · · · · · · · · · · · · · · ·

Health Financial Systems	MEMORIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
				From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	pared:
					5/25/2018 3:5	
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		201. 00
202.00 TOTAL (sum lines 118 through 201)) 0	40, 583, 353		0 40, 583, 353		202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10 Provider CCN: 15-0058

					o 12/31/2017	Date/lime Pre 5/25/2018 3:5	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG & FIXT (SQUARE	NEW MVBLE EQUIP (SQUARE	EMPLOYEE BENEFITS DEPARTMENT	Reconci I i ati on	& GENERAL (ACCUM.	
		FEET)	FEET)	(GROSS SALARI ES)		COST)	
		1.00	2.00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS	1 000 007		ı	1		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1, 289, 227	1 200 227				1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	3, 460	1, 289, 227 3, 460	1	,		2. 00 4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	59, 965	59, 965			334, 136, 161	5. 00
6.00	00600 MAINTENANCE & REPAIRS	3, 019	3, 019				6. 00
7.00	00700 OPERATION OF PLANT	204, 355	204, 355	2, 452, 715			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	151	151	•			8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	21, 835 27, 196	21, 835 27, 196			6, 325, 696 4, 269, 982	9. 00 10. 00
11. 00	01100 CAFETERI A	4, 641	4, 641			1, 082, 847	11.00
13.00	01300 NURSING ADMINISTRATION	11, 126	11, 126			3, 675, 806	•
14. 00	01400 CENTRAL SERVICES & SUPPLY	32, 164	32, 164				1
15.00	01500 PHARMACY	10, 901	10, 901			6, 760, 780	ı
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	4, 978 8, 643	4, 978 8, 643				1
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0, 043	0, 043			.,	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	15, 984	15, 984				ł
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	3, 721	3, 721				23. 00
23. 01	02301 PARAMED ED	0	0	C	0	0	23. 01
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	240, 579	240, 579	31, 025, 103	0	53, 559, 190	30. 00
31. 00	03100 INTENSIVE CARE UNIT	28, 506	28, 506				1
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	28, 909	28, 909				1
40.00	04000 SUBPROVI DER - I PF	12, 683	12, 683	1, 200, 601	0	2, 038, 839	40. 00
41.00	04100 SUBPROVI DER – I RF	11, 728	11, 728				41.00
43. 00	04300 NURSERY	4, 605	4, 605	1, 415, 426	0	1, 966, 621	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	107, 438	107, 438	13, 628, 033	0	32, 576, 952	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	36, 622	36, 622				
54.00	05400 RADI OLOGY-DI AGNOSTI C	54, 623	54, 623	8, 342, 191	0	14, 922, 765	54.00
57. 00	05700 CT SCAN	2, 863	2, 863			.,,	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	4, 334	4, 334				1
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	17, 006 11, 029	17, 006 11, 029			,	1
60. 01	06001 BLOOD LABORATORY	0	0				60. 01
65.00	06500 RESPI RATORY THERAPY	7, 369	7, 369	3, 139, 890	0	5, 101, 253	65. 00
66. 00	06600 PHYSI CAL THERAPY	12, 990	12, 990				66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	0	,		1, 274, 688	1
66. 10 67. 00	06601 PHYSICAL THERAPY LIVING CENTER 06700 OCCUPATIONAL THERAPY	6, 428	6, 428	392, 659 1, 659, 223			
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0, 420	0, 420				
68. 00	06800 SPEECH PATHOLOGY	395	395			1, 180, 138	68. 00
	06801 SPEECH THERAPY LIVING CENTER	0	0	178, 042		219, 818	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	O	0	10 017 277	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	10, 817, 377 24, 059, 019	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	l o	0	6, 112, 703	_	27, 044, 578	
76. 00	03020 CARDI OLOGY	7, 553	7, 553				1
	OUTPATIENT SERVICE COST CENTERS			_	_	_	
90. 00 90. 10	09000 CLINIC 09001 FAMILY PRACTICE CLINIC	0	0	0		0 0	90. 00 90. 10
90. 10	09001 FAMILY PRACTICE CLINIC	10, 100	10, 100			1, 304, 068	90. 10
90. 50	09004 SLEEP DI SORDERS CLINIC	0	0, 100	683, 549		930, 905	90. 50
91.00	09100 EMERGENCY	35, 396	35, 396			20, 590, 511	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
112 00	SPECIAL PURPOSE COST CENTERS			ı			112 00
118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	1, 053, 295	1, 053, 295	134, 690, 989	-53, 075, 554	319, 023, 229	113.00
110.00	NONREI MBURSABLE COST CENTERS	1,055,275	1,055,275	134, 070, 707	33, 073, 334	317, 023, 227	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 761	4, 761	C	0	149, 871	190. 00
	19300 NONPALD WORKERS	224, 869	224, 869			7, 733, 233	1
	19301 HEALTH PROPERTIES	0 (200	0	1, 790, 364		3, 872, 387	1
	19303 LEI GHTON CENTER 19305 WELLNESS CENTER	6, 302	6, 302 0	1, 664, 095	_	198, 380 2, 868, 928	
	19305 WELLNESS CENTER 19308 UNUSED SPACE		0	1, 004, 095	, 0		193. 80
193. 90	19309 OCCUPATIONAL HEALTH		0	, c	o o	0	193. 90
	19310 RESEARCH AND PROTOCOL	0	0	C			193. 91
193. 92	2 19311 CCOP	0	0	0	0	0	193. 92

Peri od: Worksheet B-1 From 01/01/2017 To 12/31/2017 Date/Time Prepared:

						5/25/2018 3:5	6 pm
		CAPITAL RELA	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE		Reconciliation	ADMI NI STRATI VE	
		FLXT	EQUI P	BENEFITS		& GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
				SALARI ES)			
		1. 00	2. 00	4. 00	5A	5. 00	
193. 93	19312 REASEARCH ADMIN	0	0	215, 408	0	290, 133	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,	20, 797, 638	19, 785, 715	1, 365, 649		53, 075, 554	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	16. 131867	15. 346960	0.009849		0. 158844	203. 00
204.00	Cost to be allocated (per Wkst. B,			108, 916		1, 891, 859	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part			0. 000785		0. 005662	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Provider CCN: 15-0058

| Period: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

					o 12/31/2017	Date/Time Pre 5/25/2018 3:5	
	Cost Center Description	MAINTENANCE &	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	o piii
		REPAI RS (SQUARE	PLANT (SQUARE	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	
		FEET)	FEET)	LAUNDRY)	JERVI GE)	JERVED)	
	GENERAL SERVICE COST CENTERS	6.00	7. 00	8. 00	9. 00	10. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	1, 222, 783					6. 00
7.00	00700 OPERATION OF PLANT	204, 355	1, 018, 428				7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	151 21, 835	151 21, 835	988, 395 0	l		8. 00 9. 00
10. 00	01000 DI ETARY	27, 196	27, 196	1	l	315, 465	10.00
11.00	01100 CAFETERI A	4, 641	4, 641	C	0	0	11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	11, 126 32, 164	11, 126 32, 164	0 4, 129		0	13. 00 14. 00
15. 00	01500 PHARMACY	10, 901	10, 901	7, 127	238	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 978	4, 978		544	0	16. 00
17. 00 21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD	8, 643	8, 643 0	0	177	0	17. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	15, 984	15, 984	Ö	o o	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	3, 721	3, 721	55, 041	I I	0	23. 00
23. 01	O2301 PARAMED ED I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	C	0	0	23. 01
30. 00	03000 ADULTS & PEDIATRICS	240, 579	240, 579	292, 961	40, 720	259, 648	30. 00
31.00	03100 I NTENSI VE CARE UNI T	28, 506	28, 506		,	29, 405	1
31. 01 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	28, 909 12, 683	28, 909 12, 683		I	0 13, 378	31. 01 40. 00
41. 00	04100 SUBPROVI DER - I RF	11, 728	11, 728		I	13, 034	•
43.00	04300 NURSERY	4, 605	4, 605			0	1
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	107, 438	107, 438	333, 394	12, 321	0	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	36, 622	36, 622	66, 848		0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	54, 623	54, 623			0	54. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 863 4, 334	2, 863 4, 334		1	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	17, 006	17, 006	1	1	0	59.00
60.00	06000 LABORATORY	11, 029	11, 029		I	0	60.00
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0 7, 369	0 7, 369	0	-	0	60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	12, 990	12, 990			0	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	o	0	C	0	0	66. 01
66. 10 67. 00	06601 PHYSICAL THERAPY LIVING CENTER 06700 OCCUPATIONAL THERAPY	0 6, 428	0 6, 428	C	0 198	0	66. 10 67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0, 420	0, 426		0	0	67. 10
68. 00	06800 SPEECH PATHOLOGY	395	395	C	31	0	68. 00
68. 10 70. 00	06801 SPEECH THERAPY LIVING CENTER 07000 ELECTROENCEPHALOGRAPHY	0	0	1	1 1	0	68. 10
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0			0	70. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	O	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0 7 553	7 553	C	-	0	73.00
76.00	03020 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS	7, 553	7, 553	C	0	0	76. 00
90.00	09000 CLI NI C	0	0	C	0	0	90. 00
	09001 FAMILY PRACTICE CLINIC	10, 100	10, 100	0	-	0	90. 10
	09002 HEMATOLOGY ONCOLOGY CLINIC 09004 SLEEP DISORDERS CLINIC	10, 100	10, 100 0	367 371		0	90. 30 90. 50
91.00	09100 EMERGENCY	35, 396	35, 396	•	l l	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
113.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE			I			113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	986, 851	782, 496	988, 144	89, 384	315, 465	1
100.00	NONREI MBURSABLE COST CENTERS	1 7/1	4 7/1	1 .	ا ما		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19300 NONPAID WORKERS	4, 761 224, 869	4, 761 224, 869		- 1		190. 00 193. 00
	19301 HEALTH PROPERTIES	0	0	C	I		193. 10
	19303 LEIGHTON CENTER	6, 302	6, 302	0	0		193. 40
	19305 WELLNESS CENTER 19308 UNUSED SPACE		0	20	1		193. 50 193. 80
193. 90	19309 OCCUPATI ONAL HEALTH	0	0	ď	o o	0	193. 90
	19310 RESEARCH AND PROTOCOL	0	0	0	O		193. 91
	2 19311 CCOP 3 19312 REASEARCH ADMIN	0	0		0		193. 92 193. 93
200.00			Ü		ή	Ü	200. 00
201.00							201. 00

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of F							
COST ALLO	CATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2017	Worksheet B-1	
					To 12/31/2017	Date/Time Pre 5/25/2018 3:5	
	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, Part I)	5, 734, 713	19, 155, 596	1, 903, 338	7, 843, 593	5, 769, 485	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	4. 689886	18. 808984	1. 925686	84. 807519	18. 288828	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	123, 501	6, 544, 331	15, 020	868, 289	1, 079, 354	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 101000	6. 425914	0. 015196	9. 388228	3. 421470	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0058 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/25/2018 3:56 pm Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL SERVICES & RECORDS & (HOURS OF ADMI NI STRATI ON (COSTED SERVICE) **SUPPLY** REQUIS.) LI BRARY (COSTED (DI RECT (TIME NRSING HRS) REQUIS.) SPENT) 11.00 13.00 14.00 15.00 16.00 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 4, 083, 298 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 108, 397 1, 555, 587 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 94,019 100 14.00 01500 PHARMACY 20, 959, 933 15 00 152, 497 15 00 C 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 3, 195 16.00 01700 SOCIAL SERVICE 17.00 99, 519 5, 415 0 0 0 17.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 21 00 0 0 21 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 110, 766 C 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 23.00 23.00 7.541 C 02301 PARAMED ED 23.01 23.01 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 167, 984 659, 556 0 943 523 30.00 03100 INTENSIVE CARE UNIT 187, 960 142, 773 0 223 31.00 40 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 175,605 133, 710 0 150 14 31.01 04000 SUBPROVI DER - I PF 52, 280 0 28 40.00 40.00 21, 386 0 04100 SUBPROVI DER - I RF 0 41.00 41, 466 25, 627 805 13 41.00 04300 NURSERY 42, 309 43.00 27, 932 0 10 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50 00 401.834 213, 451 0 16, 295 734 52.00 05200 DELIVERY ROOM & LABOR ROOM 127, 978 89, 946 0 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 264, 956 0 54.00 39, 475 4, 934 552 54.00 57.00 05700 CT SCAN 30, 252 0 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58 00 35 0 58.00 05900 CARDIAC CATHETERIZATION 29, 934 913 59.00 59.00 12, 447 0 60.00 06000 LABORATORY 112, 226 C 0 0 248 60.00 0 06001 BLOOD LABORATORY 60.01 60.01 C 0 0 65.00 06500 RESPIRATORY THERAPY 103.272 4.727 0 65.00 66,00 06600 PHYSI CAL THERAPY 69.582 4,728 496 345 66.00 06602 PHYSICAL THERAPY EAST BANK 66.01 31, 538 0 0 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0 0 66.10 11, 139 Ω Ω 66.10 67.00 06700 OCCUPATIONAL THERAPY 49,773 0 0 85 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 7,934 0 67.10 0 06800 SPEECH PATHOLOGY 25, 091 0 68.00 0 75 39 68.00 0 68.10 06801 SPEECH THERAPY LIVING CENTER 4,575 C 0 0 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 o 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 59 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 41 72.00 0 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 20, 916, 514 0 73.00 03020 CARDI OLOGY 10, 057 76.00 50, 759 272 231 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 0 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 90.30 21,032 14,084 0 182 90.30 0 90.50 09004 SLEEP DISORDERS CLINIC 20 210 0 90.50 0 09100 EMERGENCY 91.00 287,808 144,078 0 13, 369 333 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 through 117) 20, 959, 933 3, 195 118. 00 118.00 3, 890, 236 1, 544, 671 100 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 193. 00 19300 NONPALD WORKERS 12, 183 0 0 0 193.00 1 623 193. 10 19301 HEALTH PROPERTIES 84, 425 6,841 0 0 0 193. 10 193. 40 19303 LEI GHTON CENTER 0 0 0 193. 40 0 193. 50 19305 WELLNESS CENTER 89, 750 0 0 0 193. 50 193.80 19308 UNUSED SPACE C 0 0 0 193, 80 0 193. 90 19309 OCCUPATIONAL HEALTH 0 0 0 193. 90 0 0 193. 91 19310 RESEARCH AND PROTOCOL 0 Λ 0 0 193. 91 193. 92 19311 CCOP 0 0 193. 92 0 193. 93 19312 REASEARCH ADMIN 6,704 0 0 193. 93 2, 452 200.00 Cross Foot Adjustments 200.00

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of	f Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0058	Peri od: Wor From 01/01/2017	rksheet B-1
			te/Time Prepared:

				10) 12/31/201/	5/25/2018 3:5	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	J
		(HOURS OF	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		SERVI CE)		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, 363, 909	4, 566, 840	11, 840, 968	8, 161, 971	346, 985	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 334021	2. 935766	118, 409. 680000	0. 389408	108. 602504	203. 00
204.00	Cost to be allocated (per Wkst. B,	183, 521	451, 366	1, 305, 508	461, 797	195, 197	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 044944	0. 290158	13, 055. 080000	0. 022032	61. 094523	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-0058

			Т	o 12/31/2017	Date/Time Pre 5/25/2018 3:5	
		INTERNS	& RESIDENTS			
Cost Center Description	SOCIAL SER	VI CE SERVI CES-SAL	AR SERVI CES-OTHER	PARAMED ED	PARAMED ED	
	/TIME	Y & FRINGES		PRGM (ASSI GNED	(ASSI GNED	
	(TIME SPENT)	(ASSI GNED TI ME)	TI ME)	TIME)	TIME)	
CENEDAL SEDVICE COST CENTEDS	17. 00	21. 00	22. 00	23. 00	23. 01	
GENERAL SERVI CE COST CENTERS 1.00 OO100 NEW CAP REL COSTS-BLDG & F	IXT					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQ	UI P					2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTME 5.00 00500 ADMINISTRATIVE & GENERAL	NI					4. 00 5. 00
6. 00 00600 MAI NTENANCE & REPAI RS						6. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00 01500 PHARMACY						15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	20	127				16. 00 17. 00
21. 00 02100 1 &R SERVICES - SALARY & FRIN		, 136 0 2, 6	51			21.00
22.00 02200 I &R SERVI CES-OTHER PRGM CO	STS APPRVD	0	2, 651	1		22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY) 23. 01 02301 PARAMED ED		0		100	0	23. 00 23. 01
I NPATI ENT ROUTI NE SERVI CE COST C	ENTERS	<u> </u>			0	23.01
30. 00 03000 ADULTS & PEDIATRICS	1	, 739 1, 7		l l	0	
31.00 03100 INTENSIVE CARE UNIT 31.01 02060 NEONATAL INTENSIVE CARE UN	1	, 427 783	8 8		0	31. 00 31. 01
40. 00 04000 SUBPROVI DER - PF	1	, 795			0	40. 00
41. 00 04100 SUBPROVI DER - I RF		707	0 0	_	0	41.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS		0	0 0	0	0	43.00
50. 00 05000 OPERATING ROOM		8 1	23 123	0	0	50. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		74	0 0		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN		798 0	12 12		0	54. 00 57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING	(MRI)	O	0 0		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY		0	0 0	_	0	59. 00 60. 00
60. 01 06000 LABORATORY		0		_	0	60.00
65. 00 06500 RESPIRATORY THERAPY		0	35 35		0	65. 00
66. 00 06600 PHYSI CAL THERAPY 66. 01 06602 PHYSI CAL THERAPY EAST BANK		0		-	0	66. 00 66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CE	NTER	0		-	0	66. 10
67.00 06700 OCCUPATI ONAL THERAPY		o	0 0	-	0	67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVIN 68. 00 06800 SPEECH PATHOLOGY	G CENTER	0			0	67. 10 68. 00
68. 10 06801 SPEECH THERAPY LIVING CENT	ER	o	o c	o o	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	O DATI ENTO	0	0 0		0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO 72.00 07200 MPL. DEV. CHARGED TO PATI		0			0	
73.00 07300 DRUGS CHARGED TO PATIENTS		o	o c	o	0	73. 00
76. 00 03020 CARDI OLOGY		0	69 69	0	0	76. 00
90. 00 O9000 CLINIC		0	ol c	ol	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC			501 501	O	0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC 90. 50 09004 SLEEP DI SORDERS CLINIC		720	4	0	0	90. 30 90. 50
91. 00 09100 EMERGENCY		, 085 1	27 127	100	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DIST	INCT PART)					92. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1	through 117) 30	, 136 2, 6	32 2, 632	100		118. 00
NONREI MBURSABLE COST CENTERS						100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP 193.00 19300 NONPALD WORKERS	& CANIEEN	ol	0 0			190. 00 193. 00
193. 10 19301 HEALTH PROPERTIES		o o	o c			193. 10
193. 40 19303 LEIGHTON CENTER		0	0 0	O		193. 40
193.50 19305 WELLNESS CENTER 193.80 19308 UNUSED SPACE						193. 50 193. 80
193. 90 19309 OCCUPATI ONAL HEALTH		O	0 0	o	0	193. 90
193. 91 19310 RESEARCH AND PROTOCOL 193. 92 19311 CCOP		0	0 0	0		193. 91 193. 92
193. 92 19311 CCOP 193. 93 19312 REASEARCH ADMIN		0		0	0	193. 92
· · ·	ı			1		·

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/25/2018 3:56 pm

						5/25/2018 3:5	6 pm
			INTERNS &	RESI DENTS			
	Cost Center Description	SOCI AL SERVI CE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED (ASSIGNED	
		(TIME	(ASSI GNED	(ASSI GNED	(ASSI GNED	TIME)	
		SPENT) 17.00	TI ME) 21. 00	TI ME) 22. 00	TI ME) 23. 00	23. 01	
200.00	Cross Foot Adjustments	17.00	21.00	22.00	20.00		200. 00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	4, 978, 268	2, 233, 440	7, 472, 013	461, 386	0	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	165. 193390	842. 489627	2, 818. 563938	4, 613. 860000	0. 000000	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	361, 384	12, 410	649, 496	143, 963	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	11. 991771	4. 681252	245. 000377	1, 439. 630000	0. 000000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0	0	206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0. 000000	0.000000	207. 00

Provider CCN: 15-0058 Peri od: Worksheet C From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/25/2018 3:56 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 82, 130, 633 82, 130, 633 11, 111 82, 141, 744 03100 INTENSIVE CARE UNIT 13, 297, 760 13, 297, 760 144, 193 13, 441, 953 31.00 31.00 11, 795, 621 31.01 02060 NEONATAL INTENSIVE CARE UNIT 11, 795, 621 7, 411 11, 803, 032 31.01 04000 SUBPROVI DER - I PF 40.00 40.00 3, 707, 625 3, 707, 625 3, 707, 625 0 04100 SUBPROVIDER - IRF 41.00 3, 374, 253 3, 374, 253 0 3, 374, 253 41.00 43.00 04300 NURSERY 2, 574, 852 2, 574, 852 2, 574, 852 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 42, 811, 446 42, 811, 446 42, 823, 841 50.00 12.395 52.00 05200 DELIVERY ROOM & LABOR ROOM 10, 158, 614 10, 158, 614 30, 036 10, 188, 650 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 19, 394, 414 19, 394, 414 69, 688 19, 464, 102 54.00 05700 CT SCAN 2, 145, 063 2, 145, 063 2, 145, 063 57.00 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 861.916 861, 916 861, 916 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 3, 180, 152 3, 180, 152 25, 398 3, 205, 550 59.00 06000 LABORATORY 60.00 14, 740, 009 14, 740, 009 0 14, 740, 009 60.00 06001 BLOOD LABORATORY 60 01 0 60 01 0 65.00 06500 RESPIRATORY THERAPY 6, 130, 487 6, 130, 487 0 6, 130, 487 65.00 06600 PHYSI CAL THERAPY 4, 754, 585 4, 754, 585 6,050 4, 760, 635 66.00 66.00 06602 PHYSI CAL THERAPY EAST BANK 1, 487, 699 1, 487, 699 1, 487, 699 66.01 66.01 06601 PHYSICAL THERAPY LIVING CENTER 573, 569 0 573, 569 66 10 573 569 66 10 67.00 06700 OCCUPATIONAL THERAPY 2, 771, 426 2, 771, 426 0 2, 771, 426 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 363, 937 363, 937 363, 937 67.10 0 06800 SPEECH PATHOLOGY 1, 392, 153 1, 392, 153 1, 392, 153 68 00 68 00 06801 SPEECH THERAPY LIVING CENTER 0 68.10 256, 263 256, 263 256, 263 68.10 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 19, 521, 823 19, 521, 823 19, 521, 823 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 32, 735, 447 32, 735, 447 0 32, 735, 447 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 39, 485, 511 39, 485, 511 0 39, 485, 511 73.00 03020 CARDI OLOGY 4, 510, 345 4, 510, 345 110, 015 4, 620, 360 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLINIC 0 0 0 90.10 09001 FAMILY PRACTICE CLINIC 0 0 0 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 2,024,769 12, 273 2, 037, 042 90.30 2, 024, 769 90.30 1, 086, 239 90.50 09004 SLEEP DISORDERS CLINIC 1,086,239 19, 959 1, 106, 198 90. 50 91.00 09100 EMERGENCY 26, 821, 810 91.00 26, 821, 810 561, 649 27, 383, 459 09200 OBSERVATION BEDS (NON-DISTINCT PART) 10, 243, 476 10, 243, 476 10, 243, 476 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 365, 342, 075 200. 00 364, 331, 897 364, 331, 897 200.00 Subtotal (see instructions) 0 1, 010, 178 201.00 Less Observation Beds 10, 243, 476 10, 243, 476 10, 243, 476 201. 00 202.00 Total (see instructions) 354, 088, 421 354, 088, 421 1, 010, 178 355, 098, 599 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0058 Peri od: Worksheet C From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/25/2018 3:56 pm 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 165, 455, 778 165, 455, 778 03000 ADULTS & PEDIATRICS 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 33, 331, 941 33, 331, 941 31.00 02060 NEONATAL INTENSIVE CARE UNIT 28, 424, 004 31.01 28, 424, 004 31.01 04000 SUBPROVIDER - IPF 40.00 4, 276, 855 4, 276, 855 40.00 04100 SUBPROVI DER - I RF 41.00 9, 103, 815 9, 103, 815 41.00 43.00 04300 NURSERY 4, 368, 429 4, 368, 429 43.00 ANCILLARY SERVICE COST CENTERS 48, 546, 596 50.00 05000 OPERATING ROOM 62, 166, 609 110, 713, 205 0.386688 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 18, 206, 965 1, 353, 079 19, 560, 044 0.519355 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 32, 403, 677 82, 784, 237 115, 187, 914 0.168372 0.000000 54.00 57.00 05700 CT SCAN 20, 207, 005 42, 707, 828 62, 914, 833 0.034095 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 3, 220, 235 0.000000 58.00 2, 616, 721 603, 514 0.267656 58.00 05900 CARDIAC CATHETERIZATION 59.00 9, 982, 502 15, 231, 797 25, 214, 299 0. 126125 0.000000 59.00 06000 LABORATORY 75, 709, 963 122, 883, 396 0.119951 0.000000 60.00 47, 173, 433 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 3, 862, 693 06500 RESPIRATORY THERAPY 36, 434, 148 40, 296, 841 65.00 0.152133 0.000000 65 00 66.00 06600 PHYSI CAL THERAPY 6, 601, 879 2, 616, 736 9, 218, 615 0. 515759 0.000000 66.00 06602 PHYSI CAL THERAPY EAST BANK 3, 768, 708 3, 770, 484 0. 394564 0.000000 66, 01 1,776 66.01 06601 PHYSICAL THERAPY LIVING CENTER 1, 685, 212 1, 687, 367 0. 339920 0.000000 2.155 66.10 66.10 06700 OCCUPATI ONAL THERAPY 2, 155, 334 67.00 4, 387, 382 6, 542, 716 0.423590 0.000000 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 372 1, 117, 757 1, 118, 129 0.325487 0.000000 67.10 1, 987, 105 68.00 06800 SPEECH PATHOLOGY 2, 215, 564 4, 202, 669 0.331254 0.000000 68.00 06801 SPEECH THERAPY LIVING CENTER 0 879, 927 879, 927 0 291232 0.000000 68 10 68 10 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0.000000 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 73, 641, 531 45, 429, 043 119, 070, 574 0. 163952 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 99, 795, 512 50, 858, 503 150, 654, 015 0.217289 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 100, 957, 951 202, 797, 707 73.00 101, 839, 756 0.194704 0.000000 73.00 76.00 03020 CARDI OLOGY 6, 715, 208 6, 685, 017 13, 400, 225 0.336587 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 40, 328 862, 802 903, 130 2. 241946 0.000000 90.30 90.30 90.50 09004 SLEEP DISORDERS CLINIC 3, 922, 763 3, 922, 763 0.276907 0.000000 90.50 09100 EMERGENCY 37, 293, 291 51, 755, 876 91 00 91 00 14, 462, 585 0.518237 0.000000 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.328668 92.00 31, 166, 639 31, 166, 639 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 548, 151, 783 1, 346, 042, 425 797, 890, 642 200. 00 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 797, 890, 642 548, 151, 783 1, 346, 042, 425 202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2017	Part
To 12/31/2017	Date/Time Prepared:
5/25/2018 3:56 pm	

				5/25/2018 3:56 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30. 00
31.00 03100 INTENSIVE CARE UNIT				31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT				31. 01
40. 00 04000 SUBPROVI DER - 1 PF				40. 00
41. 00 04100 SUBPROVI DER - RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 386800			50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 520891			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 168977			54.00
57. 00 05700 CT SCAN	0. 034095			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 267656			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 127132			59. 00
60. 00 06000 LABORATORY	0. 119951			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 152133			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 516415			66. 00
66.01 06602 PHYSICAL THERAPY EAST BANK	0. 394564			66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	0. 339920			66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0. 423590			67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0. 325487			67. 10
68.00 06800 SPEECH PATHOLOGY	0. 331254			68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0. 291232			68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 163952			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 217289			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 194704			73. 00
76. 00 03020 CARDI OLOGY	0. 344797			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	2. 255536			90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	0. 281995			90. 50
91. 00 09100 EMERGENCY	0. 529089			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 328668			92. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 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

In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0058 Peri od: Worksheet C From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/25/2018 3:56 pm Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 82, 130, 633 82, 130, 633 11, 111 82, 141, 744 03100 INTENSIVE CARE UNIT 13, 297, 760 13, 297, 760 144, 193 13, 441, 953 31.00 31.00 11, 795, 621 31.01 02060 NEONATAL INTENSIVE CARE UNIT 11, 795, 621 7, 411 11, 803, 032 31.01 04000 SUBPROVI DER - I PF 40.00 40.00 3, 707, 625 3, 707, 625 3, 707, 625 0 04100 SUBPROVIDER - IRF 41.00 3, 374, 253 3, 374, 253 0 3, 374, 253 41.00 43.00 04300 NURSERY 2, 574, 852 2, 574, 852 2, 574, 852 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 42, 811, 446 42, 811, 446 42, 823, 841 50.00 12.395 52.00 05200 DELIVERY ROOM & LABOR ROOM 10, 158, 614 10, 158, 614 30, 036 10, 188, 650 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 19, 394, 414 19, 394, 414 69, 688 19, 464, 102 54.00 05700 CT SCAN 2, 145, 063 2, 145, 063 2, 145, 063 57.00 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 861.916 861, 916 861, 916 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 3, 180, 152 3, 180, 152 25, 398 3, 205, 550 59.00 06000 LABORATORY 60.00 14, 740, 009 14, 740, 009 0 14, 740, 009 60.00 06001 BLOOD LABORATORY 60 01 0 60 01 0 65.00 06500 RESPIRATORY THERAPY 6, 130, 487 6, 130, 487 0 6, 130, 487 65.00 06600 PHYSI CAL THERAPY 4, 754, 585 4, 754, 585 6,050 4, 760, 635 66.00 66.00 06602 PHYSI CAL THERAPY EAST BANK 1, 487, 699 1, 487, 699 1, 487, 699 66.01 66.01 06601 PHYSICAL THERAPY LIVING CENTER 573, 569 0 573, 569 66 10 573 569 66 10 67.00 06700 OCCUPATIONAL THERAPY 2, 771, 426 2, 771, 426 0 2, 771, 426 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 363, 937 363, 937 363, 937 67.10 0 06800 SPEECH PATHOLOGY 1, 392, 153 1, 392, 153 1, 392, 153 68 00 68 00 06801 SPEECH THERAPY LIVING CENTER 0 68.10 256, 263 256, 263 256, 263 68.10 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 19, 521, 823 19, 521, 823 19, 521, 823 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 32, 735, 447 32, 735, 447 0 32, 735, 447 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 39, 485, 511 39, 485, 511 0 39, 485, 511 73.00 03020 CARDI OLOGY 4, 510, 345 4, 510, 345 110, 015 4, 620, 360 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLINIC 0 0 0 90.10 09001 FAMILY PRACTICE CLINIC 0 0 0 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 2,024,769 12, 273 2, 037, 042 90.30 2, 024, 769 90.30 1, 086, 239 90.50 09004 SLEEP DISORDERS CLINIC 1,086,239 19, 959 1, 106, 198 90. 50 91.00 09100 EMERGENCY 26, 821, 810 91.00 26, 821, 810 561, 649 27, 383, 459 09200 OBSERVATION BEDS (NON-DISTINCT PART) 10, 243, 476 10, 243, 476 10, 243, 476 92.00 92.00

364, 331, 897

354, 088, 421

10, 243, 476

364, 331, 897

10, 243, 476

354, 088, 421

1, 010, 178

1, 010, 178

0

113.00

365, 342, 075 200. 00

10, 243, 476 201. 00

355, 098, 599 202. 00

SPECIAL PURPOSE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

113. 00 11300 | INTEREST EXPENSE

200.00

201.00

202.00

40, 328

14, 462, 585

797, 890, 642

797, 890, 642

862, 802

548, 151, 783 1, 346, 042, 425

548, 151, 783 1, 346, 042, 425

3, 922, 763

37, 293, 291

31, 166, 639

0.000000

0.000000

2. 241946

0.276907

0.518237

0.328668

903, 130

3, 922, 763

51, 755, 876

31, 166, 639

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

90 00

90.10

90.30

90.50

91 00

92.00

113.00

200. 00

201.00

202.00

90.00

90.10

90. 30 90. 50

91 00

92.00

113.00

200.00

201.00

202.00

09000 CLINIC

09100 EMERGENCY

09001 FAMILY PRACTICE CLINIC

09004 SLEEP DISORDERS CLINIC

SPECIAL PURPOSE COST CENTERS

11300 INTEREST EXPENSE

09002 HEMATOLOGY ONCOLOGY CLINIC

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Peri od: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

			10 12/01/201/	5/25/2018 3:56 pm
		Title XIX	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 I NTENSI VE 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				
50. 00 05000 OPERATI NG ROOM	0. 386800			50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 520891			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 168977			54.00
57. 00 05700 CT SCAN	0. 034095			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 267656			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 127132			59.00
60. 00 06000 LABORATORY	0. 119951			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 152133			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 516415			66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0. 394564			66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	0. 339920			66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0. 423590			67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0. 325487			67. 10
68. 00 06800 SPEECH PATHOLOGY	0. 331254			68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0. 291232			68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 163952			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 217289			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 194704			73. 00
76. 00 03020 CARDI OLOGY	0. 344797			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	2. 255536			90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	0. 281995			90. 50
91. 00 09100 EMERGENCY	0. 529089			91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 328668			92. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 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

Heal th Financial Systems MEMORIAL HOSPITA CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Provi der CCN: 15-0058

				1	0 12/31/2017	5/25/2018 3:5	
			Ti tl	e XIX	Hospi tal	PPS	o piii
Cost Center Description		Total Cost		Operating Cost		Operating Cost	
	'	(Wkst. B, Part			Reduction	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						
	05000 OPERATI NG ROOM	42, 811, 446	4, 524, 440			0	
	05200 DELIVERY ROOM & LABOR ROOM	10, 158, 614	1, 508, 502	8, 650, 112	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 394, 414	2, 278, 826		0	0	54.00
57.00	05700 CT SCAN	2, 145, 063	121, 373			0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	861, 916	168, 453			0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 180, 152	693, 474			0	59. 00
60.00	06000 LABORATORY	14, 740, 009	521, 089	1		0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	1	_	0	60. 01
65.00	06500 RESPI RATORY THERAPY	6, 130, 487	317, 202			0	65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 754, 585	549, 269			0	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	1, 487, 699	9, 403			0	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	573, 569	3, 593	1		0	66. 10
67. 00	06700 OCCUPATI ONAL THERAPY	2, 771, 426	267, 487			0	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	363, 937	2, 307			0	67. 10
68. 00	06800 SPEECH PATHOLOGY	1, 392, 153	26, 227			0	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	256, 263	1, 591	1		0	68. 10
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	_	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 521, 823	831, 498			0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	32, 735, 447	671, 480			0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	39, 485, 511	618, 763			0	73. 00
76. 00	03020 CARDI OLOGY	4, 510, 345	329, 054	4, 181, 291	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	Ü	0		1	
	09001 FAMILY PRACTICE CLINIC	0 004 7/0	447.404	0	_	0	90. 10
	09002 HEMATOLOGY ONCOLOGY CLINIC	2, 024, 769				0	90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	1, 086, 239	6, 722			0	90. 50
91.00	09100 EMERGENCY	26, 821, 810	1, 621, 735			-	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)		10, 243, 476	1, 404, 012	8, 839, 464	0	0	92.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE			1] 113. 00
200.00		247, 451, 153	16, 893, 994	230, 557, 159	0		200. 00
200.00		1	16, 893, 994	1			200.00
201.00		10, 243, 476 237, 207, 677					201.00
202.00	Trotal (Title 200 IIII lus Title 201)	231,201,011	10, 407, 982	221, /1/, 093	ı	ı	1202.00

 Heal th Financial Systems
 MEMORIAL HOSPITAL OF SOUTH BEND, INC

 CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
 Provider CCN: 1

 REDUCTIONS FOR MEDICALD ONLY
 In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2017	Part II
To 12/31/2017	Date/Time Prepared:
5/25/2018 3:56 pm	Provi der CCN: 15-0058

						5/25/2018 3:56 pm
			Ti tl	e XIX	Hospi tal	PPS
Cost Center Description		Cost Net of	Total Charges			
		Capital and	(Worksheet C,	Cost to Charg	je	
		Operating Cost	Part I, column	Ratio (col.	6	
		Reducti on	8)	/ col. 7)		
		6.00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
50. 00	05000 OPERATING ROOM	42, 811, 446	110, 713, 205	0. 38668	88	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 158, 614	19, 560, 044	0. 51935	55	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 394, 414	115, 187, 914	0. 16837	'2	54. 00
57. 00	05700 CT SCAN	2, 145, 063	62, 914, 833	0. 03409	95	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	861, 916	3, 220, 235	0. 26765	66	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 180, 152	25, 214, 299	0. 12612	25	59. 00
60. 00	06000 LABORATORY	14, 740, 009	122, 883, 396	0. 11995	51	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0.00000	00	60. 01
65. 00	06500 RESPI RATORY THERAPY	6, 130, 487	40, 296, 841	0. 15213	3	65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 754, 585	9, 218, 615	0. 51575	19	66.00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	1, 487, 699	3, 770, 484	0. 39456	04	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	573, 569	1, 687, 367	0. 33992	20	66. 10
67. 00	06700 OCCUPATI ONAL THERAPY	2, 771, 426	6, 542, 716			67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	363, 937	1, 118, 129	0. 32548	37	67. 10
68. 00	06800 SPEECH PATHOLOGY	1, 392, 153	4, 202, 669	0. 33125	54	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	256, 263	879, 927	0. 29123	32	68. 10
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	00	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 521, 823	119, 070, 574	0. 16395	52	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	32, 735, 447	150, 654, 015	0. 21728	39	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	39, 485, 511	202, 797, 707	0. 19470)4	73.00
76. 00	03020 CARDI OLOGY	4, 510, 345	13, 400, 225	0. 33658	37	76.00
	OUTPATIENT SERVICE COST CENTERS			•	<u>'</u>	
90. 00	09000 CLI NI C	0	0	0.00000	00	90.00
90. 10	09001 FAMILY PRACTICE CLINIC	0	0	0. 00000	00	90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	2, 024, 769	903, 130	2. 24194	6	90. 30
	09004 SLEEP DISORDERS CLINIC	1, 086, 239				90. 50
	09100 EMERGENCY	26, 821, 810				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 243, 476				92.00
	SPECIAL PURPOSE COST CENTERS		. ,			1 - 1 - 1
	11300 I NTEREST EXPENSE					113. 00
200.00	Subtotal (sum of lines 50 thru 199)	247, 451, 153	1, 101, 081, 603			200. 00
201.00		10, 243, 476				201. 00
202.00			1, 101, 081, 603			202. 00
	1 (==== ==./		, , , , , , , , , , , , , , , , , , , ,	1	1	1==2.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider Co		Period: From 01/01/2017 To 12/31/2017		
		Title	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 CENTER	S					
30. 00 ADULTS & PEDIATRICS	11, 258, 704	0	11, 258, 70	4 80, 181	140. 42	30.00
31.00 INTENSIVE CARE UNIT	1, 334, 916		1, 334, 91	6 8, 042	165. 99	31.00
31.01 NEONATAL INTENSIVE CARE UNIT	1, 226, 026		1, 226, 02	6 9, 755	125. 68	31.01
40.00 SUBPROVIDER - IPF	612, 541	0	612, 54	1 3, 716	164. 84	40.00
41.00 SUBPROVIDER - IRF	551, 126	0	551, 12	6 3, 475	158. 60	41.00
43. 00 NURSERY	207, 749		207, 74	9 4, 431	46. 89	43.00
200.00 Total (lines 30 through 199)	15, 191, 062		15, 191, 06	2 109, 600		200.00
Cost Center Description	I npati ent	Inpatient		•		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 ADULTS & PEDIATRICS	21, 975					30.00
31.00 INTENSIVE CARE UNIT	2, 035	337, 790				31.00
31.01 NEONATAL INTENSIVE CARE UNIT	0	0				31. 01
40. 00 SUBPROVI DER - I PF	1, 362	224, 512				40.00
41.00 SUBPROVIDER - IRF	1, 051	166, 689				41.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	26, 423	3, 814, 721				200.00

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0058 Peri od: Worksheet D From 01/01/2017 Part II 12/31/2017 Date/Time Prepared: 5/25/2018 3:56 pm Title XVIII Hospi tal PPS Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent to Charges Related Cost (from Wkst. C. (column 3 x Program (from Wkst. B. column 4) Part I, col. $(col. 1 \div col.$ Charges 2) Part II, col. 8) 26) 2.00 3.00 4.00 5.00 1.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 524, 440 110, 713, 205 0.040866 18, 118, 628 740, 436 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 1,508,502 19, 560, 044 0.077122 32, 661 2, 519 52.00 05400 RADI OLOGY-DI AGNOSTI C 2, 278, 826 115, 187, 914 0.019784 11, 771, 333 54.00 232, 884 54.00 05700 CT SCAN 121, 373 62, 914, 833 0.001929 6, 696, 258 12, 917 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 1, 118, 093 58.00 168, 453 3, 220, 235 0.052311 58, 489 58.00 59.00 05900 CARDIAC CATHETERIZATION 693, 474 25, 214, 299 0.027503 3, 853, 162 105, 974 59.00 60.00 06000 LABORATORY 521,089 122, 883, 396 0.004241 24, 336, 053 103, 209 60.00 06001 BLOOD LABORATORY 0.000000 60 01 Ω 60 01 06500 RESPIRATORY THERAPY 317, 202 40, 296, 841 65.00 0.007872 10, 646, 327 83, 808 65.00 66.00 06600 PHYSI CAL THERAPY 549, 269 9, 218, 615 0.059583 2, 091, 695 124, 629 66.00 66.01 06602 PHYSICAL THERAPY EAST BANK 9, 403 3, 770, 484 0.002494 0 66.01 06601 PHYSICAL THERAPY LIVING CENTER 1, 687, 367 0.002129 3 593 66 10 66 10 0 67.00 06700 OCCUPATIONAL THERAPY 267, 487 6, 542, 716 0.040883 968, 155 39, 581 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 0.002063 67.10 2, 307 1, 118, 129 0 67.10 06800 SPEECH PATHOLOGY 450, 869 68 00 26 227 4 202 669 0.006241 2,814 68 00 68. 10 06801 SPEECH THERAPY LIVING CENTER 1, 591 879, 927 0.001808 Λ 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0.000000 0 0 70.00

73.00 07300 DRUGS CHARGED TO PATIENTS 618, 763 202, 797, 707 0.003051 36, 863, 180 112, 470 73.00 03020 CARDI OLOGY 329, 054 13, 400, 225 0.024556 2, 719, 652 66, 784 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 0.000000 90 00 09000 CLI NI C 90 00 0 90. 10 09001 FAMILY PRACTICE CLINIC 0 0.000000 0 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 417, 494 903, 130 0.462275 0 90.30 0 09004 SLEEP DISORDERS CLINIC 3, 922, 763 0.001714 90. 50 6,722 0 90.50 1, 621, 735 5, 258, 667 91. 00 09100 EMERGENCY 0.031334 51, 755, 876 164, 775 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 404, 012 31, 166, 639 0.045049 0 92.00 184, 079, 224 2, 172, 960 200. 00 200.00 Total (lines 50 through 199) 16, 893, 994 1, 101, 081, 603

831, 498

671, 480

119, 070, 574

150, 654, 015

0.006983

0.004457

22, 968, 866

36, 185, 625

160, 392

161, 279

71.00

72 00

71.00

72 00

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07200 I MPL. DEV. CHARGED TO PATIENTS

Heal th Financial	Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC					In Li€	eu of Form CMS-2	2552-10	
APPORTI ONMENT OF	INPATIENT	ROUTINE SERVICE	OTHER PAS	PASS THROUGH COSTS Provider CCN:			Peri od: Worksheet D From 01/01/2017 Part III To 12/31/2017 Date/Time Pre 5/25/2018 3:5			
						Titl∈	e XVIII	Hospi tal	PPS	
Cost	Center De	scription		Nursing School	Nursir	ng School	Allied Healt	Allied Health	All Other	
				Post-Stepdown			Post-Stepdown	Cost	Medi cal	
				Adjustments			Adjustments		Education Cost	
				1 1			2.4	2 00	2 00	

				o 12/31/2017	Date/lime Pre 5/25/2018 3:5	
		Title	e XVIII	Hospi tal	PPS	о р
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown	3	Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0) c	0	0	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0) c	0	0	31. 01
40. 00 04000 SUBPROVI DER - I PF	0	0) c	0	0	40.00
41. 00 04100 SUBPROVI DER - RF	0	0) c	0	0	41.00
43. 00 04300 NURSERY	0	0	o c	0	0	43.00
200.00 Total (lines 30 through 199)	0	0) c	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	80, 181			
31.00 03100 INTENSIVE CARE UNIT		0	8, 042			
31.01 02060 NEONATAL INTENSIVE CARE UNIT		0	9, 755			
40. 00 04000 SUBPROVI DER - I PF	0	0	3, 716			
41. 00 04100 SUBPROVI DER - I RF	0	0	3, 475			
43. 00 04300 NURSERY		0	1 .,			
200.00 Total (lines 30 through 199)		0	109, 600)	26, 423	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
INDATI ENT. DOUTINE CERVI OF COCT. CENTERS	9. 00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS						20.00
	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT						31. 01
40. 00 04000 SUBPROVI DER - I PF	0					40.00
41. 00 04100 SUBPROVI DER - I RF	0					41.00
43. 00 04300 NURSERY	0					43. 00
200.00 Total (lines 30 through 199)	0					200. 00

 Heal th Financial
 Systems
 MEMORIAL HOSPITAL OF SOUTH BEND, INC

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-0058
 THROUGH COSTS

						5/25/2018 3:5	6 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	O	0)	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54.00
57.00	05700 CT SCAN	o	0)	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0)	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0)	0	0	59. 00
60.00	06000 LABORATORY	o	0)	0	0	60.00
60. 01	06001 BLOOD LABORATORY	o	0)	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	o	Ō	1	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	o	Ō	1	0	0	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	o	Ō	1	0	0	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	o	Ō	1	0	0	66. 10
67.00	06700 OCCUPATI ONAL THERAPY	o	0)	0 0	0	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	o	0)	0 0	0	67. 10
68. 00	06800 SPEECH PATHOLOGY	o	0)	0 0	0	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	o	0)	0 0	0	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	ol	0	,	0	o	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	ol	0	,	0	o	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	ol	0	,	0	o	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	ol	0	,	0	o	73. 00
76. 00	03020 CARDI OLOGY	ol	0	,	0	o	76. 00
	OUTPATIENT SERVICE COST CENTERS				-		
90.00	09000 CLI NI C	0	O		0 0	0	90. 00
90. 10	09001 FAMILY PRACTICE CLINIC	o	0	,	0	o	90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	o	0)	0 0	0	90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	o	0)	0 0	0	90. 50
91. 00	09100 EMERGENCY	o	0		o o	461, 386	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	l ol			o	0	92.00
200.00		l ol	0		0 0	461, 386	
		-1				, , , , , , ,	

Health Financial Systems MEMORIAL HOSPITAL OF SAPPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 15-0058 THROUGH COSTS

				'	12/01/201/	5/25/2018 3:5	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of col 1		(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS				_	,	
50.00	05000 OPERATI NG ROOM	0	0	(110, 713, 205		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(19, 560, 044		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(
57.00		0	0	(62, 914, 833		
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(3, 220, 235	0.000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(25, 214, 299		59. 00
60.00	06000 LABORATORY	0	0	(122, 883, 396	0.000000	60. 00
60. 01	06001 BLOOD LABORATORY	0	0	(0	0.000000	60. 01
65.00	06500 RESPI RATORY THERAPY	0	0	(40, 296, 841	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(9, 218, 615	0.000000	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	0	(3, 770, 484	0.000000	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	(1, 687, 367	0.000000	66. 10
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(6, 542, 716	0.000000	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	(1, 118, 129	0.000000	67. 10
68.00	06800 SPEECH PATHOLOGY	0	0	(4, 202, 669	0.000000	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0	0	(879, 927	0.000000	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	O	0	(0	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0	(119, 070, 574	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	0	(150, 654, 015	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	O	0	(202, 797, 707		
76.00	03020 CARDI OLOGY	O	0		13, 400, 225	0.000000	76. 00
	OUTPATIENT SERVICE COST CENTERS				*		
90.00	09000 CLI NI C	0	0	(0	0.000000	90.00
90. 10	09001 FAMILY PRACTICE CLINIC	O	0		o	0.000000	90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	O	0		903, 130	0.000000	90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	o	0		3, 922, 763	0.000000	90. 50
91.00		o	461, 386	461, 386			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	0		31, 166, 639		
200.00		o	461, 386	461. 386	1, 101, 081, 603		200. 00
		1	, , , , , , , , , , , , , , , , , , , ,			1	

ealth Financial	Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	eu of Form CMS-2552-10
DDODTI ONNENT OF	L NID ATL ENT (QUITDATLENT		D 1 1 001 45 0050	5 1 1	

Hea APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0058 Peri od: Worksheet D From 01/01/2017 To 12/31/2017 THROUGH COSTS Part IV Date/Time Prepared: 5/25/2018 3:56 pm Title XVIII Hospi tal PPS Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col Costs (col. 8 Costs (col. x col. 12) 13.00 7) x col. 10) 9.00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 0 50.00 18, 118, 628 14, 617, 723 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 32, 661 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 11, 771, 333 0 24, 156, 699 54.00 54.00 0 05700 CT SCAN 0.000000 6, 696, 258 0 10, 126, 482 57.00 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 1, 118, 093 0 58.00 111, 048 0 59.00 05900 CARDIAC CATHETERIZATION 0.000000 3, 853, 162 0 5, 390, 903 0 59.00 9, 959, 296 60.00 06000 LABORATORY 0.000000 24, 336, 053 0 60.00 06001 BLOOD LABORATORY 0.000000 0 60 01 0 60 01 06500 RESPIRATORY THERAPY 0 965, 956 65.00 0.000000 10, 646, 327 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 2, 091, 695 876, 943 0 66.00 0 66.01 06602 PHYSICAL THERAPY EAST BANK 0.000000 77, 168 0 66.01 0 06601 PHYSICAL THERAPY LIVING CENTER 0.000000 42,096 0 66.10 66 10 67.00 06700 OCCUPATIONAL THERAPY 0.000000 968, 155 93, 761 0 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 0.000000 0 69, 163 67.10 0 67.10 06800 SPEECH PATHOLOGY 10, 295 68 00 0.000000 450, 869 0 68 00 0 68.10 06801 SPEECH THERAPY LIVING CENTER 0.000000 17, 546 0 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 22, 968, 866 0 10, 612, 962 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 36, 185, 625 0 72 00 0.000000 16, 525, 371 72.00 Ω 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 36, 863, 180 28, 939, 068 0 73.00 03020 CARDI OLOGY 0.000000 2, 719, 652 1, 945, 124 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0.000000 0 0 90 00 0 90. 10 09001 FAMILY PRACTICE CLINIC 0.000000 0 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 0.000000 0 90.30 90.30 0 09004 SLEEP DISORDERS CLINIC 0.000000 670, 133 90. 50 90. 50 0 0 5, 258, 667 5, 890, 635 91.00 91. 00 09100 EMERGENCY 0.008915 46, 881 52, 515 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 4, 327, 284 0 92.00

184, 079, 224

46, 881

135, 425, 656

52, 515 200. 00

Total (lines 50 through 199)

	RIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Period: From 01/01/2017	Worksheet D Part V	
				Γο 12/31/2017	Date/Time Pre 5/25/2018 3:5	pared:
		Title	xVIII	Hospi tal	PPS	о ріп
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Servi ces (see	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.		
	1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0. 386688	14, 617, 723		0	5, 652, 498	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 519355		•		0,002,170	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 168372	l .	69	0	4, 067, 312	54.00
57. 00 05700 CT SCAN	0. 034095			0	345, 262	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 267656			0	29, 723	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 126125	5, 390, 903		0	679, 928	59.00
60. 00 06000 LABORATORY	0. 119951	9, 959, 296		0	1, 194, 628	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 152133	965, 956		0	146, 954	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 515759	876, 943		0	452, 291	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0. 394564			0	30, 448	
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	0. 339920			0	14, 309	66. 10
67.00 06700 OCCUPATIONAL THERAPY	0. 423590			0	39, 716	67. 00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0. 325487			0	22, 512	
68. 00 06800 SPEECH PATHOLOGY	0. 331254			0	3, 410	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0. 291232		1	0	5, 110	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 163952				1, 740, 016	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 217289				3, 590, 781	
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 CARDI OLOGY	0. 194704 0. 336587	28, 939, 068 1, 945, 124		0	5, 634, 552 654, 703	73. 00 76. 00
OUTPATIENT SERVICE COST CENTERS	0. 330587	1, 945, 124		<u> </u>	654, 703	76.00
90. 00 09000 CLINIC	0. 000000	0		0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC	0. 000000			0	0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	2. 241946	ŀ			Ö	90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	0. 276907	l e		0	185, 565	•
91. 00 09100 EMERGENCY	0. 518237	5, 890, 635		0	3, 052, 745	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 328668			0	1, 422, 240	
200.00 Subtotal (see instructions)		135, 425, 656		0	28, 964, 703	
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	1	135, 425, 656	16, 38	0	28, 964, 703	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0058 Peri od: Worksheet D From 01/01/2017 To 12/31/2017 Part V Date/Time Prepared: 5/25/2018 3:56 pm 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.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 116 05700 CT SCAN 0 0 57.00 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 00000000000 0 59.00 06000 LABORATORY 0 60.00 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66 00 06602 PHYSI CAL THERAPY EAST BANK 66.01 0 66.01 66. 10 06601 PHYSICAL THERAPY LIVING CENTER 0 66. 10 06700 OCCUPATIONAL THERAPY 67.00 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 0 67. 10 67.10 68.00 06800 SPEECH PATHOLOGY 0 68.00 06801 SPEECH THERAPY LIVING CENTER 68. 10 68. 10 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 105 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 270 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 0 03020 CARDI OLOGY 76.00 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09001 FAMILY PRACTICE CLINIC 0 0 90. 10 90.10 0 90.30 09002 HEMATOLOGY ONCOLOGY CLINIC 0 90.30 09004 SLEEP DISORDERS CLINIC 0 0 90.50 90.50 91. 00 09100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 200.00 Subtotal (see instructions) 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201. 00

3, 491

0

202.00

Only Charges

Net Charges (line 200 - line 201)

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			Provider CCN: 15-0058		Worksheet D		
		Component	CCN: 15-S058	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/25/2018 3:5	pared: 6 pm	
		Title	xVIII	Subprovi der -	PPS		
. IPF							
Cost Center Description	Capi tal	Total Charges			Capital Costs		
		(from Wkst. C,		Program	(column 3 x		
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)		
	Part II, col.	8)	2)				
	26)	0.00	0.00	4.00	F 00		
ANGLI LADV CEDVI CE COCT CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00		
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM	4, 524, 440	110, 713, 205	0. 04086	6 285, 072	11, 650	50.00	
52. 00 05200 DELIVERY ROOM & LABOR ROOM			1			1	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 508, 502				0 192		
57. 00 05700 CT SCAN	2, 278, 826 121, 373				l	1	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	168, 453				97	58.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	693, 474		1		0		
60. 00 06000 LABORATORY	521, 089						
60. 01 06001 BLOOD LABORATORY	321,007		0.00000		0	60. 01	
65. 00 06500 RESPI RATORY THERAPY	317, 202	-	1			65. 00	
66. 00 06600 PHYSI CAL THERAPY	549, 269				8, 754		
66. 01 06602 PHYSI CAL THERAPY EAST BANK	9, 403				0,751	1	
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	3, 593		1		o o	66. 10	
67. 00 06700 OCCUPATI ONAL THERAPY	267, 487					1	
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	2, 307		1		0	1	
68. 00 06800 SPEECH PATHOLOGY	26, 227		1		10	68. 00	
68. 10 06801 SPEECH THERAPY LIVING CENTER	1, 591				0	68. 10	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0. 00000	0 0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	831, 498	119, 070, 574	0. 00698	3 3, 541	25	71. 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	671, 480	150, 654, 015	0. 00445	7 1, 604	7	72. 00	
73.00 07300 DRUGS CHARGED TO PATIENTS	618, 763	202, 797, 707	0.00305	1 604, 901	1, 846	73.00	
76. 00 03020 CARDI OLOGY	329, 054	13, 400, 225	0. 02455	6 312	8	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. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	417, 494				0		
90. 50 09004 SLEEP DI SORDERS CLINIC	6, 722				0		
91. 00 09100 EMERGENCY	1, 621, 735					1	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	,,	1		0		
200.00 Total (lines 50 through 199)	15, 489, 982	1, 101, 081, 603	I	1, 239, 665	24, 196	200. 00	

Health Financial Systems	MEMORIAL HOSPITAL	OF SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PA	SS Provider CCN: 15-0058	Peri od: From 01/01/2017	Worksheet D
THOUGH COSTS		Component CCN: 15-S058		
		Ti +Lo VVIII	Subprovi dor	DDS

		Titl∈	e XVIII	Subprovi der -	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
oost conten boschiption	Anesthetist	Post-Stepdown		Post-Stepdown	/ I I I Gu I I Gui tii	
	Cost	Adjustments		Adjustments		
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS		•		"		
50. 00 05000 OPERATING ROOM	C	0) (0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0) (0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0) (0	0	54.00
57. 00 05700 CT SCAN	C	0) (0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0) (0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0) (0	0	59. 00
60. 00 06000 LABORATORY	C	0) (0	0	60.00
60. 01 06001 BLOOD LABORATORY		0) (0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY		0) (0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	C	0) (0	0	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK		0) (0	0	66. 01
66. 10 06601 PHYSICAL 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	C	0		0	0	67. 10
68. 00 06800 SPEECH PATHOLOGY) 0) (0	0	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER) 0) (0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY) 0) (0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0) (0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0) (0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0) (0	0	73. 00
76. 00 03020 CARDI OLOGY	C	0) (0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	C	0) (0	0	90. 00
90. 10 09001 FAMILY PRACTICE CLINIC	C	0) (0	0	90. 10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	C	0) (0	0	90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	C	0) (0	0	90. 50
91. 00 09100 EMERGENCY	C) 0) (0	461, 386	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C)	0	92. 00
200.00 Total (lines 50 through 199)	C) 0) (0	461, 386	200. 00

Heal th	Financial Systems MEMO	RIAL HOSPITAL O	F SOUTH BEND.	INC	In Li∈	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF				Peri od:	Worksheet D	
THROUG	H COSTS		Component CCN: 15-S058		From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre 5/25/2018 3:5	pared:
			Ti tl e	e XVIII	Subprovi der -	PPS	
					I PF		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of col 1				
		Education Cost	J	Cost (sum o		(col. 5 ÷ col.	
			4)	col . 2, 3 ar	nd 8)	7)	
		4.00	5. 00	4) 6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00	05000 OPERATING ROOM	0	C	1	0 110, 713, 205	0.000000	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	_		0 19, 560, 044	l	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	_		0 115, 187, 914		
57. 00	05700 CT SCAN	0			0 62, 914, 833		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0 3, 220, 235		
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Č		0 25, 214, 299		
60.00	06000 LABORATORY	0	Č		0 122, 883, 396		
60. 01	06001 BLOOD LABORATORY	0	Č		0 .22,000,00	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	Ċ		0 40, 296, 841	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	Ċ		0 9, 218, 615		
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	C		0 3, 770, 484	l	
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0	C		0 1, 687, 367	0.000000	66. 10
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0 6, 542, 716	0.000000	67.00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	C		0 1, 118, 129	0.000000	67. 10
68.00	06800 SPEECH PATHOLOGY	0	C		0 4, 202, 669	0.000000	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0	C		0 879, 927	0.000000	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C)	0 0	0.000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 119, 070, 574	•	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 150, 654, 015		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	_		0 202, 797, 707	l	
76. 00	03020 CARDI OLOGY	0	C)	0 13, 400, 225	0.000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	_)	0 0	0.000000	
90. 10	09001 FAMILY PRACTICE CLINIC	0	C)	0 0	0.000000	
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	C		0 903, 130		
90. 50	09004 SLEEP DI SORDERS CLINIC	0	4/1 22/	1/1 2	0 3, 922, 763		
91.00	09100 EMERGENCY	0	,	461, 3			
92. 00 200. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) Total (lines 50 through 199)	0	_	161 2	0 31, 166, 639 86 1, 101, 081, 603	l	200.00
∠00.00	Tiotal (Titles 30 tillough 199)	1	401, 380	y 401, 3	00 1, 101, 001, 003	I	₁ 200.00

Health Financial Systems MEMC	RIAL HOSPITAL OF	SOUTH BEND,	I NC	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI		Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS			Component CCN: 15-S058		Part IV Date/Time Pre 5/25/2018 3:5	
		Title	XVIII	Subprovi der -	PPS	
				' I PF		
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	285, 072		0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	9, 680		0 0	0	54.00
57. 00 05700 CT SCAN	0. 000000	5, 020		0 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 857		0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	130, 970		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000	26, 325		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	146, 922		0 0	0	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0. 000000	0	1	0 0	0	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	0. 000000	0		0 0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	15, 484		0 0	0	67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0. 000000	. 0		0 0	0	67. 10
68. 00 06800 SPEECH PATHOLOGY	0. 000000	1, 527		0 0	0	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0. 000000	0	1	0 0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	3, 541		0 0	0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 604		0 0	0	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	604, 901		0 0	0	73. 00
76. 00 03020 CARDI OLOGY	0. 000000	312		0	0	
OUTPATIENT SERVICE COST CENTERS			I.			1
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC	0. 000000	0	1	0 0		
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	0. 000000	0		0 0	0	
90. 50 09004 SLEEP DI SORDERS CLINI C	0. 000000	0		0 0	0	90. 50
91. 00 09100 EMERGENCY	0. 008915	6, 450	Į į	58 0	o o	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0, 430		0 0	0	
200.00 Total (lines 50 through 199)	0.000000	1, 239, 665		58 0		200. 00
255. 55 ₁ Total (Tries 55 through 177)	1	1, 207, 000	1	, S ₁		1200.00

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			Provi der CCN: 15-0058		Worksheet D		
				From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/25/2018 3:5		
	Title	e XVIII	Subprovi der - I RF	PPS			
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		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							
50. 00 05000 OPERATI NG ROOM	4, 524, 440				331		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 508, 502				0	52. 00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 278, 826				1, 684	•	
57. 00 05700 CT SCAN	121, 373				68		
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	168, 453			· ·	291	58. 00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	693, 474				16	59. 00	
60. 00 06000 LABORATORY	521, 089				911		
60. 01 06001 BLOOD LABORATORY	0	-	0.00000		0	60. 01	
65. 00 06500 RESPI RATORY THERAPY	317, 202				655	65. 00	
66. 00 06600 PHYSI CAL THERAPY	549, 269				25, 027	66. 00	
66. 01 06602 PHYSI CAL THERAPY EAST BANK	9, 403				0	66. 01	
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	3, 593				0	66. 10	
67. 00 06700 OCCUPATI ONAL THERAPY	267, 487				16, 168	1	
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	2, 307				0	67. 10	
68. 00 06800 SPEECH PATHOLOGY	26, 227				1, 804		
68. 10 06801 SPEECH THERAPY LIVING CENTER	1, 591				0	68. 10	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	-	1 0.0000		0	70. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	831, 498						
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	671, 480						
73. 00 07300 DRUGS CHARGED TO PATIENTS	618, 763						
76. 00 03020 CARDI OLOGY	329, 054	13, 400, 225	0. 02455	9, 593	236	76. 00	
OUTPATIENT SERVICE COST CENTERS	_	_	T	1			
90. 00 09000 CLI NI C	0	1			0		
90. 10 09001 FAMILY PRACTICE CLINIC	0	_			0		
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	417, 494				0		
90. 50 09004 SLEEP DI SORDERS CLINIC	6, 722		1		0	90. 50	
91. 00 09100 EMERGENCY	1, 621, 735				0	91.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	,,	1				
200.00 Total (lines 50 through 199)	15, 489, 982	1, 101, 081, 603		2, 150, 432	49, 443	200.00	

Health Financial Systems	MEMORIAL HOSPITAL	OF SOUTH BENE), INC	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER P	ASS Provi der	CCN: 15-0058	Peri od: From 01/01/2017	Worksheet D Part IV
		Componer	nt CCN: 15-T058	To 12/31/2017	Date/Time Prepared: 5/25/2018 3:56 pm
		Ti ·	tle XVIII	Subprovi der -	PPS

			Title	· XVIII	Subprovi der -	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	IRF Allied Health	Allied Health	
	cost denter bescription		Post-Stepdown	Indi Siring Scribbi	Post-Stepdown	Airred hearth	
		Cost	Adjustments		Adjustments		
		1.00	2A	2, 00	3A	3. 00	
P	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	C	0	0	50.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52. 00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
57.00	D5700 CT SCAN	0	0	C	0	0	57.00
58.00	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	0	58. 00
59.00	D5900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59. 00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
60. 01	D6001 BLOOD LABORATORY	0	0	C	0	0	60. 01
65.00	06500 RESPIRATORY THERAPY	0	0	C	0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
66. 01	06602 PHYSICAL THERAPY EAST BANK	0	0	C	0	0	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	C	0	0	66. 10
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	C	0	0	67. 10
68.00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0	0	C	0	0	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
	D7300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
	03020 CARDI OLOGY	0	0	C	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS	1					
	09000 CLI NI C	0	0	C	0	0	, , , , , ,
	09001 FAMILY PRACTICE CLINIC	0	0	C	0	0	90. 10
	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	C	0	0	90. 30
	09004 SLEEP DI SORDERS CLINIC	0	0	C	0	0	90. 50
	09100 EMERGENCY	0	0	0	0	461, 386	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92. 00
200.00	Total (lines 50 through 199)	0	0	(C	0	461, 386	200. 00

Health Financial Systems MEMO	RIAL HOSPITAL O	IF SOUTH REND	LNC	In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER				Peri od:	Worksheet D	2332 10
THROUGH COSTS		Component	CCN: 15-T058	From 01/01/2017 To 12/31/2017		pared: 6 pm
		Titl∈	XVIII	Subprovi der -	PPS	
Cost Center Description	All Other	Total Cost	Total	IRF Total Charges	Ratio of Cost	
cost center bescription	Medi cal	(sum of col 1		(from Wkst. C,	to Charges	
	Education Cost	, ·	Cost (sum o		(col . 5 ÷ col .	
	Ludcati on cost	4)	col. 2, 3 an	·	7)	
		''	4)	u	, ,	
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS			•		•	
50. 00 05000 OPERATING ROOM	0	0	1	0 110, 713, 205	0.000000	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 19, 560, 044	0.000000	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 115, 187, 914	0.000000	54.00
57. 00 05700 CT SCAN	0	0)	0 62, 914, 833	0.000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0 3, 220, 235	0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0 25, 214, 299	0. 000000	59. 00
60. 00 06000 LABORATORY	0	0)	0 122, 883, 396	0.000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0	1	0	0.000000	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0	1	0 40, 296, 841	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0	0)	0 9, 218, 615		
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0	0)	0 3, 770, 484		
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	0	0)	0 1, 687, 367		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 6, 542, 716		1
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0		0 1, 118, 129		
68.00 06800 SPEECH PATHOLOGY	0	0	1	0 4, 202, 669		
68. 10 06801 SPEECH THERAPY LIVING CENTER	0	0	1	0 879, 927		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	1	0 0	0.00000	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 119, 070, 574		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		1	0 150, 654, 015		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		1	0 202, 797, 707		
76. 00 03020 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS	0	0	1	0 13, 400, 225	0.000000	76. 00
90. 00 09000 CLINIC	1 0			0 0	0. 000000	90.00
90. 10 09000 CEINIC 90. 10 09001 FAMILY PRACTICE CLINIC	0				0.00000	
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC				0 903, 130		
90. 50 09004 SLEEP DI SORDERS CLINIC				0 3, 922, 763		
91. 00 09100 EMERGENCY		461, 386	461, 38			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1	1	0 31, 166, 639		
200.00 Total (lines 50 through 199)		1	1	31, 100, 037		200. 00
	1	1 .5., 666		,,,	1	,_ 30. 00

Health Financial Syste		ORIAL HOSPITAL OF				eu of Form CMS-	2552-10
	TIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS			Component		From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre 5/25/2018 3:5	
			Title	: XVIII	Subprovi der -	PPS	
					I RF		
Cost Cent	er Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI	CE COST CENTERS						
50. 00 05000 OPERATI NG	ROOM	0. 000000	8, 111		0 0	0	50. 00
52. 00 05200 DELI VERY	ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
54. 00 05400 RADI OLOGY	-DI AGNOSTI C	0. 000000	85, 123		0 0	0	54.00
57.00 05700 CT SCAN		0. 000000	35, 332		0 0	0	57. 00
58. 00 05800 MAGNETIC	RESONANCE IMAGING (MRI)	0. 000000	5, 571		0 0	0	58. 00
59. 00 05900 CARDI AC C		0. 000000	579		0 0	0	59. 00
60. 00 06000 LABORATOR	Y	0. 000000	214, 916		0 0	0	60.00
60. 01 06001 BL00D LAB	DRATORY	0. 000000	0		0 0	o o	60. 01
65. 00 06500 RESPI RATO	RY THERAPY	0. 000000	83, 150		0	o o	65. 00
66. 00 06600 PHYSI CAL		0. 000000	420, 035	•	0	Ō	66. 00
	THERAPY EAST BANK	0. 000000	,,	•	o o	Ō	66. 01
	THERAPY LIVING CENTER	0. 000000	0		o o	ő	66. 10
67. 00 06700 OCCUPATI 0		0. 000000	395, 461		0 0	o o	67. 00
	NAL THERAPY LIVING CENTER	0. 000000	0,0, .0.		0 0	o o	67. 10
68. 00 06800 SPEECH PA		0. 000000	288, 984	1	0 0	o o	68. 00
	ERAPY LIVING CENTER	0. 000000	200, 701		0	ő	68. 10
70. 00 07000 ELECTROEN		0. 000000	0		0 0	0	70.00
	JPPLIES CHARGED TO PATIENTS	0. 000000	92, 029	1	0	o o	71.00
	CHARGED TO PATIENTS	0. 000000	34, 299		0	o o	72.00
	RGED TO PATIENTS	0. 000000	477, 249		o o	_	73. 00
76. 00 03020 CARDI OLOG		0. 000000	9, 593		0 0		76.00
	ICE COST CENTERS	0.000000	7, 373		0 0	0	70.00
90. 00 09000 CLI NI C	TCE COST CENTERS	0. 000000	0		ol o	0	90.00
90. 10 09001 FAMILY PR	ACTICE CLINIC	0. 000000	0		0 0		90. 10
	Y ONCOLOGY CLINIC	0. 000000	0		0	0	90. 10
		0. 000000	0		0	0	90. 50
90. 50 09004 SLEEP DI SI 91. 00 09100 EMERGENCY	DRUENS CEINIC	0. 000000	0		0	0	91.00
	ON DEDC (NON DICTINGT DART)	1 1	0		0	_	
	ON BEDS (NON-DISTINCT PART)	0. 000000	· ·		0 0	0	1
200.00 Total (li	nes 50 through 199)	1 1	2, 150, 432	I	υ 0	ı	200. 00

Health Financial Systems MEMO	RIAL HOSPITAL C	F SOUTH BEND,	I NC	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2017 To 12/31/2017		
		Ti tl	e XIX	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	11, 258, 704	0	11, 258, 70	4 80, 181	140. 42	30.00
31.00 INTENSIVE CARE UNIT	1, 334, 916		1, 334, 91		165. 99	31.00
31. 01 NEONATAL INTENSIVE CARE UNIT	1, 226, 026		1, 226, 02	6 9, 755	125. 68	31. 01
40. 00 SUBPROVI DER - I PF	612, 541	0	612, 54	1 3, 716	164. 84	40.00
41. 00 SUBPROVI DER - I RF	551, 126	0	551, 12	6 3, 475	158. 60	41.00
43. 00 NURSERY	207, 749		207, 74	9 4, 431	46. 89	43. 00
200.00 Total (lines 30 through 199)	15, 191, 062		15, 191, 06	2 109, 600		200. 00
Cost Center Description	Inpati ent	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	2, 982	418, 732				30. 00
31.00 INTENSIVE CARE UNIT	0	0				31.00
31.01 NEONATAL INTENSIVE CARE UNIT	1, 666	209, 383				31. 01
40. 00 SUBPROVI DER - I PF	106	17, 473				40.00
41. 00 SUBPROVI DER - I RF	26	4, 124				41. 00
43. 00 NURSERY	379	17, 771				43.00
200.00 Total (lines 30 through 199)	5, 159	667, 483				200. 00

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0058 Peri od: Worksheet D From 01/01/2017 Part II 12/31/2017 Date/Time Prepared: 5/25/2018 3:56 pm Title XIX Hospi tal PPS Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent to Charges (from Wkst. C. (column 3 x Related Cost Program (from Wkst. B. column 4) Part I, col. $(col. 1 \div col.$ Charges 2) Part II, col. 8) 26) 2.00 3.00 4.00 5.00 1.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4. 524. 440 110, 713, 205 0.040866 16, 978, 845 693, 857 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 1,508,502 19, 560, 044 0.077122 9, 969, 764 768, 888 52.00 05400 RADI OLOGY-DI AGNOSTI C 2, 278, 826 115, 187, 914 0.019784 8, 328, 640 54.00 164, 774 54.00 05700 CT SCAN 121, 373 62, 914, 833 0.001929 3, 878, 794 7, 482 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 168, 453 3, 220, 235 0.052311 583, 170 30, 506 58.00 59.00 05900 CARDIAC CATHETERIZATION 693, 474 25, 214, 299 0.027503 2, 405, 625 66, 162 59.00 60.00 06000 LABORATORY 521,089 122, 883, 396 0.004241 18, 192, 778 77, 156 60.00 06001 BLOOD LABORATORY 0.000000 60 01 Ω 60 01 06500 RESPIRATORY THERAPY 317, 202 40, 296, 841 65.00 0.007872 11, 504, 834 90, 566 65.00 66.00 06600 PHYSI CAL THERAPY 549, 269 9, 218, 615 0.059583 730, 499 43, 525 66.00 66.01 06602 PHYSICAL THERAPY EAST BANK 9, 403 3, 770, 484 0.002494 880 66.01 06601 PHYSICAL THERAPY LIVING CENTER 1, 687, 367 0.002129 3 593 285 66 10 66 10 67.00 06700 OCCUPATIONAL THERAPY 267, 487 6, 542, 716 0.040883 625, 246 25, 562 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 0.002063 67.10 2, 307 1, 118, 129 372 67.10 06800 SPEECH PATHOLOGY 68 00 26 227 4 202 669 0.006241 275, 427 1,719 68 00 68. 10 06801 SPEECH THERAPY LIVING CENTER 1, 591 879, 927 0.001808 Ω 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0.000000 0 70.00 1, 779 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 831, 498 119, 070, 574 0.006983 254, 829 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 671, 480 0.004457 150, 654, 015 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 618, 763 202, 797, 707 0.003051 21, 986, 882 67,082 73.00 03020 CARDI OLOGY 329, 054 13, 400, 225 0.024556 76.00 965, 315 23, 704 76.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0.000000 90 00 0 90. 10 09001 FAMILY PRACTICE CLINIC 0 0.000000 Λ 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 417, 494 903, 130 0.462275 90.30 24,677 11, 408 09004 SLEEP DISORDERS CLINIC 3, 922, 763 0.001714 90. 50 6,722 0 90.50 1, 621, 735 91. 00 09100 EMERGENCY 51, 755, 876 0.031334 4, 227, 447 132, 463 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 404, 012 31, 166, 639 0.045049 0 92.00 100, 934, 309 200.00 Total (lines 50 through 199) 16, 893, 994 1, 101, 081, 603 2, 206, 637 200. 00

Health Financial Systems	N	EMORIAL HOSPITAL (OF SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT	ROUTINE SERVICE OTHE	R PASS THROUGH COS	TS Provi der	CCN: 15-0058	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Pre 5/25/2018 3:5	
			Ti 1	le XIX	Hospi tal	PPS	
Cost Center De	escription	Nursing School	Nursing Schoo	Allied Heal	th Allied Health	All Other	

				rom 01/01/2017 o 12/31/2017		pared:
					5/25/2018 3:5	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adj ustments	1.00	Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	C	0	0	00.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0	C	0	0	31. 01
40. 00 04000 SUBPROVI DER - I PF	0	0	C	0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	C	0	0	41.00
43. 00 04300 NURSERY	0	0	C	0	0	43. 00
200.00 Total (lines 30 through 199)	0	0	C	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		,		
	instructions)	minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•		•		•	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	80, 181	0.00	2, 982	30.00
31. 00 03100 INTENSIVE CARE UNIT		l o	8, 042	0.00	0	31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT		0	9, 755	0.00	1, 666	1
40. 00 04000 SUBPROVI DER - I PF	0	0	3, 716			
41. 00 04100 SUBPROVI DER - RF	0	0				41. 00
43. 00 04300 NURSERY		0				
200.00 Total (lines 30 through 199)		0			•	200. 00
Cost Center Description	I npati ent	0	107,000	1	J, 137	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	cost (cor. 7 x					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 NTENSI VE CARE UNI T	0	1				31. 00
	0	1				
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	_	•				31. 01
40. 00 04000 SUBPROVI DER - 1 PF	0	1				40.00
41. 00 04100 SUBPROVI DER - RF	0					41. 00
43. 00 04300 NURSERY	0					43. 00
200.00 Total (lines 30 through 199)	0	1				200. 00

 Heal th Financial
 Systems
 MEMORIAL HOSPITAL OF SOUTH BEND, INC

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-0058
 THROUGH COSTS

				'		5/25/2018 3:5	6 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	0	0	(0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
57. 00	05700 CT SCAN	0	0	(0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
60.00	06000 LABORATORY	0	0	(0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	0	(0	0	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	(0	0	66. 10
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	·	0	0	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	·	0	0	67. 10
68. 00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0	0	(0	0	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
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	0	(0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
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	0	(0	461, 386	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
200.00	Total (lines 50 through 199)	0	0		0	461, 386	200. 00
		•	•	•	•	•	•

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: Health Financial Systems MEMORIAL HOSPITAL OF SAPPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 15-0058 THROUGH COSTS

				'	0 12/31/201/	5/25/2018 3:5	
			Ti tl	e XIX	Hospi tal	PPS	
Cost Center Desc	cription	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVICE COST	T CENTERS			1 -	1		
50. 00 05000 OPERATI NG ROOM		0	0	C			1
52.00 05200 DELI VERY ROOM &		0	0	C			
54. 00 05400 RADI OLOGY-DI AGNO	OSTI C	0	0	C			•
57. 00 05700 CT SCAN		0	0	C	02/ / 1 1/ 000		57. 00
58.00 05800 MAGNETIC RESONAN		0	0	C	3, 220, 235		58. 00
59. 00 05900 CARDI AC CATHETER	RI ZATI ON	0	0	C	,		59. 00
60. 00 06000 LABORATORY		0	0	C	122, 883, 396		60.00
60. 01 06001 BLOOD LABORATOR\		0	0	C	0	0. 000000	
65. 00 06500 RESPI RATORY THEF		0	0	C	40, 296, 841	0. 000000	
66. 00 06600 PHYSI CAL THERAP)		0	0	C	9, 218, 615		1
66. 01 06602 PHYSI CAL THERAP)		0	0	C	3, 770, 484		1
66. 10 06601 PHYSI CAL THERAP)		0	0	C	1, 687, 367		1
67. 00 06700 OCCUPATI ONAL THE		0	0	C	6, 542, 716		•
67. 10 06701 OCCUPATI ONAL THE		0	0	C	1, 118, 129		
68. 00 06800 SPEECH PATHOLOGY		0	0	C	4, 202, 669		
68. 10 06801 SPEECH THERAPY L		0	0	C	879, 927		
70. 00 07000 ELECTROENCEPHALO		0	0	C	0	0.000000	1
71.00 07100 MEDICAL SUPPLIES	S CHARGED TO PATIENTS	0	0	C	119, 070, 574		
72.00 07200 I MPL. DEV. CHARC		0	0	C	150, 654, 015	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO) PATIENTS	0	0	C	202, 797, 707		
76. 00 03020 CARDI OLOGY		0	0	C	13, 400, 225	0.000000	76. 00
OUTPATIENT SERVICE COS	ST CENTERS						
90. 00 09000 CLI NI C		0	0	C	0	0.000000	1
90. 10 09001 FAMILY PRACTICE		0	0	C	0	0.000000	
90. 30 09002 HEMATOLOGY ONCOL		0	0	C	903, 130		
90. 50 09004 SLEEP DI SORDERS	CLINIC	0	0	C	-,,		
91.00 09100 EMERGENCY		0	461, 386	461, 386			1
92. 00 09200 OBSERVATI ON BEDS	,	0	0	C			•
200.00 Total (lines 50	through 199)	0	461, 386	461, 386	1, 101, 081, 603		200. 00

MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10 Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Worksheet D Part IV Date/Time Prepared: Provi der CCN: 15-0058 Peri od: From 01/01/2017 To 12/31/2017 THROUGH COSTS 5/25/2018 3:56 pm Title XIX Hospi tal PPS Cost Center Description Outpati ent Inpati ent Inpati ent Outpati ent Outpati ent Outpatron Program Pass-Through Program
Pass-Through Ratio of Cost Program Program to Charges Charges Charges (col. 6 ÷ col Costs (col. 8 Costs (col. x col. 10) 11.00 x col . 12) 13.00 7) 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 16, 978, 845 50.00 0.000000 0 0 50.00 0 0 0 0 0. 000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 9, 969, 764 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 8, 328, 640 0 0 0 0 54.00 57. 00 05700 CT SCAN 0. 000000 3, 878, 794 0 57.00 58. 00 | 05800 | MAGNETI C RESONANCE I MAGING (MRI) | 59. 00 | 05900 | CARDI AC CATHETERI ZATI ON 583, 170 0.000000 0 58.00 2, 405, 625 0.000000 0 59.00

60. 00	06000 LABORATORY	0. 000000	18, 192, 778	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	O	0	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0. 000000	11, 504, 834	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	730, 499	0	0	0	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0. 000000	880	0	0	0	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0. 000000	285	0	0	0	66. 10
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	625, 246	0	0	0	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0. 000000	372	0	0	0	67. 10
68. 00	06800 SPEECH PATHOLOGY	0. 000000	275, 427	0	0	0	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0. 000000	0	0	0	0	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	254, 829	0	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	21, 986, 882	0	0	0	73. 00
76. 00	03020 CARDI OLOGY	0. 000000	965, 315	0	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
	09000 CLI NI C	0. 000000	0	0	0	0	90.00
	09001 FAMILY PRACTICE CLINIC	0. 000000	0	0	0	0	90. 10
	09002 HEMATOLOGY ONCOLOGY CLINIC	0. 000000	24, 677	0	0	0	90. 30
	09004 SLEEP DI SORDERS CLINIC	0. 000000	0	0	0	0	90. 50
	09100 EMERGENCY	0. 008915	4, 227, 447	37, 688	0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	0	0	0	1 /2.00
200.00	Total (lines 50 through 199)		100, 934, 309	37, 688	0	0	200. 00

WEIGHT STATE OF THE STATE OF TH	DIAL HOCDITAL O	OF COUTH DEND			6.5. 046	0550 40
Health Financial Systems MEMO APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	RIAL HOSPITAL C	Provider C		IN LIE Period:	eu of Form CMS-: Worksheet D	2552-10
AFFORTIONWENT OF INFATTENT ANGIELARY SERVICE CAPITA	AL 00313			From 01/01/2017 To 12/31/2017	Part II	pared:
			e XIX	Subprovider - IPF	PPS	
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	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	4, 524, 440		1		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 508, 502				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 278, 826					54.00
57. 00 05700 CT SCAN	121, 373					
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	168, 453				103	
59. 00 05900 CARDI AC CATHETERI ZATI ON	693, 474				0	59. 00
60. 00 06000 LABORATORY	521, 089				266	
60. 01 06001 BLOOD LABORATORY	0	1	0. 00000		0	60. 01
65. 00 06500 RESPIRATORY THERAPY	317, 202				0	65. 00
66. 00 06600 PHYSI CAL THERAPY	549, 269				3, 182	
66. 01 06602 PHYSI CAL THERAPY EAST BANK	9, 403				0	
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	3, 593				0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	267, 487				165	
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	2, 307				0	67. 10
68.00 06800 SPEECH PATHOLOGY	26, 227				0	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	1, 591	1			0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1	0.0000		0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	831, 498				0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	671, 480				0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	618, 763					
76. 00 03020 CARDI OLOGY	329, 054	13, 400, 225	0. 02455	6 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	1			0	
90.10 09001 FAMILY PRACTICE CLINIC	0	1	0.0000		0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	417, 494				0	90. 30
90. 50 09004 SLEEP DISORDERS CLINIC	6, 722				0	90. 50
91. 00 09100 EMERGENCY	1, 621, 735					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
200.00 Total (lines 50 through 199)	15, 489, 982	2 1, 101, 081, 603		351, 386	4, 554	200. 00

Health Financial Systems	MEMORIAL HOSPITAL	OF SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PA	ASS Provider CCN: 15-0058	Peri od: From 01/01/2017	Worksheet D
Inkough COSTS		Component CCN: 15-S058		
		Ti +Lo VIV	Subprovidor	DDC

		Ti tl	e XIX	Subprovi der -	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
cost center bescription	Anesthetist	Post-Stepdown	Indi 31 fig 301001	Post-Stepdown	Airrea near th	
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1 0	0		0	0	54.00
57. 00 05700 CT SCAN	1 0	0		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1 0	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	l c	0	0	59. 00
60. 00 06000 LABORATORY	0	0	ol c	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	ol c	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	0	ol c	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	ol c	0	0	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0	0	ol c	0	0	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	ıl c	0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	ıl c	0	0	67. 00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	l c	0	0	67. 10
68. 00 06800 SPEECH PATHOLOGY	0	0	l c	0	0	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0	0	ol c	0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	ol c	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	ol c	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	ol c	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0) c	0	0	73. 00
76. 00 03020 CARDI OLOGY	0	0	C	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0) c	0	0	90. 00
90.10 09001 FAMILY PRACTICE CLINIC	0	0) c	0	0	90. 10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0) c	0	0	90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	0	0	C	0	0	90. 50
91. 00 09100 EMERGENCY	0	0	(C	0	461, 386	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		[C)	0	
200.00 Total (lines 50 through 199)	0	0	() C	0	461, 386	200. 00

Health Financial Systems MEMC	RIAL HOSPITAL O	DE SOUTH BEND	I NC	In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CN: 15-0058	Peri od:	Worksheet D	2002 10
THROUGH COSTS		Component	CCN: 15-S058	From 01/01/2017 To 12/31/2017		pared:
		Ti tl	e XIX	Subprovi der -	PPS	<u>o p</u>
				I PF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1		(from Wkst. C,		
	Education Cost	J .	Cost (sum o		(col. 5 ÷ col.	
		4)	col. 2, 3 ar	ld 8)	7)	
	4.00	5.00	4)	7.00		
ANOLLI ADV. CEDVI OF COCT. CENTEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				0 440 740 005	0.000000	
50. 00 05000 OPERATI NG ROOM	0	-	1	0 110, 713, 205		
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	1	1	0 19, 560, 044		
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	C	2	0 115, 187, 914		
57. 00 05700 CT SCAN	0		2	0 62, 914, 833		
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		2	0 3, 220, 235		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		2	0 25, 214, 299		1
60. 00 06000 LABORATORY	0		2	0 122, 883, 396		
60. 01 06001 BLOOD LABORATORY	0		(0 0	0.000000	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0			0 40, 296, 841 0 9 218 615	0. 000000 0. 000000	
66. 00 06600 PHYSI CAL THERAPY 66. 01 06602 PHYSI CAL THERAPY EAST BANK	0			0 9, 218, 615 0 3, 770, 484		
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	0				0.00000	
67. 00 06700 OCCUPATIONAL THERAPY	0			0 1, 687, 367 0 6, 542, 716		1
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER				0 1, 118, 129		
68. 00 06800 SPEECH PATHOLOGY				0 4, 202, 669		
68. 10 06801 SPEECH THERAPY LIVING CENTER				0 4, 202, 869		1
70. 00 07000 ELECTROENCEPHALOGRAPHY				0 874, 427	0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 119, 070, 574		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 150, 654, 015		1
73. 00 07300 DRUGS CHARGED TO PATIENTS				0 202, 797, 707	0. 000000	
76. 00 03020 CARDI OLOGY	0			0 13, 400, 225		
OUTPATIENT SERVICE COST CENTERS			1	0 13, 400, 223	0.000000	70.00
90. 00 09000 CLI NI C	0)	0 0	0.000000	90.00
90. 10 09001 FAMILY PRACTICE CLINIC	0		1	0 0		
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC				0 903, 130		1
90. 50 09004 SLEEP DI SORDERS CLINIC	1 0			0 3, 922, 763		
91. 00 09100 EMERGENCY	0	461, 386	461, 3			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1 .5., 556	.51, 5	0 31, 166, 639		
200.00 Total (lines 50 through 199)	0	461, 386	461. 3	36 1, 101, 081, 603		200. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	,		, , , , , , , , , , , , , , , , , , , ,	1	

Health Financial Systems	MEMORIAL HOSPITAL OF	SOUTH BEND,	I NC	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI				Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre 5/25/2018 3:5	
		Ti tl	e XIX	Subprovi der -	PPS	о р
				IPF		
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	0		0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 863		0	0	54.00
57.00 05700 CT SCAN	0. 000000	3, 896		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MR	0.000000	1, 973		0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	62, 803		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	53, 405		0 0	0	66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0. 000000	0		0 0	0	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	0. 000000	0		0 0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	4, 041		0 0	0	67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CE	NTER 0. 000000	0		0 0	0	67. 10
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0. 000000	0		0 0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PA	TI ENTS 0. 000000	0		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	219, 049		0 0	0	73. 00
76. 00 03020 CARDI OLOGY	0. 000000	0		0 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0. 000000	0		0 0	0	90. 10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0. 000000	0		0 0	0	90. 30
90. 50 09004 SLEEP DISORDERS CLINIC	0. 000000	0		0 0	0	90. 50
91. 00 09100 EMERGENCY	0. 008915	3, 356	3	0 0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART) 0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		351, 386	3	0	0	200. 00
	·					

W	NAL HOODITAL O	E COUTU DEND	LNO		6.5	2550 40
Health Financial Systems MEMOI APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	RIAL HOSPITAL O	Provider C		In Lie Period:	u of Form CMS-2 Worksheet D	2552-10
ALTOKITONMENT OF THE ATTENT ANGLERAKT SERVICE CALLER	L 00313			From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/25/2018 3:5	pared: 6 pm
			e XIX	Subprovider - IRF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	· ·		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
ANOLILA DIV. OFDIVI OF COOT, OFFITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	4 504 440	440 740 005	0.0400/		0.0/0	F0 00
50. 00 05000 OPERATING ROOM	4, 524, 440				2, 362	l
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 508, 502				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 278, 826				2, 465	
57. 00 05700 CT SCAN	121, 373					1
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)	168, 453				584 0	•
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	693, 474 521, 089				305	59. 00 60. 00
60. 01 06000 LABORATORY	521,069		0.00424		0	60.00
65. 00 06500 RESPI RATORY THERAPY	317, 202	1	0.00000		260	
66. 00 06600 PHYSI CAL THERAPY	549, 269				9, 530	
66. 01 06602 PHYSI CAL THERAPY EAST BANK	9, 403				7, 330	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	3, 593		0.00247		0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	267, 487				6, 086	
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	2, 307				0,000	67. 10
68. 00 06800 SPEECH PATHOLOGY	26, 227				741	68.00
68. 10 06801 SPEECH THERAPY LIVING CENTER	1, 591	879, 927			0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	831, 498	119, 070, 574	0. 00698		213	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	671, 480	150, 654, 015	0. 00445	7 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	618, 763	202, 797, 707	0. 00305	1 338, 576	1, 033	73. 00
76. 00 03020 CARDI OLOGY	329, 054	13, 400, 225	0. 02455	6 4, 954	122	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			0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	417, 494				0	90. 30
90. 50 09004 SLEEP DISORDERS CLINIC	6, 722				0	90. 50
91. 00 09100 EMERGENCY	1, 621, 735					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
200.00 Total (lines 50 through 199)	15, 489, 982	1, 101, 081, 603		1, 114, 814	23, 780	200. 00

Health Financial Systems	MEMORIAL HOSPITAL	OF SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PAS	SS Provider CCN: 15-0058	Peri od: From 01/01/2017	Worksheet D
THROUGH COSTS		Component CCN: 15-T058		
		Ti +I o VI V	Subprovi dor	5/25/2018 3:56 piii

			Titl	e XIX	Subprovi der -	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	IRF Allied Health	Allied Health	
	cost center bescription	Anesthetist	Post-Stepdown	Indi Si ilg Scriooi	Post-Stepdown	Airred hearth	
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	C	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	ol c	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	ol c	0	0	54.00
57.00	05700 CT SCAN	0	0	ol c	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0) c	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0) c	0	0	59. 00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0) c	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	0) c	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0) c	0	0	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	0) c	0	0	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0	0) c	0	0	66. 10
67.00	06700 OCCUPATI ONAL THERAPY	0	0) c	0	0	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0) c	0	0	67. 10
68.00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0	0	C	0	0	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0) c	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0) c	0	0	73. 00
76.00	03020 CARDI OLOGY	0	0	C	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0) C	0	0	, , , , , ,
	09001 FAMILY PRACTICE CLINIC	0	0) C	0	0	90. 10
	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	C	0	0	90. 30
	09004 SLEEP DI SORDERS CLINIC	0	0) C	0	0	90. 50
	09100 EMERGENCY	0	0	(C	0	461, 386	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		[C		0	92. 00
200.00	Total (lines 50 through 199)	0	0	() C	0	461, 386	200. 00

Heal th	Financial Systems MEMO	RIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C	CN: 15-0058	Peri od:	Worksheet D	
THROUG	CH COSTS		Component	CCN: 15-T058	From 01/01/2017 To 12/31/2017	Part IV Date/Time Prep 5/25/2018 3:50	pared: 6 pm
			Ti tl	e XIX	Subprovi der -	PPS	•
					IRF		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of col 1		(from Wkst. C,		
		Education Cost	through col.	Cost (sum o		(col. 5 ÷ col.	
			4)	col. 2, 3 an	d 8)	7)	
				4)			
	T	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	_					
50. 00	05000 OPERATING ROOM	0	1	1	0 110, 713, 205		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 19, 560, 044		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	C)	0 115, 187, 914		
57. 00	05700 CT SCAN	0	C)	0 62, 914, 833		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C)	0 3, 220, 235		
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	C)	0 25, 214, 299		1
60.00	06000 LABORATORY	0	C)	0 122, 883, 396		
60. 01	06001 BLOOD LABORATORY	0	C)	0 0	0.000000	
65.00	06500 RESPI RATORY THERAPY	0	C)	0 40, 296, 841		1
66. 00	06600 PHYSI CAL THERAPY	0	C)	0 9, 218, 615		
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	C)	0 3, 770, 484		
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0	C)	0 1, 687, 367		
67. 00	06700 OCCUPATI ONAL THERAPY	0	C)	0 6, 542, 716		
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	C)	0 1, 118, 129		
68. 00	06800 SPEECH PATHOLOGY	0	C)	0 4, 202, 669		
68. 10	06801 SPEECH THERAPY LIVING CENTER	0	C)	0 879, 927		
70.00	07000 ELECTROENCEPHALOGRAPHY	0)	0 0	0.00000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		2	0 119, 070, 574		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		2	0 150, 654, 015		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 202, 797, 707		
76. 00	03020 CARDI OLOGY	0	C)	0 13, 400, 225	0.000000	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS	1 0				0.000000	00.00
90.00	09000 CLINIC	0	C	2	0 0		
90. 10	09001 FAMILY PRACTICE CLINIC	0		(0 000 100	0.000000	
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	0		(0 903, 130		
90. 50	09004 SLEEP DI SORDERS CLINIC	0	4/1 22/	1 4/4 0	0 3, 922, 763		
91.00	09100 EMERGENCY	0	461, 386	1			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4/1 20/		0 31, 166, 639		
200.00	Total (lines 50 through 199)	0	461, 386	ր 401, 30	36 1, 101, 081, 603		200. 00

	ncial Systems MEMO NT OF INPATIENT/OUTPATIENT ANCILLARY SE	RIAL HOSPITAL OF	SOUTH BEND,		In Li∈ Period:	eu of Form CMS-2 Worksheet D	<u>2552-10</u>
THROUGH COS		WIGE OTHER TAGS	Component	CCN: 15-T058	From 01/01/2017 To 12/31/2017	Part IV	
			Ti tl	e XIX	Subprovi der – I RF	PPS	
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13.00	
ANCI L	LARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0. 000000	57, 792		0 0	0	50. 00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
54.00 05400	RADI OLOGY-DI AGNOSTI C	0. 000000	124, 576		0	0	54.00
57.00 05700	CT SCAN	0. 000000	12, 944		0 0	0	57. 00
58. 00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	11, 166		0 0	0	58. 00
	CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
	LABORATORY	0. 000000	71, 993		0 0	0	60.00
60. 01 06001	BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
65. 00 06500	RESPI RATORY THERAPY	0. 000000	33, 028		0 0	0	65. 00
66. 00 06600	PHYSI CAL THERAPY	0. 000000	159, 948		0 0	0	66. 00
	PHYSICAL THERAPY EAST BANK	0. 000000	0		0 0	0	66. 01
•	PHYSICAL THERAPY LIVING CENTER	0. 000000	0		0 0	0	66. 10
•	OCCUPATIONAL THERAPY	0. 000000	148, 871		0 0	0	67. 00
	OCCUPATIONAL THERAPY LIVING CENTER	0. 000000	0		0 0	0	67. 10
	SPEECH PATHOLOGY	0. 000000	118, 735		0 0	0	68. 00
	SPEECH THERAPY LIVING CENTER	0. 000000	0		0 0	0	68. 10
	ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	30, 501		0 0	0	71. 00
	IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72. 00
	DRUGS CHARGED TO PATIENTS	0. 000000	338, 576		0 0	0	73. 00
	CARDI OLOGY	0. 000000	4, 954		0	Ō	76. 00
	ATIENT SERVICE COST CENTERS		.,	<u> </u>			1
	CLINIC	0. 000000	0		0 0	0	90.00
	FAMILY PRACTICE CLINIC	0. 000000	0		o o		90. 10
	HEMATOLOGY ONCOLOGY CLINIC	0. 000000	0		0	0	90. 30
	SLEEP DISORDERS CLINIC	0. 000000	0		0	Ō	90. 50
	EMERGENCY	0. 008915	1, 730	1	5 0	0	91. 00
	OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 700		0 0	o o	
200. 00	Total (lines 50 through 199)	3. 333000	1, 114, 814		5 0	_	200. 00
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1	.,, 0	'	-1	'	,

Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0058	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Preps/25/2018 3:56	
		Title XVIII	Hospi tal	PPS	
Coot Conton Docomintion					

MRIT ALL PROFITER CORPORERIS 1.00					5/25/2018 3:50	6 pm	
MAIL PROVIDER COMPONENTS 1.00			Title XVIII	Hospi tal	PPS		
NAMILIE DWS		Cost Center Description					
MARTIERT DAYS 1.00 Inpatient days (Including private room days and swing-bed days, excluding newborn) 80, 181 2.00 1.00 Inpatient days (Including private room days, excluding swing-bed and newborn days) 57, 60 3.00 1.00					1.00		
1,000 Inpatient days (including private room days, and swing-bed days, excluding newborn) 80,181 1,000							
Impatient days (including private room days, excluding saing-bed and nesborn days) 1.7 you have only private room days, 5.7 o							
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 57,900 3.00	1.00				80, 181		
do not complete this line. 4. 00 Sell-private room days (excluding saling-bed and observation bed days) through December 31 of the cost	2.00			80, 181	2. 00		
Semi-private room days (excluding swing-bed and observation bed days) through December 31 of the cost coporting period in the swing-bed SMF type inputient days (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting D	3.00		vate room days,	57, 960	3. 00		
Total saying-bed SNF type inpatient days (including private room days) after December 31 of the cost of 10tal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)							
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and subject of the cost reporting period (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) after Swing-bed SNF type inpatient days applicable to the swing-bed SNF type inpatient days applicable to the Program (excluding private room days) after Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) after Swing-bed SNF type inpatient days applicable to tritle SV or XIX only (including private room days) after December 31 of the cost reporting period (see instructions) 13.00 Swing-bed NF type inpatient days applicable to tritles V or XIX only (including private room days) after December 31 of the cost reporting period (see instructions) 14.00 Swing-bed NF type inpatient days applicable to tritles V or XIX only (including private room days) after December 31 of the cost reporting period (see instructions) 15.00 None of the NF type inpatient days applicable to tritles V or XIX only (including private room days) applicable to tritles V or XIX only (including private room days) 16.00 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost reporting period (see instructions) 17.00 NF William (see the NF type inpatient days applicable to services after December 31 of the cost reporting period (see instructions) 18.00 NF William (see the NF type inpatient days applicable to ser					12, 222	1	
10 10 10 10 10 10 10 10	5.00		om days) through Decembe	r 31 of the cost	0	5. 00	
reporting period (if calendar year, enter 0 on this line) 0							
1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 0 0 0	6. 00		om days) after December :	31 of the cost	0	6. 00	
Proporting period Proporting period Proporting period Proporting period (if calendar year, enter 0 on this line) Proporting period (if it will be proporting period (if it is period wi					_		
10 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if r cal endar year, enter 0 on this line) 9.00 10 10 10 10 10 10 10	7.00		m days) through December	31 of the cost	ان	7.00	
reporting period (if calendar year, enter 0 on this line) 10.00 10	0.00			1 -6		0.00	
1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0.00 0.00	8.00		m days) after December 3	i or the cost	ا	8.00	
newborn days	0 00		the Dreamam (eveluding	cwing had and	21 075	0.00	
10.00 Swing-bed SMT type inpatient days applicable to title XVIII only (including private room days) after brown becember 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMT type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Amount of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Amount of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Amount of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Amount of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Amount of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Amount of the cost (if the value) 12.00 Amount of the value 12.00 Amount of t	9.00		the Program (excruding	Swifig-bed and	21,973	9.00	
through December' 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 1.00 Swing-bed Nortype inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed Nortype inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed Nortype inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed Nortype inpatient days applicable to titles V or XIX only (including private room days) 1.00 Medically in excessing private room days applicable to the Program (excluding swing-bed days) 1.00 Medically in excessing private room days applicable to the Program (excluding swing-bed days) 1.00 Medical room of the Victor of XIX only) 1.00 Medical care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 1.00 Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 2.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to S	10 00	, ,	alv (including private r	nom dave)	, o	10 00	
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendary sear, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 X Iline 18) 23.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 X Iline 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 X Iline 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 X Iline 18) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 X Iline 18) 27.00 Comment Inpatient routine service cost (line 20 Iline 30 Iline 3	10.00			Joili days)	ا	10.00	
December 31 of The cost reporting period (if calendar year, enter 0 on this line) 12.00	11 00			nom days) after	ا م ا	11 00	
12.00 Swing-bed NF type inpatient days applicable to titles \(\tilde{V}\) or XIX only (including private room days) 0 12.00	11.00			Join days) arter	ا	11.00	
through December 31 of the cost reporting period 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medical planets are provided by the cost reporting period (if calendar year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (acare rate for swing-bed SNF services applicable to services after December 31 of the cost 17.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 medical dar for swing-bed NF services applicable to services through December 31 of the cost 19.00 medical dar for swing-bed NF services applicable to services after December 31 of the cost 19.00 medical dar for swing-bed NF services applicable to services after December 31 of the cost 19.00 medical dar for swing-bed NF services applicable to services after December 31 of the cost 19.00 medical dar for swing-bed NF services applicable to services after December 31 of the cost 19.00 medical dar for swing-bed NF services applicable to services after December 31 of the cost 19.00 medical dar for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 12) 20.01 Total general inpatient routine service services after December 31 of the cost reporting period (line 6 x line 13) 20.02 ming-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 13) 20.03 ming-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 13) 20.04 ming-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 23) 20.05 ming-bed cost applicable to NF type services after December 31 of the cos	12.00			e room days)	0	12.00	
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line) 14.00 15.00	.2.00		t only (morearing private	o i oom dayo,	ا	12.00	
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 17.00 Nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Nursery days (title V or XIX only) 19.00 Medicader rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Nursery days (title V or XIX only) 20.01 Nursery days (title V or XIX only) 20.02 Nursery days (title V or XIX only) 20.03 Nursery days (title V or XIX only) 20.04 Nursery days (title V or XIX only) 20.05 Nursery days (title V or XIX only) 20.06 Nursery days (title V or XIX only) 20.07 Nursery days (title V or XIX only) 20.08 Nursery days (title V or XIX only) 20.09 Nursery days (title V or XIX only) 20.00 Nursery days (title Vor XIX only)	13.00		only (including private	e room davs)	0	13.00	
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 0 15.00 16.00 Nursery, days (title V or XIX only) 0 15.00 15.00 Nursery, days (title V or XIX only) 0 15.00 15.00 Nursery, days (title V or XIX only) 0 15.00 1							
16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 17.00 Nursery	14.00				0	14. 00	
SWING BED ADJUSTMENT 1. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period need to report the period medicare rate for swing-bed NF services applicable to services through December 31 of the cost need to report the period need to r	15.00	Total nursery days (title V or XIX only)		3 ,	0	15. 00	
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 reporting period decide rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 Period of the cost reporting period of 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Period of the cost reporting period of 19.00 Pe	16.00	Nursery days (title V or XIX only)			0	16. 00	
Reporting period 18.00 18.00 18.00 18.00 19.00 1		SWING BED ADJUSTMENT				1	
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Title 2011 Registral PPS Program post Program by PS Program Cost Pr	COMPUTA	ATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-0058	From 01/01/2017	Date/Time Pre	pared:
Total				Title	XVIII	Hospi tal		о рііі
Accordance		Cost Center Description		Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
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		Intensive Care Type Inpatient Hospital Units						
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66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICCF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 7 minus line 77) 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) 81.00 Inpatient routine service cost per diem limitation 81.01 Inpatient routine service cost limitation (line 9 x line 81) 82.02 Reasonable inpatient routine service costs (see instructions)	65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the c	ost reporting	period (See	0	65. 00
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67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.01 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 9 x line 76) 77.00 Program capital-related costs (line 75 + line 2) 77.01 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost (see instructions) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00	66.00		ne costs (Tine	o4 prus rine o	o)(title xvii	i oniy). For	0	00.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period ((ine 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Reasonable inpatient routine service costs (see instructions) 83.00	67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	n December 31 o	f the cost re	porting period	0	67. 00
70.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 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) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions)	68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after [December 31 of	the cost repo	rting period	0	68. 00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 80.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions)	69. 00	1 '	routine costs ((line_67 + line	68)		0	69. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.01 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.01 Inpatient routine service cost per diem limitation 81.02 Inpatient routine service cost limitation (line 9 x line 81) 82.03 Reasonable inpatient routine service costs (see instructions) 83.00								ļ
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions)			-		, ,			70.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 83.00		, ,		The 70 ÷ Tine	2)			71.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1npatient routine service cost (line 74 minus line 77) 78.00 Inpatient routine service costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 83.00		·	•	m (line 14 x li	ne 35)			73. 00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 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) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions)		1			,			74. 00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.01 Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 79.01 Inpatient routine service cost per diem limitation 79.02 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00	75. 00		routine service	e costs (from W	orksheet B, F	art II, column		75. 00
77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 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) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 83.00	74 00		2)					74 00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 83.00			. *					77.00
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) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 79.0 80.0 81.0 82.0 83.0								78. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions)		00 0	,		*.			79. 00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient routine service costs (see instructions)				cost limitation	(line 78 min	us line 79)		80.00
83.00 Reasonable inpatient routine service costs (see instructions)				1)				81. 00 82. 00
				* .				83. 00
		,		•				84. 00
								85. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				nrough 85)				86. 00

9, 999 87. 00 1, 024. 45 88. 00 10, 243, 476 89. 00

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)

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

Health Financial Systems MEMO	RIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/25/2018 3:50	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	11, 258, 704	82, 141, 744	0. 13706	10, 243, 476	1, 404, 012	90.00
91.00 Nursing School cost	0	82, 141, 744	0.000000	10, 243, 476	0	91.00
92.00 Allied health cost	0	82, 141, 744	0.000000	10, 243, 476	0	92.00
93.00 All other Medical Education	0	82, 141, 744	0. 000000	10, 243, 476	0	93. 00

Health Financial Systems	MEMORIAL HOSPITAL OF S	OUTH BEND, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058	Peri od: From 01/01/2017	Worksheet D-1
		Component CCN: 15-S058	To 12/31/2017	Date/Time Prepared: 5/25/2018 3:56 pm
		Title XVIII	Subprovi der -	PPS

		litle XVIII	Subprovider -	PPS		
	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			3, 716	1. 00	
2.00	Inpatient days (including private room days, excluding swing-			3, 716		
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	rivate room days,	0	3. 00	
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 716	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5. 00	
	reporting period					
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00	
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	r 31 of the cost	0	7. 00	
,, 00	reporting period	dayo, t oag becombe.	0. 0. 1 1	Ĭ	7.00	
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	31 of the cost	0	8. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	a the Dragram (avaludina	a cui na had and	1 2/2	9. 00	
9. 00	Total inpatient days including private room days applicable to newborn days)	o the Program (excruding	g swillg-bed and	1, 362	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10. 00	
	through December 31 of the cost reporting period (see instruc			_		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		room days) after	0	11. 00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12. 00	
	through December 31 of the cost reporting period					
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13. 00	
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			o	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				
	SWING BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	0.00	17. 00			
18. 00	Medicare rate for swing-bed SNF services applicable to service	0. 00	18. 00			
	reporting period					
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	0.00	19. 00			
20. 00	Medicaid rate for swing-bed NF services applicable to services	0. 00	20. 00			
04.00	reporting period			2 707 (05	04 00	
21. 00 22. 00	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through December		ting period (line	3, 707, 625 0		
22.00	5 x line 17)	ci 31 di the cost report	tring period (Trine	ŏ	22.00	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23. 00	
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ing period (line	0	24. 00	
24.00	7 x line 19)	1 31 of the cost reporti	riig perrou (iriic	ŏ	24.00	
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25. 00	
26. 00	x line 20) Total swing-bed cost (see instructions)			o	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 707, 625		
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)		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	÷ line 28)		0. 000000		
32.00	Average private room per diem charge (line 29 ÷ line 3)	ŕ		0.00	32. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 00) (0.00		
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li		ctions)	0. 00 0. 00		
36. 00	Private room cost differential adjustment (line 3 x line 35)	01)		0.00	36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost	3, 707, 625	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			997. 75	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line			1, 358, 936		
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		1 358 036		
41.00	Tiotai Trogram general Impatrent routine service cost (ITNe 39	+ 1111C 40)		1, 358, 936	41.00	

Heal th	Financial Systems MEMOI	RLAL HOSPITAL OF	SOUTH BEND,	I NC	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0058	Peri od: From 01/01/2017	Worksheet D-1	
			Component	CCN: 15-S058	To 12/31/2017	Date/Time Pre 5/25/2018 3:5	
			Title	× XVIII	Subprovi der -	PPS	о рііі
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
	cost center bescription	Inpatient Cost I		Diem (col. 1	3	(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	2.00 C				42.00
40.00	Intensive Care Type Inpatient Hospital Units				20		40.00
43. 00 43. 01	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	0	C	1		l e	
44. 00	CORONARY CARE UNIT		_				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
	Cost Center Description	,					
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 337, 451	48. 00
	Total Program inpatient costs (sum of lines			ons)		1, 696, 387	
F0 00	PASS THROUGH COST ADJUSTMENTS			WI 1 D		004 540	F0 00
50. 00	Pass through costs applicable to Program inp.	atient routine s	ervices (from	1 WKST. D, SUI	n or Parts I and	224, 512	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	24, 254	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				248, 766	52. 00
53. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anestl	netist, and	1, 447, 621	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program di scharges					0	54.00
	Target amount per discharge					l	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tare	net amount (1	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	ring cost and tary	get amount (i	THE 30 III HGS	11110 33)	ő	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndi ng 1996, ι	ipdated and co	ompounded by the	0.00	59. 00
60. 00	market basket 00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						
	61.00 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)						
62.00	Relief payment (see instructions)	0	62.00				
63. 00							
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	ber 31 of the	cost reporti	ng period (See	0	64. 00
(F. 00	instructions)(title XVIII only)		- 21 -6 +1				/ F 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December	r 31 or the d	cost reporting	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-hed NF inpatient routing	e costs through l	December 31 d	of the cost re	enorting period	0	67. 00
07.100	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	cember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	: 68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						70.00
70. 00 71. 00	Adjusted general inpatient routine service c				,		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line			05)			72.00
73. 00 74. 00							73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient				Part II, column		75. 00
76. 00	26, line 45) Per diem capital related costs (line 75 : line 2)						76. 00
77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)						77. 00
78. 00							78. 00
79. 00 80. 00	, 55 5						79. 00 80. 00
81. 00	Inpatient routine service cost per diem limitation						81. 00
82. 00 83. 00							82. 00 83. 00
84. 00	· · · · · · · · · · · · · · · · · · ·						84. 00
85.00							85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		ougn 85)				86. 00
87. 00	Total observation bed days (see instructions)				0	
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (se	•	iine 2)			ł	88. 00 89. 00
57.00	(36)	o doc 0113)					, 57.00

Health Financial Systems MEMO	RIAL HOSPITAL O	F SOUTH BEND,	I NC	In Lie	eu of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1		
		Component (From 01/01/2017 To 12/31/2017			
		Title	XVIII	Subprovi der - I PF	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line 21)	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	612, 541	3, 707, 625	0. 16521	1 0	0	90.00	
91.00 Nursing School cost	0	3, 707, 625	0.00000	0	0	91.00	
92.00 Allied health cost	0	3, 707, 625	0.00000	0	0	92.00	
93.00 All other Medical Education	0	3, 707, 625	0.00000	0 0	0	93. 00	

Health Financial Systems	MEMORIAL HOSPITAL OF S	OUTH BEND, INC	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058	Peri od: From 01/01/2017	Worksheet D-1	
		Component CCN: 15-T058	To 12/31/2017	Date/Time Prepared: 5/25/2018 3:56 pm	
		Title XVIII	Subprovi der -	PPS	

		II the XVIII	I RF	FF3			
	Cost Center Description						
	PART I - ALL PROVIDER COMPONENTS			1. 00			
	INPATIENT DAYS						
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		3, 475	1.00		
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)				2. 00		
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, 1,879				3. 00		
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed davs)		1, 596	4. 00		
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost				5. 00		
	reporting period						
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	or the cost	0	6. 00		
7. 00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00		
	reporting period						
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00		
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 051	9. 00		
	newborn days)						
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10. 00		
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00		
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)					
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	(only (including private	e room days)	0	12.00		
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	(only (including private	room days)	0	13. 00		
13.00	after December 31 of the cost reporting period (if calendar ye			O	13.00		
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	lays)	0	14.00		
15. 00	Total nursery days (title V or XIX only)			0	15. 00		
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			U	16. 00		
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17.00		
10.00	reporting period			0.00	40.00		
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	the cost	0.00	18. 00		
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00		
	reporting period	G					
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0. 00	20. 00		
21. 00	Total general inpatient routine service cost (see instructions	5)		3, 374, 253	21. 00		
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00		
22.00	5 x line 17)	21 of the cost reporting	, nominal (line (0	22.00		
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	perrod (Trie 6	U	23. 00		
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24.00		
05.00	7 x line 19)				05.00		
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	of the cost reporting	period (line 8	0	25. 00		
26. 00	Total swing-bed cost (see instructions)			0			
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 374, 253	27. 00		
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had cha	rges)	9, 103, 815	28 00		
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed cha	ii ges)	5, 046, 923			
30.00	Semi -pri vate room charges (excluding swing-bed charges)			4, 056, 892	30.00		
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 370642			
32.00	Average private room per diem charge (line 29 ÷ line 3)			2, 685. 96			
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	ions)	2, 541. 91 144. 05			
35. 00	Average per diem private room cost differential (line 34 x lin		/	53. 39	35. 00		
36. 00	Private room cost differential adjustment (line 3 x line 35)			100, 320			
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			971. 01			
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		1, 020, 532 0	39. 00 40. 00		
	Total Program general inpatient routine service cost (line 39	•		1, 020, 532			
		•	'				

		RIAL HOSPITAL OF				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Peri od: From 01/01/2017	Worksheet D-1	
			Component	CCN: 15-T058	To 12/31/2017	Date/Time Pre 5/25/2018 3:5	
			Ti tl e	e XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	npatient Days	col. 1	÷	(col. 3 x col. 4)	
10.00	INUDOEDY (1) II WA WAY II N	1.00	2.00	3.00	4. 00	5. 00	40.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. (00 0	0	42.00
43.00	INTENSIVE CARE UNIT	0	C	1		l e	
43. 01 44. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	0	O	0.0	00 0	0	43. 01 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
10.00			11, 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ons)		657, 643 1, 678, 175	
	PASS THROUGH COST ADJUSTMENTS	<u> </u>		,			
50. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	n Wkst. D, sun	n of Parts I and	166, 689	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	49, 443	51.00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				216, 132	52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital rel	ated, non-phy	sician anesth	netist, and	1, 462, 043	1
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program di scharges					0	54. 00
	Target amount per discharge					l	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	get amount (L	ine 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	•			ŕ	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	0.00	59. 00				
60.00							
61. 00							
	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)						
62. 00 63. 00	Relief payment (see instructions)	l e	62. 00 63. 00				
03.00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstruc	tions)			0	03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reporting	period (See	0	65. 00
// 00	instructions)(title XVIII only)	(1: (4				
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (fine 6	4 prus rine d	ob)(title XVII	i 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	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period						68. 00
	(line 13 x line 20)						
09.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rout	ine service c	cost (line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne /U ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applications	able to Program					73. 00
74. 00 75. 00	Total Program general inpatient routine servi				Part II column		74. 00 75. 00
73.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)						76. 00 77. 00
78. 00	, ,						78. 00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80. 00 81. 00							80. 00 81. 00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82. 00
83. 00 84. 00							83. 00 84. 00
85. 00							
86. 00							
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)						87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00
89. UU	Observation bed cost (line 87 x line 88) (see	e instructions)				l 0	89. 00

Health Financial Systems MEMO	RIAL HOSPITAL O	F SOUTH BEND,	I NC	In Lie	eu of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1		
		Component (From 01/01/2017 To 12/31/2017			
		Title	XVIII	Subprovi der – I RF	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost	1	
				line 89)	(col. 3 x col.		
					4) (see	1	
					instructions)		
	1.00	2.00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00 Capital -related cost	551, 126	3, 374, 253	0. 16333	3 0	0	90.00	
91.00 Nursing School cost	0	3, 374, 253	0.00000	o o	0	91.00	
92.00 Allied health cost	0	3, 374, 253	0.00000	o o	0	92.00	
93.00 All other Medical Education	0	3, 374, 253	0.00000	o o	0	93. 00	

Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0058	Peri od: From 01/01/2017	Worksheet D-1	
			To 12/31/2017	Date/Time Prep 5/25/2018 3:50	
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	

		Title XIX	Hospi tal	5/25/2018 3: 50 PPS	6 pm
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed day do not complete this line.	ped and newborn days)	ivate room days,	80, 181 80, 181 0	1. 00 2. 00 3. 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roof reporting period		r 31 of the cost	70, 182 0	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)			2, 982	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	i ons)		0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	,	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX 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 after December 31 of the cost reporting period (if calendar years).	ear, enter O on this line	e)	0	13. 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	nm (excluding swing-bed o	days)	0 4, 431	15. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			379	
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	9			17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period			0. 00	
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	<u> </u>			19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period		he cost	0. 00	
21. 00 22. 00	Total general inpatient routine service cost (see instructions $Swing$ -bed cost applicable to SNF type services through $Decembe 5 \times 1$ ine 17)		ing period (line	82, 141, 744 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ([line 21 minus line 26)		0 82, 141, 744	26. 00 27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		,		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	28. 00 29. 00
	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32.00
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 mir		tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0. 00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost α	and private room cost di	fferential (line	0 82, 141, 744	36. 00 37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		1, 024. 45 3, 054, 910	
40. 00	Medically necessary private room cost applicable to the Progra	•		3, 034, 710	40. 00
41. 00	Total Program general inpatient routine service cost (line 39			3, 054, 910	

OMPUTATION OF INPATIENT OPERATING COST		Provi der	CCI	F	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre	narod:
						5/25/2018 3:56	
Cost Center Description	Total	Total	tl∈	Average Per	Hospital Program Days	PPS Program Cost	
5555 55.115.1 55551 , p 1 5.1	Inpatient Cost	Inpatient Day	ysE	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
2.00 NURSERY (title V & XIX only)	1. 00 2, 574, 852	2.00	31	3. 00 581. 10	4. 00	5. 00 220, 237	42. 00
Intensive Care Type Inpatient Hospital Units			J 1	301.10	, 377	220, 237	72.00
8. 00 INTENSIVE CARE UNIT	13, 441, 953			1, 671. 47		0	
OI NEONATAL INTENSIVE CARE UNIT	11, 803, 032	9, 75	25	1, 209. 95	1, 666	2, 015, 777	43. 01 44. 00
. OO BURN INTENSIVE CARE UNIT							45. 00
0.00 SURGICAL INTENSIVE CARE UNIT							46.00
. 00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47.00
						1. 00	
.00 Program inpatient ancillary service cost (W .00 Total Program inpatient costs (sum of lines			i or	ns)		25, 376, 399 30, 667, 323	
PASS THROUGH COST ADJUSTMENTS OO Pass through costs applicable to Program in	patient routine	services (fro	om	Wkst. D, sum	of Parts I and	645, 886	50.00
III) 00 Pass through costs applicable to Program in	patient ancillar	ry services (f	fro	om Wkst. D, su	m of Parts II	2, 244, 325	51. 00
and IV) Total Program excludable cost (sum of lines)	50 and 51)					2, 890, 211	52.00
00 Total Program inpatient operating cost excludes	,	elated, non-ph	hys	sician anesthe	etist, and	27, 777, 112	
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)	<u> </u>					
00 Program discharges						0	54.0
00 Target amount per discharge						0.00	1
00 Target amount (line 54 x line 55) 00 Difference between adjusted inpatient opera	ting cost and ta	arget amount ((1 i	ne 56 minus I	ine 53)	0	56. 0 57. 0
00 Bonus payment (see instructions)	tring cost and to	arget amount ((11	Tie 50 iii Tius T	THE 33)	0	58. 0
00 Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996,	up	dated and com	pounded by the	0. 00	59. 0
market basket .00 Lesser of lines 53/54 or 55 from prior year	cost report um	ndated by the	ma	irket hasket		0.00	60. 0
.00 If line 53/54 is less than the lower of line					he amount by	0.00	61. 0
which operating costs (line 53) are less the		ts (lines 54 x	x 6	00), or 1% of	the target		
amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)					0	62. 0
.00 Allowable Inpatient cost plus incentive pay	ment (see instru	uctions)				Ö	
PROGRAM INPATIENT ROUTINE SWING BED COST		1 04 6 11					
OD Medicare swing-bed SNF inpatient routine con instructions)(title XVIII only)	sts through Dece	ember 31 of tr	ne	cost reportir	ig period (See	0	64.0
00 Medicare swing-bed SNF inpatient routine co- instructions)(title XVIII only)	sts after Decemb	per 31 of the	CC	st reporting	period (See	0	65. 0
00 Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	ine costs (line	64 plus line	65	(title XVIII	only). For	0	66. 0
00 Title V or XIX swing-bed NF inpatient routi	ne costs through	n December 31	of	the cost rep	orting period	0	67. 0
(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing the state of the	ne costs after [December 31 of	ft	he cost repor	ting period	0	68. 0
(line 13 x line 20) Total title V or XIX swing-bed NF inpatient						0	69. 0
PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci		· · · · · · · · · · · · · · · · · · ·					70.0
.00 Adjusted general inpatient routine service	,			,			71.0
OO Program routine service cost (line 9 x line		n (line 14 : '		. 2E)			72.0
.00 Medically necessary private room cost appli .00 Total Program general inpatient routine ser				ie 35)			73. 0 74. 0
00 Capital-related cost allocated to inpatient	•		_	orksheet B, Pa	ırt II, column		75. 0
26, line 45)	ino 2)						76.0
.00 Per diem capital-related costs (line 75 ÷ 1 .00 Program capital-related costs (line 9 x lin	. *						76. 00 77. 00
00 Inpatient routine service cost (line 74 min	us line 77)						78. 0
Aggregate charges to beneficiaries for exce					- 1: 70)		79.0
.00 Total Program routine service costs for com .00 Inpatient routine service cost per diem lim		cost iimitatio	บท	(iine /8 minu	is line /9)		80. 0 81. 0
2.00 Inpatient routine service cost limitation (, 5

82.00

83.00

84. 00 85. 00

86.00

9, 999 87. 00 1, 024. 45 88. 00 10, 243, 476 89. 00

84.00

85.00

86.00

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

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

Total observation bed days (see instructions)

83.00 Reasonable inpatient routine service costs (see instructions)

Program inpatient ancillary services (see instructions)
Utilization review - physician compensation (see instructions)

88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Observation bed cost (line 87 x line 88) (see instructions)

Total Program inpatient operating costs (sum of lines 83 through 85)

Health Financial Systems MEMO	RIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/25/2018 3:50	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	11, 258, 704	82, 141, 744	0. 13706	4 10, 243, 476	1, 404, 012	90.00
91.00 Nursing School cost	0	82, 141, 744	0.00000	0 10, 243, 476	0	91.00
92.00 Allied health cost	0	82, 141, 744	0.00000	10, 243, 476	0	92.00
93.00 All other Medical Education	0	82, 141, 744	0. 000000	10, 243, 476	0	93. 00

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-00	058 Peri od: From 01/01/2017	Worksheet D-1
	Component CCN: 15-S	S058 To 12/31/2017	
	Title XIX	Subprovi der -	PPS
		LDE	

		TI LIE XIX	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		3, 716	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			3, 716	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 716	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period		4 6 11		, 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	or the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	106	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		om days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		om davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)			
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private)	room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including private	room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar ye			G	10.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed d	ays)	0	14. 00
15. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)				15.00
16. 00	SWING BED ADJUSTMENT			3/9	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	he cost	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
	reporting period	<u> </u>			
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	e cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		3, 707, 625	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	g period (line	0	24.00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 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 ((line 21 minus line 26)		3, 707, 625	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	l and sheerwation had also	~~~)	0	20.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	rges)	0	28. 00 29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	ions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line)		10113)	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 a	and private room cost dif	ferential (line	3, 707, 625	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		997. 75	
39.00	Program general inpatient routine service cost (line 9 x line			105, 762	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	*		0 105, 762	40. 00 41. 00
00	1.2.2		ı	100, 702	55

	Financial Systems MEMOR ATION OF INPATIENT OPERATING COST	RLAL HOSPITAL OF	SOUTH BEND, Provider C		In Lie	worksheet D-1	
COMPUT	ATTON OF INPATTENT OPERATING COST			CCN: 15-0058	From 01/01/2017 To 12/31/2017		
			·			5/25/2018 3:5	
			liti	e XIX	Subprovi der - I PF	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	2. 00 C				42. 00
42.00	Intensive Care Type Inpatient Hospital Units				00	1 0	1 42 00
43. 00 43. 01	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	0	C	1			
44. 00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 82, 395	48. 00
	Total Program inpatient costs (sum of lines			ons)		188, 157	
F0 00	PASS THROUGH COST ADJUSTMENTS			WII 1 D		47.470	F0 00
50. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (Tron	1 WKST. D, SUI	n or Parts I and	17, 473	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	4, 584	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				22, 057	52. 00
53. 00	Total Program inpatient operating cost exclude		ated, non-phy	sician anest	netist, and	166, 100	1
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge						55. 00
56. 00 57. 00	Target amount (line 54 x line 55)	ing cost and tar	got amount (1	ino 56 minus	lino 52)	0	
58. 00							
59. 00							
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. upd	ated by the m	narket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60 e	nter the less	er of 50% of		0	
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(lines 54 x	60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	instructions)				0	62.00
63. 00		ent (see instruc	tions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost report	na period (See	0	64. 00
	instructions)(title XVIII only)		04 6 11				/
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decembe	r 31 of the d	cost reporting	g period (See	0	65. 00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost r	enorting period	0	67. 00
07.00	(line 12 x line 19)	c costs till ough	becember 51 c	ine cost in	sporting period	Ĭ	07.00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	cember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	e 68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of)		70.00
72.00	Program routine service cost (line 9 x line	71)					72.00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services.						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient				Part II, column		75.00
7/ 00	26, line 45)	ma 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			*	nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limit			. (81. 00
82.00							82.00
83. 00 84. 00	Reasonable inpatient routine service costs (: Program inpatient ancillary services (see in:)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 85)				86. 00
87. 00						0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)				88. 00
	Observation bed cost (line 87 x line 88) (see	e instructions)				. ()	89.00

Health Financial Systems MEMO	RIAL HOSPITAL O	F SOUTH BEND,	I NC	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2017 To 12/31/2017		
		Ti tl	e XIX	Subprovi der - I PF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	612, 541	3, 707, 625	0. 16521	1 0	0	90.00
91.00 Nursing School cost	0	3, 707, 625	0.00000	0	0	91.00
92.00 Allied health cost	0	3, 707, 625	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 707, 625	0.00000	0 0	0	93. 00

Health Financial Systems MEMOF	RIAL HOSPITAL OF SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0058	Peri od: From 01/01/2017	Worksheet D-1
	Component CCN: 15-T058		
	Title XIX	Subprovi der -	PPS
	Title XIX	Subprovi der -	

Cost Center Description DATE All Description			II the XIX	I RF	FF3	
NAME MAX NAME MAX NAME NA		Cost Center Description				
NATLENT DAYS		DADT I ALL DDOVIDED COMPONENTS			1. 00	
1.00 Inpatient days (including private room days and seing-bed days, excluding newborn) 3, 475 1.00						
200 200 201	1.00		s, excluding newborn)		3, 475	1.00
do not complete this line. do					•	
Semi-private room days (excluding swing-bed and observation bed days) Tool Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period. Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period. Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period. Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period. Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period. Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period. Total swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and reporting period. Total swing-bed SMF type inpatient days applicable to the Tito XVIII only (including private room days) Total inpatient days including private room days applicable to the Tito XVIII only (including private room days) Total supplication of the cost reporting period (if callendar year, enter 0 on this line) Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) Total swing-bed SMF	3.00		(s). If you have only pri	vate room days,	0	3.00
Total swing-bed SNF Type Inpatient days (Including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this I ine) reporting period (Ine) rep	4.00		ed days)		3. 475	4.00
10 10 10 10 10 10 10 10				31 of the cost	•	
reporting period (if calendar year, enter 0 on this line) 1.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SW type inpatient days applicable to the Program (excluding swing-bed and newborn days) 1.00 Swing-bed SW type inpatient days applicable to the Program (excluding swing-bed and newborn days) 1.00 Swing-bed SW type inpatient days applicable to the Itile XWIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SW type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period (including type type type type type type type type				4 6 11		, ,,,
1.00 10tal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period 0 7.00	6.00		om days) after becember 3	or the cost	Ü	6.00
10	7. 00		n days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 10.00 Soling-bed SNP type inpatient days applicable to the Program (excluding swing-bed and newborn days) 11.00 Soling-bed SNP type inpatient days applicable to title XVIII only (including private room days) 11.00 Soling-bed SNP type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (see instructions) 11.00 Soling-bed SNP type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (it calendar year, enter 0 on this line) 12.00 Soling-bed NP type inpatient days applicable to titles V or XIX only (including private room days) 13.30 Through becember 31 of the cost reporting period (it calendar year, enter 0 on this line) 14.00 Medical ly necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Total nursery days (title V or XIX only) 17.00 Medical nursery days (title V or XIX only) 18.00 Medical nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SNP services applicable to services through December 31 of the cost period (it calendar year) 19.00 Medicare rate for swing-bed SNP services applicable to services through December 31 of the cost period (it new year) 19.00 Medical rate for swing-bed SNP services applicable to services after December 31 of the cost period (it new year) 19.00 Medical rate for swing-bed NP services applicable to services after December 31 of the cost period (it new year) 19.00 Medical rate for swing-bed NP services applicable to services after December 31 of the cost period (it new year) 19.00 Soling-bed cost applicable to SNF type services through December 31 of the cost reporting period (line on year) 19.00 Soling-bed cost applicable to SNF type services after December 31 of the cost reporting period (line on year) 19.00 Soling-bed cost applicable to NP type services after December 31 of the cost reporting period (line on year) 19.00 Soling-bed cos		'				
Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 0 10.00	8. 00		n days) after December 31	of the cost	0	8. 00
newborn days	9. 00		the Program (excluding	swing-bed and	26	9.00
through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed NP type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NP type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Swing-bed NP type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Swing-bed NP type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Number y days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line Swing-bed SNF services applicable to SNF type services through December 31 of the cost reporting period (line Swing-bed SNF services applicable to SNF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services after December 31 of the cost re						
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December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00	11 00			om davs) after	0	11 00
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13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) after December 31 of the cost reporting period (if called andary year, enter 0 on this line) 14.00 14.00 15.	12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 14.00 15	12 00		/ only (including private	room days)	0	12 00
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16.00 Nursery days (title V or XIX only) 379 16.00 SWIM BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 17.00 medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 medicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 medicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 medicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 medicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 medicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 medicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 20.00 medicare rate for swing-bed cost spplicable to SNF type services through December 31 of the cost reporting period (line 0.00 20	14. 00	Medically necessary private room days applicable to the Progra	· ·	, I	0	14. 00
SWING BED ADJUSTMENT 1. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost cost reporting period reporting period medical drate for swing-bed NF services applicable to services through December 31 of the cost cost reporting period report						
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42. 00 NUR Intervence NUR	RSERY (title V & XIX only) Rensive Care Type Inpatient Hospital Units FENSIVE CARE UNIT DNATAL INTENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT RCICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY) Cost Center Description Ogram inpatient ancillary service cost (Wks stal Program inpatient costs (sum of lines 4 AS THROUGH COST ADJUSTMENTS ESS through costs applicable to Program inpatient Program inpatient cost (sum of lines 5 AS THROUGH COST ADJUSTMENTS ESS through costs applicable to Program inpatient Program inpatient Operating cost excludical education costs (line 49 minus line 5 AGET AMOUNT AND LIMIT COMPUTATION Degram discharges Toget amount per discharge Toget amount (line 54 x line 55) Fference between adjusted inpatient operati	atient routine solution and sol	Total npatient Days 2.00 0 0 line 200) see instruction services (from a services (from ated, non-physical services)	e XIX Average Per Di em (col. 1 = col. 2) 3.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	4.00 O	1. 00 319, 032 344, 278 4, 124 23, 795 27, 919 316, 359	42. 00 43. 00 43. 00 44. 00 45. 00 47. 00 50. 00 51. 00 52. 00 53. 00 54. 00 55. 00		
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43. 00 INT 43. 01 NEO 44. 00 COR 45. 00 BUR 46. 00 SUR 47. 00 OTH 48. 00 Pro 49. 00 Pas 50. 00 Pas 51. 00 Pas 51. 00 Pas 52. 00 Tot 53. 00 Tot 53. 00 Tot 56. 00 Tar 56. 00 Tar 56. 00 Bon 57. 00 Di f 58. 00 Bon 59. 00 Les 61. 00 If whi amo 62. 00 Rel 63. 00 All PRO 64. 00 Med i ns 65. 00 Med	RSERY (title V & XIX only) rensive Care Type Inpatient Hospital Units TENSIVE CARE UNIT DNATAL INTENSIVE CARE UNIT RONARY CARE UNIT RRICAL INTENSIVE CARE UNIT RGICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY) Cost Center Description Ogram inpatient ancillary service cost (Wks tal Program inpatient costs (sum of lines 4 ST THROUGH COST ADJUSTMENTS as through costs applicable to Program inpatient operating cost excluded in the cost of the cost operating cost excluded in the cost of the cost	Inpatient Cost I 1.00 0 0 0 0 1.1 through 48)(statient routine statient ancillary and 51) In g capital relicity In g cost and tar	line 200) See instruction services (from y services (from ated, non-physical parts)	Di em (col. 1 = col. 2) 3.00 0.00 0.00 0.00 Wkst. D, sum om Wkst. D, sussician anesthe	Program Days 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 319, 032 344, 278 4, 124 23, 795 27, 919 316, 359 0 0. 00 0	43. 00 43. 01 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 50. 00 51. 00 52. 00 53. 00 54. 00 55. 00		
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57. 00 Di f 58. 00 Bon 59. 00 Les mar 60. 00 Les 61. 00 If whi amo 62. 00 Rel 63. 00 Med i ns 65. 00 Med	Fference between adjusted inpatient operations payment (see instructions) sser of lines 53/54 or 55 from the cost repretet basket	0	get amount (I			-			
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60. 00 Les 61. 00 If whi amo 62. 00 Rel 63. 00 AII PRO 64. 00 Med i ns			ending 1996, u	pdated and con	npounded by the	0. 00	59. 00		
61. 00 If whi amo 62. 00 Rel 63. 00 All PRO 64. 00 Med ins		cost report, upd	dated by the ma	arket basket		0. 00	60.00		
62. 00 Rel 63. 00 All PRO 64. 00 Med i ns 65. 00 Med i ns	line 53/54 is less than the lower of lines	s 55, 59 or 60 e	enter the less	er of 50% of t		0	61.00		
62. 00 Rel 63. 00 All PRO 64. 00 Med i ns 65. 00 Med i ns	ch operating costs (line 53) are less than ount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% of	the target				
64. 00 Med i ns 65. 00 Med i ns	ief payment (see instructions)	nstructions)				0	62. 00		
64.00 Med ins 65.00 Med ins	owable Inpatient cost plus incentive payme	ent (see instruc	ctions)			0	63. 00		
65.00 i ns 65.00 Med i ns	GRAM INPATIENT ROUTINE SWING BED COST dicare swing-bed SNF inpatient routine cost	s through Decem	ber 31 of the	cost reportin	na period (See	0	64. 00		
i ns	structions)(title XVIII only)	J		•	`				
	dicare swing-bed SNF inpatient routine cost structions)(title XVIII only)	s after Decembe	er 31 of the c	ost reporting	peri od (See	0	65. 00		
66.00 Tot	tal Medicare swing-bed SNF inpatient routin	ne costs (line 6	64 plus line 6	5)(title XVIII	only). For	o	66. 00		
	H (see instructions)		December 21 o	f the cost was	anting nominal		47.00		
	<pre>tle V or XIX swing-bed NF inpatient routine ne 12 x line 19)</pre>	e costs through	December 31 0	Title cost rep	borting period	١	67. 00		
	tle V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repor	ting period	0	68. 00		
	ne 13 x line 20) tal title V or XIX swing-bed NF inpatient r	coutine costs (L	ine 67 + line	68)		o	69. 00		
PAR ⁻	T III - SKILLED NURSING FACILITY, OTHER NU	RSING FACILITY,	AND ICF/IID (ONLÝ					
	Iled nursing facility/other nursing facili						70.00		
1 -	usted general inpatient routine service co ogram routine service cost (line 9 x line 7		ne /U = IIIIe .	۷)			71. 00		
73.00 Med	dically necessary private room cost applica	able to Program		ne 35)			73.00		
	tal Program general inpatient routine servi bital-related cost allocated to inpatient r			orkshoot P Ps	art II column		74. 00 75. 00		
	line 45)	outilie service	COSTS (110111 W	orksneet b, Fa	irt ir, coruiiir		75.00		
	diem capital-related costs (line 75 ÷ lin						76. 00		
1	ogram capital-related costs (line 9 x line patient routine service cost (line 74 minus						77. 00 78. 00		
	gregate charges to beneficiaries for excess		ovi der record	s)		,	79.00		
1	tal Program routine service costs for compa		st limitation	(line 78 minu	ıs line 79)		80.00		
	patient routine service cost per diem limit patient routine service cost limitation (li						81. 00 82. 00		
1 .	asonable inpatient routine service costs (s					,	83. 00		
	ogram inpatient ancillary services (see ins		`			,	84.00		
			15.)				85. 00		
	lization review - physician compensation (1 86 00		
	lization review - physician compensation (tal Program inpatient operating costs (sum TIV - COMPUTATION OF OBSERVATION BED PASS	of lines 83 thr					86.00		
88. 00 Adj 89. 00 Obs	tal Program inpatient operating costs (sum	of lines 83 thr THROUGH COST	rough 85)			0			

Health Financial Systems MEMO	RIAL HOSPITAL O	F SOUTH BEND,	I NC	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2017 To 12/31/2017		
		Ti tl	e XIX	Subprovi der – I RF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	551, 126	3, 374, 253	0. 16333	3 0	0	90.00
91.00 Nursing School cost	0	3, 374, 253	0.00000	0	0	91.00
92.00 Allied health cost	0	3, 374, 253	0.00000	0	0	92.00
93.00 All other Medical Education	0	3, 374, 253	0.00000	0 0	0	93. 00

Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, IN	NC	In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der CCN	l: 15-0058	Peri od: From 01/01/2017	Worksheet D-3
					Date/Time Prepared: 5/25/2018 3:56 pm
		Title	XVIII	Hospi tal	PPS

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider Co	UN: 15-0058	From 01/01/2017	worksneet D-3	
			To 12/31/2017	Date/Time Prepared:		
				10 12/01/2017	5/25/2018 3:56 pm	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpatient	
	555 551161 55561 pt 611		To Charges	Program	Program Costs	
			l ro onar goo		(col. 1 x col.	
				onal gos	2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS			60, 105, 548		30. 00
31. 00	03100 I NTENSI VE CARE UNI T			9, 301, 017		31.00
31. 00	02060 NEONATAL INTENSIVE CARE UNIT			7, 301, 017		31.00
40. 00	04000 SUBPROVIDER - I PF			0		
				474 204		40.00
41.00	04100 SUBPROVI DER - I RF			171, 306		41. 00
43. 00	04300 NURSERY					43. 00
	ANCI LLARY SERVI CE COST CENTERS		1		T	
50.00	05000 OPERATING ROOM		0. 38680			
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 52089	· ·	17, 013	1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1689	77 11, 771, 333	1, 989, 085	54. 00
57.00	05700 CT SCAN		0. 0340	95 6, 696, 258	228, 309	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 2676	1, 118, 093	299, 264	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 12713	3, 853, 162	489, 860	59. 00
60.00	06000 LABORATORY		0. 1199!		2, 919, 134	
60. 01	06001 BLOOD LABORATORY		0. 00000		0	1
65. 00	06500 RESPI RATORY THERAPY		0. 15213		1, 619, 658	
66. 00	06600 PHYSI CAL THERAPY		0. 5164			
66. 01	06602 PHYSI CAL THERAPY EAST BANK		0. 39456		0	
66. 10	06601 PHYSI CAL THERAPY LIVING CENTER		0. 33992		0	
67. 00			l .			67. 00
	06700 OCCUPATIONAL THERAPY		0. 42359			1
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 32548		0	
68. 00	06800 SPEECH PATHOLOGY		0. 3312		149, 352	
68. 10	06801 SPEECH THERAPY LIVING CENTER		0. 29123		0	
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1639		3, 765, 792	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 21728	36, 185, 625	7, 862, 738	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 19470	36, 863, 180	7, 177, 409	73.00
76.00	03020 CARDI OLOGY		0. 34479	97 2, 719, 652	937, 728	76. 00
	OUTPATIENT SERVICE COST CENTERS					Ī
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		2. 25553		0	90. 30
90. 50	09004 SLEEP DI SORDERS CLINIC		0. 2819		0	90. 50
91. 00	09100 EMERGENCY		0. 52908		2, 782, 303	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 32866		n	92. 00
200.00			0.02000	184, 079, 224	38, 736, 214	
201.00		(line 61)		104, 077, 224	30, 730, 214	201.00
201.00		(11116-01)		184, 079, 224		202.00
202.00	Inet charges (Title 200 IIII lius Title 201)		I	104, 077, 224	I	1202.00

Mendel the Financial Cyctoma	COUTU DEND	LNC	المانا	u of Form CMC	2552 10
Health Financial Systems MEMORIAL HOSPITAL OF INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od:	u of Form CMS-3 Worksheet D-3	
THE THE PROPERTY SERVICE GOOD AND SKITCH MEAN		F	From 01/01/2017 Fo 12/31/2017		pared:
	Title	e XVIII	Subprovi der -	PPS	о рііі
Cost Center Description		Ratio of Cost To Charges	Inpatient Program	Inpatient Program Costs (col. 1 x col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY			0 0 0 0 1, 592, 118 0		30. 00 31. 00 31. 01 40. 00 41. 00 43. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 386800 0. 52089	0	110, 266 0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN		0. 168977 0. 034095	5, 020	1, 636 171	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 267656 0. 127132		497 0	58. 00 59. 00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		0. 11995° 0. 000000		15, 710 0	60. 00 60. 01
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 152133 0. 516415		4, 005 75, 873	
66. 01 06602 PHYSI CAL THERAPY EAST BANK		0. 394564	1 0	0	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER 67. 00 06700 OCCUPATIONAL THERAPY		0. 339920 0. 423590	15, 484		1
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER 68. 00 06800 SPEECH PATHOLOGY		0. 325487 0. 331254		0 506	
68. 10 06801 SPEECH THERAPY LIVING CENTER 70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 291232 0. 000000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 163952	3, 541	581	71. 00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 217289 0. 194704	604, 901	117, 777	73. 00
76. 00 03020 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS		0. 344797	7 312	108	76. 00
90. 00 09000 CLI NI C 90. 10 09001 FAMI LY PRACTI CE CLI NI C		0. 000000 0. 000000		0	
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC		2. 255536	0	0	90. 30
90. 50 09004 SLEEP DI SORDERS CLINI C 91. 00 09100 EMERGENCY		0. 281995 0. 529089		0 3, 413	90. 50 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 328668		0 337 451	92. 00

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

337, 451 200. 00 201. 00 202. 00

200.00 201.00 202.00

Heal th	Financial Systems MEMORIAL HOSPITAL OF	SOUTH BEND.	LNC	In Lie	eu of Form CMS-:	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
		Component	CCN: 15-T058	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/25/2018 3:5	
		Ti tl e	× XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDI ATRI CS			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			0		40.00
41. 00	04100 SUBPROVI DER – I RF			2, 762, 334		41. 00
43.00	04300 NURSERY			, , , , , , , , , , , , , , , , , , , ,		43. 00
	ANCI LLARY SERVI CE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 38680	00 8, 111	3, 137	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 52089			1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1689		14, 384	54.00
57.00	05700 CT SCAN		0. 0340		1, 205	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 2676		1, 491	1
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 1271:			1
60.00	06000 LABORATORY		0. 1199!	51 214, 916	25, 779	60.00
60. 01	06001 BLOOD LABORATORY		0.0000	00 0	0	1
65.00	06500 RESPI RATORY THERAPY		0. 1521:		12, 650	65. 00
66.00	06600 PHYSI CAL THERAPY		0. 5164			
66. 01	06602 PHYSI CAL THERAPY EAST BANK		0. 3945			
66. 10	06601 PHYSI CAL THERAPY LIVING CENTER		0. 33992	20 0	0	66. 10
67.00	06700 OCCUPATI ONAL THERAPY		0. 42359	90 395, 461	167, 513	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 32548	37 0	0	1
68.00	06800 SPEECH PATHOLOGY		0. 3312	54 288, 984	95, 727	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER		0. 2912	32 0	0	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY		0.0000	00	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1639	52 92, 029	15, 088	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2172	34, 299	7, 453	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 19470	04 477, 249	92, 922	73. 00
76.00	03020 CARDI OLOGY		0. 34479	97 9, 593	3, 308	76. 00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		0.0000	00 0	0	90. 00
90. 10	09001 FAMILY PRACTICE CLINIC		0.0000	00	0	90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC		2. 2555	36 0	0	90. 30
90. 50	09004 SLEEP DI SORDERS CLINIC		0. 2819	95 0	0	90. 50
91.00	09100 EMERGENCY		0. 5290	39 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 3286	68 0	0	92.00
200.00			1	2, 150, 432	657, 643	200 00

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

657, 643 200. 00

2, 150, 432

201. 00

200.00

201.00 202.00

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

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BE	ND, INC	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provide	er CCN: 15-0058	Peri od:	Worksheet D-3	
		From 01/01/2017	D 1 /T' D	
		To 12/31/2017	Date/Time Pre 5/25/2018 3:5	
	Title XIX	Hospi tal	PPS	о ріп
Cost Center Description	Ratio of Cos		I npati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
INDATIENT DOUTINE CEDALCE COCT CENTEDO	1. 00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS		36, 622, 111		30.00
31. 00 03100 NTENSI VE CARE UNIT		9, 980, 294		31.00
31. 01 02060 NEONATAL NTENSI VE CARE UNI T		18, 349, 033		31.00
40. 00 04000 SUBPROVI DER - PF		10, 347, 033		40.00
41. 00 04100 SUBPROVI DER - RF		0		41.00
43. 00 04300 NURSERY		2, 420, 771		43.00
ANCI LLARY SERVI CE COST CENTERS		2, 420, 771		45.00
50. 00 05000 OPERATING ROOM	0. 3868	00 16, 978, 845	6, 567, 417	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 5208		5, 193, 160	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 1689			
57. 00 05700 CT SCAN	0. 0340		132, 247	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 2676	56 583, 170	156, 089	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 1271	32 2, 405, 625	305, 832	59. 00
60. 00 06000 LABORATORY	0. 1199	51 18, 192, 778	2, 182, 242	60.00
60. 01 06001 BL00D LABORATORY	0.0000	00	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 1521	33 11, 504, 834	1, 750, 265	65. 00
66.00 06600 PHYSI CAL THERAPY	0. 5164	15 730, 499	377, 241	66. 00
66.01 06602 PHYSICAL THERAPY EAST BANK	0. 3945		347	66. 01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0. 3399	20 285	97	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0. 4235	90 625, 246	264, 848	67. 00
67.10 06701 0CCUPATIONAL THERAPY LIVING CENTER	0. 3254	372	121	67. 10
68.00 06800 SPEECH PATHOLOGY	0. 3312	54 275, 427	91, 236	68. 00
68.10 06801 SPEECH THERAPY LIVING CENTER	0. 2912		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 1639			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 2172		0	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0. 1947			1
76. 00 03020 CARDI OLOGY	0. 3447	97 965, 315	332, 838	76. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0.0000		0	
90. 10 09001 FAMILY PRACTICE CLINIC	0.0000		0	
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	2. 2555		55, 660	
90. 50 09004 SLEEP DI SORDERS CLINI C 91. 00 09100 EMERGENCY	0. 2819		0	
	0. 5290		2, 236, 696	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 3286		0 25 274 200	92. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only charges (line of	41)	100, 934, 309	25, 376, 399	200.00
	01)	100, 934, 309		201.00
202.00 Net charges (line 200 minus line 201)	I	100, 934, 309		1202. UU

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 15-0058 CCN: 15-S058	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Pre 5/25/2018 3:5	pared:
		Ti ti	le XIX	Subprovi der - I PF	PPS	•
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	UNDATIONE DOUTING CERVICES COOK CENTERS		1.00	2. 00	3. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		I	20.0
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT			0		30. 0 31. 0
31. 00	02060 NEONATAL INTENSIVE CARE UNIT			0		31.0
40. 00	04000 SUBPROVI DER - I PF			603, 810		40.0
41. 00	04100 SUBPROVI DER - I RF			000,010		41. (
13.00	04300 NURSERY			0		43. (
	ANCILLARY SERVICE COST CENTERS		•	'	•	1
0.00	05000 OPERATING ROOM		0. 38680	00 0	0	50.
2.00	05200 DELIVERY ROOM & LABOR ROOM		0. 52089	91 0	0	52.
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1689		484	
7. 00	05700 CT SCAN		0. 0340		133	
8.00	05800 MAGNETIC RESONANCE MAGING (MRI)		0. 2676		528	
9.00	05900 CARDI AC CATHETERI ZATI ON		0. 12713		7 522	59.
0.00	06000 LABORATORY 06001 BLOOD LABORATORY		0. 1199		7, 533 0	60. 60.
5. 00	06500 RESPI RATORY THERAPY		0. 00000 0. 1521			
6. 00	06600 PHYSI CAL THERAPY		0. 5164		27, 579	
6. 01	06602 PHYSI CAL THERAPY EAST BANK		0. 3945		27,377	1
6. 10	06601 PHYSI CAL THERAPY LIVING CENTER		0. 3399		Ö	66.
7. 00	06700 OCCUPATI ONAL THERAPY		0. 42359		1, 712	
7. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 32548	87 0	0	1
8. 00	06800 SPEECH PATHOLOGY		0. 3312	54 0	0	68.
8. 10	06801 SPEECH THERAPY LIVING CENTER		0. 2912	32 0	0	68.
0.00	07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1639		0	
2. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 21728		0	72.
	07300 DRUGS CHARGED TO PATIENTS		0. 19470		l	
6. 00	03020 CARDI OLOGY		0. 3447	97 0	0	76.
0. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		0.0000	00 0	0	90.
0. 00			0.0000		0	
0. 10	09002 HEMATOLOGY ONCOLOGY CLINIC		2. 2555		0	
	09004 SLEEP DI SORDERS CLINIC		0. 2819		0	1
	00100 EMERGENCY		0. 2017		1 776	

0. 529089 0. 328668

91. 00 92. 00

201. 00

202. 00

82, 395 200. 00

200.00

201.00

202.00

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

	Financial Systems MEMORIAL HOSP ENT ANCILLARY SERVICE COST APPORTIONMENT	TAL OF SOUTH BEND,	CN: 15-0058	Peri od:	wof Form CMS-2 Worksheet D-3	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0058	From 01/01/2017	worksneet D-3	
		Component	CCN: 15-T058	To 12/31/2017	Date/Time Pre 5/25/2018 3:5	
		Titl	e XIX	Subprovi der – I RF	PPS	•
	Cost Center Description		Ratio of Cos	t Inpatient	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	
30. 00	03000 ADULTS & PEDIATRICS			0		30.0
31. 00	03100 NTENSI VE CARE UNI T			0		31.0
31. 01	02060 NEONATAL INTENSIVE CARE UNIT			0		31.0
40.00	04000 SUBPROVI DER - I PF			0		40.0
41.00	04100 SUBPROVI DER - I RF			1, 021, 347		41.0
43.00	04300 NURSERY			0		43.0
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 38680	00 57, 792	22, 354	50.0
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 52089		0	52. 0
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1689		21, 050	54.0
57.00	05700 CT SCAN		0. 0340	95 12, 944	441	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 2676			
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 12713		0	
60.00	06000 LABORATORY		0. 1199	· ·	8, 636	1
60. 01	06001 BLOOD LABORATORY		0.00000		0	
65. 00	06500 RESPI RATORY THERAPY		0. 15213		5, 025	
66.00	06600 PHYSI CAL THERAPY		0. 5164		82, 600	•
66. 01	06602 PHYSI CAL THERAPY EAST BANK		0. 39450		0	
66. 10 67. 00	O6601 PHYSI CAL THERAPY LIVING CENTER O6700 OCCUPATI ONAL THERAPY		0. 33992 0. 42359		63, 060	66. 1
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 4235		03,000	67. 1
68. 00	06800 SPEECH PATHOLOGY		0. 32348		39, 331	
68. 10	06801 SPEECH THERAPY LIVING CENTER		0. 29123	· ·	0	68. 1
70.00	07000 ELECTROENCEPHALOGRAPHY		0.00000		o o	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1639		5, 001	71.0
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 21728		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 19470		65, 922	
76. 00	03020 CARDI OLOGY		0. 34479	· ·	1, 708	
	OUTPATIENT SERVICE COST CENTERS		•			1
90.00	09000 CLI NI C		0.00000	00 00	0	90.0
90. 10	09001 FAMILY PRACTICE CLINIC		0. 00000	00	0	90. 1
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC		2. 25553	36 0	0	90. 30
90. 50	09004 SLEEP DI SORDERS CLINIC		0. 28199		0	
	09100 EMERGENCY		0. 52908			
92 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.32866	68 O	1 0	92 0

0. 281995 0. 529089 0. 328668

90. 50 91. 00 92. 00

201. 00

202. 00

0

319, 032 200. 00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

200.00

201.00

202.00

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0058	Peri od: Worksheet E
		From 01/01/2017 Part A
		To 12/21/2017 Data/Time Propared:

CALCOL	ATTOW OF RETWINDORSEMENT SETTLEMENT	Trovider dan. 15 dasa	From 01/01/2017 To 12/31/2017	Part A Date/Time Pre 5/25/2018 3:5	pared:
		Title XVIII	Hospi tal	PPS	<u>о рііі</u>
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurri	ing prior to October 1 (see	33, 068, 616	1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurri	ing on or after October	1 (see	12, 108, 524	1, 02
1.02	instructions)	ing on or area october	1 (300	12, 100, 02 1	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	prior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	on or after	0	1. 04
	October 1 (see instructions)	or ar cerial geo cocai i i i ig	o., o. a. to.	· ·	
2.00	Outlier payments for discharges. (see instructions)			2, 034, 957	2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructi	i one)		0	2. 01
3. 00	Managed Care Simulated Payments	10113)		19, 119, 044	3. 00
4.00	Bed days available divided by number of days in the cost report	rting period (see instru	ctions)	360. 61	1
F 00	Indirect Medical Education Adjustment			4/ 7/	F 00
5. 00	FTE count for allopathic and osteopathic programs for the mosor before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	16. 76	5. 00
6.00	FTE count for allopathic and osteopathic programs which meet	the criteria for an add-	on to the cap	0.00	6. 00
	for new programs in accordance with 42 CFR 413.79(e)		·		
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under			0. 00 0. 00	1
7.01	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.	42 CIR 9412. 103(1)(1)(1	v)(b)(2) II the	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopa	thic and osteopathic pro	grams for	0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.	79(c)(2)(iv), 64 FR 2634	0 (May 12,		
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slo	nts under 8 5503 of the	ACA If the cost	3.00	8. 01
0.01	report straddles July 1, 2011, see instructions.	ors under 3 dood of the	Non. II the cost	0.00	0.01
8. 02	The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachi	ng hospital	0. 00	8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	as (8 8 01 and 8 02) (500	19. 76	9. 00
7.00	instructions)	es (0, 0,01 and 0,02) (366	17. 70	9.00
10.00	FTE count for allopathic and osteopathic programs in the curre	ent year from your recor	ds	26. 50	1
	FTE count for residents in dental and podiatric programs.			0.00	11. 00 12. 00
	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			19. 76	1
14. 00	Total allowable FTE count for the penultimate year if that year	ar ended on or after Sep	tember 30, 1997,	19. 76	1
45.00	otherwise enter zero.			40.74	45.00
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program				15. 00 16. 00
	Adjustment for residents in the years of the program Adjustment for residents displaced by program or hospital clos	sure		0.00	1
	Adjusted rolling average FTE count			19. 76	18. 00
	Current year resident to bed ratio (line 18 divided by line 4)).		0. 054796	
	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 052207 0. 052207	
	IME payment adjustment (see instructions)			1, 270, 020	
	IME payment adjustment - Managed Care (see instructions)				22. 01
22.00	Indirect Medical Education Adjustment for the Add-on for § 422		FD 410 10F	0.00	22.00
23. 00	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$.	ent cap slots under 42 C	FR 412. 105	0. 00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)			6.74	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the	lower of line 23 or line	24 (see	0. 00	25. 00
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00					27. 00
	IME add-on adjustment amount (see instructions)				28. 00
					28. 01
29. 00 29. 01	0 Total IME payment (sum of lines 22 and 28) 1 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29. 00 29. 01
0 !	Di sproporti onate Share Adjustment	,		537, 475] =
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	6. 24	
	Percentage of Medicaid patient days (see instructions)			36. 32 42. 56	
	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions))		42. 56 24. 33	
	Disproportionate share adjustment (see instructions)				34. 00

	Financial Systems MEMORIAL HOSPITAL OF			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 01/01/2017 To 12/31/2017		
		Title XVIII	Hospi tal	PPS	o piii
		THE AVIII		On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment		1.00	2.00	
35. 00	Total uncompensated care amount (see instructions)		5, 977, 483, 147	6, 766, 695, 164	35.00
35. 01	Factor 3 (see instructions)		0. 000870846	0. 000810874	
35. 02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (see			•
00.02	instructions)	2010 011 11110 11110) (000	0,200,100	0, 100, 700	00.02
35. 03	Pro rata share of the hospital uncompensated care payment amo	ount (see instructions)	3, 893, 404	1, 383, 010	35. 03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.0)3)	5, 276, 414		36.00
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throug	h 46)		ĺ
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding	discharges for MS-DRGs	0		40. 00
	652, 682, 683, 684 and 685 (see instructions)	G			
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0		41.00
	instructions)				
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-	DRGs 652, 682, 683, 684	0		41. 01
	an 685. (see instructions)				
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali	fy for adjustment)	0.00		42. 00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	32, 683, 684 an 685. (see	0		43.00
	instructions)				
44. 00					44. 00
	days)				
45.00	Average weekly cost for dialysis treatments (see instructions		0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41	. 01)	0		46. 00
47. 00	Subtotal (see instructions)		56, 506, 431		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48. 00
	only. (see instructions)			A +	
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions	.)		57, 043, 906	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar			4, 271, 054	
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt. 1 a)			4, 271, 034	51.00
52. 00	Direct graduate medical education payment (from Wkst. E-4, li			804, 601	
53. 00	Nursing and Allied Health Managed Care payment	THE 49 SEE THISTI UCTIONS).		25, 792	
54. 00	Special add-on payments for new technologies			9, 281	ı
54. 00	Islet isolation add-on payment			9, 201	
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	50)		0	
56. 00	Cost of physicians' services in a teaching hospital (see intr			0	56.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I	,	rough 25)	0	57.00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt. 1		ii ougii 33).	46, 881	
59. 00	Total (sum of amounts on lines 49 through 58)	TV, COI. II TITIE 200)		62, 201, 515	ı
60.00	Primary payer payments			41, 804	ı
61. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		62, 159, 711	
62. 00	Deductibles billed to program beneficiaries	, , , , , , , , , , , , , , , , , , , ,		4, 688, 852	
63. 00	Coinsurance billed to program beneficiaries			173, 537	
64. 00	Allowable bad debts (see instructions)			656, 744	1
65. 00	Adjusted reimbursable bad debts (see instructions)			426, 884	•
66. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		314, 265	
67 00	Subtotal (line 61 nlus line 65 minus lines 62 and 63)	,		57 724 206	

Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)

Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)

Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)

57, 724, 206

67.00

68.00

69.00

70.00

70.87

70.88

70.89

70. 90

70. 91

70. 92 70. 93

70. 94

0 70.95

0 70.50

-5, 210

-15, 975

70.00

70.50

70.87

70.89

70.90

70. 91

67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)

OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)

Demonstration payment adjustment amount before sequestration

Pioneer ACO demonstration payment adjustment amount (see instructions)

SCH or MDH volume decrease adjustment (contractor use only)

HSP bonus payment HVBP adjustment amount (see instructions)

HSP bonus payment HRR adjustment amount (see instructions)

Bundled Model 1 discount amount (see instructions)

70.93 HVBP payment adjustment amount (see instructions)

70.94 | HRR adjustment amount (see instructions)

70. 95 Recovery of accelerated depreciation

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC			In Lieu of Form CMS-2552-10
CALCULATION OF DELMBURSEMENT SETTLEMENT		Provider CCN: 15-0058	Dari ad:	Workshoot F

From 01/01/2017 Part A 12/31/2017 Date/Time Prepared: 5/25/2018 3:56 pm Title XVIII Hospi tal PPS FFY (yyyy) Amount 1.00 0 70. 96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 0 70.96 the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 0 70.97 70.97 the corresponding federal year for the period ending on or after 10/1) 70.98 Low Volume Payment-3 70.98 0 70 99 HAC adjustment amount (see instructions) Ω 70 99 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 57, 703, 021 71.00 71.00 71.01 Sequestration adjustment (see instructions) 1, 154, 060 71 01 Demonstration payment adjustment amount after sequestration 71.020 71.02 72.00 Interim payments 56, 021, 158 72.00 73.00 Tentative settlement (for contractor use only) 73.00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 527, 803 74.00 74.00 73) 75.00 Protested amounts (nonallowable cost report items) in accordance with 978, 658 75.00 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 instructions) 90.00 Capital outlier from Wkst. L, Pt. I, line 2 91.00 0 91.00 92.00 Operating outlier reconciliation adjustment amount (see instructions) 0 92 00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 The rate used to calculate the time value of money (see instructions) 0.00 94.00 94 00 95.00 Time value of money for operating expenses (see instructions) 0 95.00 96.00 Time value of money for capital related expenses (see instructions) 96.00 Prior to 10/1 On/After 10/1 1.00 2.00 HSP Bonus Payment Amount 0 100. 00 100.00 HSP bonus amount (see instructions) 0 HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 0. 9991000000 101. 00 1.00000000000 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 0 102. 00 HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 0. 9997 0. 9995 103. 00 104.00 HRR adjustment amount for HSP bonus payment (see instructions) 0 104. 00 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 200.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 200.00 Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 201 00 202.00 Medicare discharges (see instructions) 202.00 203.00 Case-mix adjustment factor (see instructions) 203. 00 Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration peri od) 204.00 Medicare target amount 204.00 205.00 Case-mix adjusted target amount (line 203 times line 204) 205.00 206.00 206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 207 00 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 208. 00 209.00 Adjustment to Medicare IPPS payments (see instructions) 209 00 210.00 Reserved for future use 210.00 211.00 Total adjustment to Medicare IPPS payments (see instructions) 211. 00 Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211) 212 00 213.00 Low-volume adjustment (see instructions) 213. 00 218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) 218. 00 (line 212 minus line 213) (see instructions)

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0058	Peri od: From 01/01/2017 To 12/31/2017 Worksheet E Part B Date/Time Prepared: 5/25/2018 3:56 pm

			10 12/31/2017	5/25/2018 3:5	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	+:>		3, 491	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	ti ons)		28, 912, 188	2.00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			27, 144, 657 496, 500	3. 00 4. 00
4. 00	Outlier reconciliation amount (see instructions)			490, 500	4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5.00
6. 00	Line 2 times line 5	311 3113)		0.000	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8. 00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200		52, 515	9. 00
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3, 491	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12. 00	Ancillary service charges			16, 380	
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			16, 380	14. 00
15 00	Customary charges			0	1 1 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pamounts that would have been realized from patients liable for			0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(. 3	ii a Cilai yebasi s	l	16.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	5)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			16, 380	ł
19. 00	Excess of customary charges over reasonable cost (complete onl	vifline 18 exceeds Li	ne 11) (see	12, 889	
	instructions)	ye ie eneedde	, (555	12,007	
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21. 00	Lesser of cost or charges (see instructions)			3, 491	ı
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			27, 693, 672	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			2 27/	1 25 00
25. 00 26. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	c CAU soo instructions)		3, 276 4, 760, 732	25. 00 26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p		and 231 (see	22, 933, 155	
27.00	instructions)	orus the sum of Triles 22	ana 25] (300	22, 733, 133	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 50)		342, 803	28. 00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	•		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			23, 275, 958	30.00
31. 00	Primary payer payments			3, 863	31. 00
32.00	Subtotal (line 30 minus line 31)			23, 272, 095	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			799, 945	
35. 00	Adjusted reimbursable bad debts (see instructions)	quati ana)		519, 964	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	uctions)		552, 700 23, 792, 059	
38. 00	MSP-LCC reconciliation amount from PS&R			103	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		i	39. 50
39. 97	Demonstration payment adjustment amount before sequestration	3)		0	39. 97
39. 98	Partial or full credits received from manufacturers for replacements	ced devices (see instruc	tions)	Ö	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	204 401. 000 (000		Ö	39. 99
40.00	Subtotal (see instructions)			23, 791, 956	•
40. 01	Sequestration adjustment (see instructions)			475, 839	
40.02	Demonstration payment adjustment amount after sequestration			0	40. 02
41.00	Interim payments			23, 187, 397	41.00
42.00	Tentative settlement (for contractors use only)			0	42. 00
43.00	Balance due provider/program (see instructions)			128, 720	43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR			_	00.00
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0.00	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
94. 00				0	•
, 1. 00	1.111. (Odm. 01.11.100 7.1 drid 70)		!		, , , , , , ,

Part I

From 01/01/2017 12/31/2017 Date/Time Prepared: 5/25/2018 3:56 pm Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 55, 949, 358 23, 187, 397 1. 00 2.00 Interim payments payable on individual bills, either 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 07/24/2017 71,800 0 3.01 3.02 0 C 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 3.51 0 3.51 0 0 3.52 3.52 3.53 0 3.53 0 3.54 Ω 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 71,800 Ω 3.99 3.50-3.98) 56, 021, 158 23, 187, 397 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 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 5.01 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 527, 803 128, 720 6.01 SETTLEMENT TO PROGRAM 6 02 0 6.02 7.00 Total Medicare program liability (see instructions) 56, 548, 961 23, 316, 117 7.00 Contractor NPR Date (Mo/Day/Yr)

Provider CCN: 15-0058

Peri od:

Number

1 00

2 00

8.00

0

8.00 Name of Contractor

Heal th FinancialSystemsMEMORIAL HOSPITAL OF SOUTH BEND, INCANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDEREDProvider CCN: 1 Provider CCN: 15-0058 Component CCN: 15-S058

		Title XVIII S		Subprovi der - F		
		Inpatien	t Part A	Part 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		1, 122, 86		0	1. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		'	0	0	2. 00
	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)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER			0		3. 01
3. 03				0		3. 02
3. 04				o	o o	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 3. 53				0		3. 52 3. 53
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			Ö	l o	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 122, 86	4	0	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
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	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	12			Ö	Ö	5. 51
5. 52				O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		11, 38	1	o	6. 01
6. 02	SETTLEMENT TO PROGRAM		11, 30	0		6. 02
7. 00	Total Medicare program liability (see instructions)		1, 134, 24	5	Ö	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2. 00	0.00
8.00	Name of Contractor			I	l l	8. 00

Heal th FinancialSystemsMEMORIAL HOSPITAL OF SOUTH BEND, INCANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDEREDProvider CCN: 1 Provider CCN: 15-0058 Component CCN: 15-T058 Title XVIII

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	t 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, 745, 664 C		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		C		0	3. 01
3.02			C)	0	3. 02
3.03			C)	0	3. 03
3.04			C)	0	3. 04
3.05			C)	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3.51			C		0	3. 51
3.52			C		0	3. 52
3.53			C		0	3. 53
3.54			C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3. 99
4.00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		1, 745, 664		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
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)					5. 00
	Program to Provider		_	1	_	
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			0		0	5. 02
5. 03	Dravi dan ta Draggan		C		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		C		0	5. 50
5. 51	TENTATI VE TO PROGRAW		0			5. 50
5. 52			0			5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on		C			6. 00
	the cost report. (1)		_			
6. 01	SETTLEMENT TO PROVIDER		20.022	1	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		29, 032		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 716, 632		NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
0.00	News of Contractor	()	1. 00	2. 00	0.00
8. 00	Name of Contractor			I	1	8. 00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0058 Period: From 01/01/2017 To 12/31/2017 To 12	Heal th	Financial Systems MEMORIAL HOSPITAL OF	SOUTH BEND, INC	In Lie	u of Form CMS-	2552-10
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD 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 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from Wkst C, Pt. I, col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify)		CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0058 Period: Work From 01/01/2017 To 12/31/2017 Date				
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD 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 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Other Adjustment (specify) 31.00			Title XVIII	Hospi tal	PPS	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD 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 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Other Adjustment (specify) 31.00						
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 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify)					1. 00	
Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 31.00 Other Adjustment (specify) 30.00 31.00		TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I ine 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Other Adjustment (specify) 31.00						
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 31.00 Other Adjustment (specify)	1.00			2 14		
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify)	2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			
Total hospital charges from Wkst C, Pt. I, col. 8 line 200 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 Calculation of the HIT incentive payment (see instructions) Sequestration adjustment amount (see instructions) Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify)	3.00					
Total hospital charity care charges from Wkst. S-10, col. 3 line 20 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I			-12			
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 31.00	5.00					5. 00
Line 168 R. 00 Cal culation of the HIT incentive payment (see instructions) R. 00 R. 00 Sequestration adjustment amount (see instructions) R. 00 Cal culation of the HIT incentive payment after sequestration (see instructions) INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH Calculation of the HIT payment adjustment (see instructions) R. 00 Initial/interim HIT payment adjustment (see instructions) R. 00 R. 0						
9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial / interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify)	7. 00		ertified HIT technology	Wkst. S-2, Pt. I		7. 00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions) INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify)	8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify) 31.00	9.00	Sequestration adjustment amount (see instructions)				9. 00
30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00	10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00
31.00 Other Adjustment (specify)		INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	30.00	.00 Initial/interim HIT payment adjustment (see instructions)				
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	31.00					
	32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32.00

Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	u of Form CMS-2552	-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0058	Peri od:	Worksheet E-3	
			From 01/01/2017	Part II	
		Component CCN: 15-S058	To 12/31/2017		
				5/25/2018 3:56 pm	<u></u>
		Title XVIII	Subprovi der -	PPS	
			IPF		

	I PF		
	DADT II. MEDICADE DADT A CEDIUCEO. LDE DOC	1. 00	
1. 00	PART II - MEDICARE PART A SERVICES - IPF PPS Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1, 204, 486	1. 00
2.00	Net IPE PPS Outlier Payments	50, 117	2. 00
3.00	Net IPF PPS ECT Payments	33, 558	3. 00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4. 00
4.00	15, 2004. (see instructions)	0.00	4. 00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	4. 01
	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)		
5.00	New Teaching program adjustment. (see instructions)	0.00	5. 00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	6. 00
	teaching program" (see instuctions)		
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
0.00	teaching program" (see instuctions)	0.00	0.00
8. 00 9. 00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0. 00 10. 180822	8. 00 9. 00
10.00	Average Daily Census (see instructions) Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000	10.00
11. 00	Teaching Adjustment (line 1 multiplied by line 10).	0.000000	11. 00
12. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1, 288, 161	12.00
13. 00	Nursing and Allied Health Managed Care payment (see instruction)	1, 288, 101	13. 00
14. 00	Organ acqui si ti on (DO NOT USE THIS LINE)		14. 00
15. 00		o	15. 00
16. 00	Subtotal (see instructions)	1, 288, 161	16. 00
17. 00	Primary payer payments	0	17. 00
18. 00		1, 288, 161	
19. 00	Deducti bl es	98, 616	
20.00		1, 189, 545	
21.00		43, 757	21.00
22.00	Subtotal (line 20 minus line 21)	1, 145, 788	22. 00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	17, 764	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	11, 547	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	5, 164	25.00
26.00	Subtotal (sum of lines 22 and 24)	1, 157, 335	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)	58	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	Demonstration payment adjustment amount before sequestration	0	30. 99
31. 00	Total amount payable to the provider (see instructions)	1, 157, 393	31. 00
31. 01	Sequestration adjustment (see instructions)	23, 148	31. 01
31. 02		0	31. 02
32.00	Interim payments	1, 122, 864	
33.00	Tentative settlement (for contractor use only)	0	33.00
34. 00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	11, 381	
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35. 00
	TO BE COMPLETED BY CONTRACTOR		
50. 00		50, 117	50. 00
51. 00	Outlier reconciliation adjustment amount (see instructions)	30, 117	51. 00
	The rate used to calculate the Time Value of Money	0.00	52. 00
	Time Value of Money (see instructions)	0.00	53.00
	The second secon	, 91	

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0058 Component CCN: 15-T058	Peri od: From 01/01/2017 To 12/31/2017	
	Title XVIII	Subprovi der – I RF	PPS

	I RF		
		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	1, 601, 266	1. 00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0254	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	107, 285	3. 00
4. 00	Outlier Payments	52, 661	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior		5. 00
	to November 15, 2004 (see instructions)		
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	5. 01
	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
0.00	teaching program" (see instructions)	0.00	0.00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8. 00
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)	9. 520548	10.00
11. 00	Teaching Adjustment Factor (see instructions)	0.000000	11. 00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	1, 761, 212	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15. 00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17. 00	Subtotal (see instructions)	1, 761, 212	17. 00
18. 00	Primary payer payments	0	18. 00
19. 00	Subtotal (line 17 less line 18).	1, 761, 212	
20. 00	Deducti bl es	10, 528	
21. 00	Subtotal (line 19 minus line 20)	1, 750, 684	
22. 00	Coi nsurance	7, 238	
23. 00	Subtotal (line 21 minus line 22)	1, 743, 446	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	12, 645	
25. 00	Adjusted reimbursable bad debts (see instructions)	8, 219	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9, 800	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	1, 751, 665	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	0	29. 00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Prioneer ACO demonstration payment adjustment (see instructions)	1	31. 50 31. 99
31. 99 32. 00	Demonstration payment adjustment amount before sequestration	1 751 445	
32. 00	Total amount payable to the provider (see instructions)	1, 751, 665 35, 033	
32. 01	Sequestration adjustment (see instructions)	35, 033	32. 01
32. 02	Demonstration payment adjustment amount after sequestration Interim payments	1, 745, 664	32. 02
34. 00	Tentative settlement (for contractor use only)	1, 745, 664	34. 00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-29, 032	
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	12, 260	36. 00
30.00	§115. 2	12, 200	30.00
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Wkst. E-3, Pt. III, line 4	52, 661	50.00
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	
53. 00	Time Value of Money (see instructions)	0	53. 00

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der Co	CN: 15-0058	Peri od:	Worksheet E-4	
EDI CA	L EDUCATION COSTS			From 01/01/2017 To 12/31/2017	Date/Time Prep	
		Title	: XVIII	Hospi tal	5/25/2018 3: 50 PPS	o piii
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng periods	24. 76	1. (
00	Unweighted FTE resident cap add-on for new programs per 42 CF Amount of reduction to Direct GME cap under section 422 of MM		1) (see instr	uctions)	0. 00 0. 00	
01	Direct GME cap reduction amount under ACA §5503 in accordance linstructions for cost reporting periods straddling 7/1/2011)		§413.79 (m).	(see	0.00	
00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0. 00	4.
01	ACA Section 5503 increase to the Direct GME FTE Cap (see instant straddling 7/1/2011)		cost reporti	ng periods	0. 00	4.
02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	·			3. 00	
00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts		·		27. 76	5.
00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	26. 50	
00	Enter the lesser of line 5 or line 6		Primary Care	Other	26. 50 Total	7.
			1.00	2. 00	3. 00	
00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.		26. 5		26. 50	
00	If line 6 is less than 5 enter the amount from line 8, otherwind multiply line 8 times the result of line 5 divided by the amount 6.		26. 5	0.00	26. 50	9
. 00	Weighted dental and podiatric resident FTE count for the curr			0.00		10
. 01 . 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	urrent year	26. 5	0.00		10 11
. 00	Total weighted resident FTE count for the prior cost reportir instructions)	ng year (see	26. 6			12
. 00	Total weighted resident FTE count for the penultimate cost relyear (see instructions)	eporti ng	27. 1	3 0.00		13
. 00	Rolling average FTE count (sum of lines 11 through 13 divided	d by 3).	26. 7			14
. 00 . 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs	orograms	0. 0 0. 0			15 15
. 00	Adjustment for residents displaced by program or hospital clo		0.0			16
. 01	Unweighted adjustment for residents displaced by program or h		0.0			16
. 00	Adjusted rolling average FTE count		26. 7			17
. 00	Per resident amount Approved amount for resident costs		116, 765. 3 3, 123, 47		3, 123, 473	18 19
					1. 00	
00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	FTE resident	cap slots rec	eived under 42	0. 00	20
. 00	Direct GME FTE unweighted resident count over cap (see instru	,			0.00	
. 00	Allowable additional direct GME FTE Resident Count (see instr Enter the locally adjustment national average per resident an		structions)		0. 00 0. 00	
	Multiply line 22 time line 23	ilount (300 mi	311 4011 0113)		0.00	
00	Total direct GME amount (sum of lines 19 and 24)		l		3, 123, 473	25
			Inpatient Par A	t Managed care		
	POOUBLITATION OF PROPERTY BATTERIT LOAD		1.00	2. 00	3. 00	
. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions)		26, 42	3 10, 345		 26
. 00	Total Inpatient Days (see instructions)		96, 11			27
	Ratio of inpatient days to total inpatient days		0. 27492	2 0. 107636		28
. 00	In Our .		858, 71	1 336, 198		29
00 0.00 0.00	Program direct GME amount Reduction for direct GME payments for Medicare Advantage		030, 71	47, 505		30

Heal th	Financial Systems MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0058	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2017 To 12/31/2017	Date/Time Prep 5/25/2018 3:50	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	·		CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 an	nd 23, lines 74	0	32. 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	e 32 ÷ line 33)		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			0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
	Reasonable cost (see instructions)			68, 024, 506	
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38. 00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39. 00
	Primary payer payments (see instructions)			41, 804	
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minus	s line 40)		67, 982, 702	41. 00
	Part B Reasonable Cost				
	Reasonable cost (see instructions)			28, 968, 194	
43.00	1 3 1 3 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1				43.00
	Total Part B reasonable cost (line 42 minus line 43)			28, 964, 331	
	Total reasonable cost (sum of lines 41 and 44)	44 11 45		96, 947, 033	
	Ratio of Part A reasonable cost to total reasonable cost (line			0. 701236	
47.00	Ratio of Part B reasonable cost to total reasonable cost (line ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART			0. 298764	47.00
40 00		KI B		1 147 404	10 00
	Total program GME payment (line 31)	(!+		1, 147, 404	
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)			804, 601	
ou. 00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see Instructions)		342, 803	50.00

Health Financial Systems MEMORIAL HOSPITA
BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-0058

Peri od: Worksheet G From 01/01/2017 To 12/31/2017 Date/Time Prepared:

onl y)			'	0 12/31/2017	5/25/2018 3:5	
		General Fund	Speci fi c	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS		1			
1.00	Cash on hand in banks	-141, 000		0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	12, 000		_	0	2. 00 3. 00
4. 00	Accounts receivable	111, 985, 073	1	Ö	0	4. 00
5. 00	Other receivable	28, 098, 000		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-22, 656, 073	C	0	0	6. 00
7. 00	Inventory	16, 813, 000		0	0	7. 00
8.00	Prepai d expenses	1, 075, 000		0	0	
9. 00 10. 00	Other current assets Due from other funds	0	6, 814, 000	0	0	9.00
11. 00	Total current assets (sum of lines 1-10)	135, 186, 000	6, 814, 000		0	11.00
	FIXED ASSETS	1007 1007 000	7 0,011,000	<u> </u>		
12.00	Land	21, 318, 000	C	0	0	12. 00
13.00	Land improvements	0	C		0	13. 00
14. 00	Accumulated depreciation	0	C	0	0	14. 00
15. 00 16. 00	Buildings Accumulated depreciation	492, 306, 000 -437, 839, 000	1	0	0	15. 00 16. 00
17. 00	Leasehold improvements	-437, 639, 000 0		0	0	17. 00
18. 00	Accumulated depreciation	Ö		Ö	0	18. 00
19.00	Fi xed equipment	293, 352, 000	C	O	0	19. 00
20.00	Accumulated depreciation	0	C	0	0	20. 00
21. 00	Automobiles and trucks	0	O.	0	0	21. 00
22. 00	Accumulated depreciation	0		0	0	22.00
23. 00 24. 00	Major movable equipment Accumulated depreciation	0	O	0	0	23. 00
25. 00	Mi nor equi pment depreci abl e	0		0	0	25. 00
26. 00	Accumulated depreciation	0	o c	0	0	26. 00
27. 00	HIT designated Assets	0	o c	0	0	27. 00
28. 00	Accumulated depreciation	0	C	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	C		0	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	369, 137, 000	<u> </u>	0	0	30.00
31. 00	Investments	0		O	0	31. 00
32.00	Deposits on Leases	0	C	0	0	32. 00
33. 00	Due from owners/officers	0	C	0	0	33. 00
34. 00	Other assets	11, 051, 000	1	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	11, 051, 000		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	515, 374, 000	6, 814, 000	U U	U	36.00
37. 00	Accounts payable	39, 169, 000	C	ol	0	37. 00
38. 00	Salaries, wages, and fees payable	0	C	0	0	38. 00
39. 00	Payroll taxes payable	0	C	0	0	39. 00
40. 00	Notes and Loans payable (short term)	5, 564, 000	C	0	0	40. 00
41. 00 42. 00	Deferred income	0		0	0	41.00
42.00	Accelerated payments Due to other funds	0		0	0	42. 00 43. 00
44. 00	Other current liabilities	5, 119, 000		Ö	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	49, 852, 000		0	0	
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	O.	_	0	
47. 00	Notes payable	158, 230, 000	1		0	
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	16, 305, 000	C	_	0	48. 00 49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	174, 535, 000	l .		0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	224, 387, 000	l .	_	0	51. 00
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	290, 987, 000	l .			52. 00
53.00	Specific purpose fund		6, 814, 000			53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
==	replacement, and expansion	005				
59.00	Total fund balances (sum of lines 52 thru 58)	290, 987, 000			0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	515, 374, 000	6, 814, 000		0	60.00
	1 /	ı	1	ı I		1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0058

				T	o 12/31/2017	Date/Time Prep 5/25/2018 3:50	
		General	Fund	Speci al Pu	rpose Fund	Endowment Fund	o piii
		1. 00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		343, 265, 000 97, 533, 000		8, 628, 000		1. 00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	440, 798, 000	0	8, 628, 000	0	3. 00 4. 00
5. 00	CAPITAL CONTRIBUTIONS			-1, 814, 000		0	5. 00
6.00	NET ASSETS RELEASED FROM RESTRICTION	2, 335, 000		0		0	6. 00
7.00		0		0		0	7. 00
8.00		0		0		0	8. 00
9. 00 10. 00	Total additions (sum of line 4-9)		2, 335, 000	0	-1, 814, 000	·	9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)		443, 133, 000		6, 814, 000		11. 00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13. 00		0		0		0	13.00
14. 00 15. 00	TRANSFER TO BEACON HEALTH SYSTEM	152, 146, 000		0		0	14. 00 15. 00
16. 00						0	16. 00
17. 00				ĺ		o o	17. 00
18. 00	Total deductions (sum of lines 12-17)		152, 146, 000		0		18.00
19. 00	Fund balance at end of period per balance		290, 987, 000		6, 814, 000		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		Endowner Turid	Truit	T dila			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0		0			1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0		0			2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)		0	Ĭ			4. 00
5.00	CAPITAL CONTRIBUTIONS		0				5.00
6.00	NET ASSETS RELEASED FROM RESTRICTION		0				6. 00
7. 00 8. 00			0				7. 00 8. 00
9. 00			0				9. 00
10. 00	Total additions (sum of line 4-9)	O	J	0			10.00
11. 00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13. 00 14. 00	TRANSFER TO BEACON HEALTH SYSTEM		0				13. 00 14. 00
15. 00	TRANSFER TO BEACON HEALTH STSTEM		0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19. 00

Health Financial Systems MEMORIA STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0058

			То	12/31/2017	Date/Time Prep	
	Cost Center Description	Inpati ent		Outpati ent	5/25/2018 3:50 Total	o piii
	cost center bescription	1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00		2.00	3.00	
	General Inpatient Routine Services					
1.00	Hospi tal	214, 177, 4	79		214, 177, 479	1. 00
2. 00	SUBPROVI DER - I PF	4, 283, 8			4, 283, 879	2. 00
3.00	SUBPROVI DER - I RF	9, 601, 8			9, 601, 866	3. 00
4. 00	SUBPROVI DER	7,001,0	00		7, 001, 000	4. 00
5. 00	Swi ng bed - SNF		0		o	5. 00
6.00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY				J	7. 00
8. 00	NURSI NG FACI LI TY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	228, 063, 2	24		228, 063, 224	10.00
10.00	Intensive Care Type Inpatient Hospital Services	220,000,2	27		220, 003, 224	10.00
11. 00	INTENSIVE CARE UNIT	39, 938, 4	19		39, 938, 419	11. 00
11. 01	NEONATAL INTENSIVE CARE UNIT	29, 033, 2			29, 033, 239	11. 01
12. 00	CORONARY CARE UNIT	27,000,2	٠,		27,000,207	12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	68, 971, 6	58		68, 971, 658	16. 00
10.00	11-15)	00, 771, 0			00, 771, 000	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	297, 034, 8	82		297, 034, 882	17. 00
18. 00	Ancillary services	557, 908, 8		0	557, 908, 856	18. 00
19. 00	Outpati ent servi ces		0	557, 002, 227	557, 002, 227	19. 00
20. 00	RURAL HEALTH CLINIC		O	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY					22. 00
23. 00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27. 00	OTHER (SPECIFY)		0	o	0	27.00
28.00	Total patient revenues (sum of lines 17-27) (transfer column 3 to Wk	st. 854, 943, 7	38	557, 002, 227	1, 411, 945, 965	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES	•				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			423, 219, 473		29.00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37. 00	DEDUCT (SPECIFY)		0			37.00
38. 00			0			38.00
39. 00			0			39. 00
40.00			0			40.00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	nsfer		423, 219, 473		43.00
	to Wkst. G-3, line 4)					

Health Financial Systems MEMORIAL HOSP		SOUTH BEND, INC	In Lie	In Lieu of Form CMS-2552-10		
STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-0058	Peri od:	Worksheet G-3		

Health Financial Systems		MEMORIAL HOSPITAL OF S	In Lie	In Lieu of Form CMS-2552-10		
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-0058	Peri od:	Worksheet G-3	
				From 01/01/2017	D-+- /T: D	
	To 12/31/2017				Date/Time Prepared: 5/25/2018 3:56 pm	
					1. 00	
1. 00	Total patient revenues (from Wkst. 0	G-2, Part I, column 3, lin	e 28)		1, 411, 945, 965	1. 00
2.00	Less contractual allowances and disc	counts on patients' accoun	ts		918, 238, 758	2.00
3.00	Net patient revenues (line 1 minus l	ine 2)			493, 707, 207	3.00
4.00	Less total operating expenses (from	Wkst. G-2, Part II, line	43)		423, 219, 473	4.00
5.00	Net income from service to patients	(line 3 minus line 4)			70, 487, 734	5. 00
	OTHER INCOME					
6.00	Contributions, donations, bequests,	etc			0	6. 00
7.00	Income from investments				785, 507	7. 00
8.00	Revenues from telephone and other mi		servi ces		0	8. 00
9.00	Revenue from television and radio se	ervi ce			0	9. 00
10.00	Purchase di scounts				0	10.00
11. 00	Rebates and refunds of expenses				1, 220, 953	
12. 00	Parking lot receipts				315, 288	
13. 00	Revenue from laundry and linen servi				0	13.00
14. 00	Revenue from meals sold to employees				1, 367, 322	
	Revenue from rental of living quarte				0	
	Revenue from sale of medical and sur		han patients		0	16. 00
	Revenue from sale of drugs to other				0	17. 00
	Revenue from sale of medical records				0	18. 00
	Tuition (fees, sale of textbooks, ur				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
23. 00	Governmental appropriations				2, 328, 949	
24. 00	MI SC OTHER REVENUE				14, 131, 721	24. 00
25. 00	Total other income (sum of lines 6-2	24)			20, 149, 740	
26. 00	Total (line 5 plus line 25)				90, 637, 474	
27. 00	UNREALIZED LOSS ON SWAP				-6, 895, 526	
	Total other expenses (sum of line 27				-6, 895, 526	
29. 00	Net income (or loss) for the period	(line 26 minus line 28)			97, 533, 000	29. 00

Heal th	Financial Systems	MEMORIAL HOSPITAL OF	SOUTH BEND, INC	In Lie	u of Form CMS-	2552-1
CALCULATION OF CAPITAL PAYMENT		Provi der CCN: 15-0058	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Pre 5/25/2018 3:5		
			Title XVIII	Hospi tal	PPS	
	PART I - FULLY PROSPECTIVE METHOL				1. 00	
	CAPITAL FEDERAL AMOUNT	J				1
1. 00	Capital DRG other than outlier				3, 648, 071	1.0
1. 01	Model 4 BPCI Capital DRG other t	han outlier			0,010,071	1.0
2. 00	Capital DRG outlier payments				211, 116	
2. 01	Model 4 BPCI Capital DRG outlier	payments			0	2.0
3. 00	Total inpatient days divided by	number of days in the cost r	reporting period (see inst	tructions)	247. 21	3.0
4. 00	Number of interns & residents (s	ee instructions)		,	19. 76	4.0
5. 00	Indirect medical education percentage (see instructions)				2. 29	5.0
6. 00	00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)					6.0
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)					7.0
3. 00	Percentage of Medicaid patient days to total days (see instructions)			36. 32	8.0	
9. 00	Sum of lines 7 and 8				42. 56	9. 0
10.00	00 Allowable disproportionate share percentage (see instructions)				9. 00	10.0
	00 Disproportionate share adjustment (see instructions)			328, 326	11. C	
12. 00	2.00 Total prospective capital payments (see instructions)					12. C
					1. 00	
	PART II - PAYMENT UNDER REASONABI					١.,
1.00	Program inpatient routine capita				0	1.0
2.00	Program inpatient ancillary capi				0	2. (
3. 00	Total inpatient program capital cost (line 1 plus line 2)				0	3. (
1. 00 5. 00						4. 0 5. 0
J. UU	Total Theatrent program capital	cost (THE 3 X THE 4)			0	5.0
					1. 00	
	PART III - COMPUTATION OF EXCEPTI					
1. 00	Program inpatient capital costs				0	
2 00	Drogram inpatient capital costs	for ovtraordinary direumetar	acoc (coo instructions)		Λ.	1 2

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1. 00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3. 00
4.00	Capital cost payment factor (see instructions)	0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5. 00
		1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1. 00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3. 00
4.00	Applicable exception percentage (see instructions)	0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	
7. 00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8. 00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9. 00
10. 00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	1
11. 00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11. 00
12.00		0	12. 00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13. 00
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)	0	14. 00
15 00	Current year allowable operating and capital payment (see instructions)	0	15. 00
	Current year operating and capital costs (see instructions)	0	
		l ol	1
		- 1	1