required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai	lure to report can res	sult in all interim	FORM APPROVED
since the beginning of the cost reporting period being	deemed overpayments ((42 USC 1395g).	OMB NO. 0938-0050
			EXPIRES 05-31-2019
HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provider CCN: 15-0058	From 01/01/2018	
REPORT STATUS			
1.[X]Electronically filed cost report		Date: 5/29/20	19 Time: 8:36 am
2. [] Manually submitted cost report			
		resubmitted this co	ost report
5. [1] Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for (4) Reopened (5) Amended	or this Provider CCN 12	1.Contractor's Vendo 2.[0]If line 5, co	
	Since the beginning of the cost reporting period being MOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY REPORT STATUS 1. [X] Electronically filed cost report 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 "I 5. [1] Cost Report Status 6. Date Received:	Since the beginning of the cost reporting period being deemed overpayments of COSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0058 SUMMARY Provider CCN: 15-0058 S	REPORT STATUS 1. [X] Electronically filed cost report 2. [] Manually submitted cost report 3. [0] If this is an amended report enter the number of times the provider resubmitted this code. 4. [F] Medicare Utilization. Enter "F" for full or "L" for low. 5. [1] Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, contractor in the provider CCN 12. [0] If line 5, contractor in the provider CCN 13. [0] If line 5, contractor in the provider CCN 14. [15. [0] If line 5, contractor in the provider CCN 15.

PART II - CERTIFICATION

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

CERTIFICATION BY 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 01/01/2018 and ending 12/31/2018 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)_						
		Offi cer	or	Admi ni strator	of F	Provi der(s)
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٦	itle					
_						
)ate					

			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	-489, 326	-44, 114	0	0	1.00
2.00	Subprovider - IPF	0	5, 894	0		0	2. 00
3.00	Subprovider - IRF	0	-34, 042	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	-517, 474	-44, 114	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.

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.

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 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 8:36 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 615 N MICHIGAN ST 1.00 PO Box: 1.00 State: IN 2.00 City: SOUTH BEND Zip Code: 46601 County: ST. **JOSEPH** 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type 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 Subprovi der - IPF 155058 43780 Р 4.00 04/07/2011 Р 4 00 4 Ν 5.00 Subprovider - IRF REHABILITATION UNIT 15T058 43780 5 01/01/1984 Ρ Ρ 5.00 Ν Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate 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 22.01 Υ Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N Ν Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d days paid days el i gi bl e Medi cai d Medi cai d paid days unpai d el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 2. 755 12, 348 0 24.00 3.059 14.926 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.

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provi der CC	N: 15-0058	Peri od: From 01/0 To 12/3	01/2018 31/2018	Part I Date/T	eet S-2	pared:
		In-State Medicaid paid days	unpai d days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	nid (019 8:3 Ither di cai d days	o alli
5. 00	If this provider is an IRF, enter the in-state 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-stat Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		2.00	3.00	4. 00 0	5. 00	302	6. 00	25. (
					Urban/F		Date of	Geogr	
6. 00	Enter your standard geographic classification (not	wage) status	s at the beg	jinning of t		1	۷.	00	26.0
7. 00	cost reporting period. Enter "1" for urban or "2" f Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban enter the effective date of the geographic reclassi	wage) status or "2" for m	rural. If ap		t	1			27. (
5. 00	If this is a sole community hospital (SCH), enter t			H status in		0			35.0
	effect in the cost reporting period.				Begi n		Endi		
6. 00	Enter applicable beginning and ending dates of SCH	status. Subs	script line	36 for numb	1. er	00	2.	00	36. (
	of periods in excess of one and enter subsequent da If this is a Medicare dependent hospital (MDH), ent	ates.	•			0			37. (
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y"	the MDH tran	' nsitional pa	nyment in	5	U			37. (
8. 00	instructions) If line 37 is 1, enter the beginning and ending dat greater than 1, subscript this line for the number enter subsequent dates.	tes of MDH st	tatus. If li	ne 37 is					38.
					Y/			′N	1
9. 00	Does this facility qualify for the inpatient hospit	tal payment a	adjustment f	or low volu	me 1.		2.	V 00	39. (
0. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (or "N" for no. (see instructions) Is this hospital subject to the HAC program reducti "N" for no in column 1, for discharges prior to Oct no in column 2, for discharges on or after October	t the mileage (iii)? Enter on adjustmer tober 1. Ente	e requiremen in column 2 nt? Enter "Y er "Y" for y	nts in 2 "Y" for ye 7" for yes o	s r N	I	1	ı	40. (
	,	('	V 1. 00	XVIII	XIX	
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
5. 00	Does this facility qualify and receive Capital paym with 42 CFR Section §412.320? (see instructions)	ment for disp	oroporti onat	e share in	accordance	N	Y	N	45. (
6. 00	Is this facility eligible for additional payment expursuant to 42 CFR §412.348(f)? If yes, complete WkPt. III.					N	N	N	46.
7. 00 8. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital payme Teaching Hospitals	•		,		N N	N N	N N	47. 48.
6. 00	Is this a hospital involved in training residents i or "N" for no.	n approved (GME programs	? Enter "Y	" for yes	Y			56.
7. 00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" is "Y" did residents start training in the first mo for yes or "N" for no in column 2. If column 2 is	for yes or "N onth of this "Y", complet	N" for no in cost report te Worksheet	n column 1. ing period?	If column Enter "Y				57.
8. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. If line 56 is yes, did this facility elect cost rei defined in CMS Pub. 15-1, chapter 21, §2148? If yes	mbursement 1	for physicia	ıns' servi ce	s as	N			58.
9. 00	Are costs claimed on line 100 of Worksheet A? If y	yes, complete	e Wkst. D-2,	Pt. I. NAHE 413.8 Y/N	85 Worksh Lin	e #	Pass-T Qual i fi Cri teri	cation	
				1. 00	2.	00	3.	00	-
				1. ()()					
0. 00	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?			Y	2.	00		00	60.

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

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Fo					u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: rom 01/01/2018 o 12/31/2018	Worksheet S-2 Part I Date/Time Prep	pared:
	Y/N	IME	Direct GME	IME	5/29/2019 8:36 Direct GME	5 am
	1. 00	2. 00	3. 00	4.00	5. 00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	Y	2.00	0.00	3.00		61. 00
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	Dro	ogram Name	Drogram Codo	Unweighted IME	Unwei ghted	61. 06
	PI	ogi alli Nalle	Program code		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 special ty, 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	
ACA Provisions Affecting the Health Resources and Ser 62.00 Enter the number of FTE residents that your hospital	rvi ces i	Administration	(HRSA)	od for which	0.00	62. 00
62.01 Enter the number of FTE residents that your hospital received HRSA PCRE funding (see instruction of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression of the property of the property of the progression of the p	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62. 01
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			N	63. 00
1 Tol yes of N Tol Ho TH Column 1. 11 yes, compre		es o4 through c	Unwei ghted FTEs		Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te	Hospi tal	2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base year	2.00	3.00 eporting	
period that begins on or after July 1, 2009 and before 64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June sy train n-priman all non n column	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0. 0C			64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0058 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 8:36 am Program Name Program Code Unwei ghted Unwei ghted 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 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 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 ahted Unwei ghted Ratio (col. 3/ Program Code 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)

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 19	5-0058 Peri	od:	of Form CMS Worksheet S	
	From To	01/01/2018 12/31/2018	Part I Date/Time Pi 5/29/2019 8	
			1. 00	
Long Term Care Hospital PPS				
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 81.00 Is this a LTCH co-located within another hospital for part or all of the cost "Y" for yes and "N" for no. TEFRA Providers	reporting per	riod? Enter	N N	80. 00 81. 00
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y"		N" for no.	N	85. 00 86. 00
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease are hospital classified under	r section		N	87. 00
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		V	XI X	
		1. 00	2. 00	
Title V and XIX Services				
90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter yes or "N" for no in the applicable column.	"Y" for	N	Υ	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through the cost report eit 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
instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX "Y" for yes or "N" for no in the applicable column.	X? Enter	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. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 96.00 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
applicable column.				
97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and resident stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for		0. 00 Y	0. 00 Y	97. 00 98. 00
column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in colu		Υ	Y	98. 01
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of obser		Υ	Υ	98. 02
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in co for title V, and in column 2 for title XIX.	olumn 1			
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospit reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in		N	N	98. 03
for title V, and in column 2 for title XIX. 98.04 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		N	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallow Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title		Υ	Υ	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wks Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, ar column 2 for title XIX.	st. D,	Υ	Υ	98. 06
Rural Providers				
105.00 Does this hospital qualify as a CAH?		N		105. 00
106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of for outpatient services? (see instructions)	or payment			106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for training programs? Enter "Y" for yes or "N" for no in column 1. (see instructives, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the programs.	ons) If			107. 00

reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	·	3	N		108. 00
	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 therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 00
				1. 00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worksheet E.	"Y" for yes or	"N" for no. If	yes,	N	110. 00

MEMORIAL HOSPITAL OF MEMORIAL HOSPITAL OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	SOUTH BEND, INC Provider CCN: 15-0058	Peri od:	IN LIE	Worksheet S	
IOSITTAL AND HOSITTAL HEALTH CARL COMM LEX TRENTITION DATA	Trovider Con. 13-0030	From 01/	01/2018 31/2018	Part I	repared:
		1	00	2. 00	-
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	st reporting period? Ent umn 1 is Y, enter the icipating in column 2.	er	N	2.00	111.0
hu u a a a a a a a a a a a a a a a a a a			1. 0	0 2.00 3.0	0
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1.	If column 2 is "E", ent for long term care (ir based on the definiti	er in colum cludes	nn	0	115. 0
116.00 s this facility classified as a referral center? Enter "Y" f 117.00 s this facility legally-required to carry malpractice insura no.	nnce? Enter "Y" for yes		N		116. 0 117. 0
118.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence.			1		118. 0
	Premi um	s Los	sses	Insurance	
	1.00		00	3. 00	
118.01 List amounts of malpractice premiums and paid losses:	1, 081	, 165	561, 275		0 118. 0
		1.	00	2.00	
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 119.00 DO NOT USE THIS LINE			N		118. 0
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes o Nifies for the Outpation	r	N	N	120. 0
121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.	ntable devices charged t	О	Υ		121. 0
122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			N		122. 0
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N" for no. If	7	N		125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2.		ite			126. 0
27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certification dat	е			127. 0
28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certification dat	е			128. 0
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	the certification date	in			129. 0
30.00 If this is a Medicare certified pancreas transplant center, edate in column 1 and termination date, if applicable, in column 1.	ımn 2.				130. 0
131.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 2	ımn 2.				131. 0
[32.00] If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.					132. 0
I33.00 If this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2. I34.00 If this is an organ procurement organization (OPO), enter the					133. 0 134. 0
and termination date, if applicable, in column 2. All Providers	, or o maniper TH COLUMN 1				-134.0
140.00 Are there any related organization or home office costs as dechapter 10? Enter "Y" for yes or "N" for no in column 1. If y			Y	15H013	140. 0

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 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/29/2019 8:36 am 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 Ν 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 01/01/2018 12/31/2018 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)

	Financial Systems MEMORIAL HOSPITAL OF TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Peri od:	u of Form CMS- Worksheet S-2	
10371	AL AND HUSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider		From 01/01/2018 To 12/31/2018	Part II	epared
				Y/N	Date	
		6 11 110		1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Ente	r all dates in t	:he	
	COMPLETED BY ALL HOSPITALS					-
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	heainning of	the cost	Υ	12/01/2011	1.
00	reporting period? If yes, enter the date of the change in c				12/01/2011	''
		,	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for	N			2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe	ffices, drug er or its f the board	N			3.
	relationships? (see instructions)		V /N	T	D-+-	
			1.00	7ype 2. 00	Date 3.00	-
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A		4.
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
				Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2. 00	-
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If yes is th	ne provider is	N		6.
00	the legal operator of the program?	11 yes, 15 ti	ie provider 13	· IN		0
00	Are costs claimed for Allied Health Programs? If "Y" see in	structions.		Υ		7.
00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	d during the	N		8.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	Y		9.
0. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		the current	N		10
. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	oroved	Υ		11.
	1. 122g 11 ogram on normander m. 11 your odd filotholis.				Y/N	
					1.00	
	Bad Debts					
. 00	Is the provider seeking reimbursement for bad debts? If yes				Y	12
. 00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	3	J		N	13
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? In	fyes, see ins	tructions.	N	14
. 00	Did total beds available change from the prior cost reporti				Y	15
			rt A	Par		
		Y/N 1.00	2.00	Y/N 3. 00	Date 4.00	
	PS&R Data	1.00	2.00	3.00	7.00	
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16

	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	Υ	04/11/2019	Y	04/11/2019	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	Υ		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 0	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 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Pre 5/29/2019 8:3	epared:		
			i pti on	Y/N	Y/N			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00		
	Report data for Other? Describe the other adjustments:)/ /NI)/ (A)				
		Y/N 1. 00	2. 00	Y/N 3.00	Date 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)					
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost	N	23. 00		
24. 00	Were new leases and/or amendments to existing leases entere If 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 instructions.	the cost repor	ting period?	If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th linstructions.	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 treated as a funded depreciation account? If yes, see instr		ebt Service R	eserve Fund)	N	29. 00		
30. 00	Has existing debt been replaced prior to its scheduled matulinstructions.	, 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		
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	vices furnishe	ed through co	ntractual	N	32. 00		
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app	ctions. lied pertainir	ng to competi	tive bidding? If	N	33. 00		
	no, see instructions. Provider-Based Physicians							
34. 00	If yes, see instructions.	9	•	. ,	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		nts with the		N	35. 00		
				Y/N 1. 00	2. 00			
	Home Office Costs			1.00	2.00			
36. 00	Were home office costs claimed on the cost report?			Y		36. 00		
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.					37. 00		
38. 00	the provider? If yes, enter in column 2 the fiscal year end	of the home of	ffi ce.			38. 00		
39. 00	If line 36 is yes, did the provider render services to othe see instructions.		39. 00					
40. 00	If line 36 is yes, did the provider render services to the instructions.		40. 00					
	1.00 2.00							
	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, respectively.	JEREMY		KUSKYE		41.00		
42. 00	'	BEACON HEALTH	SYSTEM			42. 00		
43. 00		574-647-1144		JKUSKYE@BEACON RG	HEALTHSYSTEM. O	43.00		

Heal th Financi	al Systems	MEMORIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	u of Form	CMS-2	2552-10
HOSPITAL AND H	HOSPITAL HEALTH CARE REIMBURSEME	NT QUESTIONNAIRE	Provi der	CCN: 15-0058	1/01/2018	Worksheet Part II Date/Time		pared:
					 	5/29/2019	8: 36	5 am
				3. 00				
Cost Re	port Preparer Contact Informati	on						
41.00 Enter t	he first name, last name and th	e title/position	REI MBURSEMEN	Γ ANALYST				41.00
held by	the cost report preparer in co	lumns 1, 2, and 3,						
respect	i vel y.							
42.00 Enter t	he employer/company name of the	cost report						42.00
prepare	r.							
43.00 Enter t	he telephone number and email a	ddress of the cost						43.00
report	preparer in columns 1 and 2, re	specti vel y.						

 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 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared:

							5/29/2019 8: 3	6 am
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		315	114, 97	5 0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO 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			315	114, 97	5 0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		46			0	8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT	31. 01		30	10, 95	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)			391	142, 71	0.00	0	14.00
15.00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF	40. 00		24	8, 76	O	0	16. 00
17.00	SUBPROVI DER - I RF	41. 00		20	7, 30	O	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	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			435	;			27. 00
28. 00	Observation Bed Days						0	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)			9	3, 28	5		32. 00
32. 01	Total ancillary labor & delivery room			•		1		32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33. 00
	LTCH site neutral days and discharges							33. 01
	, , , , , , , , , , , , , , , , , , , ,	'	'		1	1	'	

33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-0058

Peri od: Worksheet S-3 From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

5/29/2019 8:36 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 10.00 7.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 23, 916 2, 501 73, 367 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) 11, 462 2 00 29, 665 3.00 HMO IPF Subprovider 428 3.00 HMO IRF Subprovider 4.00 0 475 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 C C Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 23, 916 2, 501 73, 367 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 2, 261 9, 208 8.00 8.01 NEONATAL INTENSIVE CARE UNIT 338 8, 919 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 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 161 4, 201 13.00 Total (see instructions) 27.86 2, 308. 53 14.00 26, 177 3,000 95, 695 14.00 15.00 CAH visits 15.00 SUBPROVIDER - IPF 3,090 16.00 993 65 0.00 21.91 16.00 SUBPROVIDER - IRF 17.00 1, 180 11 2, 907 0.00 17.37 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 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23 00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 89 24. 10 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 26. 25 27.00 Total (sum of lines 14-26) 27.86 2, 347.81 27.00 Observation Bed Days 28.00 0 10, 516 28.00 29 00 Ambul ance Trips 0 29 00 30.00 Employee discount days (see instruction) 1, 409 30.00 31.00 Employee discount days - IRF 31.00 110 Labor & delivery days (see instructions) 0 423 32.00 32.00 735 Total ancillary labor & delivery room 0 32.01 outpatient days (see instructions) LTCH non-covered days 33.00

33.01 LTCH site neutral days and discharges

33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0058

Peri od: Worksheet S-3 From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

5/29/2019 8:36 am Full Time Di scharges Equi val ents Title V Title XVIII Total All Component Nonpai d Title XIX Workers Pati ents 12.00 13.00 11.00 14.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 5, 111 536 18, 456 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) 4, 508 2 00 2.161 HMO IPF Subprovider 3.00 3.00 HMO IRF Subprovider 4.00 36 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.00 NEONATAL INTENSIVE CARE UNIT 8.01 8.01 9.00 CORONARY CARE UNIT 9.00 10.00 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 14.00 0.00 5, 111 536 18, 456 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 0.00 80 304 16.00 SUBPROVIDER - IRF 17.00 0.00 102 256 17.00 SUBPROVI DER 18.00 18.00 19 00 SKILLED NURSING FACILITY 19 00 NURSING FACILITY 20.00 20.00 21.00 OTHER LONG TERM CARE 21.00 HOME HEALTH AGENCY 22.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23 00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 27.00 Observation Bed Days 28.00 28.00 29 00 Ambul ance Trips 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 32.00 32.00 Total ancillary labor & delivery room 32.01 outpatient days (see instructions) LTCH non-covered days 33.00

33.01 LTCH site neutral days and discharges

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION MEMORIAL HOSPITAL OF SOUTH BEND, INC
Provider CCN: 15-0058

| Period: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared:

Ministration Mini						T	o 12/31/2018	Date/Time Pre	
Number Reported On of Statistics Saliaries Coil 2 + col. Saliaries Coil			Wkst. A Line	Amount	Recl assi fi cati	Adjusted	Pai d Hours		o am
Mil. 1 - Sec. DATA					on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
No. Part 1 - AMOF DATA 1.00 2.00 3.00 4.00 5.00 6.00						C		col. 5)	
SAMABLE SAMA			1 00	2 00				6.00	
Total sall aris is (see 200.00 147, 259, 041 0 147, 259, 041 0 477, 259, 041 0 30.00 30.00 30.00 2.00 30.00 30.00 2.00 30.00 30.00 30.00 2.00 30.00		PART II - WAGE DATA	1.00	2.00	0.00	1. 00	0. 00	0.00	
Instructions Instructions					_				
Mon-physic claim anesthetist Part 0	1.00		200.00	147, 259, 041	0	147, 259, 041	4, 883, 444. 00	30. 15	1.00
## And In its Fractive	2.00			0	0	0	0.00	0. 00	2. 00
## And In its Fractive	0.00	A					0.00		0.00
Admin strative 4. 01 Physicians - Part A - Teaching 5. 00 Physicians - Part A - Teaching 9. 2, 279, 225 0 2, 279, 225 10, 362, 00 117, 72 4. 01 90, 360, 00 10, 00	3.00	B and an anesthetist Part		U	0	0	0.00	0.00	3.00
4.01 Physicians - Part A - Tosching 2.279,225 0 2.279,225 19,302.00 117.72 4.01	4.00	Physician-Part A -		1, 267, 247	0	1, 267, 247	5, 036. 00	251. 64	4. 00
Physic I an And Non	4 01			2 270 225		2 270 225	10 2/2 00	117 70	4 01
Physician-Part 8 600				2, 279, 225		2, 2/9, 225			
hospital based Bild and Folic Services		Physician-Part B		_	_				
Services 1,000 1,938,385 1,938,385 56,467,73 34,33 7,00 2,000 3,000 0,000	6. 00			0	0	0	0. 00	0. 00	6. 00
200 3									
7.01 Contracted interns and residents (in an approved programs) 8.00 Home office and/or related	7.00	· ` '	21. 00	0	1, 938, 385	1, 938, 385	56, 467. 73	34. 33	7. 00
R.00 Home office and/or related	7 01			0	,	0	0.00	0.00	7 01
Nome office and/or related of property of the property of th	7.01			U		U	0.00	0.00	7.01
Organization personnel Section Company									
9.00 SNF 44.00 0 0 0 0 0 0 0 0 0	8. 00	Home office and/or related		0	0	0	0. 00	0. 00	8. 00
Instructions	9. 00		44. 00	0	0	0	0.00	0. 00	9. 00
OTHER WACES & RELATED COSTS 1.00 OTHER WACES & RELATED COSTS 1.00 OTHER CATE above: Direct Patient S. 373, 158 0 S. 373, 158 81, 842.00 65.65 1.10 OTHER CATE Above: Top I level management and other management and	10. 00			6, 821, 511	184, 925	7, 006, 436	312, 859. 00	22. 39	10.00
11.00 Contract labor: Direct Patient Care Care Care Care Contract labor: Top level management and other management and other management and administrative services 277,763 0 277,763 1,586.00 175.13 13.00 14.00 15.00									
12.00 Contract labor: Top level management and other management and other management and administrative services 13.00 Contract labor: Physician=Part 277, 763 0 277, 763 1,586.00 175, 13 13.00 A - Administrative	11. 00			5, 373, 158	0	5, 373, 158	81, 842. 00	65. 65	11. 00
management and other management and other management and odimin istrative services servic	40.00								40.00
management and admin istrative Services 13.00 Contract Labor: Physician-Part 277,763 0 277,763 1,586.00 175.13 13.00 A - Admin istrative 0 0 0 0 0 0.00 14.00 14.00 0 0 0 0 0 0 0 0 0	12.00	· ·		0	0	0	0.00	0.00	12.00
13. 00 Contract Labor: Physician - Part 277, 763 0 277, 763 1, 586.00 175.13 13. 00 14. 00 Home office and/or related organization sal aries and wage-related costs 14, 087, 870 0 14, 087, 870 397, 257.00 35, 46 14, 01 14. 01 Related organization sal aries 14, 087, 870 0 14, 087, 870 397, 257.00 35, 46 14, 01 15. 02 Related organization sal aries 14, 087, 870 0 14, 087, 870 397, 257.00 35, 46 14, 01 15. 02 Related organization sal aries 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 0.00 15, 00 16. 00 Physicians Part A - Teaching									
A - Administrative	12 00			277 7/2		277 7/2	1 50/ 00	175 10	12 00
14. 00 Home office and/or related or organization salaries and wage-related costs 14. 087, 870 0 14. 087, 870 397, 257. 00 35. 46 14. 01 14. 01 Home office salaries 14. 087, 870 0 14. 087, 870 397, 257. 00 35. 46 14. 01 14. 02 Related organization salaries 0 0 0 0 0 0.00 0.00 14. 02 15. 00 Home office and contract 0 0 0 0 0 0.00 0.00 15. 00 16. 00 Home office and Contract 0 0 0 0 0.00 0.00 16. 00 16. 00 Physicians Part A - Teaching 121, 779 0 121, 779 18. 00 18. 00 Wage-related costs (core) (see instructions) 121, 779 0 121, 779 18. 00 19. 00 Excluded areas 2, 749, 736 0 2, 749, 736 19. 00 19. 00 Excluded areas 2, 749, 736 0 2, 749, 736 19. 00 19. 00 Excluded areas 2, 749, 736 0 2, 749, 736 19. 00 19. 00 Physician anesthetist Part 0 0 0 0 10. 00 Physician Part A - A 0 0 0 0 10. 00 Physician Part B 0 0 0 0 10. 00 Physician Part B 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 11. 00 0 0 12. 00 0 0 13. 00 0 0 14. 02 0 0 0 15. 00 0 0 15. 00 0 0 16. 00 0 0 17. 00 0 0 18. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0	13.00			211, 103	0	211, 103	1, 586. 00	1/5. 13	13.00
Wage-related costs 14, 087, 870 0 14, 087, 870 397, 257, 00 35. 46 14, 01	14. 00	Home office and/or related		0	0	0	0. 00	0. 00	14. 00
14. 01 Home office salaries 14,087,870 0 14,087,870 397,257.00 35. 46 14. 01 14. 02 Related organization salaries 0 0 0 0 0 0 15. 00 Home office: Physician Part A 0 0 0 0 0 0 16. 00 Home office: and Contract 0 0 0 0 0 0 16. 00 Mage-related Costs (core) (see instructions) 17. 00 18. 00 Wage-related costs (core) (see instructions) 121,779 0 121,779 18. 00 19. 00 Excluded areas 2,749,736 0 2,749,736 19. 00 10. 00 Non-physician anesthetist Part 0 0 0 0 10. 00 Physician Part A - Reaching 20. 00 10. 00 Physician Part A - Reaching 20. 00 10. 00 Non-physician anesthetist Part 0 0 0 10. 00 Physician Part A - Reaching 20. 00 10. 00 Physician Part A - Reaching 20. 00 10. 00 Physician Part B 0 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 11. 00 0 0 12. 00 0 12. 00 0 13. 00 0 14. 087, 870 0 0 15. 00 0 16. 00 0 17. 00 0 18. 00 19. 00 0 19. 00 0 19. 00 0 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 10.									
15.00 Home office: Physician Part A	14. 01			14, 087, 870	0	14, 087, 870	397, 257. 00	35. 46	14. 01
- Administrativé Home office and Contract Home office wage-related (core) - Administrative Home office & Contract Home o				0	0	0			
16.00 Home office and Contract Physicians Part A - Teaching NAGE_RELATED COSTS 17.00 Wage-related costs (core) (see instructions) 121,779 121,779 121,779 121,779 18.00 18.00 121,779 18.00	15. 00			0	0	0	0. 00	0.00	15. 00
WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see instructions) 17.00 wage-related costs (other) 121,779 0 121,779 18.00 wage-related costs (other) 121,779 0 121,779 18.00 value 18.00	16. 00			0	О	0	0.00	0.00	16. 00
17.00 Wage-related costs (core) (see instructions) 17.00 121,779 1									
18.00 Wage-related costs (other) 121,779 0 121,779 121	17 00			55 763 560	Ι ο	55 763 560			17 00
19.00 Excluded areas 2,749,736 0 2,749,736 19.00 20.00 2.000									
19. 00 Excluded areas 2,749,736 0 2,749,736 20.00 20.00 Non-physician anesthetist Part 0 0 0 0 0 0 0 0 0	18. 00			121, 779	0	121, 779			18. 00
20.00 Non-physician anesthetist Part 0 0 0 0 0 21.00	19. 00			2, 749, 736	0	2, 749, 736			19. 00
B		1		0	0	0			
B	21 00	Non-physician anesthetist Part		0	0	_			21 00
Administrative Administrative Physician Part A - Teaching 309,627 0 309,627 22.01		В		O					
22. 01 Physician Part A - Teaching	22. 00			0	0	0			22. 00
23. 00 24. 00 Wage-related costs (RHC/FQHC) 25. 00 Interns & residents (in an approved program) Home office wage-related (core) 25. 51 Related organization Wage-related (core) Home office: Physician Part A Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) 26. 00 Employee Benefits Department O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 01			309, 627	0	309, 627			22. 01
25. 00 Interns & residents (in an approved program) 25. 00 25. 50 Home office wage-related (core) 25. 51 Related organization 25. 52 Home office: Physician Part A 25. 52 Administrative - wage-related (core) Home office & Contract 25. 53 Physicians Part A - Teaching - wage-related (core) 25. 53 Physicians Part A - Teaching - wage-related (core) 25. 52 Employee Benefits Department 4. 00 230, 795 11, 558 242, 353 23, 177. 00 10. 46 26. 00	23.00	Physician Part B		0	0	0			23.00
approved program Home office wage-related (core) Government Go				415 000	0	415.000			
Core Related organization O O O O O O O O O O O O O O O O O O	23.00			415, 090		415, 090			23.00
25. 51 Related organization wage-related (core) Home office: Physician Part A	25. 50	Home office wage-related		6, 293, 886	0	6, 293, 886			25. 50
wage-related (core)	25 51			0	_	_			25 51
- Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 4.00 25.53 26.00	20.01			O	١				20.01
25. 53 wage-rel ated (core) Home office & Contract 0 Physicians Part A - Teaching - wage-rel ated (core) OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department 4. 00 230, 795 11, 558 242, 353 23, 177. 00 10. 46 26. 00	25. 52			0	0	0			25. 52
25. 53 Home office & Contract 0 0 0 0 25. 53 Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 4. 00 230, 795 11, 558 242, 353 23, 177. 00 10. 46 26. 00									
wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 230,795 11,558 242,353 23,177.00 10.46 26.00	25. 53			0	0	0			25. 53
OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 230,795 11,558 242,353 23,177.00 10.46 26.00		Physicians Part A - Teaching -							
26. 00 Employee Benefits Department 4. 00 230, 795 11, 558 242, 353 23, 177. 00 10. 46 26. 00		wage-related (core) OVERHEAD COSTS - DIRECT SALARIE	ES .						
27. 00 Admi ni strati ve & General 5. 00 8, 561, 016 -2, 943, 353 5, 617, 663 184, 741. 00 30. 41 27. 00		Employee Benefits Department	4. 00						
	27. 00	Administrative & General	5. 00	8, 561, 016	-2, 943, 353	5, 617, 663	184, 741. 00	30. 41	27. 00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0058

Peri od: Worksheet S-3 From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/29/2019 8:36 am 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 167, 711 167, 711 492.00 340. 88 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 540, 450 555, 770 16, 791. 00 29.00 15, 320 33. 10 Operation of Plant 30.00 7.00 108, 998. 00 24. 88 30.00 2, 631, 156 80, 466 2, 711, 622 31.00 8.00 0.00 Laundry & Linen Service 0.00 31.00 32.00 Housekeepi ng 9.00 2, 955, 255 78, 105 3, 033, 360 187, 631. 00 16. 17 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 18. 61 -1, 256, 215 106, 910. 00 34.00 10.00 3, 245, 582 1, 989, 367 34.00 Di etary 35.00 Di etary under contract (see 0.00 0.00 35.00 instructions) Cafeteri a 11.00 76, 375. 00 17.71 36.00 1, 352, 307 1, 352, 307 36.00 37.00 Maintenance of Personnel 12.00 0.00 0.00 37.00 38.00 Nursing Administration 13.00 2, 132, 869 82, 852 2, 215, 721 100, 514. 00 22. 04 38.00 39.00 Central Services and Supply 14.00 2,085,423 61, 450 2, 146, 873 103, 338. 00 20. 78 39.00 Pharmacy -6, 176, 232 2,080.00 129. 32 40.00 15.00 6, 445, 212 268, 980 40.00 Medical Records & Medical 41.00 16.00 0.00 0.00 41.00 Records Library 29. 53 42. 00 42.00 Social Service 17.00 2, 944, 260 54, 830 2, 999, 090 101, 563. 00 43.00 Other General Service 18.00 0.00 0.00 43.00 HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0058 Worksheet S-3 Peri od: From 01/01/2018 To 12/31/2018 Part III Date/Time Prepared: 5/29/2019 8:36 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col. (from Salaries in col . 5) 3) col. 4 Worksheet A-6) 1.00 6.00 2.00 5.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 145, 147, 527 -1, 938, 385 143, 209, 142 4, 808, 106. 27 29. 78 1.00 instructions) 2.00 184, 925 7, 006, 436 312, 859. 00 22. 39 2.00 Excluded area salaries (see 6, 821, 511 instructions) 3.00 Subtotal salaries (line 1 138, 326, 016 -2, 123, 310 136, 202, 706 4, 495, 247. 27 30.30 3.00 minus line 2) 4.00 Subtotal other wages & related 19, 738, 791 19, 738, 791 480, 685. 00 41.06 4.00 costs (see inst.) Subtotal wage-related costs 45. 65 5.00 62, 179, 225 C 62, 179, 225 0.00 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 220, 244, 032 -2, 123, 310 218, 120, 722 4, 975, 932. 27 43 84 7.00 Total overhead cost (see 31, 939, 729 -8, 638, 912 23, 300, 817 1, 012, 610. 00 23.01 7.00

instructions)

Health Financial Systems
HOSPITAL WAGE RELATED COSTS MEMORIAL HOSPITAL OF SOUTH BEND, INC
Provider CCN: 15-0058

	To 12/31/2018	Date/Time Prep 5/29/2019 8:30	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	4, 489, 336	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	20, 459, 597	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. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	22, 867, 257	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	279, 457	10. 00
11. 00	Life Insurance (If employee is owner or beneficiary)	91, 854	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)	459, 129	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	99, 996	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	10, 433, 099	
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	58, 288	
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	
23. 00	Tuition Reimbursement	0	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	59, 238, 013	24. 00
	Part B - Other than Core Related Cost		
25. 00	SERVI CE AWARDS	121, 779	25. 00

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0058	Period: Worksheet S-3

		To 12/31/2018	Date/Time Pre 5/29/2019 8:3	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:	_		
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - IPF	0	0	3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (0ther)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14. 00
15.00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17. 00	Renal Dialysis			17. 00
18.00	Other	0	0	18. 00

	Financial Systems MEMORIAL HOSPITAL OF S AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCN: 15	5-0058	Peri od:	u of Form CMS-2 Worksheet S-10				
				From 01/01/2018					
				To 12/31/2018	Date/Time Prep 5/29/2019 8:30				
			•						
	Uncompensated and indigent care cost computation				1. 00				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by line 20	2 column	8)	0. 260022	1.00			
1.00	Medicaid (see instructions for each line)	videa by iiiie 20	<u> </u>	<u> </u>	0. 200022	1.00			
2.00	Net revenue from Medicaid				51, 514, 599	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3. 00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemer	tal payments fro	om Medicai	id?	N	4. 00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicaid			18, 730, 000	5. 00			
6.00	Medi cai d charges				296, 679, 296				
7.00	Medicaid cost (line 1 times line 6)				77, 143, 144				
8.00	Difference between net revenue and costs for Medicaid program	(line 7 minus su	um of line	es 2 and 5; if	6, 898, 545	8. 00			
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for the continuous for the continuous</pre>	on cook line)							
9. 00	Children's Health Insurance Program (CHIP) (see instructions f Net revenue from stand-alone CHIP	or each line)			6, 223	9.00			
10.00	Stand-alone CHIP charges				6, 223 47, 293				
11. 00	Stand-alone CHIP cost (line 1 times line 10)				12, 297	11.00			
12. 00		(line 11 minus l	line 0: it	f / zero then	6, 074				
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 6,074 12 enter zero)								
	Other state or local government indigent care program (see ins	tructions for ea	ach line)						
13.00									
14.00	Charges for patients covered under state or local indigent car	e program (Not i	ncl uded i	in lines 6 or	1, 923, 748	14. 00			
	10)								
15. 00	State or local indigent care program cost (line 1 times line 1				500, 217				
16. 00	Difference between net revenue and costs for state or local in	digent care pro	gram (line	e 15 minus line	104, 672	16.00			
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CH	ID and state/loo	sal india	ont care program	ne (eno	1			
	instructions for each line)	ii and state/ioc	zai i nai ge	ent care program	13 (366				
17. 00	Private grants, donations, or endowment income restricted to f	unding charity o	care		0	17. 00			
18.00	Government grants, appropriations or transfers for support of				0	18. 00			
19.00	Total unreimbursed cost for Medicaid, CHIP and state and loca	l indigent care	programs	(sum of lines	7, 009, 291	19. 00			
	8, 12 and 16)								
			i nsured	Insured	Total (col. 1				
		pa	atients	pati ents	+ col . 2)				
	Uncompensated Care (see instructions for each line)		1. 00	2. 00	3. 00				
20. 00	Charity care charges and uninsured discounts for the entire fa	cility	14, 012, 13	8 3, 366, 019	17, 378, 157	20.00			
20.00	(see instructions)	Cirrity	14, 012, 13	3, 300, 017	17, 370, 137	20.00			
21. 00	Cost of patients approved for charity care and uninsured disco	unts (see	3, 643, 46	4 3, 366, 019	7, 009, 483	21. 00			
	instructions)		-,,]	.,,				
22.00	Payments received from patients for amounts previously writter	off as	187, 810	0 221, 925	409, 735	22. 00			
	charity care								
23. 00	Cost of charity care (line 21 minus line 22)		3, 455, 65	4 3, 144, 094	6, 599, 748	23. 00			
0.4.00				6 1 11 11	1.00	24. 00			
24. 00									
25. 00	imposed on patients covered by Medicaid or other indigent care program? .00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of								
25.00	stay limit	ne murgent Care	= program	3 religiti oi	U	25. 00			
26. 00	1 3	structions)			38, 194, 104	26. 00			
27. 00	Medicare reimbursable bad debts for the entire hospital comple	x (see instructi	ons)	l	891, 6351	1 27.00			

1, 371, 746

36, 822, 358 10, 054, 734

16, 654, 482

23, 663, 773 31. 00

27. 01

28. 00

29.00

30.00

27.01 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)

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)

Heal th F	Financial Systems MEMOF	RIAL HOSPITAL O	F SOUTH BEND, IN	С	In Lie	u of Form CMS-:	2552-10
RECLASS	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CCN:	15-0058	Period: From 01/01/2018	Worksheet A	
					To 12/31/2018	Date/Time Pre	epared:
	Cost Center Description	Adjustments	Net Expenses			5/29/2019 8: 3	36 am
	cost center bescription		For Allocation				
		6.00	7. 00				
_	SENERAL SERVICE COST CENTERS	440 421	22 107 020				1 00
1	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	460, 631 -262, 702	22, 197, 039 15, 681, 855				1.00
- 1	0300 OTHER CAPITAL RELATED COSTS	0	0				3. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT	18, 608, 144	20, 211, 755				4. 00
	00500 ADMINISTRATIVE & GENERAL	-19, 994, 332	55, 569, 100				5. 00
	00600 MAINTENANCE & REPAIRS	-286, 217	4, 542, 203				6.00
- 1	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	-585, 839 0	9, 556, 425 1, 583, 352				7. 00
	00900 HOUSEKEEPI NG	-705	5, 156, 923				9. 00
- 1	01000 DI ETARY	-208, 784	3, 613, 385				10.00
1	01100 CAFETERI A	-1, 895, 652	859, 045				11. 00
	01300 NURSI NG ADMI NI STRATI ON	-31, 015	3, 057, 248				13.00
1	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	-113, 115 0	9, 575, 327 6, 552, 299				14. 00 15. 00
1	11600 MEDICAL RECORDS & LIBRARY	0	0, 332, 299				16. 00
	1700 SOCIAL SERVICE	0	3, 986, 200				17. 00
21. 00 0	2100 I&R SERVICES-SALARY & FRINGES APPRVD	o	1, 938, 385				21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	-11, 948	5, 267, 244				22. 00
	2300 PARAMED ED PRGM-(SPECIFY)	-3, 356	138, 709				23. 00
)2301 PARAMED ED NPATIENT ROUTINE SERVICE COST CENTERS	0	0				23. 01
	33000 ADULTS & PEDIATRICS	-438, 631	50, 117, 156				30.00
	03100 I NTENSI VE CARE UNI T	-1, 326, 353	9, 990, 998				31.00
	02060 NEONATAL INTENSIVE CARE UNIT	-340, 472	7, 594, 155				31. 01
40.00 0	04000 SUBPROVI DER - I PF	0	1, 467, 563				40.00
	04100 SUBPROVI DER – I RF	0	1, 606, 331				41. 00
	04300 NURSERY	0	1, 732, 112				43. 00
	NCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM	-3, 313, 910	29, 511, 413				50.00
	05200 DELIVERY ROOM & LABOR ROOM	-1, 390, 442	6, 329, 218				52. 00
- 1	05400 RADI OLOGY-DI AGNOSTI C	-350, 743	14, 152, 993				54.00
57.00 0	05700 CT SCAN	-29, 325	1, 838, 237				57. 00
- 1	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 078, 626				58. 00
- 1	05900 CARDI AC CATHETERI ZATI ON	-16, 378	1, 773, 514				59.00
	06000 LABORATORY 06001 BLOOD LABORATORY	-3, 838 0	11, 545, 862				60.00
	06500 RESPI RATORY THERAPY	l ő	5, 809, 976				65. 00
	06600 PHYSI CAL THERAPY	-254, 964	3, 513, 669				66. 00
	06602 PHYSICAL THERAPY EAST BANK	0	1, 287, 081				66. 01
	06601 PHYSI CAL THERAPY LIVING CENTER	0	509, 570				66. 10
	06700 OCCUPATIONAL THERAPY	-107, 158	2, 154, 290				67.00
1	06701 OCCUPATIONAL THERAPY LIVING CENTER 06800 SPEECH PATHOLOGY	0	325, 766 1, 216, 954				67. 10
1	06801 SPEECH THERAPY LIVING CENTER	l o	228, 994				68. 10
	07000 ELECTROENCEPHALOGRAPHY	o	0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10, 311, 293				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	26, 351, 594				72.00
1	07300 DRUGS CHARGED TO PATIENTS 03020 CARDIOLOGY	-307, 262 -189, 599	32, 876, 713 3, 736, 849				73.00
	UTPATIENT SERVICE COST CENTERS	- 107, 377	3, 730, 047				1 70.00
	99000 CLI NI C	0	0				90.00
90. 10 0	99001 FAMILY PRACTICE CLINIC	0	O				90. 10
	199002 HEMATOLOGY ONCOLOGY CLINIC	-3, 498	1, 000, 869				90. 30
	09004 SLEEP DI SORDERS CLINIC	-18, 858	822, 420				90. 50
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-9, 035, 156	19, 780, 293				91. 00 92. 00
	PECIAL PURPOSE COST CENTERS						72.00
	1300 I NTEREST EXPENSE	0	0				113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-21, 451, 477	418, 151, 003				118. 00
	ONREI MBURSABLE COST CENTERS						4
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	(02, 721				190.00
	9300 NONPALD WORKERS 9301 HEALTH PROPERTIES	0	683, 731 3, 965, 481				193. 00 193. 10
	9303 LEIGHTON CENTER	0	3, 965, 481				193. 10
	9305 WELLNESS CENTER	o	3, 061, 223				193. 50
	9308 UNUSED SPACE	o	o				193. 80
102 00 1	9309 OCCUPATI ONAL HEALTH	0	O				193. 90
	9310 RESEARCH AND PROTOCOL	1 0	0				193. 91
193. 91 1		1	. 1				
193. 91 1 193. 92 1	9311 CCOP	0	0				193. 92
193. 91 1 193. 92 1		0 0 -21, 451, 477	0 313, 992 426, 175, 430				193. 92 193. 93 200. 00

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

					To 12/31/2018 Date/Time Prep 5/29/2019 8:36	pared: 6 am
		Increases			372772017 0. 30	J alli
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - DRUGS CHARGED TO PATIENTS					
1. 00	DRUGS CHARGED TO PATIENTS	7300	0_	<u>26, 900, 728</u>		1. 00
	O CURRILLES QUARGER TO DATE	NTC	0	26, 900, 728		
1 00	B - SUPPLIES CHARGED TO PATIE		ما	2/ 5// 410		1 00
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	36, 566, 419		1. 00
2.00	PATTENTS	0.00	o	0		2. 00
3.00		0.00	Ö	0		3. 00
4. 00		0.00	o	0		4. 00
5. 00		0.00	Ö	0		5. 00
6. 00		0.00	o	0		6. 00
7. 00		0.00	o	0		7. 00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13. 00
14. 00		0.00	0	0		14.00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17. 00		0.00	0_	0		17. 00
	O AMORTI ZATI ON TO CARL TAL		0	36, 566, 419		
1 00	C - AMORTIZATION TO CAPITAL NEW CAP REL COSTS-BLDG &	1.00	o	76, 898		1 00
1. 00	FIXT	1.00	٩	70, 898		1. 00
		+				
	D - INTEREST TO CAPITAL		<u> </u>	70, 070		
1.00	NEW CAP REL COSTS-BLDG &	1.00	O	5, 826, 771		1. 00
	FIXT		Ĭ	0,020,77		
				5, 826, 771		
	H - EE UTILIZATION OF H&L					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	693, 646		1.00
	0			693, 646		
	I - MEDICAL DIRECTOR RECLASS					
1.00	SUBPROVI DER - I RF	41. 00	•			1. 00
	TOTALS		0	8, 519		
	O - CAFETERIA FROM DIET SALAR		4 050 007			
1. 00	CAFETERI A	11.00	<u>1, 352, 307</u>	0		1. 00
	U		1, 352, 307	0		
1 00	R - REBATES ADMINISTRATIVE & GENERAL	5. 00	ol	1, 583, 399		1. 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL	0.00	o	1, 363, 399		2. 00
3.00		0.00	o	0		3. 00
4. 00		0.00	Ö	0		4. 00
5. 00		0.00	o o	0		5. 00
6. 00		0.00	o	0		6. 00
	TOTALS			1, 583, 399		
	V - MEDICAL DIRECTOR RECLASS	•				
1.00	ADULTS & PEDIATRICS	30.00	0	17, 902		1.00
	0			17, 902		
	W - WORKERS COMP EH&W					
1.00	EMPLOYEE BENEFITS DEPARTMENT			9 <u>9, 9</u> 96		1. 00
	0		0	99, 996		
	X - PROPERTY INSURANCE TO CAP					
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	253, 779		1. 00
	FIXT — — — —	+				
	U CADACE TO ASC		U	253, 779		
1.00	Y - GARAGE TO A&G ADMI NI STRATI VE & GENERAL	5. 00	0	172, 598		1. 00
1.00	O GENERAL			172, 598		1.00
	Z - INCENTIVE		<u> </u>	172, 370		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	11, 558	0		1. 00
2.00	ADMI NI STRATI VE & GENERAL	5. 00	352, 255	0		2. 00
3.00	MAINTENANCE & REPAIRS	6.00	15, 320	0		3. 00
4. 00	OPERATION OF PLANT	7. 00	80, 466	o		4. 00
5. 00	HOUSEKEEPI NG	9.00	78, 105	0		5. 00
6. 00	DI ETARY	10.00	96, 092	0		6. 00
7. 00	NURSING ADMINISTRATION	13. 00	82, 852	o		7. 00
8.00	CENTRAL SERVICES & SUPPLY	14. 00	61, 450	o		8. 00
9.00	PHARMACY	15.00	107, 015	0		9. 00
10.00	SOCIAL SERVICE	17. 00	54, 830	0		10.00
11.00	I&R SERVICES-OTHER PRGM	22. 00	370, 745	0		11.00
	COSTS APPRVD					
	·	*	·	<u> </u>	<u> </u>	

Heal th	Financial Systems	MEMO	RIAL HOSPITAL (OF SOUTH BEND,	INC	In Lie	u of Form CMS-	-2552-10
	SIFICATIONS				CCN: 15-0058	Peri od:	Worksheet A-	
						From 01/01/2018 To 12/31/2018	Date/Time Pro	epared:
						12, 01, 2010	5/29/2019 8:	
	Cost Center	Increases Line #	Sal ary	Other				
	2. 00	3.00	4. 00	5. 00				
12. 00	PARAMED ED PRGM-(SPECIFY)	23.00	1, 634	0.00				12. 00
13.00	ADULTS & PEDIATRICS	30.00	591, 124	0				13. 00
14. 00	INTENSIVE CARE UNIT	31.00	91, 476	0				14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	31. 01	76, 024	0				15. 00
16. 00	SUBPROVI DER - I PF	40. 00	22, 869	0				16. 00
17. 00	SUBPROVI DER - I RF	41.00	17, 424	0				17. 00
18.00	NURSERY	43.00	9, 800	0				18.00
19.00	OPERATING ROOM	50.00	238, 092	0				19.00
20. 00 21. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52. 00 54. 00	59, 310 246, 987	0				20.00
22. 00	CT SCAN	57. 00	10, 346	0				22. 00
23. 00	CARDI AC CATHETERI ZATI ON	59.00	10, 653	0				23. 00
24. 00	LABORATORY	60.00	61, 318	0				24. 00
25. 00	RESPIRATORY THERAPY	65. 00	44, 649	0				25. 00
26.00	PHYSI CAL THERAPY	66.00	47, 524	0				26. 00
27.00	PHYSICAL THERAPY EAST BANK	66. 01	12, 251	0				27. 00
28. 00	PHYSICAL THERAPY LIVING	66. 10	16, 040	0				28. 00
	CENTER							
29. 00	OCCUPATI ONAL THERAPY	67.00	20, 963	0				29. 00
30. 00	OCCUPATIONAL THERAPY LIVING	67. 10	4, 356	0				30.00
31. 00	CENTER SPEECH PATHOLOGY	68. 00	18, 488	0				31.00
32. 00	SPEECH THERAPY LIVING CENTER	68. 10	2, 178	0				32.00
33. 00	CARDI OLOGY	76.00	66, 237	0				33. 00
34. 00	HEMATOLOGY ONCOLOGY CLINIC	90. 30	11, 162	0				34.00
35. 00	SLEEP DI SORDERS CLINIC	90. 50	7, 623	0				35. 00
36. 00	EMERGENCY	91.00	153, 394	0				36. 00
37.00	NONPALD WORKERS	193.00	5, 717	0				37. 00
38. 00	HEALTH PROPERTIES	193. 10	55, 716	0				38. 00
39. 00	WELLNESS CENTER	193. 50	71, 610	0				39. 00
40.00	REASEARCH ADMIN	193.93	<u>9, 9</u> 55	0				40. 00
	TOTALS		3, 295, 608	0				
1. 00	AB - DEPRECIATION TO CAPITAL NEW CAP REL COSTS-BLDG &	1.00	o	15 072 210	Ī			1.00
1.00	IFIXT	1.00	٥	15, 872, 310				1.00
2.00	NEW CAP REL COSTS-MVBLE	2.00	o	13, 978, 090				2. 00
	EQUI P		_	,,				
	0		0	29, 850, 400				
4 00	BA - IMPLANTS CHARGED TO PATI		ما	0/ 054 50/	T			4.00
1. 00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	26, 351, 594				1.00
2.00	PATTENTS	0.00	o	0				2. 00
3.00		0.00	0	0				3. 00
4. 00		0.00	o	0				4. 00
	0 — — — — —		— — -	26, 351, 594				
	DA - DACC TP CAPITAL							
1.00	NEW CAP REL COSTS-MVBLE	2. 00	0	12, 767				1. 00
	EQUI P			40.004				
2. 00	NEW CAP REL COSTS-MVBLE	2. 00	0	19, 921				2. 00
3.00	EQUI P	0.00	o	0				3. 00
4. 00	NEW CAP REL COSTS-MVBLE	2.00		143, 370				4. 00
	EQUI P	2.30						
5.00	NEW CAP REL COSTS-MVBLE	2. 00	o	6, 000				5. 00
	EQUI P							
6. 00	NEW CAP REL COSTS-MVBLE	2. 00	0	1, 165, 656				6. 00
7 00	EQUI P	2.00		F2 0FF				7 00
7. 00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	52, 055				7. 00
8. 00	NEW CAP REL COSTS-MVBLE	2.00	o	33, 726				8. 00
0.00	EQUI P	2.00	o o	00, 720				0.00
9.00	NEW CAP REL COSTS-MVBLE	2.00	О	37, 870				9. 00
	EQUI P			• • •				
10. 00	NEW CAP REL COSTS-MVBLE	2.00	o	387				10.00
	EQUI P	_						
11. 00	NEW CAP REL COSTS-MVBLE	2. 00	0	48, 692				11. 00
12 00	EQUI P	0.00		0				12.00
12. 00 13. 00	NEW CAP REL COSTS-MVBLE	0. 00 2. 00	0	62, 322				12. 00 13. 00
13.00	EQUIP	2.00		02, 322				13.00
14. 00	NEW CAP REL COSTS-MVBLE	2.00	o	331, 962				14.00
	EQUI P	30						
15. 00	NEW CAP REL COSTS-MVBLE	2. 00	o	19, 200				15. 00
	EQUI P	l l			l			

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-0058	Period: Worksheet A-6 From 01/01/2018

Cost Center						From 01/01/2018 To 12/31/2018	Date/Time Pr 5/29/2019 8:	epared: 36 am
16.00 New CAP REL COSTS-MVBLE 2.00 0 9,069 16.00			Increases		·			
16. 00 NEW CAP REL COSTS-MVBLE		Cost Center	Li ne #	Sal ary	0ther			
17. 00 NEW CAP REL COSTS-MVBLE 2. 00 0 23, 470 17. 00 EQUI P 0 0 1, 966, 467		2. 00	3. 00	4.00	5.00			
EQUI P	16. 00		2.00	0	9, 069			16. 00
DD - INTEREST EXPENSE	17. 00		2.00	0	23, 470			17. 00
1. 00 INTEREST EXPENSE		0			1, 966, 467			
1.00 IR - INTERNS SALARY FROM LN 22 TO LN 21 IR SERVICES-SALARY & 21.00 1,938,385 0		DD - INTEREST EXPENSE						Ī
IR - INTERNS SALARY FROM LN 22 TO LN 21	1.00	INTEREST EXPENSE	113. 00	0	5, 826, 771			1.00
1. 00 I&R SERVICES-SALARY & 21. 00 1, 938, 385 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		0	5, 826, 771			
FRI NGES APPRVD 0		IR - INTERNS SALARY FROM LN 2	22 TO LN 21					
1. 00 CAFETERI A FROM DIET NON-SALARIES 1. 00 CAFETERI A 11. 00 0 1, 402, 390 0 0 1, 402, 390 0 0 1, 402, 390 0 0 1, 402, 390 0 0 0 1, 402, 390 0 0 0 0 0 0 0 0 0	1. 00		21.00	1, 938, 385	0			1.00
1. 00 CAFETERI A 11. 00 0 1, 402, 390 0 1. 00 1, 402, 390 0 1. 00 1, 402, 390 0 1. 00 1. 00 1, 402, 390 0 1. 00 0 1, 402, 390 0 1. 00 0 1, 402, 390 0 1. 00 0 1, 402, 390 0 1. 00 0 0 0 0 0 0 0, 402, 347 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 — — — — — —		1, 938, 385	— — ₀			İ
The image of the		OO - CAFETERIA FROM DIET NON-	-SALARI ES					
PH - PHARMACY 1. 00 DRUGS CHARGED TO PATIENTS 73. 00 6, 283, 247 0 O 6, 283, 247 0 YY - PROPERTIES 1. 00 HEALTH PROPERTIES 193. 10 0 293, 350 O 293, 350 O 293, 350	1.00	CAFETERI A	11. 00	0	1, 402, 390			1.00
1. 00 DRUGS CHARGED TO PATIENTS 73. 00 6, 283, 247 0 1. 00 7. 00 6, 283, 247 0 7. 00		0 — — — — — —			1, 402, 390			
0 6, 283, 247 0 YY - PROPERTIES 1. 00 HEALTH PROPERTIES 193. 10 0 293, 350 0 1. 00 0 293, 350 1. 00		PH - PHARMACY						Ī
YY - PROPERTIES 1. 00 HEALTH PROPERTIES 193. 10 0 293, 350 0 0 293, 350 1. 00	1.00	DRUGS CHARGED TO PATIENTS	73. 00	6, 283, 247	0			1.00
1. 00 HEALTH PROPERTIES 193. 10 0 293, 350 1. 00 0 293, 350		0		6, 283, 247	0			
0 293, 350		YY - PROPERTIES						Ī
	1.00	HEALTH PROPERTIES	193. 10	0	293, 350			1.00
500. 00 Grand Total: Increases 12, 869, 547 137, 891, 627 500. 00		0 = = = = =			293, 350			
	500.00	Grand Total: Increases		12, 869, 547	137, 891, 627			500.00

Health Financial Systems RECLASSIFICATIONS MEMORIAL HOSPITAL OF SOUTH BEND, INC
Provider CCN: 15-0058 Peri od: Worksheet A-6 From 01/01/2018 Date/Time Prepared: 5/29/2019 8:36 am

					10	/2019 8: 36 am
		Decreases				
	Cost Center 6.00	Li ne # 7. 00	Sal ary	0ther 9.00	Wkst. A-7 Ref.	
	A - DRUGS CHARGED TO PATIENTS	7.00	8. 00	9.00	10. 00	
1. 00	PHARMACY	15. 00	0	26, 900, 728	0	1.00
	0		0	26, 900, 728		
	B - SUPPLIES CHARGED TO PATIE					
1. 00 2. 00	CENTRAL SERVICES & SUPPLY ADULTS & PEDIATRICS	14. 00 30. 00	0	2, 526	1	1.00
3. 00	INTENSIVE CARE UNIT	31.00	0	418, 291 146, 704	1	2. 00 3. 00
4. 00	NEONATAL INTENSIVE CARE UNIT	31. 01	o	2, 644	-	4. 00
5.00	SUBPROVI DER - I RF	41.00	0	333		5. 00
6.00	NURSERY	43.00	0	486	1	6. 00
7.00	OPERATING ROOM	50.00	0	24, 670, 787	1	7. 00
8. 00 9. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52. 00 54. 00	0	122, 814 3, 524, 590		8. 00 9. 00
10. 00	CARDI AC CATHETERI ZATI ON	59.00	0	7, 403, 656		10.00
11. 00	RESPI RATORY THERAPY	65. 00	Ö	205, 452	l l	11. 00
12.00	PHYSI CAL THERAPY	66. 00	0	15, 523	O	12. 00
13.00	CARDI OLOGY	76. 00	0	4	. 0	13. 00
14.00	HEMATOLOGY ONCOLOGY CLINIC	90. 30	0	81		14.00
15. 00 16. 00	EMERGENCY PHARMACY	91. 00 15. 00	0	51, 883 8		15. 00 16. 00
17. 00	LABORATORY	60.00	o	637	l i	17. 00
				36, 566, 419		
	C - AMORTIZATION TO CAPITAL					
1. 00	ADMI NI STRATI VE & GENERAL		0	7 <u>6, 8</u> 98		1. 00
	O D - INTEREST TO CAPITAL		O[76, 898		
1. 00	INTEREST EXPENSE	113.00	ol	5, 826, 771	11	1. 00
1.00	0		— — ŏ	5, 826, 771		1.00
	H - EE UTILIZATION OF H&L		- 1			
1.00	WELLNESS CENTER	193.50	0	693, 646		1. 00
	0		0	693, 646		
1. 00	I - MEDICAL DIRECTOR RECLASS PHYSICAL THERAPY	66. 00	ol	8, 519	0	1.00
1.00	TOTALS		0	<u>8, 519</u> 8, 519		1.00
	O - CAFETERIA FROM DIET SALAR	IES	<u></u>	0,017	I L	
1.00	DI ETARY	10.00	<u>1, 352, 3</u> 07	0	0	1. 00
	0		1, 352, 307	0		
1 00	R - REBATES	F 00	ما	701 100		1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL DIETARY	5. 00 10. 00	0	781, 100 130, 590	l l	1. 00 2. 00
3. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	40, 677	l l	3. 00
4.00	PHARMACY	15. 00	0	212, 484	l l	4. 00
5.00	OPERATING ROOM	50.00	0	261, 703	l l	5. 00
6. 00	CARDI AC CATHETERI ZATI ON		0	156, 845		6. 00
	TOTALS V - MEDICAL DIRECTOR RECLASS		U	1, 583, 399		
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	17, 902	. 0	1. 00
	0		0	17, 902		
	W - WORKERS COMP EH&W					
1.00	ADMI NI STRATI VE & GENERAL		0	9 <u>9, 9</u> 96		1. 00
	O CAR	1 T A I	0	99, 996		
1.00	X - PROPERTY INSURANCE TO CAP ADMINISTRATIVE & GENERAL	5. 00	ol	253, 779	12	1. 00
1.00	0		— — ŏ	25 <u>3, 77</u> 253, 779	 	1.00
	Y - GARAGE TO A&G		-1			
1.00	HEALTH PROPERTIES	193. 10	0	17 <u>2, 5</u> 98		1. 00
	0		0	172, 598		
1. 00	Z - I NCENTI VE ADMI NI STRATI VE & GENERAL	5. 00	3, 295, 608	0	0	1. 00
2. 00	ADMINISTRATIVE & GENERAL	0.00	3, 293, 606 N	0	1	2.00
3. 00		0.00	o	0	1	3. 00
4.00		0.00	0	0	0	4. 00
5.00		0.00	0	0	1	5. 00
6.00		0.00	O	0	1	6. 00
7.00		0. 00 0. 00	0	0		7. 00
8. 00 9. 00		0.00	0	0	1	8. 00 9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	o	0	0	11. 00
12.00		0.00	0	0	l i	12. 00
13.00		0.00	0	0	1	13.00
14. 00 15. 00		0. 00 0. 00	0	0	l l	14. 00 15. 00
16. 00		0.00	0	0	l l	16. 00
. 5. 50	1	0.00	<u> </u>		<u> </u>	10.00

RECLASSI FI CATIONS

Provider CCN: 15-0058

Peri od: Worksheet A-6 From 01/01/2018 12/31/2018

Date/Time Prepared:

5/29/2019 8:36 am Decreases Wkst. A-7 Ref. Cost Center Sal ary 0ther Line # 6.00 7.00 8.00 9.00 10.00 17.00 0.00 0 0 17 00 18.00 0.00 18.00 0 0 19.00 0.00 0 19.00 20.00 0.00 0 0 0 20.00 0 0 21.00 0.00 0 21.00 0 0 22.00 0.00 0 22.00 o 0 23.00 0.00 23.00 0 0 24.00 0.00 0 24.00 25.00 0.00 0 0 25.00 0 26.00 0.00 0 26.00 0 00 0 0 27 00 O 27 00 0 28.00 0.00 0 0 28.00 29.00 0.00 o 0 29.00 30.00 0.00 0 0 0 30.00 0 0 0 00 31 00 31 00 0 32.00 0.00 0 0 32.00 33.00 0.00 o 0 33.00 0 34.00 0.00 0 34.00 01 0 0.00 0 35.00 35.00 36.00 0.00 0 0 0 36.00 o 0 37.00 0.00 37.00 0 0 38.00 0.00 0 38.00 39.00 0.00 0 0 0 39.00 40.00 40.00 0.00 0 TOTALS 3, 295, 608 AB - DEPRECIATION TO CAPITAL 1.00 ADMINISTRATIVE & GENERAL 5.00 29, 850, 400 9 1.00 9 2.00 0.00 2.00 29, 850, 400 BA - IMPLANTS CHARGED TO PATIENTS 1.00 RADI OLOGY-DI AGNOSTI C 54.00 0 8, 709 0 1.00 2.00 CARDIAC CATHETERIZATION 59.00 0 74, 977 0 2.00 12, 782 3.00 PHYSICAL THERAPY 66.00 0 0 3.00 MEDICAL SUPPLIES CHARGED TO 4.00 71.00 0 26, 255, 126 0 4.00 PATI ENTS ō 26, 351, 594 DA - DACC TP CAPITAL ADMINISTRATIVE & GENERAL 1.00 5.00 12, 767 10 1.00 19, 921 2.00 OPERATION OF PLANT 7.00 0 10 2.00 3.00 0.00 0 10 3.00 4 00 CENTRAL SERVICES & SUPPLY 14 00 0 143 370 10 4 00 5.00 OPERATING ROOM 50.00 0 6,000 10 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54.00 1, 165, 656 10 6.00 7.00 CARDIAC CATHETERIZATION 59.00 0 52,055 10 7.00 0 8 00 II ABORATORY 60.00 33.726 10 8 00 9.00 RESPIRATORY THERAPY 65.00 0 37, 870 10 9.00 10.00 SLEEP DISORDERS CLINIC 90.50 o 387 10 10.00 EMERGENCY 91.00 11.00 48, 692 10 11.00 0 10 12.00 0.00 12.00 13.00 HEALTH PROPERTIES 193.10 0 62, 322 10 13.00 WELLNESS CENTER 193.50 o 14.00 331, 962 10 14.00 I&R SERVICES-OTHER PRGM 22.00 19, 200 10 15.00 15.00 COSTS APPRVD 16.00 ADULTS & PEDIATRICS 30.00 9, 069 10 16.00 17.00 CARDI OLOGY 76.00 23, 470 10 17.00 1, 966, 467 DD - INTEREST EXPENSE 1.00 ADMINISTRATIVE & GENERAL 5.00 5, 826, 771 0 1.00 5, 826, 771 IR - INTERNS SALARY FROM LN 22 TO LN 21 1.00 I&R SERVICES-OTHER PRGM 22.00 1, 938, 385 0 0 1.00 COSTS APPRVD 1, 938, 385 ō 00 - CAFETERIA FROM DIET NON-SALARIES 1.00 1, 402, 390 DI ETARY 10.00 0 1.00 1, 402, 390 PH - PHARMACY 1.00 PHARMACY 15. 00 6, 283, 247 1.00 0 0 6, 283, 247 0 YY - PROPERTIES 1.00 NEW CAP REL COSTS-BLDG & 1.00 293, 350 14 1.00 F<u>I X</u>T 293. 350 500.00 Grand Total: Decreases 12, 869, 547 137, 891, 627 500.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0058 Peri od: Worksheet A-7 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/29/2019 8:36 am 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, 068 183, 342 183, 342 0 1.00 0 510, 218 2.00 Land Improvements 3, 426, 869 510, 218 0 2.00 0 3.00 486, 870, 628 12, 302, 756 12, 302, 756 3 00 Buildings and Fixtures 233, 205 0 4.00 Building Improvements 851, 999 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 293, 352, 469 8, 707, 561 8, 707, 561 7, 557, 452 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 805, 820, 033 21, 703, 877 21, 703, 877 7, 790, 657 8.00 9.00 Reconciling Items 0 9.00 805, 820, 033 7<u>, 790, 657</u> Total (line 8 minus line 9) 21, 703, 877 10.00 0 21, 703, 877 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 21, 501, 410 1.00 2.00 Land Improvements 3, 937, 087 2, 065, 183 2.00 48, 671, 204 3.00 Buildings and Fixtures 498, 940, 179 3.00 851, 999 4.00 Building Improvements 851, 999 4.00 5.00 Fixed Equipment C 5.00 Movable Equipment 6.00 294, 502, 578 202, 362, 771 6.00 7.00 HIT designated Assets 7.00 Subtotal (sum of lines 1-7) 8.00 819, 733, 253 253, 951, 157 8.00 9.00 Reconciling Items 9.00

819, 733, 253

253, 951, 157

10.00 Total (line 8 minus line 9)

Health Fina	ancial Systems MEMOI	RIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	eu of Form CMS-	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der C	CN: 15-0058	Peri od:	Worksheet A-7	
					From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 8:3	
			Sl	JMMARY OF CAP	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	,	
		9. 00	10.00	11. 00	12. 00	13. 00	
PART	ΓΙΙ - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00 NEW	CAP REL COSTS-BLDG & FLXT	0	0)	0 0	0	1.00
2.00 NEW	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00 Tota	al (sum of lines 1-2)	0	0		0 0	0	3.00
·		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	,				
D.1.D.7	F. L. PERSONALLI ATLAN OF ANOLUTA FROM WAR	14. 00	15. 00	L			

0 0 0

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

1.00 NEW CAP REL COSTS-BLDG & FIXT
2.00 NEW CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

0 0 0

1. 00 2. 00 3. 00

	MENO.	DIAL HOODITAL O	AE COUTU DEND	LNO		6.5 040.6	NEEO 40
		RIAL HOSPITAL C			In Lie Period:	u of Form CMS-2	2552-10
RECO	ONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		rom 01/01/2018	Worksheet A-7 Part III	
					To 12/31/2018	Date/Time Prep	oared:
						5/29/2019 8: 3	<u> </u>
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col .			
		1. 00	2.00	2) 3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		2.00	3.00	4.00	3.00	
1. 00		525, 230, 676	1	525, 230, 676	0. 644256	0	1. 00
2. 00		294, 502, 578					2. 00
3.00		819, 733, 254					3. 00
			TION OF OTHER O		SUMMARY 0		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	col s. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00		0	0	(15, 614, 712		1. 00
2.00		0	0	(13, 978, 090		2. 00
3.00	Total (sum of lines 1-2)	0	0	[(29, 592, 802	5, 886, 220	3. 00
			Sl	JMMARY OF CAPI	ΓAL		
	Cook Cooker Doceriation	1 4 4	l	T /	0+1	T-+-1 (2) (

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0058 Peri od: Worksheet A-8 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 8:36 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1.00 REL COSTS-BLDG & FLXT (chapter IFT XT 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 REL COSTS-MVBLE EQUIP (chapter FOUI P 3 00 Investment income - other 3 00 0 00 (chapter 2) 4 00 Trade, quantity, and time В -72, 612 ADMI NI STRATI VE & GENERAL 5.00 4.00 di scounts (chapter 8) Refunds and rebates of -1, 583, 399 ADMI NI STRATI VE & GENERAL 5.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0 0.00 7.00 stations excluded) (chapter 21) 8.00 Tel evision and radio service 0.00 0 (chapter 21) Parking Lot (chapter 21) 9.00 0.00 9.00 10.00 Provider-based physician A-8-2 -15, 736, 953 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 (chapter 23) 12.00 Related organization A-8-1 8, 075, 183 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0.00 14.00 Cafeteria-employees and guests В -1, 617, 322 CAFETERI A 11.00 15.00 Rental of quarters to employee 0.00 and others 16.00 Sale of medical and surgical 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 pati ents 18.00 Sale of medical records and 0 00 abstracts 19.00 Nursing and allied health 0.00 education (tuition, fees, books, etc.) 19.01 Nursing and allied health 0.00 19.01 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 Income from imposition of 21.00 0.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 therapy costs in excess of limitation (chapter 14) OPHYSICAL THERAPY 24.00 Adjustment for physical A-8-3 66.00 therapy costs in excess of limitation (chapter 14)

Heal th Financial Systems

MEMORIAL HOSPITAL OF SOUTH BEND, INC

In Lieu of Form CMS-2552-10

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0058
From 01/01/2018
To 12/31/2018
Date/Time Prepared: 5/29/2019 8: 36 am

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

				To	12/31/2018	Date/Time Prep 5/29/2019 8:30	
				Expense Classification on		372772017 0.3	o aiii
				To/From Which the Amount is 1	to be Adjusted		
	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	
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest		10 / 10 515				
33. 00 33. 01	PENSION ADJUSTMENT OTHER REVENUE - MED STAFF	B B		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	33. 00 33. 01
33.01	OFFI CE	В	-17,030	ADMINISTRATIVE & GENERAL	3.00	0	33.01
33. 02	OTHER REVENUE - PEDS	В		ADULTS & PEDIATRICS	30.00		33. 02
33. 03 33. 04	OTHER REVENUE - SLEEP CLINIC	B B		SLEEP DI SORDERS CLINIC	90. 50 52. 00	0	33. 03 33. 04
33. 05	OTHER REVENUE - CBU TAXABLE SALES - FCMC	В		DELIVERY ROOM & LABOR ROOM ADULTS & PEDIATRICS	30.00	0	33. 04
33. 06	OTHER REVENUE - OTHER ADMIN	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07	OTHER REVENUE - BCC	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 07
33. 08 33. 09	OTHER REVENUE - CARD NSG ADMIN MEDICAL EDUC. CME REVENUE	B B		CARDI OLOGY ADMI NI STRATI VE & GENERAL	76. 00 5. 00	0	33. 08 33. 09
33. 10	CONTRACTED SERVICES	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
33. 11	INTEREST INCOME - WORKING	В	-85, 679	NEW CAP REL COSTS-MVBLE	2. 00	11	33. 11
22 12	CAPI TAL	D		EQUIP	14 00	0	22 12
33. 12 33. 14	OTHER REVENUE - DISTRIBUTION OTHER REVENUE - BIOMED	B B		CENTRAL SERVICES & SUPPLY MAINTENANCE & REPAIRS	14. 00 6. 00	0	33. 12 33. 14
33. 15	PROGRAM MEAL OFFSET	В	-175, 206		10. 00	0	33. 15
33. 16	VISITOR MEAL OFFSET	В	•	CAFETERI A	11. 00	0	33. 16
33. 17 33. 19	OTHER REVENUE - ENGINEERING OTHER REVENUE - REHAB ADMIN	B B		OPERATION OF PLANT PHYSICAL THERAPY	7. 00 66. 00	0	33. 17 33. 19
33. 20	OTHER REVENUE - EMPLOYEE	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 19
	BENEFITS						
33. 22	OTHER REVENUE - RADIOLOGY	В	-2, 878	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 22
33. 23	DI AGN OTHER REVENUE - MED ED	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 23
33. 24	OTHER REVENUE - NICU	В		NEONATAL INTENSIVE CARE UNIT	31. 01	0	33. 24
33. 25	OTHER REVENUE-MRI	В	0	MAGNETIC RESONANCE IMAGING	58. 00	0	33. 25
33. 26	OTHER REVENUE - NEONATAL	В	-10 170	(MRI) NEONATAL INTENSIVE CARE UNIT	31. 01	0	33. 26
33. 20	SERVI CES		10, 170	NEONATAL TIVILIUSI VE CARE ON T	31.01	0	33. 20
33. 27	OTHER REVENUE - GROUND	В	-115, 881	EMERGENCY	91. 00	0	33. 27
33. 28	TRANSPORT PACE CONSULTING AMORTIZATION	A	0	NEW CAP REL COSTS-BLDG &	1. 00	10	33. 28
00. 20	THE CONSELLING PRINCIPLE AND CONSELLING	, ,		FIXT	1.00	10	00.20
33. 30	OTHER REVENUE - DRIVER'S ED	В	-28, 948	OCCUPATI ONAL THERAPY	67. 00	0	33. 30
33. 33	CON OTHER REVENUE - RAD ADMIN	В	-543	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 33
	NONALLOWABLE CAPITALIZED	A		NEW CAP REL COSTS-BLDG &	1. 00	-	33. 35
	INTERE	_		FIXT			
33. 36 33. 39	OTHER REVENUE - MAIN STREET PT PACE COMPONENT DEPREC 29 V 23	B A		PHYSICAL THERAPY NEW CAP REL COSTS-BLDG &	66. 00 1. 00		
33. 37	Y	^		FIXT	1.00	10	33.37
33. 42	EXCESS CAPITALIZED INTEREST	A		NEW CAP REL COSTS-BLDG &	1. 00	10	33. 42
33. 46	PAC ALLOWABLE CAPITALZED INTEREST	A		FIXT NEW CAP REL COSTS-BLDG &	1. 00	10	33. 46
JJ. 40	ALLOWADLE ON FIALZED INTEREST			FIXT	1.00	10	33. 40
33. 48	NONALLOWABLE CAPITALIZED	A	•	NEW CAP REL COSTS-BLDG &	1. 00	10	33. 48
33. 50	INTERE INCORRECT LIFING ON ASBESTOS	A		FIXT NEW CAP REL COSTS-BLDG &	1. 00	10	33. 50
33. 30	AN	^		FIXT	1.00	10	33.30
33. 55	OTHER REVENUE - RENT	В		NEW CAP REL COSTS-BLDG &	1. 00	14	33. 55
33. 57	MEMBERSHI P REVENUE	В		FIXT ADMINISTRATIVE & GENERAL	5. 00	0	33. 57
33. 58	SPECIAL PROGRAM REVENUE	В		ADMINISTRATIVE & GENERAL	5.00	0	
33. 59	SEMI NAR REVENUE	В	-29, 403	EMPLOYEE BENEFITS DEPARTMENT	4. 00		
33. 63	STERILIZATION REVENUE	B B		DELIVERY ROOM & LABOR ROOM	52. 00 10. 00		33. 63
33. 66	OTHER REVENUE - NUTRITIONAL SER	В	-33, 5/8	DI ETARY	10. 00		33. 66
33. 76	OTHER REVENUE - CATH LAB	В		CARDIAC CATHETERIZATION	59. 00		
33. 88	OTHER REVENUE - SBCSC PT	В		PHYSICAL THERAPY	66.00		33. 88
33. 94 33. 96	EDUC SERVICES EMS PARKING GARAGE - OPERATING	B A		PARAMED ED PRGM-(SPECIFY) ADMINISTRATIVE & GENERAL	23. 00 5. 00		
33. 97	PARKING GARAGE - CAPITAL	A		NEW CAP REL COSTS-BLDG &	1. 00		•
				FLXT			

Provider CCN: 15-0058 ADJUSTMENTS TO EXPENSES Peri od: Worksheet A-8 From 01/01/2018 | Worksheet A-8

					To 12/31/2018		
				Expense Classification or	Worksheet A	5/29/2019 8: 3	o alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	_	Wkst. A-7 Ref.	
34. 03	NON ALLOWABLE 1999 INTEREST	1. 00 A	2.00	3.00 NEW CAP REL COSTS-MVBLE	4. 00	5. 00	34. 03
34. 03	NON ALLOWABLE 1777 THTEREST	^	- 703, 043	EQUI P	2.00	11	34.03
34. 23	ADMISSION REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00		
34. 31	SKYWAY INTEREST AMORTIZATION	A	3, 580	NEW CAP REL COSTS-BLDG &	1.00	10	34. 31
34. 36	OLD CAPITAL - BUILDING	А	26, 887	FIXT NEW CAP REL COSTS-BLDG &	1.00	14	34. 36
34. 37	NEW CAPITAL BUILDING	А	-5, 543	FIXT NEW CAP REL COSTS-BLDG &	1.00	14	34. 37
35. 02	OTHER REVENUE - AMBULANCE	В	-113, 115	FIXT CENTRAL SERVICES & SUPPLY	14.00	0	35. 02
36. 01	SUPPL LOBBY EXPENSE	A	_12_022	ADMINISTRATIVE & GENERAL	5. 00	0	36. 01
36. 05	HAF EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00		36. 05
36. 18	TRUSTEE FEES	A		ADMINISTRATIVE & GENERAL	5. 00		36. 18
36. 23	CONTRI BUTI ONS	A	-362, 634	ADMINISTRATIVE & GENERAL	5. 00	0	36. 23
36. 25	NON-ALLOWED EXPENSES	A	-706	ADMINISTRATIVE & GENERAL	5. 00	0	36. 25
36. 26	ENTRY FEES	В	-266, 278	ADMINISTRATIVE & GENERAL	5. 00	0	36. 26
37. 00	OTHER REVENUE - MATERNAL CHILD ADMIN	В	-9, 500	ADULTS & PEDIATRICS	30.00	0	37. 00
37. 01	OTHER REVENUE - OSTC	В		NURSING ADMINISTRATION	13. 00		37. 01
37. 03	OTHER REV - TRAUMA SVCS	В		EMERGENCY	91. 00		37. 03
39. 00	OTHER REVENUE - TEAM PHARMACY	В		DRUGS CHARGED TO PATIENTS	73.00		39. 00
40.00	OTHER REVENUE - PEDS REHAB OT	В		OCCUPATIONAL THERAPY	67.00		40.00
41. 00 42. 00	OTHER REVENUE - FCMC OTHER REVENUE - PULMONARY	B B		ADULTS & PEDIATRICS ADULTS & PEDIATRICS	30. 00 30. 00		41. 00 42. 00
44.00	MED/SURG	D.	0	CARRIOLOGY	7/ 00		44.00
44. 00 44. 01	OTHER REVENUE - CARDI AC REHAB OTHER REVENUE - OSTC	B B		CARDIOLOGY PHYSICAL THERAPY EAST BANK	76. 00		44. 00 44. 01
44. 01	OTHER REVENUE - OSTC	В		NURSING ADMINISTRATION	66. 01 13. 00		44. 01
44. 03	OTHER REVENUE - 11 SOUTH	В		ADULTS & PEDIATRICS	30.00		44. 03
44. 04	OTHER REVENUE - 12 SOUTH	В		ADULTS & PEDIATRICS	30.00		44. 04
44. 05	OTHER REVENUE - SOCIAL SERVICES	В		SOCI AL SERVI CE	17. 00		44. 05
44. 06	OTHER REVENUE - PHARMACY	В	-53, 668	DRUGS CHARGED TO PATIENTS	73. 00	0	44. 06
44. 07	OTHER REVENUE - FPC	В		I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	44. 07
44. 08	OTHER REVENUE - ICU	В	0	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 REHAB	В	0	CARDI OLOGY	76. 00	0	44. 10
44. 11	OTHER REVENUE - RES SVCS	В	0	NURSING ADMINISTRATION	13. 00	0	44. 11
	OTHER REVENUE - 8 SOUTH	В		ADULTS & PEDIATRICS	30.00		44. 12
	OTHER REVENUE - SOCIAL SVCS	В		SOCI AL SERVI CE	17. 00		
44. 14			0		0.00		
44. 15	OTHER REVENUE - NSG FLOATS OTHER REVENUE - ER	B B		NURSING ADMINISTRATION	13. 00 91. 00		
44. 16 44. 17	OTHER REVENUE - EPWORTH ADULT	В		EMERGENCY ADULTS & PEDIATRICS	30.00		
44. 18	OTHER REVENUE - ENVIRONMENTAL	В	-705	HOUSEKEEPI NG	9. 00	0	44. 18
44. 19	PSYCH OTHER REVENUE - HEART VASCULAR	В	_4_000	CARDI OLOGY	76. 00	0	44. 19
44. 19	OTHER REVENUE - HEART VASCULAR	В		ADMI NI STRATI VE & GENERAL	5. 00		
44. 21	OTHER REVENUE - GROUNDS	B		OPERATION OF PLANT	7.00		44. 21
44. 22	HOME OFFICE ADJUSTMENT	A	-257, 598	NEW CAP REL COSTS-BLDG &	1.00		44. 22
44. 23	HOME OFFICE TO BUILDING	В		NEW CAP REL COSTS-BLDG &	1.00	14	44. 23
44. 24	HOME OFFICE TO MME	В		NEW CAP REL COSTS-MVBLE	2.00	14	44. 24
44. 25	HOME OFFICE TO MAINTENANCE	В		MAINTENANCE & REPAIRS	6. 00	0	44. 25
44. 26	HOME OFFICE TO PLANT	В		OPERATION OF PLANT	7. 00		1
50. 00	TOTAL (sum of lines 1 thru 49)		-21, 451, 477	1			50.00
	(Transfer to Worksheet A, column 6, line 200.)						
				•	•		

column 6, line 200.)
(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 01/01/2018
To 12/31/2018
Date/Time Prepared:
5/29/2019 8: 36 am

					5/29/2019 8: 3	36 am
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	0.00		HOME OFFICE OLD CAP-BUILD	0	0	1.00
2.00	0.00		HOME OFFICE OLD CAP-EQUIP	0	0	2.00
3.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE NEW CAP-BUILD	1, 560, 278	0	3.00
4.00	2. 00	NEW CAP REL COSTS-MVBLE EQUI	HOME OFFICE NEW CAP-EQUIP	2, 400, 591	0	4.00
4.01	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE NON-CAPITAL	39, 127, 964	0	4. 01
4.02	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE NON-ALLOWABLE	0	35, 013, 650	4. 02
5.00	TOTALS (sum of lines 1-4).			43, 088, 833	35, 013, 650	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	В	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	2		In Li€	eu of Form CMS-	-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED (ORGANI ZATI ON	IS AND HOME	Provi der	CCN:	15-0058	Peri o	d:	Worksheet A-8	3-1
OFFICE	COSTS									01/01/2018		
									To	12/31/2018	Date/Time Pro	
			1						L.		5/29/2019 8:	36 am
	Net	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQU	JIRED AS A F	RESULT OF TRA	ANSACTI ONS	WI TH	I RELATED C	RGANI Z	ATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:										
1.00	0	0										1.00
2.00	0	0										2. 00
3.00	1, 560, 278	10										3.00
4.00	2, 400, 591	10										4.00

* 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.

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.

4.01

4 02

5.00

39, 127, 964

-35, 013, 650

8,075,183

0

0

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0058

Peri od: Worksheet A-8-2 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

5/29/2019 8:36 am Physi ci an/Prov Wkst. A Line # Cost Center/Physician Professi onal Provi der RCE Amount Total ider Component I denti fi er Remuneration Component Component Hours 1. 00 2.00 4.00 3.00 5. 00 6. 00 7. 00 4.00 DR. S 1.00 6,000 0 6,000 211, 500 1 00 2.00 5. 00 DR. AN 185, 850 0 185, 850 181, 300 1,062 2.00 3.00 5. 00 DR. Z 16, 938 0 16, 938 211, 500 263 3.00 4.00 13.00 DR. H 2, 100 2, 100 211, 500 4.00 0 34 13. 00 DR. D 5.00 48, 750 0 48, 750 211, 500 311 5.00 22.00 DR. H 211, 500 6.00 170 170 6.00 7.00 30. 00 DR. DU 12.188 0 12.188 211, 500 7.00 1 31.00 DR. DE 8.00 53.769 0 53.769 211, 500 8.00 9.00 30.00 DR. DT 8,880 0 8,880 211, 500 9.00 10.00 31.00 DR. AW 32, 850 O 32,850 211, 500 10.00 31.00 DR. K 161.788 921 11.00 161, 788 211, 500 11.00 0 31. 00 AGGREGATE-INTENSIVE CARE 12.00 1, 171, 800 1, 171, 800 0 12.00 UNI T 13.00 31. 01 DR. L 67, 083 67,083 13.00 14.00 31. 01 AGGREGATE-NEONATAL INTENSIVE 14, 925 14, 925 169,700 100 14.00 0 CARE UN 15.00 15.00 50 00 DR C 34.344 34, 344 246, 400 224 16.00 50. 00 AGGREGATE-OPERATING ROOM 3, 296, 169 3, 296, 169 0 16.00 50.00 DR. S 79 17.00 13, 345 13, 345 246, 400 17.00 50.00 DR. H 27, 300 246, 400 182 18.00 18.00 27, 300 0 19 00 50.00 DR. S 680 0 680 246, 400 19 00 20.00 52. 00 AGGREGATE-DELIVERY ROOM & 1, 344, 100 1, 344, 100 0 20.00 LABOR ROOM 237, 100 21.00 52.00 DR. DU 21.00 30, 450 0 30, 450 54. 00 DR. D 22.00 700 0 700 260, 300 22.00 23.00 54. 00 AGGREGATE-RADI OLOGY-DI AGNOST 47,818 0 47,818 271, 900 239 23.00 54. 00 AGGREGATE-RADI OLOGY-DI AGNOST 24.00 301,000 301,000 C 0 24.00 lı C 54. 00 AGGREGATE-RADI OLOGY-DI AGNOST 4, 700 25.00 4,700 0 271,900 24 25.00 lı C 26.00 54.00 DR. R 21,000 21,000 211,500 26.00 27.00 54. 00 AGGREGATE-RADI OLOGY-DI AGNOST 6,550 6.550 0 27.00 lı c 15, 400 59. 00 DR. 28.00 15.400 0 211, 500 28.00 59.00 DR. M 29 00 2, 300 0 2,300 211, 500 12 29 00 30.00 60. 00 AGGREGATE-LABORATORY 23, 110 23, 110 260, 300 154 30.00 31.00 66.00 DR. P 28, 100 0 28, 100 211, 500 141 31.00 66.00 DR. CO 9,063 32.00 0 9.063 211.50073 32.00 33.00 76. 00 DR. F 1,000 1,000 211,500 33.00 3, 580 3, 580 76. 00 AGGREGATE-CARDI OLOGY 0 34.00 34.00 0 35.00 76. 00 AGGREGATE-CARDI OLOGY 108, 792 108, 792 35.00 76.00 DR. F 36.00 1, 300 Ω 1, 300 211, 500 1 36.00 76.00 DR. S 37.00 1, 200 0 1, 200 211, 500 37.00 76.00 DR. M 38.00 21,800 21,800 211, 500 38.00 76. 00 DR. D 39.00 550 0 550 211, 500 1 39.00 76. 00 DR. 40.00 38, 500 0 38, 500 211, 500 1 40.00 41.00 90. 30 DR. M 3,600 0 3,600 211, 500 41.00 90. 50 DR. F 42.00 50, 400 0 50, 400 211, 500 401 42.00 90. 50 DR. AN 192 43.00 28, 725 0 28. 725 211, 500 43 00 44.00 91.00 DR. BO 100,000 0 100,000 211,500 133 44.00 91. 00 AGGREGATE-EMERGENCY 45.00 8, 280, 670 8, 280, 670 0 45.00 46.00 91. 00 AGGREGATE-EMERGENCY 1.360 1.360 211, 500 8 46.00 45, 543 91.00 DR. R 211, 500 47.00 0 45, 543 237 47.00 48.00 91. 00 DR. R 53, 380 0 53, 380 211, 500 314 48.00 91.00 DR. S 49.00 235, 960 0 235, 960 211, 500 1, 388 49.00 50 00 91. 00 DR. Т 408 532 408, 532 211, 500 50 00 131 51.00 57. 00 AGGREGATE-CT SCAN 29, 325 29, 325 51.00 16, 403, 437 14, 609, 069 1, 794, 368 6, 644 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provi der Physician Cost Unadjusted RCE of Mal practice Memberships & Identi fi er Li mi t Component Insurance Share of col. Limit Conti nui na Educati on 1.00 2.00 8.00 9.00 13.00 14.00 12.00 1.00 4. 00 DR. 102 1. 00 0 5. 00 DR. AN 92, 568 4.628 0 2.00 2 00 0 0 3.00 5. 00 DR. Ζ 26, 742 1, 337 0 0 3.00 4.00 13. 00 DR. Н 3, 457 173 0 0 4.00 13. 00 DR. D 5.00 31, 623 1,581 0 0 0 5.00 22. 00 DR. H 0 6.00 6.00 0 102 5 30. 00 DR. DU 7.00 102 5 0 0 7.00 31.00 DR. DE 0 8.00 102 0 8.00 0 30.00 DR. DT 5 0 9.00 9.00 102

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0058

Peri od: Worksheet A-8-2

68, 138

67, 083

6, 766

7,809

1, 171, 800

C

6,766

7, 809

8, 159

26, 535

11.00

12.00

13.00

14.00

15.00

From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 8:36 am Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of of Mal practice I denti fi er Limit Unadjusted RCE Memberships & Component Conti nui ng Share of col. Insurance Limit Educati on 12 9.00 14.00 1.00 2.00 8.00 12.00 13.00 10.00 31.00 DR. AW 102 0 0 10.00 0 11.00 31.00 DR. K 93,650 4,683 11.00 31.00 AGGREGATE-INTENSIVE CARE 0 0 0 12.00 12.00 0 luni t 31. 01 DR. L 13.00 0 0 13.00 14.00 31. 01 AGGREGATE-NEONATAL INTENSIVE 8, 159 408 0 0 0 14.00 CARE UN 50.00 DR. C 1, 327 0 0 0 15.00 26, 535 15.00 0 0 50. 00 AGGREGATE-OPERATING ROOM 0 16.00 16.00 17.00 50.00 DR. S 9, 359 468 0 0 17.00 50.00 DR. H 0 0 0 18.00 21,560 1,078 18.00 0 50.00 DR. S 0 474 0 19.00 19.00 24 20.00 52. 00 AGGREGATE-DELIVERY ROOM & 0 0 20.00 LABOR ROOM 21.00 52.00 DR. DU 114 0 21.00 0 54.00 DR. D 0 0 22.00 125 22.00 0 23.00 54. 00 AGGREGATE-RADI OLOGY-DI AGNOST 31, 242 1,562 0 0 23.00 I C 24.00 54. 00 AGGREGATE-RADI OLOGY-DI AGNOST 0 0 0 0 24.00 25.00 54. 00 AGGREGATE-RADI OLOGY-DI AGNOST 3, 137 157 0 0 0 25.00 lı C 54 00 DR R 102 0 0 26 00 0 26 00 5 0 27.00 54. 00 AGGREGATE-RADI OLOGY-DI AGNOST 0 0 0 27.00 28.00 59.00 DR. A 102 0 0 28.00 59.00 DR. M 0 0 29.00 0 29.00 1.220 61 30.00 60. 00 AGGREGATE-LABORATORY 19, 272 964 30.00 0 31.00 66.00 DR. P 14, 337 717 0 0 31.00 32.00 66.00 DR. CO 7, 423 371 0 0 32.00 0 0 0 33.00 76.00 DR. F 33.00 102 5 76. 00 AGGREGATE-CARDI OLOGY 0 34.00 0 34.00 76. 00 AGGREGATE-CARDI OLOGY 35.00 35.00 0 0 0 36.00 76.00 DR. F 102 36.00 5 0 0 76.00 DR. S 0 37.00 37.00 102 38.00 76.00 DR. M 102 38.00 76. 00 DR. 0 0 0 39.00 39.00 102 76. 00 DR. 0 0 0 40.00 40.00 102 0 0 0 41.00 90. 30 DR. M 102 41.00 0 42.00 90. 50 DR. F 40, 775 2,039 0 42.00 90. 50 DR. AN 0 0 43.00 19, 523 976 43.00 0 0 0 44.00 91.00 DR. BO 13, 524 676 44.00 45.00 91. 00 AGGREGATE-EMERGENCY 0 0 0 45.00 91. 00 AGGREGATE-EMERGENCY 0 46.00 813 46.00 0 0 0 91.00 DR. R 24, 099 1, 205 47.00 47.00 0 91. 00 DR. 0 0 48.00 R 31, 928 1,596 48.00 49.00 91.00 DR. S 141, 136 7,057 0 0 49.00 91. 00 DR. 0 0 50.00 13, 320 666 0 50.00 57. 00 AGGREGATE-CT SCAN 0 51 00 51 00 0 200.00 677, 645 33, 882 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment Identi 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 4.00 DR. S 102 5,898 5,898 1.00 2.00 5. 00 DR. AN 92, 568 93, 282 93, 282 2.00 5. 00 DR. 0 3.00 3.00 Ζ 26.742 Ω C 13. 00 DR. 0 4.00 Н 3, 457 C 4.00 5.00 13. 00 DR. D 31, 623 17, 127 17, 127 5.00 6.00 22. 00 DR. Н 0 102 6.00 68 68 30. 00 DR. DU 0 7 00 12 086 12,086 102 7 00 8.00 31.00 DR. DE 0 102 53,667 53,667 8.00 9.00 30.00 DR. DT o 102 8,778 8,778 9.00 31. 00 DR. AW 0 32, 748 32, 748 10.00 10.00 102 31. 00 DR. K 0 93, 650 68, 138

31. 00 AGGREGATE-INTENSIVE CARE

31. 01 AGGREGATE-NEONATAL INTENSIVE

UNI T

CARE UN

31. 01 DR. L

50.00 DR. C

11.00

12.00

13.00

14.00

15.00

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0058

						To 12/31/2018	Date/Time Prepared: 5/29/2019 8:36 am
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	072772017 G. GG dill
		I denti fi er	Component	Limit	Di sal I owance		
			Share of col.				
	1.00	0.00	14	1/ 00	17.00	10.00	
16. 00	1.00	2.00 AGGREGATE-OPERATING ROOM	15. 00	16. 00	17. 00	18. 00 3, 296, 169	16, 00
17. 00		DR. S	0	_	_		17. 00
18. 00		DR. H	0	21, 560			18. 00
19. 00	•	DR. S	0	474	206		19. 00
20. 00	•	AGGREGATE-DELIVERY ROOM &	0	0		1	20.00
		LABOR ROOM		_		', ', ', ', ', ', ', ', ', ', ', ', ',	
21. 00	52. 00	DR. DU	0	114	30, 336	30, 336	21. 00
22.00		DR. D	0	125			22. 00
23. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST	0	31, 242	16, 576	16, 576	23. 00
04.00	F4.00	I C					0.4.00
24. 00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	0	0	C	301, 000	24. 00
25. 00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	0	3, 137	1, 563	1, 563	25. 00
23.00	34.00	I C		3, 137	1, 303	1, 303	23.00
26.00	54.00	DR. R	0	102	20, 898	20, 898	26. 00
27.00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	0	0	C	6, 550	27. 00
		I C					
28. 00	•	DR. A	0				28. 00
29. 00		DR. M	0	1, 220			29. 00
30.00		AGGREGATE-LABORATORY	0				30.00
31.00		DR. P	0	14, 337	13, 763	1	31.00
32. 00 33. 00		DR. CO DR. F	0	7, 423 102	1, 640 898		32. 00 33. 00
34. 00		AGGREGATE-CARDI OLOGY	0	102			34.00
35. 00	•	AGGREGATE-CARDI OLOGY	0	0	_	1	35. 00
36. 00		DR. F	0	102	1, 198		36. 00
37. 00		DR. S	0	102	· · · · · · · · · · · · · · · · · · ·		37. 00
38. 00		DR. M	0	102			38.00
39.00	76. 00	DR. D	0	102	448	448	39. 00
40.00	76. 00	DR. L	0	102	38, 398	38, 398	40. 00
41.00		DR. M	0	102	3, 498	3, 498	41. 00
42.00		DR. F	0	40, 775	9, 625		42.00
43.00		DR. AN	0	19, 523			43.00
44. 00		DR. BO	0	13, 524			44. 00
45. 00		AGGREGATE - EMERGENCY	0	0	0	0, 200, 0.0	45. 00
46. 00		AGGREGATE-EMERGENCY	0	813			46. 00
47. 00		DR. R	0	24, 099			47. 00
48. 00		DR. R DR. S		31, 928	· · · · · · · · · · · · · · · · · · ·		48. 00 49. 00
49. 00 50. 00		DR. T	0	141, 136 13, 320			50.00
50.00		AGGREGATE-CT SCAN	0	13, 320			50.00
200.00		NOOKEONTE-OT JOHN	0	_	_		200. 00
200.00	1	l .	1	0,,,043	1, 12,,004	1 10, 700, 700	1 200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0058 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 8:36 am CAPITAL RELATED COSTS Cost Center Description Net Expenses NEW BLDG & NEW MVBLE **EMPLOYEE** Subtotal for Cost FIXT **FOULP BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 22, 197, 039 22, 197, 039 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 15, 681, 855 15, 681, 855 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 20, 211, 755 3, 951 2, 791 20, 218, 497 4.00 00500 ADMINISTRATIVE & GENERAL 401, 772 57, 027, 287 5 00 283, 846 772, 569 5 00 55, 569, 100 6.00 00600 MAINTENANCE & REPAIRS 4, 542, 203 53, 539 37, 824 76, 432 4, 709, 998 6.00 7.00 00700 OPERATION OF PLANT 9, 556, 425 3, 591, 803 2, 537, 551 372, 916 16, 058, 695 7.00 00800 LAUNDRY & LINEN SERVICE 1, 583, 352 2, 675 1,890 1, 587, 917 8.00 8.00 6, 232, 918 00900 HOUSEKEEPI NG 272, 756 417, 163 9 00 5, 156, 923 386, 076 9 00 3, 613, 385 10.00 01000 DI ETARY 484, 260 342, 122 273, 588 4, 713, 355 10.00 01100 CAFETERI A 859, 045 82, 222 185, 976 1, 185, 331 11.00 58, 088 11.00 01300 NURSING ADMINISTRATION 3, 057, 248 205, 227 144, 989 304, 717 3, 712, 181 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 402, 964 14.00 9, 575, 327 570, 379 295, 249 10, 843, 919 14 00 15.00 01500 PHARMACY 6, 552, 299 205, 599 145, 252 36, 991 6, 940, 141 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 86,048 60, 792 146, 840 16.00 3, 986, 200 01700 SOCIAL SERVICE 149, 579 105, 676 412, 450 4, 653, 905 17.00 17.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 1, 938, 385 266, 576 2, 204, 961 21 00 C 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 5, 267, 244 283, 179 200, 061 451, 523 6, 202, 007 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 138, 709 65, 923 46, 573 12, 537 263, 742 23.00 02301 PARAMED ED 23.01 23.01 0 INPATIENT ROUTINE SERVICE COST CENTERS 4, 675, 579 4, 299, 059 62, 129, 011 30.00 03000 ADULTS & PEDIATRICS 50, 117, 156 3, 037, 217 30.00 03100 INTENSIVE CARE UNIT 9, 990, 998 546, 320 385, 967 904, 628 11, 827, 913 31.00 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 7, 594, 155 517, 761 365, 790 826, 492 9, 304, 198 31.01 40.00 04000 SUBPROVI DER - I PF 1, 467, 563 224, 697 158, 745 150, 271 2,001,276 40.00 04100 SUBPROVI DER - I RF 207, 937 146, 904 41.00 1,606,331 161, 042 2, 122, 214 41.00 80, 875 57, 137 43.00 04300 NURSERY 1, 732, 112 187, 283 2, 057, 407 43.00 ANCILLARY SERVICE COST CENTERS 29, 511, 413 34, 678, 973 05000 OPERATING ROOM 1, 890, 587 1, 335, 669 1, 941, 304 50.00 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 6, 329, 218 649, 465 458, 837 561, 370 7, 998, 890 52.00 05400 RADI OLOGY-DI AGNOSTI C 1, 038, 428 17, 138, 786 14, 152, 993 733, 633 54 00 1, 213, 732 54 00 57.00 05700 CT SCAN 1, 838, 237 50, 492 35, 672 161, 248 2, 085, 649 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 078, 626 1, 209, 080 58.00 76, 446 54,008 58.00 05900 CARDI AC CATHETERI ZATI ON 270, 299 190, 962 162, 937 2, 397, 712 59.00 1, 773, 514 59.00 06000 LABORATORY 60.00 11, 545, 862 195, 553 138, 155 349, 237 12, 228, 807 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 65.00 06500 RESPIRATORY THERAPY 5, 809, 976 130, 676 92, 321 462, 289 6, 495, 262 65.00 4, 278, 647 06600 PHYSI CAL THERAPY 230, 348 371 892 66 00 3 513 669 162, 738 66 00 06602 PHYSICAL THERAPY EAST BANK 1, 287, 081 66. 01 C 138, 347 1, 425, 428 66.01 66.10 06601 PHYSICAL THERAPY LIVING CENTER 509, 570 57, 068 566, 638 66.10 06700 OCCUPATIONAL THERAPY 67.00 2, 154, 290 114, 519 80, 906 244, 585 2, 594, 300 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 34, 742 360, 508 67 10 325, 766 67 10 0 68.00 06800 SPEECH PATHOLOGY 1, 216, 954 6,998 4,944 135, 713 1, 364, 609 68.00 06801 SPEECH THERAPY LIVING CENTER 228, 994 25, 080 254, 074 68.10 C 0 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 O 71.00 10, 311, 293 Ω 0 10, 311, 293 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 26, 351, 594 C 0 0 26, 351, 594 72.00 32, 876, 713 07300 DRUGS CHARGED TO PATIENTS 73.00 864, 104 33, 740, 817 73.00 03020 CARDI OLOGY 4, 199, 120 76.00 3, 736, 849 60, 129 42.480 359, 662 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 0 0 0 09001 FAMILY PRACTICE CLINIC 90 10 0 0 0 90 10 1, 410, 426 179, 148 90.30 09002 HEMATOLOGY ONCOLOGY CLINIC 1,000,869 126, 565 103.844 90.30 90.50 09004 SLEEP DISORDERS CLINIC 822, 420 56, 462 39, 890 82, 437 1,001,209 90.50 09100 EMERGENCY 19, 780, 293 439, 499 1, 525, 214 91.00 91.00 622, 093 22, 367, 099 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) 118.00 410, 384, 137 118. 00 418, 151, 003 18, 020, 524 12, 731, 214 19, 578, 787 NONREI MBURSABLE COST CENTERS 143, 938 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 84.348 59.590 193. 00 19300 NONPALD WORKERS 683, 731 41, 520 7, 517, 942 193. 00 3, 980, 518 2, 812, 173 193. 10 19301 HEALTH PROPERTIES 3, 965, 481 C 305, 540 4, 271, 021 193. 10 193. 40 19303 LEI GHTON CENTER 190, 527 193. 40 78, 878 111, 649 193. 50 19305 WELLNESS CENTER 3, 061, 223 r 0 258, 206 3, 319, 429 193. 50 0 193.80 193.80 19308 UNUSED SPACE 0 0 0 0 193. 90 19309 OCCUPATIONAL HEALTH 0 0 0 0 0 193. 90 193. 91 19310 RESEARCH AND PROTOCOL 0 0 0 0 0 193, 91 193. 92 19311 CCOP 0 0 0 0 193. 92

Health Financial Systems	MEMORIAL HOSPITAL O	MORIAL HOSPITAL OF SOUTH BEND, INC			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od: From 01/01/2018				
					Date/Time Pre 5/29/2019 8:3	pared: 6 am		
		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	313, 992	0		0 34, 444	348, 436	193. 93		
200.00 Cross Foot Adjustments					0	200. 00		
201.00 Negative Cost Centers		0		0 0	0	201.00		
202.00 TOTAL (sum lines 118 through 201)	426, 175, 430	22, 197, 039	15, 681, 85	20, 218, 497	426, 175, 430	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 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 8:36 am

			''	0 12/31/2010	5/29/2019 8: 3	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	57, 027, 287					5. 00
6. 00 00600 MAI NTENANCE & REPAI RS	727, 615	5, 437, 613				6. 00
7. 00 O0700 OPERATION OF PLANT	2, 480, 795	898, 474				7. 00
						1
8.00 00800 LAUNDRY & LINEN SERVICE	245, 306	669				8. 00
9. 00 00900 HOUSEKEEPI NG	962, 880	96, 575		0	7, 705, 937	9. 00
10. 00 01000 DI ETARY	728, 133	121, 136		0	182, 499	
11. 00 01100 CAFETERI A	183, 113	20, 567	88, 076	0	0	11. 00
13.00 01300 NURSING ADMINISTRATION	573, 469	51, 337	219, 839	0	10, 228	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	1, 675, 201	142, 678	610, 990	77	226, 472	14.00
15. 00 01500 PHARMACY	1, 072, 134	51, 430	220, 237	0	23, 678	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	22, 684	21, 525		0	46, 148	
17. 00 01700 SOCIAL SERVICE	718, 949	37, 417		0	14, 980	
21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	340, 629	0,,		0	0	21. 00
22. 00 02200 Lar Services Salari a Tringes Aithred	958, 105	70, 836	_	0	Ö	22. 00
	1			117 474		
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	40, 744	16, 490		117, 474		23. 00
23. 01 02301 PARAMED ED	0	0	0	U	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	0.500.050	4 075 000	1 (05 450	(00.011	0.077.470	
30. 00 03000 ADULTS & PEDI ATRI CS	9, 598, 053	1, 075, 390		•	3, 376, 468	
31. 00 03100 I NTENSI VE CARE UNIT	1, 827, 211	136, 660				1
31.01 02060 NEONATAL INTENSIVE CARE UNIT	1, 437, 340	129, 516	554, 626	9, 661	368, 299	
40. 00 04000 SUBPROVI DER - I PF	309, 163	56, 207	240, 695	0	244, 754	40.00
41. 00 04100 SUBPROVI DER - I RF	327, 846	52, 015	222, 742	55, 316		
43. 00 04300 NURSERY	317, 834	20, 231	86, 634	3, 158	143, 196	43.00
ANCILLARY SERVICE COST CENTERS				.,		
50. 00 05000 OPERATI NG ROOM	5, 357, 312	472, 922	2, 025, 196	562, 706	998, 588	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 235, 693	162, 461		118, 411	326, 903	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 647, 651	259, 758				
	1					
57. 00 05700 CT SCAN	322, 197	12, 630		80, 587	0	57. 00
58. 00 05800 MAGNETI C RESONANCE MAGING (MRI)	186, 782	19, 123		90		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	370, 406	67, 614		0	146, 579	
60. 00 06000 LABORATORY	1, 889, 143	48, 917	209, 477	0	89, 155	
60. 01 06001 BL00D LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	1, 003, 408	32, 688	139, 980	0	14, 577	65.00
66. 00 06600 PHYSI CAL THERAPY	660, 978	57, 621	246, 749	0	62, 981	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	220, 204	. 0		0	0	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	87, 536	0	آ آ	0	Ö	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	400, 775	28, 646	122, 672	0	16, 832	1
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	55, 692	20, 040	122, 072	0	10, 632	67. 10
		1 751	_	0		1
68. 00 06800 SPEECH PATHOLOGY	210, 809	1, 751	7, 496	0	2, 658	
68. 10 06801 SPEECH THERAPY LIVING CENTER	39, 250	0	0	0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 592, 919	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 070, 873	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 212, 383	0	0	0	0	73.00
76. 00 03020 CARDI OLOGY	648, 693	15, 041	64, 411	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC		n	ő	0	Ö	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	217, 887	44, 813		-	27, 705	
90. 50 09004 SLEEP DI SORDERS CLINIC	154, 670	14, 124			27, 703	90. 50
						1
91. 00 09100 EMERGENCY	3, 455, 337	155, 614	666, 386	289, 009	290, 339	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						4
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	54, 587, 802	4, 392, 876	14, 964, 083	1, 836, 758	7, 442, 095	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	22, 236	21, 099	90, 353	0	0	190. 00
193. 00 19300 NONPALD WORKERS	1, 161, 394	995, 710			263, 842	193 00
193. 10 19301 HEALTH PROPERTIES	659, 800	7,5,710	n ., 200, 700	n		193. 10
193. 40 19303 LEI GHTON CENTER	29, 433	27, 928	119, 598	0		193. 40
		21, 720	117, 370	0		
193. 50 19305 WELLNESS CENTER	512, 795	0] 0	0		193. 50
193. 80 19308 UNUSED SPACE	0	0	0	0		193. 80
193. 90 19309 OCCUPATI ONAL HEALTH	0	0	η	0		193. 90
193. 91 19310 RESEARCH AND PROTOCOL	0	0	0	0		193. 91
193. 92 19311 CCOP	0	0	0	0		193. 92
193. 93 19312 REASEARCH ADMIN	53, 827	0	0	0	0	193. 93
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	l ol	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	57, 027, 287	5, 437, 613	19, 437, 964	1, 836, 758		
						•

Provider CCN: 15-0058

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2018	Part
To 12/31/2018	Date/Time Prepared:
5/29/2019 8:36 am	

) 12/31/2018	5/29/2019 8: 3	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI ON	SERVI CES & SUPPLY		
		10.00	11. 00	13.00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						
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						4. 00 5. 00
6. 00	OO500 ADMINISTRATIVE & GENERAL OO600 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	6, 263, 862					10.00
11. 00	01100 CAFETERI A	0	1, 477, 087	'			11. 00
13.00	01300 NURSING ADMINISTRATION	0	35, 500				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	36, 497		13, 535, 887		14. 00
15.00	01500 PHARMACY	0	55, 657	0	0	8, 363, 277	15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY	0	2E 014	10 027	0	0	16. 00 17. 00
21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	35, 914	10, 937	0	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD		38, 597		0	0	ı
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	o o	1, 120		0	Ö	23. 00
23. 01	02301 PARAMED ED	o	0		0	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 196, 619	426, 504	1, 988, 060	0	960	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	644, 704	74, 092		0	0	31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	53, 421		0	1, 074	31. 01
40. 00	04000 SUBPROVI DER - I PF	213, 791	16, 127		0	0	
41. 00	04100 SUBPROVI DER - I RF	208, 748	12, 802		0	0	
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	0	13, 921	76, 325	0	0	43. 00
50. 00	05000 OPERATING ROOM	0	145, 607	610, 413	0	124	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	o	43, 989		0		1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	94, 505		0	703	1
57.00	05700 CT SCAN	o	11, 481		0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	203	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	10, 968		0	119	1
60. 00	06000 LABORATORY	0	41, 579		0	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	0	1	0	0	60. 01
65. 00	06500 RESPIRATORY THERAPY	0	38, 025		0	1, 194	1
66. 00 66. 01	06600 PHYSI CAL THERAPY 06602 PHYSI CAL THERAPY EAST BANK	0	24, 930 11, 046		0	4	66. 00 66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0	3, 954		0	0	66. 10
67. 00	06700 OCCUPATI ONAL THERAPY	o o	18, 546		0	Ö	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	o	2, 914		0	0	67. 10
68. 00	06800 SPEECH PATHOLOGY	o	9, 065		0	7	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	O	1, 763	0	0	0	68. 10
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	7, 850, 814		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	5, 685, 073		
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 CARDI OLOGY	0	19, 224	0	0		
76.00	OUTPATIENT SERVICE COST CENTERS	U U	19, 224	33, 368		390	76. 00
90. 00	09000 CLINIC	O	0	ol	0	0	90. 00
90. 10	09001 FAMILY PRACTICE CLINIC	o	0		0	0	1
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	7, 872	38, 756	0	0	90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	0	6, 261	0	0	0	90. 50
91.00	09100 EMERGENCY	0	104, 659	434, 927	0	3, 647	91. 00
92.00							92.00
440.00	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	(2/2 0/2	1 20/ 540	4 507 700	12 525 007	0 2/2 /70	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	6, 263, 862	1, 396, 540	4, 586, 692	13, 535, 887	8, 362, 679] 118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	ol ol	0	0	190. 00
	19300 NONPALD WORKERS	0	3, 725	1	0		193. 00
	19301 HEALTH PROPERTIES	ol	41, 445		0		193. 10
	19303 LEIGHTON CENTER	o	O	0	0		193. 40
193.50	19305 WELLNESS CENTER	O	32, 618	8 o	0	0	193. 50
	19308 UNUSED SPACE	0	0	0	0		193. 80
	19309 OCCUPATIONAL HEALTH	0	0	0	0		193. 90
	19310 RESEARCH AND PROTOCOL	이	0	0	0		193. 91
	19311 CCOP	0	0 750	0	0		193. 92
	19312 REASEARCH ADMIN		2, 759	8, 290	0	0	193. 93
200. 00 201. 00			0		^	_	200. 00 201. 00
201.00		6, 263, 862	1, 477, 087	4, 602, 554	13, 535, 887		
	TOTAL (Sam Times To through 201)	0, 200, 002	1, 777, 007	1 7,002,004	10, 000, 007	3,303,277	1202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0058

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

5/29/2019 8:36 am INTERNS & RESIDENTS MEDI CAL SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Cost Center Description RECORDS & Y & FRINGES PRGM COSTS **PRGM** LI BRARY 23.00 16.00 17.00 21.00 22.00 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 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 329, 372 16.00 01700 SOCIAL SERVICE 17.00 5, 632, 331 17.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21 00 0 2 545 590 21 00 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 0 7, 572, 886 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 510, 388 23.00 23.00 02301 PARAMED ED 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 53, 916 3, 996, 808 1, 652, 384 4, 915, 686 0 30.00 4, 124 03100 INTENSIVE CARE UNIT 185, 596 31.00 7, 498 22, 306 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 1,443 103, 387 0 0 0 31.01 04000 SUBPROVIDER - IPF 2.887 0 40.00 40.00 636, 492 0 0 41.00 04100 SUBPROVIDER - IRF 1, 340 101, 566 0 0 0 41.00 04300 NURSERY 43.00 1,031 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 75,666 911 95,600 284, 401 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 11, 386 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 56, 906 115, 229 12, 184 36, 247 54.00 57.00 05700 CT SCAN 57.00 0 0 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 0 C 0 0 0 58 00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 60.00 06000 LABORATORY 25, 566 0 0 60.00 06001 BLOOD LABORATORY 60.01 60.01 0 0 0 65.00 06500 RESPIRATORY THERAPY 31, 867 94, 800 0 65.00 66,00 06600 PHYSI CAL THERAPY 35, 566 0 66.00 06602 PHYSICAL THERAPY EAST BANK 0 66.01 0 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0 0 66.10 Λ 66.10 67.00 06700 OCCUPATIONAL THERAPY 8,763 0 67.00 0 06701 OCCUPATIONAL THERAPY LIVING CENTER 67.10 67.10 06800 SPEECH PATHOLOGY 68.00 4,021 0 0 68.00 68.10 06801 SPEECH THERAPY LIVING CENTER 0 0 0 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 03020 CARDI OLOGY 76.00 23, 814 54, 361 161, 718 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 90.10 09001 FAMILY PRACTICE CLINIC 0 522, 052 1, 553, 055 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 3, 749 11, 153 90.30 0 105, 665 90.30 0 09004 SLEEP DISORDERS CLINIC 90.50 90.50 0 09100 EMERGENCY 91.00 34, 329 375, 291 136, 840 407, 084 510, 388 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) 510, 388 118. 00 118.00 329, 372 5, 632, 331 2, 516, 535 7, 486, 450 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 193. 00 19300 NONPALD WORKERS 0 0 193.00 29, 055 Ω 86, 436 0 193. 10 19301 HEALTH PROPERTIES 0 0 193. 10 C 193. 40 19303 LEI GHTON CENTER 0 0 193. 40 0 193. 50 19305 WELLNESS CENTER 0 0 0 0 0 0 193. 50 193.80 19308 UNUSED SPACE C 0 0 0 193, 80 193. 90 19309 OCCUPATIONAL HEALTH 0 193. 90 0 0 193. 91 19310 RESEARCH AND PROTOCOL 0 0 0 193. 91 0 0 193. 92 193. 92 19311 CCOP C 193. 93 19312 REASEARCH ADMIN 0 0 193. 93 200.00 Cross Foot Adjustments 0 200.00

Health Financial Systems	MEMORIAL HOSPITAL O	F SOUTH BEND,	I NC	In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	Period: From 01/01/2018 To 12/31/2018			
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE		RESIDENTS RSERVICES-OTHER PRGM COSTS	PARAMED ED PRGM		
	16. 00	17. 00	21. 00	22.00	23.00		
201.00 Negative Cost Centers	0	0	C	0	0	201. 00	
202.00 TOTAL (sum lines 118 through 201)	329, 372	5, 632, 331	2, 545, 590	7, 572, 886	510, 388	202. 00	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 8:36 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MEMORIAL HOSPITAL OF SOUTH BEND, INC Provider CCN: 15-0058 Cost Center Description PARAMED ED Subtotal Intern & Total

Cost	Center Description	PARAMED ED	Subtotal	Intern & Residents Cost & Post Stepdown	Total		
		23. 01	24.00	Adjustments 25.00	26. 00		
	RVI CE COST CENTERS						4 00
1 1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	-					1. 00 2. 00
	OYEE BENEFITS DEPARTMENT						4. 00
	NISTRATIVE & GENERAL						5.00
1 1	TENANCE & REPAIRS						6. 00
	ATION OF PLANT DRY & LINEN SERVICE						7. 00 8. 00
9. 00 00900 HOUS							9. 00
10. 00 01000 DI ET.							10. 00
11. 00 01100 CAFE						I	11. 00
1 1	ING ADMINISTRATION						13.00
15. 00 01500 PHAR	RAL SERVICES & SUPPLY MACY						14. 00 15. 00
1 1	CAL RECORDS & LIBRARY					l l	16. 00
17. 00 01700 SOCI	AL SERVICE						17. 00
	SERVICES-SALARY & FRINGES APPRVD						21. 00
1 1	SERVICES-OTHER PRGM COSTS APPRVD MED ED PRGM-(SPECIFY)					I	22. 00 23. 00
23. 01 02301 PARA		0				•	23. 00
	ROUTINE SERVICE COST CENTERS						
	TS & PEDIATRICS	0	99, 615, 023		93, 046, 953	•	30. 00
1 1	NSIVE CARE UNIT	0	15, 930, 957		15, 901, 153	•	31. 00
	ATAL INTENSIVE CARE UNIT ROVIDER - IPF	0	12, 331, 636 3, 776, 341		12, 331, 636 3, 776, 341	•	31. 01 40. 00
1 1	ROVIDER - IRF		3, 440, 710		3, 440, 710		41. 00
43. 00 04300 NURS		0	2, 719, 737		2, 719, 737	1	43. 00
	SERVI CE COST CENTERS						
50. 00 05000 OPER 52. 00 05200 DELI		0	45, 308, 419		44, 928, 418	•	50.00
1 1	VERY ROOM & LABOR ROOM OLOGY-DIAGNOSTIC	0	10, 851, 848 22, 009, 592		10, 851, 848 21, 961, 161	1	52. 00 54. 00
57. 00 05700 CT S		Ö	2, 566, 819		2, 566, 819	•	57. 00
58. 00 05800 MAGN	ETIC RESONANCE IMAGING (MRI)	0	1, 497, 167		1, 497, 167		58. 00
	I AC CATHETERI ZATI ON	0	3, 315, 747		3, 315, 747	I	59. 00
60. 00 06000 LAB00 60. 01 06001 BL000	RATORY D LABORATORY	0	14, 532, 644 0	0	14, 532, 644 0	I	60. 00 60. 01
1 1	I RATORY THERAPY		7, 852, 079		7, 725, 412	I	65. 00
	I CAL THERAPY	o	5, 388, 139		5, 388, 139	l l	66. 00
1 1	ICAL THERAPY EAST BANK	0	1, 656, 678		1, 656, 678	l l	66. 01
1 1	ICAL THERAPY LIVING CENTER	0	658, 128		658, 128		66. 10
1 1	PATIONAL THERAPY PATIONAL THERAPY LIVING CENTER	0	3, 190, 534 419, 114		3, 190, 534 419, 114	•	67. 00 67. 10
	CH PATHOLOGY		1, 600, 416		1, 600, 416		68. 00
	CH THERAPY LIVING CENTER	0	295, 087		295, 087	I	68. 10
	TROENCEPHALOGRAPHY	0	0		0	•	70. 00
	CAL SUPPLIES CHARGED TO PATIENTS	0	19, 755, 026	_	19, 755, 026	I	71.00
	. DEV. CHARGED TO PATIENTS S CHARGED TO PATIENTS		36, 107, 540 47, 307, 435		36, 107, 540 47, 307, 435		72. 00 73. 00
76. 00 03020 CARD		Ö	5, 220, 140		5, 004, 061		76. 00
	SERVICE COST CENTERS						
90. 00 09000 CLIN		0	0	0	0	•	90.00
	LY PRACTICE CLINIC TOLOGY ONCOLOGY CLINIC	0	2, 075, 107 2, 059, 929		0 2, 045, 027	•	90. 10 90. 30
	P DISORDERS CLINIC	0	1, 236, 753		1, 236, 753		90. 50
91.00 09100 EMER		0	29, 230, 949		28, 687, 025		91. 00
	RVATION BEDS (NON-DISTINCT PART)			0			92. 00
113. 00 11300 I NTE	RPOSE COST CENTERS					11.	13. 00
	OTALS (SUM OF LINES 1 through 117)	o	401, 949, 694	-10, 002, 985	391, 946, 709		18. 00
	SABLE COST CENTERS	-,			311/110/1101		
	, FLOWER, COFFEE SHOP & CANTEEN	0	277, 626		277, 626		90. 00
193. 00 19300 NONP		0	14, 330, 154		14, 214, 663		93. 00
193. 10 19301 HEAL 193. 40 19303 LEI G		0	4, 972, 316 367, 486		4, 972, 316 367, 486		93. 10 93. 40
193. 50 19305 WELL			3, 864, 842		3, 864, 842		93. 50
193. 80 19308 UNUS	ED SPACE	o	0	o	0	11	93. 80
193. 90 19309 OCCU		0	0	0	0		93. 90
193. 91 19310 RESEA	ARCH AND PROTOCOL		0		0		93. 91 93. 92
193. 93 19311 CCOP			413, 312		413, 312		93. 92 93. 93
1 1	s Foot Adjustments	0	0		0		00.00

Health Financial Systems	MEMOR	RIAL HOSPITAL (OF SOUTH BEND,	I NC	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			Provi der Co	Provider CCN: 15-0058		Worksheet B	
					From 01/01/2018 To 12/31/2018		pared.
						5/29/2019 8: 3	
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 Cos	st Centers	C	0		0 0		201. 00
202.00 TOTAL (sum I	ines 118 through 201)	c	426, 175, 430	-10, 118, 47	6 416, 056, 954		202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | From 01/2014 | Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0058

				Ic	12/31/2018	Date/lime Pre 5/29/2019 8:3	
			CAPI TAL REI	LATED COSTS		0,27,201, 0.0	- Calif
	Cook Cooker December 1	D:+1	NEW DLDC 0	NEW MADE	C	EMDL OVEE	
	Cost Center Description	Directly Assigned New	NEW BLDG & FLXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal	1171	LQUIT		DEPARTMENT	
		Related Costs					
	JOSUS DA LA CONTRACTOR DE LA CONTRACTOR	0	1. 00	2. 00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-BEDG & TTXT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	3, 951	2, 791	6, 742	6, 742	1
5.00	00500 ADMINISTRATIVE & GENERAL	0	401, 772		685, 618	258	5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	0	53, 539		91, 363	26	1
7.00	00700 OPERATION OF PLANT	0	3, 591, 803		6, 129, 354	125	1
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	2, 675 386, 076		4, 565 658, 832	0 140	
10. 00	01000 DI ETARY		484, 260	1	826, 382	92	1
11. 00	01100 CAFETERI A	o	82, 222	1	140, 310	62	1
13.00	01300 NURSING ADMINISTRATION	O	205, 227		350, 216	102	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	570, 379	1	973, 343	99	
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	205, 599	1	350, 851	12 0	1
17. 00	01700 SOCIAL SERVICE		86, 048 149, 579	1	146, 840 255, 255	138	
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0		0	89	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	283, 179	200, 061	483, 240	151	1
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	65, 923	46, 573	112, 496	4	23. 00
23. 01	02301 PARAMED ED	0	0	0	0	0	23. 01
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	l	4 200 OEO	2 027 217	7 224 274	1, 542	30.00
31. 00	03100 I NTENSI VE CARE UNI T		4, 299, 059 546, 320	1	7, 336, 276 932, 287	303	
31. 01	02060 NEONATAL INTENSIVE CARE UNIT		517, 761	1	883, 551	276	1
40.00	04000 SUBPROVI DER - I PF	0	224, 697	1	383, 442	50	1
41. 00	04100 SUBPROVI DER - I RF	0	207, 937	1	354, 841	54	1
43. 00	04300 NURSERY	0	80, 875	57, 137	138, 012	63	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	O	1, 890, 587	1, 335, 669	3, 226, 256	649	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		649, 465		1, 108, 302	188	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	1, 038, 428		1, 772, 061	406	1
57. 00	05700 CT SCAN	0	50, 492	35, 672	86, 164	54	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	76, 446		130, 454	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	270, 299	1	461, 261	55	1
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	195, 553	138, 155 0	333, 708 0	117 0	60. 00 60. 01
65. 00	06500 RESPIRATORY THERAPY		130, 676	_	222, 997	155	1
66. 00	06600 PHYSI CAL THERAPY	0	230, 348	1	393, 086	124	1
66. 01	06602 PHYSI CAL THERAPY EAST BANK	o	0	0	0	46	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	1	0	19	1
67.00	06700 OCCUPATIONAL THERAPY	0	114, 519		195, 425	82	
67. 10 68. 00	06701 OCCUPATIONAL THERAPY LIVING CENTER 06800 SPEECH PATHOLOGY	0	6, 998	0 4, 944	0 11, 942	12 45	1
	06801 SPEECH THERAPY LIVING CENTER		0, 770		11, 742	8	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	O	0	Ö	0	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	0	0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(0.120	0	102 (00	289	1
76. 00	03020 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS	l o	60, 129	42, 480	102, 609	120	76. 00
90. 00	09000 CLINIC	O	0	O	0	0	90.00
90. 10	09001 FAMILY PRACTICE CLINIC		Ö		0	0	
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	179, 148		305, 713	35	
90. 50	09004 SLEEP DI SORDERS CLINIC	0	56, 462		96, 352	28	1
91.00	09100 EMERGENCY	0	622, 093	439, 499	1, 061, 592	510	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS				0		92. 00
113.00	11300 INTEREST EXPENSE						113. 00
118.00		0	18, 020, 524	12, 731, 214	30, 751, 738	6, 528	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	84, 348	1	143, 938		190. 00
	19300 NONPALD WORKERS	0	3, 980, 518	2, 812, 173	6, 792, 691		193. 00
	19301 HEALTH PROPERTI ES 19303 LEI GHTON CENTER	0	0 111, 649	78, 878	0 190, 527		193. 10 193. 40
	19305 WELLNESS CENTER		111, 049 N	70, 070	170, 527 N		193. 40
193. 80	19308 UNUSED SPACE		0		0		193. 80
193. 90	19309 OCCUPATI ONAL HEALTH	0	0	0	0	0	193. 90
	19310 RESEARCH AND PROTOCOL	0	0	0	0		193. 91
	2 19311 CCOP	0	0	0	0		193. 92
193. 93	19312 REASEARCH ADMIN	ı O	0	0	0	12	193. 93

Health Financial Systems	MEMORIAL HOSPITAL C	In Lieu of Form CMS-2552-10				
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
				From 01/01/2018 To 12/31/2018		pared: 6 am
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Assigned New	FLXT	EQUI P		BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2.00	2A	4. 00	
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)) 0	22, 197, 039	15, 681, 85	37, 878, 894	6, 742	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | Part II |
| To | 12/31/2018 | Date/Time | Prepared: | 5/29/2019 | 8:36 am | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MEMORIAL HOSPITAL OF SOUTH BEND, INC Provider CCN: 15-0058

		Cost Contor Description	ADMI NI STRATI VE	MAINTENANCE 0	OPERATION OF	LAUNDRY &	5/29/2019 8: 3 HOUSEKEEPING	
		Cost Center Description	& GENERAL	REPAI RS	PLANT	LI NEN SERVI CE	HOUSEKEEPING	
	CENED	AL SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1.00		NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					I	2. 00
4.00	1 .	EMPLOYEE BENEFITS DEPARTMENT					I	4. 00
5.00	1 .	ADMINISTRATIVE & GENERAL	685, 876				1	5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	8, 751 29, 837	100, 140 16, 547				6. 00 7. 00
8. 00		LAUNDRY & LINEN SERVICE	2, 950			8, 437	I	8. 00
9.00	1	HOUSEKEEPI NG	11, 581	1, 779	1	0	803, 730	1
10. 00		DIETARY	8, 757	2, 231		0	19, 035	1
11.00		CAFETERI A	2, 202	379		0	0	
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	6, 897 20, 148	945 2, 628		0	1, 067 23, 621	1
15. 00		PHARMACY	12, 895	947		o	2, 470	1
16. 00		MEDICAL RECORDS & LIBRARY	273	396		О	4, 813	1
17. 00	1	SOCIAL SERVICE	8, 647	689		0	1, 562	1
21. 00 22. 00	1 1	I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD	4, 097 11, 523	0 1, 305		0	0	
23. 00	1 1	PARAMED ED PRGM-(SPECIFY)	490			540	0	
23. 01	02301	PARAMED ED	0	0		0	0	1
		ENT ROUTINE SERVICE COST CENTERS	115 100	40.000	1 4/0 455	0.75/	050.445	
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	115, 439 21, 976	19, 803 2, 517		2, 756 0	352, 165 15, 179	1
31. 00		NEONATAL INTENSIVE CARE UNIT	17, 287	2, 385		44	38, 414	1
40. 00		SUBPROVI DER - I PF	3, 718			0	25, 528	1
41. 00	1	SUBPROVI DER - I RF	3, 943			254	27, 956	1
43. 00		NURSERY	3, 823	373	27, 525	15	14, 935	43. 00
50. 00		_ARY SERVICE COST CENTERS OPERATING ROOM	64, 434	8, 709	643, 449	2, 585	104, 153	50.00
52. 00		DELIVERY ROOM & LABOR ROOM	14, 862	2, 992	·	544	34, 096	1
54.00		RADI OLOGY-DI AGNOSTI C	31, 844	4, 784		1	43, 336	1
57. 00		CT SCAN	3, 875			370	0	
58. 00 59. 00	1	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	2, 246 4, 455			0	0 15, 288	
60.00		LABORATORY	22, 721	901		o	9, 299	1
60. 01		BLOOD LABORATORY	0	0		0	0	1
65. 00	1 .	RESPI RATORY THERAPY	12, 068			0	1, 520	1
66. 00 66. 01		PHYSI CAL THERAPY PHYSI CAL THERAPY EAST BANK	7, 950 2, 648	1, 061 0	1	0	6, 569 0	1
66. 10		PHYSICAL THERAPY LIVING CENTER	1, 053	0	1	0	0	1
67. 00		OCCUPATI ONAL THERAPY	4, 820	528	1	0	1, 756	1
67. 10		OCCUPATIONAL THERAPY LIVING CENTER	670			0	0	
68. 00	1 .	SPEECH PATHOLOGY	2, 535	32		0	277	1
68. 10 70. 00		SPEECH THERAPY LIVING CENTER ELECTROENCEPHALOGRAPHY	472	0		0	0	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 158	Ö		o	Ö	
		IMPL. DEV. CHARGED TO PATIENTS	48, 961	0		O	0	1
		DRUGS CHARGED TO PATIENTS	62, 690				0	
76. 00		CARDIOLOGY FIENT SERVICE COST CENTERS	7, 802	277	20, 465	0	0	76. 00
90.00		CLI NI C	0	0	0	0	0	90.00
90. 10		FAMILY PRACTICE CLINIC	0	0		О	0	
90. 30		HEMATOLOGY ONCOLOGY CLINIC	2, 621	825		0	2, 890	
90. 50 91. 00		SLEEP DISORDERS CLINIC EMERGENCY	1, 860 41, 558			1, 328	0 30, 282	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	11,000	2,000	211,720	1, 020		92.00
	SPECI /	AL PURPOSE COST CENTERS						
		INTEREST EXPENSE	/5/ 507	00.000	4 754 444	0.407	77/ 044	113.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	656, 537	80, 900	4, 754, 414	8, 437	776, 211	1118.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	267	389	28, 707	0	0	190. 00
		NONPALD WORKERS	13, 968		1	0		193. 00
		HEALTH PROPERTIES	7, 936			0		193. 10
		LEIGHTON CENTER WELLNESS CENTER	354 6, 167	514 0	37, 999	0		193. 40 193. 50
		UNUSED SPACE	0, 107	0	0	0		193. 80
		OCCUPATI ONAL HEALTH	0	Ö	o o	o		193. 90
	1 1	RESEARCH AND PROTOCOL	0	0	0	0		193. 91
	19311		0	0	0	0		193. 92
193. 93		REASEARCH ADMIN Cross Foot Adjustments	647	0	1 0		O	193. 93 200. 00
201.00		Negative Cost Centers	0	О	o	О		201. 00
202.00	1 1	TOTAL (sum lines 118 through 201)	685, 876	100, 140	6, 175, 863	8, 437		

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0058

			To	12/31/2018	Date/Time Pre 5/29/2019 8:3	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
OFNEDAL CEDALOG COCT CENTEDO	10. 00	11. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS	1, 021, 312 0 0 0 0 0 0 0 0 0	170, 937 4, 108 4, 224 6, 441 0 4, 156 0 4, 467 130 0	433, 183 5 0 0 1, 029 0 0 19	1, 218, 193 0 0 0 0 0 0 0	443, 590 0 0 0 0 0	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 22. 00 23. 00 23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	847, 300	49, 357	187, 110	0	51	30. 00
31. 00 03100 INTENSIVE CARE UNIT 31. 01 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - IPF 41. 00 04100 SUBPROVI DER - IRF 43. 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS	105, 118 0 34, 858 34, 036 0	8, 574 6, 182 1, 866 1, 482 1, 611		0 0 0 0 0	0 57 0 0	31. 00 31. 01 40. 00 41. 00 43. 00
50. 00 05000 OPERATI NG ROOM	0	16, 850	57, 451	0	7	50. 00
50. 00 05000 0PERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC 057. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY 66. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY EAST BANK 66. 10 06601 PHYSICAL THERAPY EAST BANK 66. 10 06601 PHYSICAL THERAPY LIVING CENTER 67. 00 06700 OCCUPATIONAL THERAPY LIVING CENTER 68. 00 06800 SPEECH PATHOLOGY 68. 10 06801 SPEECH PATHOLOGY 68. 10 06801 SPEECH PATHOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 CARDIOLOGY 00100 CARDIOLOGY 001000 CARDIOLOGY 00100 CARDIOLOGY 001000 001000 001000 001000 001000 001000 001000 001000 001000	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	16, 850 5, 091 10, 937 1, 329 0 1, 269 4, 812 0 4, 400 2, 885 1, 278 458 2, 146 337 1, 049 204 0 0 0 2, 225	24, 319 11, 257 18 0 3, 088 0 26 1, 945 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 37 0 11 6 0 0 63 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 52. 00 54. 00 57. 00 58. 00 60. 00 60. 01 65. 00 66. 01 66. 10 67. 10 68. 10 67. 10 68. 10 71. 00 72. 00 73. 00 76. 00 90. 10 90. 30 90. 50 91. 00 92. 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	1, 021, 312	161, 616	431, 690	1, 218, 193	443, 558	113. 00 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 193. 00 19300 NONPAID WORKERS 193. 10 19301 HEALTH PROPERTIES 193. 40 19305 LEI GHTON CENTER 193. 50 19305 WELLNESS CENTER 193. 80 19308 USED SPACE 193. 90 19309 OCCUPATIONAL HEALTH 193. 91 19310 RESEARCH AND PROTOCOL 193. 92 19311 CCOP 193. 93 19312 REASEARCH ADMIN Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 0 0 0	0 431 4, 796 0 3, 775 0 0 0 0 319	0 708 5 0 0 0 0 0 780	0 0 0 0 0 0 0 0	32 0 0 0 0 0 0 0	190. 00 193. 00 193. 10 193. 40 193. 50 193. 80 193. 90 193. 91 193. 92 193. 93 200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 021, 312	170, 937	433, 183	1, 218, 193	443, 590	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 8:36 am

				DESCRIPTION	5/29/2019 8: 3	
			I NTERNS &	RESI DENTS		
Cost Center Description		SOCIAL SERVICE		SERVI CES-OTHER	PARAMED ED	
	RECORDS & LI BRARY		Y & FRINGES	PRGM COSTS	PRGM	
	16. 00	17. 00	21.00	22. 00	23. 00	
GENERAL SERVICE COST CENTERS	1		I			
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT 2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & 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 10. 00 01000 DI ETARY						9. 00 10. 00
11. 00 01100 CAFETERI A						11.00
13.00 01300 NURSING ADMINISTRATION						13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY	101 400					15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	181, 608 0	322, 384				16. 00 17. 00
21. 00 02100 &R SERVI CES-SALARY & FRI NGES APPRVD	0	0 322, 304	4, 186			21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		597, 064		22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0			136, 419	
23. 01 02301 PARAMED ED	0	0				23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	29, 728	228, 770	1			30.00
31. 00 03100 NTENSI VE CARE UNI T	2, 274	10, 623				31.00
31. 01 02060 NEONATAL NTENSIVE CARE UNIT	796		•			31. 01
40. 00 04000 SUBPROVI DER - I PF	1, 592	36, 432				40. 00
41. 00 04100 SUBPROVI DER - RF	739					41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	568	0				43. 00
50. 00 05000 OPERATING ROOM	41, 721	52				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	652				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	31, 376	1				54. 00
57. 00 05700 CT SCAN	0	0	1			57. 00
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 O5900 CARDIAC CATHETERIZATION	0	0				58. 00 59. 00
60. 00 06000 LABORATORY	14, 097	Ö				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY 66. 01 06602 PHYSI CAL THERAPY EAST BANK	19, 610 0	0				66. 00 66. 01
66.01 06602 PHYSICAL THERAPY EAST BANK 66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0				66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	4, 832	o o				67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0				67. 10
68. 00 06800 SPEECH PATHOLOGY	2, 217	0				68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0					68. 10
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l				70. 00 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	ł				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
76. 00 03020 CARDI OLOGY	13, 130	0				76. 00
90. 00 OOOOO CLINIC	0	0				90.00
90. 10 09001 FAMILY PRACTICE CLINIC	0	1				90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	6, 048				90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	0	0				90. 50
91. 00 09100 EMERGENCY	18, 928	21, 481				91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92. 00
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	181, 608	322, 384	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS	_	_	ı			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	l				190. 00 193. 00
193. 00 19300 NONPALD WORKERS 193. 10 19301 HEALTH PROPERTLES	0	0				193. 00
193. 40 19303 LEI GHTON CENTER	0	Ö				193. 40
193. 50 19305 WELLNESS CENTER	0	0				193. 50
193. 80 19308 UNUSED SPACE	0	0				193. 80
193. 90 19309 OCCUPATI ONAL HEALTH	0	0				193. 90
193. 91 19310 RESEARCH AND PROTOCOL 193. 92 19311 CCOP	0	0				193. 91 193. 92
193. 93 19312 REASEARCH ADMIN	0					193. 92
200.00 Cross Foot Adjustments			4, 186	597, 064	136, 419	

Health Financial Systems	MEMORIAL HOSPITAL C	OF SOUTH BEND,	I NC	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC		eri od:	Worksheet B	
				rom 01/01/2018		
			T	o 12/31/2018		
					5/29/2019 8: 3	<u>6 am </u>
			INTERNS &	RESI DENTS		
Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
	RECORDS &		Y & FRINGES	PRGM COSTS	PRGM	
	LI BRARY					
	16. 00	17. 00	21.00	22. 00	23. 00	
201.00 Negative Cost Centers	0	0	C	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)) 181, 608	322, 384	4, 186	597, 064	136, 419	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0058 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/29/2019 8:36 am Cost Center Description PARAMED ED Total Subtotal Intern & Residents Cost & Post Stepdown Adjustments 23.01 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 02301 PARAMED ED 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 10, 633, 452 0 10, 633, 452 30.00 03100 INTENSIVE CARE UNIT 1, 329, 024 0 1, 329, 024 31.00 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 1, 165, 826 0 1, 165, 826 31.01 04000 SUBPROVI DER - I PF 0 570, 167 570, 167 40.00 40.00 04100 SUBPROVI DER - I RF 0 41.00 507, 255 507, 255 41.00 04300 NURSERY 194, 109 43.00 194, 109 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 4, 166, 316 0 4, 166, 316 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 412, 088 0 1, 412, 088 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 2, 266, 056 2, 266, 056 54.00 57.00 05700 CT SCAN 109, 228 0 109, 228 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 159, 081 159, 081 58 00 58 00 59.00 05900 CARDIAC CATHETERIZATION 578, 661 578, 661 59.00 06000 LABORATORY 0 60.00 452, 210 452, 210 60.00 06001 BLOOD LABORATORY 0 60.01 60.01 06500 RESPIRATORY THERAPY 65.00 286, 306 286, 306 65.00 511, 628 66,00 06600 PHYSI CAL THERAPY 511, 628 0 66, 00 06602 PHYSI CAL THERAPY EAST BANK 3, 972 0 3, 972 66.01 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0 1, 530 1,530 66.10 66.10 67.00 06700 OCCUPATIONAL THERAPY 248, 565 0 248, 565 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 1, 019 0 1, 019 67.10 06800 SPEECH PATHOLOGY 0 20, 479 68.00 20, 479 68.00 0 68.10 06801 SPEECH THERAPY LIVING CENTER 684 684 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 725, 710 725, 710 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 560, 602 72.00 72.00 560, 602 73.00 07300 DRUGS CHARGED TO PATIENTS 506, 090 506, 090 73.00 03020 CARDI OLOGY 0 149, 790 76.00 149, 790 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90 00 0 90.10 09001 FAMILY PRACTICE CLINIC 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 0 90.30 383, 663 383, 663 90.30 09004 SLEEP DISORDERS CLINIC 0 90.50 118, 442 90.50 118 442 09100 EMERGENCY 0 91.00 1, 443, 509 1, 443, 509 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 28, 505, 462 0 28, 505, 462 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 173, 301 173, 301 190.00 193. 00 19300 NONPALD WORKERS 8, 208, 443 0 8, 208, 443 193. 00 193. 10 19301 HEALTH PROPERTIES 12, 839 0 12, 839 193. 10 193. 40 19303 LEI GHTON CENTER 0 229, 394 193. 40 229, 394 10, 028 193. 50 19305 WELLNESS CENTER 0 10, 028 193. 50 193.80 19308 UNUSED SPACE 0 0 193. 80 193. 90 19309 OCCUPATIONAL HEALTH 193. 90 0 193. 91 19310 RESEARCH AND PROTOCOL 0 0 0 193. 91 0 193. 92 19311 CCOP 193. 92 0 193. 93 19312 REASEARCH ADMIN 1,758 1, 758 193. 93 200.00 Cross Foot Adjustments 737, 669 737, 669 200. 00

Heal th Final	ncial Systems	MEMORIAL HOSPITAL C	OF SOUTH BEND,	INC	In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der Co		Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Pre 5/29/2019 8:3	
	Cost Center Description	PARAMED ED	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t		
		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	37 878 894		37 878 894		202 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0058 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 8:36 am CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliation ADMINISTRATIVE **FOULP** BENEFITS & GENERAL FIXT (SQUARE (SQUARE DEPARTMENT (ACCUM. FEET) FEET) (GROSS COST) SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1, 252, 910 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 1, 252, 910 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 223 147, 016, 688 4.00 223 00500 ADMINISTRATIVE & GENERAL 369, 148, 143 5 00 22 678 5, 617, 663 -57, 027, 287 5 00 22 678 6.00 00600 MAINTENANCE & REPAIRS 3,022 3,022 555, 770 4, 709, 998 6.00 16, 058, 695 7.00 00700 OPERATION OF PLANT 202, 739 202, 739 2, 711, 622 7.00 00800 LAUNDRY & LINEN SERVICE 151 151 0 1, 587, 917 8.00 8.00 0 6, 232, 918 00900 HOUSEKEEPI NG 21, 792 3, 033, 360 9 00 21.792 9 00 10.00 01000 DI ETARY 27, 334 27, 334 1, 989, 367 0 4, 713, 355 10.00 01100 CAFETERI A 1, 352, 307 11.00 4,641 4, 641 0 1, 185, 331 11.00 01300 NURSING ADMINISTRATION 2, 215, 721 13.00 11.584 11.584 3, 712, 181 13.00 01400 CENTRAL SERVICES & SUPPLY 32, 195 32, 195 2, 146, 873 14.00 10, 843, 919 14 00 15.00 01500 PHARMACY 11,605 11, 605 268, 980 0 6, 940, 141 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 4,857 4, 857 146, 840 16.00 0 01700 SOCIAL SERVICE 8, 443 2, 999, 090 8,443 4, 653, 905 17.00 17.00 21 00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 1, 938, 385 2, 204, 961 21 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 15, 984 15, 984 3, 283, 210 0 6, 202, 007 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 3,721 3, 721 91, 164 0 263, 742 23.00 02301 PARAMED ED 0 23.01 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 ADULTS & PEDIATRICS 242,660 242,660 33, 997, 826 62, 129, 011 30.00 0 03100 INTENSIVE CARE UNIT 30, 837 30, 837 6, 577, 915 11, 827, 913 31.00 31.00 02060 NEONATAL INTENSIVE CARE UNIT 29. 225 29, 225 6,009,756 9, 304, 198 31.01 31.01 40.00 04000 SUBPROVI DER - I PF 12,683 12, 683 1, 092, 684 0 2,001,276 40.00 04100 SUBPROVI DER - I RF 0 41.00 11,737 11, 737 1, 170, 999 2, 122, 214 41.00 43.00 04300 NURSERY 4,565 4, 565 1, 361, 810 2, 057, 407 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 106, 714 50.00 106, 714 14, 116, 007 34, 678, 973 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 36, 659 36, 659 4, 081, 951 0 7, 998, 890 52.00 05400 RADI OLOGY-DI AGNOSTI C 17, 138, 786 58.614 58, 614 54 00 8, 825, 535 54 00 57.00 05700 CT SCAN 2,850 2, 850 1, 172, 498 2, 085, 649 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 209, 080 58.00 4, 315 4, 315 0 58.00 05900 CARDI AC CATHETERI ZATI ON 1, 184, 784 2, 397, 712 59.00 15.257 15, 257 59.00 06000 LABORATORY 2, 539, 444 60.00 11,038 11, 038 12, 228, 807 60.00 0 60.01 06001 BLOOD LABORATORY 0 60.01 65.00 06500 RESPIRATORY THERAPY 7, 376 7,376 3, 361, 494 0 6, 495, 262 65.00 4, 278, 647 06600 PHYSI CAL THERAPY 2, 704, 180 66 00 13 002 13,002 66 00 06602 PHYSICAL THERAPY EAST BANK 66.01 0 C 1,005,977 1, 425, 428 66.01 66.10 06601 PHYSICAL THERAPY LIVING CENTER 414, 968 0 566, 638 66.10 06700 OCCUPATIONAL THERAPY 67.00 1, 778, 480 0 2, 594, 300 67.00 6, 464 6, 464 06701 OCCUPATIONAL THERAPY LIVING CENTER 360, 508 252 620 67 10 67 10 Ω C 68.00 06800 SPEECH PATHOLOGY 395 395 986, 825 1, 364, 609 68.00 06801 SPEECH THERAPY LIVING CENTER 182, 367 254, 074 68.10 0 C 0 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 C 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS O 71 00 0 Ω 10, 311, 293 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 26, 351, 594 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 6, 283, 247 33, 740, 817 73.00 03020 CARDI OLOGY 3, 394 3, 394 4, 199, 120 76.00 2, 615, 250 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09001 FAMILY PRACTICE CLINIC 0 90 10 0 0 90 10 90.30 09002 HEMATOLOGY ONCOLOGY CLINIC 10.112 755, 091 0 1, 410, 426 90.30 10, 112 90.50 09004 SLEEP DISORDERS CLINIC 3, 187 3, 187 599, 431 0 1,001,209 90.50 09100 EMERGENCY 11, 090, 448 91.00 91.00 35.114 35, 114 22, 367, 099 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) 118.00 -57, 027, 287 1, 017, 167 1,017,167 142, 365, 099 353, 356, 850 118. 00 NONREI MBURSABLE COST CENTERS 143, 938 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 4.761 4, 761 193. 00 19300 NONPALD WORKERS 301, 909 7, 517, 942 193. 00 224,680 224,680 0 193. 10 19301 HEALTH PROPERTIES 2, 221, 706 4, 271, 021 193. 10 0 193. 40 19303 LEI GHTON CENTER 190, 527 193. 40 6,302 6, 302 C 193. 50 19305 WELLNESS CENTER C 1, 877, 520 3, 319, 429 193. 50 193. 80 19308 UNUSED SPACE 0 0 0 0 0 193. 80 193. 90 19309 OCCUPATIONAL HEALTH 0 0 193. 90 0 0 193. 91 19310 RESEARCH AND PROTOCOL 0 0 0 0 193, 91 193. 92 19311 CCOP 0 0 0 193. 92

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0058	Peri od: Worksheet B-1 From 01/01/2018 Date/Time Prepared:

				Т	o 12/31/2018	Date/Time Pre 5/29/2019 8:3	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS SALARI ES)		COST)	
		1.00	2.00	4. 00	5A	5. 00	
193. 93	19312 REASEARCH ADMIN	0	0	250, 454	0	348, 436	193. 93
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	22, 197, 039	15, 681, 855	20, 218, 497		57, 027, 287	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	17. 716387	12. 516346	0. 137525	5	0. 154483	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			6, 742	2	685, 876	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000046		0. 001858	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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0058

In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

Cost Center Description MAINTENANCE & OPERATION OF REPAIRS (SQUARE (SQUARE FEET) LAUNDRY & HOUSEKEEPING (MEALS SERVICE) GENERAL SERVICE COST CENTERS 1.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP	5)
CSQUARE CSQUARE CPOUNDS OF SERVICE SERVED	1. 00 2. 00 4. 00 5. 00 6. 00
6. 00 7. 00 8. 00 9. 00 10. 00 GENERAL SERVICE COST CENTERS	1. 00 2. 00 4. 00 5. 00 6. 00
1. 00	2. 00 4. 00 5. 00 6. 00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUI P	2. 00 4. 00 5. 00 6. 00
	4. 00 5. 00 6. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	6. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	•
6. 00 00600 MAI NTENANCE & REPAIRS 1, 226, 987	
8. 00 00800 LAUNDRY & LI NEN SERVI CE 151 151 996, 243	8. 00
9. 00 00900 HOUSEKEEPI NG 21, 792 21, 792 0 95, 681 10. 00 01000 DI ETARY 27, 334 27, 334 0 2, 266 333	9. 00 2, 895 10. 00
10. 00 01000 DI ETARY 27, 334 27, 334 0 2, 266 332 11. 00 01100 CAFETERI A 4, 641 4, 641 0 0	2, 895 10. 00 0 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON 11, 584 0 127	0 13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 32, 195 32, 195 42 2, 812 15. 00 01500 PHARMACY 11, 605 0 294	0 14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 4, 857 4, 857 0 573	0 16.00
17. 00 01700 SOCI AL SERVI CE 8, 443 8, 443 0 186	0 17.00
21. 00 02100 1 &R SERVI CES-SALARY & FRI NGES APPRVD 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 21.00 0 22.00
23. 00 02300 PARAMED ED PRGM-(SPECI FY) 3, 721 63, 717 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 242,660 242,660 325,441 41,924 276	5, 176 30. 00
31. 00 03100 I NTENSI VE CARE UNI T 30, 837 30, 837 52 1, 807 34	1, 263 31. 00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT 29, 225 29, 225 5, 240 4, 573 40, 00 04000 SUBPROVI DER - PE 12, 683 12, 683 0 3, 039 1;	0 31.01
	, 362 40. 00 , 094 41. 00
43. 00 04300 NURSERY 4, 565 4, 565 1, 713 1, 778	0 43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM 106, 714 106, 714 305, 207 12, 399	0 50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 36, 659 36, 659 64, 225 4, 059	0 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 58, 614 58, 614 84 5, 159	0 54.00
57. 00 05700 CT SCAN	0 57.00 0 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 15, 257 15, 257 0 1, 820	0 59.00
60. 00 06000 LABORATORY 11, 038 11, 038 0 1, 107	0 60.00
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 7, 376 7, 376 0 181	0 60.01
66. 00 06600 PHYSI CAL THERAPY 13, 002 13, 002 0 782	0 66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0 66.01
67. 00 06700 OCCUPATI ONAL THERAPY 6, 464 6, 464 0 209	0 67.00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER 0 0 0	0 67. 10
68. 00 06800 SPEECH PATHOLOGY 395 395 0 33 68. 10 06801 SPEECH THERAPY LIVING CENTER 0 0 0 0 0	0 68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0 70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0	0 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 72.00 0 73.00
76. 00 03020 CARDI OLOGY 3, 394 0 0	0 76.00
OUTPATIENT SERVICE COST CENTERS O O O O O O	0 90.00
90. 00 09000 CLINI C	0 90.00
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC 10, 112 10, 112 0 344	0 90.30
90. 50 09004 SLEEP DI SORDERS CLINI C 3, 187 3, 187 4 0 91. 00 09100 EMERGENCY 35, 114 156, 756 3, 605	0 90.50
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	92. 00
SPECIAL PURPOSE COST CENTERS	112.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 991,244 788,505 996,243 92,405 333	113. 00 2, 895 118. 00
NONREI MBURSABLE COST CENTERS	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 4, 761 4, 761 0 0 193. 00 19300 NONPAI D WORKERS 224, 680 224, 680 0 3, 276	0 190.00
193. 00 19300 NONPALD WORKERS 224, 000 224, 000 0 5, 276 193. 10 19301 HEALTH PROPERTIES 0 0 0 0	0 193. 10
193. 40 19303 LEI GHTON CENTER 6, 302 6, 302 0	0 193. 40
193. 50 19305 WELLNESS CENTER 0 0 0 0 0 0 1 193. 80 19308 UNUSED SPACE 0 0 0 0 0 0	0 193. 50 0 193. 80
193. 90 19309 OCCUPATI ONAL HEALTH 0 0 0 0	0 193. 80
193. 91 19310 RESEARCH AND PROTOCOL 0 0 0 0	0 193. 91
193. 92 1931 CCOP	0 193. 92 0 193. 93
200.00 Cross Foot Adjustments	200. 00
201.00 Negative Cost Centers	201. 00

Heal th	Financial Systems MEMOF	RIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	u of Form CMS-:	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2018	Worksheet B-1	
					Γο 12/31/2018	Date/Time Pre 5/29/2019 8:3	
	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, 437, 613	19, 437, 964	1, 836, 75	7, 705, 937	6, 263, 862	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	4. 431679	18. 977791	1. 84368	80. 537797	18. 816329	203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)	100, 140	6, 175, 863	8, 43	7 803, 730	1, 021, 312	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 081615	6. 029656	0.00846	8. 400100	3. 067970	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 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 8:36 am 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 11.00 4, 182, 238 11.00 13.00 01300 NURSING ADMINISTRATION 100, 514 1, 570, 083 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 103, 338 100 14.00 18 26, 929, 840 01500 PHARMACY 15 00 157, 587 15 00 C 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 3, 195 16.00 01700 SOCIAL SERVICE 17.00 101,688 3, 731 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 22.00 109, 283 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 3, 172 0 0 0 23.00 23.00 69 02301 PARAMED ED 23.01 23.01 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 207, 601 678, 192 0 3,092 523 30.00 03100 INTENSIVE CARE UNIT 209, 786 160, 335 0 31.00 40 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 151, 258 125, 766 0 3.458 14 31.01 04000 SUBPROVI DER - I PF 0 28 40.00 40.00 45.663 18, 745 0 04100 SUBPROVI DER - I RF 0 41.00 36, 249 23, 228 0 13 41.00 04300 NURSERY 0 43.00 39, 416 26, 037 10 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50 00 412, 274 208, 232 0 400 734 52.00 05200 DELIVERY ROOM & LABOR ROOM 124, 551 88, 145 0 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 267, 581 40, 803 2, 265 552 54.00 57.00 05700 CT SCAN 32, 507 0 0 57.00 64 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58 00 653 0 58.00 05900 CARDIAC CATHETERIZATION 31,056 383 59.00 59.00 11, 191 0 60.00 06000 LABORATORY 117, 728 C 0 0 248 60.00 0 06001 BLOOD LABORATORY 60.01 60.01 C 0 0 65.00 06500 RESPIRATORY THERAPY 107, 665 95 3.844 Λ 65.00 66,00 06600 PHYSI CAL THERAPY 70.587 7,049 12 345 66.00 06602 PHYSICAL THERAPY EAST BANK 31, 276 66.01 0 0 66.01 06601 PHYSICAL THERAPY LIVING CENTER 11, 196 0 0 66.10 C Ω 66.10 67.00 06700 OCCUPATIONAL THERAPY 52, 510 0 85 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 8, 250 o 67.10 0 06800 SPEECH PATHOLOGY 0 25, 667 68.00 22 39 68.00 0 68.10 06801 SPEECH THERAPY LIVING CENTER 4, 991 C 0 0 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 o 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 58 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 42 72.00 0 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 26, 900, 728 0 73.00 03020 CARDI OLOGY 76.00 54, 432 11, 383 1, 255 231 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 0 90.10 09001 FAMILY PRACTICE CLINIC 0 0 0 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 13, 221 90.30 22, 289 0 0 90.30 0 90.50 09004 SLEEP DISORDERS CLINIC 17 728 0 90.50 0 09100 EMERGENCY 91.00 296, 333 148, 368 0 11, 742 333 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) 3, 954, 176 3, 195 118. 00 118.00 1, 564, 672 100 26, 927, 915 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 193. 00 19300 NONPALD WORKERS 0 1, 925 0 193.00 10 547 2.566 193. 10 19301 HEALTH PROPERTIES 117, 347 17 0 0 193. 10 0 193. 40 19303 LEI GHTON CENTER 0 0 193. 40 0 0 193. 50 19305 WELLNESS CENTER 92.355 0 0 0 193. 50 193.80 19308 UNUSED SPACE C 0 0 0 193, 80 193. 90 19309 OCCUPATIONAL HEALTH 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 7,813 2,828 0 0 193. 93 200.00 Cross Foot Adjustments 200.00

Health Fir	nancial Systems MEMOR	RIAL HOSPITAL C	F SOUTH BEND,	INC	In Lie	eu of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der C		eri od:	Worksheet B-1	
					rom 01/01/2018		
				Т	o 12/31/2018	Date/Time Pre 5/29/2019 8:3	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(HOURS OF	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		SERVICE)		SUPPLY	REQUIS.)	LI BRARY	
			(DI RECT	(COSTED		(TIME	
			NRSING HRS)	REQUIS.)		SPENT)	
		11. 00	13.00	14. 00	15.00	16.00	
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 477, 087	4, 602, 554	13, 535, 887	8, 363, 277	329, 372	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 353181	2. 931408	135, 358. 870000	0. 310558	103. 089828	203. 00
204. 00	Cost to be allocated (per Wkst. B,	170, 937	433, 183	1, 218, 193	443, 590	181, 608	204. 00

0.040872

0. 275898 12, 181. 930000

56. 841315 205. 00

206. 00

207. 00

0.016472

205.00

206.00 207.00 Unit cost multiplier (Wkst. B, Part

NAHE adjustment amount to be allocated (per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D, Parts III and IV)

Part II)

11)

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

				To	12/31/2018	Date/Time Pre 5/29/2019 8:3	
			INTERNS &	RESI DENTS		372772017 0. 0	- Control
	Cost Center Description	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	PARAMED ED	
	'		Y & FRINGES	PRGM COSTS	PRGM	(ASSI GNED	
		(TIME SPENT)	(ASSI GNED TIME)	(ASSIGNED TIME)	(ASSI GNED TI ME)	TIME)	
	Ta	17. 00	21. 00	22.00	23. 00	23. 01	
1. 00	GENERAL SERVICE COST CENTERS O0100 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 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10. 00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON						11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY						15. 00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	24, 733					16. 00 17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	2, 716				21. 00
22. 00 23. 00	02200 1&R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	0		2, 716	100		22. 00 23. 00
23. 01	02301 PARAMED ED	0			100	0	1
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	17 551	1 7/2	1, 763	0	0	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	17, 551 815	1, 763 8		0	0	
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	454	0	0	0	0	
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	2, 795 446	0	-	0	0	
43. 00	04300 NURSERY	0	0		Ō	0	1
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	4	102	102	0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	50	0		0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	506	13		0	0	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	-	О	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	0		0	0	
65. 00	06500 RESPIRATORY THERAPY	Ö	34		Ö	Ö	
66. 00 66. 01	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00 66. 01
66. 10	06602 PHYSI CAL THERAPY EAST BANK 06601 PHYSI CAL THERAPY LIVING CENTER	0	0	0	0	0	1
67. 00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	
67. 10 68. 00	06701 OCCUPATIONAL THERAPY LIVING CENTER 06800 SPEECH PATHOLOGY	0	0	0	0	0	
68. 10	06801 SPEECH THERAPY LIVING CENTER	0	0	0	O	0	68. 10
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	1
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
73.00	· ·	0	0		0	0	1
76.00	03020 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS	l O	58	58	0	0	76. 00
90.00	09000 CLI NI C	0	0		0	0	1
90. 10 90. 30	1	0 464	557 4	557 4	0	0	
90. 50	09004 SLEEP DISORDERS CLINIC	0	0	o O	O	0	90. 50
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 648	146	146	100	0	91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS						72.00
	11300 I NTEREST EXPENSE	0.4.700	0 (05	2 /25			113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	24, 733	2, 685	2, 685	100	0	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	D 19300 NONPALD WORKERS D 19301 HEALTH PROPERTIES	0	31	31	0		193. 00 193. 10
	19303 LEIGHTON CENTER		0		0		193. 10
	19305 WELLNESS CENTER	0	0	0	o		193. 50
	D 19308 UNUSED SPACE D 19309 OCCUPATI ONAL HEALTH	0	0	0	O 0		193. 80 193. 90
193. 9°	1 19310 RESEARCH AND PROTOCOL	0	0	o	o	0	193. 91
	2 19311 CCOP 3 19312 REASEARCH ADMIN	0	0	0	0		193. 92 193. 93
	-111	<u>, </u>		,	<u> </u>		1

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0058	Peri od: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

				To	0 12/31/2018	Date/Time Pre 5/29/2019 8:3	
			INTERNS &	RESI DENTS			
	Cost Center Description	SOCI AL SERVI CE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED (ASSI GNED	
		(TIME	(ASSI GNED	(ASSI GNED	(ASSI GNED	TIME)	
		SPENT)	TIME)	TIME)	TIME)		
		17. 00	21. 00	22. 00	23. 00	23. 01	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 632, 331	2, 545, 590	7, 572, 886	510, 388	0	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	227. 725347	937. 256996	2, 788. 249632	5, 103. 880000	0. 000000	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	322, 384	4, 186	597, 064	136, 419	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	13. 034569	1. 541237	219. 832106	1, 364. 190000	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,				0. 000000	0. 000000	207. 00
	Parts III and IV)						

					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	93, 046, 953		93, 046, 953			
31. 00	03100 INTENSIVE CARE UNIT	15, 901, 153		15, 901, 153			
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	12, 331, 636		12, 331, 636	6, 766	12, 338, 402	31. 01
40.00	04000 SUBPROVI DER - I PF	3, 776, 341		3, 776, 341	0	3, 776, 341	
41.00	04100 SUBPROVI DER - I RF	3, 440, 710		3, 440, 710	0	3, 440, 710	
43.00	04300 NURSERY	2, 719, 737		2, 719, 737	0	2, 719, 737	43. 00
	ANCILLARY SERVICE COST CENTERS	T					
50.00	05000 OPERATING ROOM	44, 928, 418		44, 928, 418			
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 851, 848		10, 851, 848			52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	21, 961, 161		21, 961, 161		22, 000, 773	
57. 00	05700 CT SCAN	2, 566, 819		2, 566, 819		2, 566, 819	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 497, 167		1, 497, 167		1, 497, 167	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 315, 747		3, 315, 747			
60.00	06000 LABORATORY	14, 532, 644		14, 532, 644	3, 838	14, 536, 482	60.00
60. 01	06001 BLOOD LABORATORY	0		0	-	0	60. 01
65.00	06500 RESPI RATORY THERAPY	7, 725, 412	0	7, 725, 412		7, 725, 412	65. 00
66. 00	06600 PHYSI CAL THERAPY	5, 388, 139		-,,			66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	1, 656, 678	0	1, 656, 678	0	1, 656, 678	
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	658, 128	0	658, 128	0	658, 128	66. 10
67.00	06700 OCCUPATI ONAL THERAPY	3, 190, 534	0	3, 190, 534	0	3, 190, 534	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	419, 114	0	419, 114	0	419, 114	67. 10
68.00	06800 SPEECH PATHOLOGY	1, 600, 416	0	1, 600, 416	0	1, 600, 416	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	295, 087	0	295, 087	0	295, 087	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 755, 026		19, 755, 026	0	19, 755, 026	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	36, 107, 540		36, 107, 540	0	36, 107, 540	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	47, 307, 435		47, 307, 435	0	47, 307, 435	73. 00
76.00	03020 CARDI OLOGY	5, 004, 061		5, 004, 061	63, 738	5, 067, 799	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0		0	0	0	
90. 10	09001 FAMILY PRACTICE CLINIC	0		0	-	0	90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	2, 045, 027		2, 045, 027	3, 498	2, 048, 525	90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	1, 236, 753		1, 236, 753	18, 827	1, 255, 580	
91. 00	09100 EMERGENCY	28, 687, 025		28, 687, 025		29, 306, 980	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 667, 502		11, 667, 502		11, 667, 502	92. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
200.00	, ,	403, 614, 211		,,			
201.00		11, 667, 502		11, 667, 502		11, 667, 502	
202.00	Total (see instructions)	391, 946, 709	0	391, 946, 709	1, 011, 509	392, 958, 218	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0058 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 8:36 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 185, 120, 476 185, 120, 476 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 40, 418, 821 40, 418, 821 31.00 27, 793, 839 02060 NEONATAL INTENSIVE CARE UNIT 27, 793, 839 31.01 31.01 04000 SUBPROVIDER - IPF 40.00 3, 753, 254 3, 753, 254 40.00 04100 SUBPROVI DER - I RF 41.00 7, 672, 079 7, 672, 079 41.00 43.00 04300 NURSERY 4, 641, 550 4, 641, 550 43.00 ANCILLARY SERVICE COST CENTERS 63, 101, 832 50.00 05000 OPERATING ROOM 56, 347, 939 119, 449, 771 0.376128 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 18, 027, 855 1,667,645 19, 695, 500 0.550981 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 35, 514, 568 88, 787, 778 124, 302, 346 0.176675 0.000000 54.00 57.00 05700 CT SCAN 23, 729, 228 45, 688, 651 69, 417, 879 0.036976 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 5, 317, 889 0. 281534 4,087,434 1, 230, 455 0.000000 58.00 58.00 05900 CARDIAC CATHETERIZATION 59.00 11, 733, 740 17, 022, 578 28, 756, 318 0.115305 0.000000 59.00 06000 LABORATORY 86, 803, 232 50, 351, 552 137, 154, 784 0. 105958 0.000000 60.00 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 06500 RESPIRATORY THERAPY 39, 122, 895 3, 590, 182 42, 713, 077 0.180868 65.00 0.000000 65 00 66.00 06600 PHYSI CAL THERAPY 6, 905, 631 5, 999, 002 12, 904, 633 0. 417535 0.000000 66.00 06602 PHYSI CAL THERAPY EAST BANK 4, 028, 312 4, 030, 393 0. 411046 0.000000 66, 01 2,081 66.01 06601 PHYSICAL THERAPY LIVING CENTER 1, 633, 752 1, 635, 307 0.402449 0.000000 1.555 66.10 66.10 7, 077, 354 06700 OCCUPATI ONAL THERAPY 0. 450809 67.00 4, 926, 995 2, 150, 359 0.000000 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 1, 295 1, 152, 924 1, 154, 219 0.363115 0.000000 67.10 68.00 06800 SPEECH PATHOLOGY 2, 389, 898 1, 965, 374 4, 355, 272 0.367466 0.000000 68.00 951, 207 06801 SPEECH THERAPY LIVING CENTER 401 950, 806 0 310224 0.000000 68 10 68 10 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 80, 454, 619 49, 273, 334 129, 727, 953 0. 152280 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 112, 140, 421 58, 261, 818 170, 402, 239 0.211896 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 116, 963, 371 0.191929 73.00 129, 521, 180 246, 484, 551 0.000000 73.00 76.00 03020 CARDI OLOGY 8, 554, 784 7, 292, 720 15, 847, 504 0.315763 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 0 0.000000 0.000000 90 00 09001 FAMILY PRACTICE CLINIC 90.10 \cap 0.000000 0.000000 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 21, 821 933, 627 955, 448 2.140385 0.000000 90.30 90.30 90.50 09004 SLEEP DISORDERS CLINIC 4, 265, 617 4, 265, 617 0. 289935 0.000000 90.50 09100 EMERGENCY 17, 032, 562 39, 349, 781 56, 382, 343 0.508794 91 00 91 00 0.000000 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 34, 980, 979 34, 980, 979 0.333538 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 613, 200, 258 1, 507, 362, 602 200. 00 200.00 Subtotal (see instructions) 894, 162, 344 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 894, 162, 344 613, 200, 258 1, 507, 362, 602 202.00

Date/Time Prepared: 5/29/2019 8:36 am Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description 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 - I PF 40.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 376277 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.552521 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 176994 54 00 57. 00 | 05700 CT SCAN 0.036976 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0. 281534 58.00 59. 00 05900 CARDIAC CATHETERIZATION 0. 115875 59.00 60.00 06000 LABORATORY 0.105986 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 06500 RESPIRATORY THERAPY 0. 180868 65.00 65.00 06600 PHYSI CAL THERAPY 0. 418729 66.00 66.00 06602 PHYSICAL THERAPY EAST BANK 66.01 0. 411046 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0. 402449 66.10 06700 OCCUPATIONAL THERAPY 67.00 0. 450809 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 67.10 67. 10 0. 363115 68.00 06800 SPEECH PATHOLOGY 0. 367466 68.00 68.10 06801 SPEECH THERAPY LIVING CENTER 0. 310224 68.10 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 152280 71 00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0. 211896 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 191929 73.00 73.00 76.00 03020 CARDI OLOGY 0. 319785 76.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0.000000 90.00 09001 FAMILY PRACTICE CLINIC 0.000000 90.10 90.10 90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC 2 144047 90.30 90. 50 09004 SLEEP DISORDERS CLINIC 0. 294349 90.50 91.00 09100 EMERGENCY 0.519790 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0. 333538 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00

201. 00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS	93, 046, 953		93, 046, 953	20, 864	93, 067, 817	30.00
31. 00	03100 INTENSIVE CARE UNIT		ł .				
	02060 NEONATAL INTENSIVE CARE UNIT	15, 901, 153		15, 901, 153			
31. 01		12, 331, 636		12, 331, 636			
40.00	04000 SUBPROVI DER - I PF	3, 776, 341		3, 776, 341		3, 776, 341	1
41. 00	04100 SUBPROVI DER - I RF	3, 440, 710		3, 440, 710		3, 440, 710	
43.00	04300 NURSERY	2, 719, 737		2, 719, 737	0	2, 719, 737	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	44, 928, 418		44, 928, 418	17, 741	44, 946, 159	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 851, 848		10, 851, 848	30, 336	10, 882, 184	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	21, 961, 161		21, 961, 161	39, 612	22, 000, 773	54.00
57.00	05700 CT SCAN	2, 566, 819		2, 566, 819	0	2, 566, 819	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 497, 167		1, 497, 167		1, 497, 167	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 315, 747		3, 315, 747			1
60.00	06000 LABORATORY	14, 532, 644		14, 532, 644		14, 536, 482	
60. 01	06001 BLOOD LABORATORY	0		0		0	60. 01
65. 00	06500 RESPIRATORY THERAPY	7, 725, 412	0			7, 725, 412	1
66. 00	06600 PHYSI CAL THERAPY	5, 388, 139				5, 403, 542	
66. 01	06602 PHYSI CAL THERAPY EAST BANK	1, 656, 678				1, 656, 678	1
66. 10	06601 PHYSI CAL THERAPY LIVING CENTER	658, 128		658, 128		658, 128	
67. 00	06700 OCCUPATI ONAL THERAPY	1	•				1
		3, 190, 534		-,,		3, 190, 534	
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	419, 114		419, 114		419, 114	
68. 00	06800 SPEECH PATHOLOGY	1, 600, 416		1, 600, 416		1, 600, 416	
68. 10	06801 SPEECH THERAPY LIVING CENTER	295, 087	0	295, 087		295, 087	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	· ·	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 755, 026		19, 755, 026			
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	36, 107, 540		36, 107, 540		36, 107, 540	
73.00	07300 DRUGS CHARGED TO PATIENTS	47, 307, 435		47, 307, 435		47, 307, 435	
76.00	03020 CARDI OLOGY	5, 004, 061		5, 004, 061	63, 738	5, 067, 799	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0		0	0	0	90.00
90. 10	09001 FAMILY PRACTICE CLINIC	0		0	o	0	90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	2, 045, 027		2, 045, 027	3, 498	2, 048, 525	90. 30
90. 50	09004 SLEEP DI SORDERS CLINIC	1, 236, 753		1, 236, 753		1, 255, 580	
91. 00	09100 EMERGENCY	28, 687, 025		28, 687, 025			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 667, 502		11, 667, 502		11, 667, 502	1
,2. 00	SPECIAL PURPOSE COST CENTERS	11,007,002		11,007,002		11,007,002	1 /2.00
113 00	11300 INTEREST EXPENSE						113. 00
200.00		403, 614, 211	0	403, 614, 211	1, 011, 509	404, 625, 720	
201.00		11, 667, 502		11, 667, 502		11, 667, 502	
202.00	Total (see instructions)	391, 946, 709	0	391, 946, 709	1, 011, 509	392, 958, 218	J2U2. UU

					To 12/31/2018	Date/Time Pre 5/29/2019 8:3	pared: 6 am
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
			Charges		·		
	Cost Center Description	I npati ent	Outpati ent	Total (col. (+ col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•	<u> </u>		
30.00	03000 ADULTS & PEDIATRICS	185, 120, 476		185, 120, 47	6		30. 00
31.00	03100 INTENSIVE CARE UNIT	40, 418, 821		40, 418, 82	1		31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	27, 793, 839		27, 793, 83	9		31. 01
40.00	04000 SUBPROVI DER - I PF	3, 753, 254		3, 753, 25			40.00
41.00	04100 SUBPROVI DER - I RF	7, 672, 079		7, 672, 07	9		41.00
43.00	04300 NURSERY	4, 641, 550		4, 641, 55	o		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	56, 347, 939	63, 101, 832	119, 449, 77	1 0. 376128	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	18, 027, 855	1, 667, 645		0. 550981	0.000000	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	35, 514, 568	88, 787, 778	124, 302, 34		0.000000	54. 00
57.00	05700 CT SCAN	23, 729, 228	45, 688, 651			0.000000	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 087, 434	1, 230, 455		9 0. 281534	0.000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	11, 733, 740	17, 022, 578			0.000000	
60.00	06000 LABORATORY	86, 803, 232	50, 351, 552	137, 154, 78		0.000000	
60. 01	06001 BLOOD LABORATORY	0	0	1	0. 000000	0.000000	
65.00	06500 RESPI RATORY THERAPY	39, 122, 895	3, 590, 182			0.000000	
66. 00	06600 PHYSI CAL THERAPY	6, 905, 631	5, 999, 002			•	
66. 01	06602 PHYSI CAL THERAPY EAST BANK	2, 081	4, 028, 312			•	
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	1, 555	1, 633, 752			0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	4, 926, 995	2, 150, 359			0.000000	
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	1, 295	1, 152, 924			0.000000	
68. 00	06800 SPEECH PATHOLOGY	2, 389, 898	1, 965, 374			l	
68. 10	06801 SPEECH THERAPY LIVING CENTER	401	950, 806			0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	80, 454, 619	49, 273, 334			0.000000	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	112, 140, 421	58, 261, 818			l	
73. 00	07300 DRUGS CHARGED TO PATIENTS	116, 963, 371	129, 521, 180			0. 000000	
76. 00	03020 CARDI OLOGY	8, 554, 784	7, 292, 720	15, 847, 50	4 0. 315763	0. 000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	l .	0. 000000		
90. 10	09001 FAMILY PRACTICE CLINIC	0	0		0. 000000	0. 000000	
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	21, 821	933, 627				
90. 50	09004 SLEEP DISORDERS CLINIC	0	4, 265, 617			0. 000000	
91. 00	09100 EMERGENCY	17, 032, 562	39, 349, 781			l e	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	34, 980, 979	34, 980, 97	9 0. 333538	0. 000000	92.00
	SPECIAL PURPOSE COST CENTERS			1	T	Γ	ļ
	11300 INTEREST EXPENSE						113. 00
200.00	, ,	894, 162, 344	613, 200, 258	1, 507, 362, 60	2		200.00
201.00	i i	004 440 544	/40 000 050	4 507 0/6 /3			201. 00
202.00	Total (see instructions)	894, 162, 344	613, 200, 258	1, 507, 362, 60	2	I	202. 00

Title XIX					To 12/31/2018	Date/Time Prepared: 5/29/2019 8:36 am
Ratio				Title XIX	Hospi tal	
INPATIENT ROUTINE SERVICE COST CENTERS		Cost Center Description	· '			
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 031000 ADULTS & PEDIATRICS 31.00 31.00 31.00 03100 INTENSI VE CARE UNIT 31.00						
30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 31.00 ADULTS & PEDIATRICS 31.00 31.00 ADULTS & PEDIATRICS & ADULTS & ADUL		1	11. 00			
31.00 03100 INTENSIVE CARE UNIT 31.00 20500 NEOMATAL INTENSIVE CARE UNIT 31.01 20500 NEOMATAL INTENSIVE CARE UNIT 31.01 40.00 04000 SUBPROVI DER - I PF 40.00 41.00 04100 SUBPROVI DER - I IFF 40.00 41.00 04100 SUBPROVI DER - I IFF 41.00 41.00 41.00 04100 SUBPROVI DER - I IFF 41.00	00.00					20.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT		1 1				
40. 00 04000 SUBPROVIDER - I PF 41. 00 04100 SUBPROVIDER - I RF 41. 00 04100 SUBPROVIDER - I RF 43. 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 55. 00 05000 OPERATI NG ROOM 55. 00 00000 55. 00 00000 OPERATI NG ROOM 55. 00 000000 55. 00 000000 OPERATI NG ROOM 55. 00 000000 56. 00 000000 OPERATI NG ROOM 55. 00 000000 56. 00 000000 OPERATI NG ROOM 56. 00 000000 57. 00 000000 OPERATI NG ROOM 57. 00 0000000 57. 00 0000000 OPERATI NG ROOM 57. 00 0000000 57. 00 0000000 OPERATI NG ROOM 57. 00 0000000 57. 00 0000000 OPERATI NG ROOM 57. 00 0000000 57. 00 0000000 OPERATI NG ROOM 57. 00 0000000 57. 00 0000000 OPERATI NG ROOM 57. 00 0000000 57. 00 0000000 OPERATI NG ROOM 57. 00 0000000 57. 00 0000000 OPERATI NG ROOM 57. 00 0000000 57. 00 0000000 OPERATI NG ROOM 57. 00 0000000 57. 00 00000000 OPERATI NG ROOM 57. 00 0000000 57. 00 00000000 OPERATI NG ROOM 57. 00 0000000 57. 00 00000000000 OPERATI NG ROOM 57. 00 00000000 OPERATI NG ROOM 57. 00 0000		1				
41. 00 04300 NURSERY 43. 00 04300 04300 NURSERY 43. 00 04300 04300 NURSERY 43. 00 04300						
43. 00 04300 NURSERY						
ANCILLARY SERVICE COST CENTERS 50.00		l l				
50. 00 05000 0FERATI NG ROOM 0.376277 50. 00 05200 05210 0521 0.00 05200 0521 0.00 05200 0521 0.00	43.00					45.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.552521 52. 00 54. 00 554.00 654.00 654.00 654.00 657.00 667.00	50 00		0.376277			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 176994 57. 00 55700 CT SCAN 0. 036976 57. 00 55700 CT SCAN 0. 036976 57. 00 55700 CT SCAN 0. 036976 57. 00 55900 MAGRETI C RESONANCE I MAGI NG (MRI) 0. 281534 58. 00 59900 (CARDI AC CATHETERI ZATI ON 0. 115875 59. 00 6000 LABORATORY 0. 105986 60. 00 6000 LABORATORY 0. 105986 60. 00 6000 LABORATORY 0. 000000 60. 01 6001 BLOOD LABORATORY 0. 0000000 60. 01 66. 00 6600 Physic I RATDRY THERAPY 0. 180868 60. 00 6600 Physic I AL THERAPY LIVING CENTER 0. 418729 66. 00 6600 Physic I AL THERAPY LIVING CENTER 0. 402449 66. 10 66. 10 6600 Physic I AL THERAPY LIVING CENTER 0. 450809 67. 00 6700 OCCUPATI ONAL THERAPY LIVING CENTER 0. 363115 67. 10 66701 OCCUPATI ONAL THERAPY LIVING CENTER 0. 363115 67. 10 66701 OCCUPATI ONAL THERAPY LIVING CENTER 0. 36316 68. 10 6800 SPEECH PATHOLOGY 0. 367466 68. 10 6800 SPEECH PATHOLOGY 0. 367466 68. 10 6800 SPEECH PATHOLOGY 0. 310224 68. 1		1	•			52.00
57. 00 05700 CT SCAN		1 1	•			
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 281534 59. 00 05900 CARDIAC CATHETERIZATION 0. 115875 59. 00 05900 CARDIAC CATHETERIZATION 0. 115875 59. 00 05900 CARDIAC CATHETERIZATION 0. 105986 60. 00 06000 LABORATORY 0. 000000 90. 000000 90. 000000 90. 000000 90. 000000 90. 000000 90. 0000000 90. 0000000 90. 0000000 90. 0000000 90. 0000000 90. 00000000		1 1				57.00
59.00 05900 CARDI AC CATHETERI ZATION 0. 115875 59.00 60.00 06000 LABORATORY 0. 105986 60.00 60.01 06000 LABORATORY 0. 000000 60.01 65.00 06500 RESPIRATORY THERAPY 0. 180868 65.00 66.00 06600 PHYSI CAL THERAPY 0. 418729 66.00 66.01 06602 PHYSI CAL THERAPY EAST BANK 0. 411046 66.01 67.00 06700 OCCUPATI ONAL THERAPY LIVING CENTER 0. 450809 67.00 67.10 06701 OCCUPATI ONAL THERAPY LIVING CENTER 0. 363115 67.10 68.10 06800 SPECH PATHOLOGY 0. 367466 68.00 68.10 06801 SPECH PATHOLOGY 0. 367466 68.00 68.10 070.00 DRUGS CHARGED TO PATI ENTS 0. 152280 71.00 0710 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 152280 73.00 07300 DRUGS CHARGED TO PATI ENTS 0. 191929 76.00 03020 CARDI OLOGY 0. 319785 76.00 09000 CLI NI C 0. 000000 90.10 09001 FAMI LY PRACTICE CLINIC 0. 000000 90.30 09002	58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1			58.00
60. 01 06001 BLOOD LABORATORY	59.00		0. 115875			59. 00
65. 00	60.00	06000 LABORATORY	0. 105986			60.00
66. 00	60. 01	06001 BLOOD LABORATORY	0. 000000			60. 01
66. 01 06602 PHYSI CAL THERAPY EAST BANK 0. 411046 66. 01 06601 PHYSI CAL THERAPY LIVING CENTER 0. 402449 66. 10 06601 PHYSI CAL THERAPY LIVING CENTER 0. 402449 66. 10 06701 06701 0CCUPATI ONAL THERAPY 0. 450809 67. 00 067001 0CCUPATI ONAL THERAPY LIVING CENTER 0. 363115 67. 10 06701 0CCUPATI ONAL THERAPY LIVING CENTER 0. 367466 68. 00 06800 SPEECH PATHOLOGY 0. 367466 68. 10 06801 SPEECH PATHOLOGY 0. 3000000 70000 ELECTROENCEPHALOGRAPHY 0. 0000000 70000 ELECTROENCEPHALOGRAPHY 0. 0000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 152280 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 211896 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 191929 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 191929 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 191929 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 191929 74. 00 03020 CARDI OLOGY 0. 319785 76. 00 09000 ELINI C 0. 000000 90. 10 09001 FAMI LY PRACTI CE CLINI C 0. 000000 90. 10 09001 FAMI LY PRACTI CE CLINI C 0. 000000 90. 10 09001 FAMI LY PRACTI CE CLINI C 0. 000000 90. 10 09000 EMERGENCY 0. 519790 90. 50 09000 EMERGENCY 0. 519790 90. 00 09200 095ERVATION BEDS (NON-DISTINCT PART) 0. 333538 92. 00 09000 DRUGS COST CENTERS	65.00	06500 RESPI RATORY THERAPY	0. 180868			65. 00
66. 10	66. 00		0. 418729			66. 00
67. 00	66. 01	1 1	1			66. 01
67. 10			1			66. 10
68. 00						
68. 10		+ I	1			
70. 00		1 1	1			
71. 00		1 1				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 211896 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 191929 73. 00 03020 CARDI OLOGY 0. 319785 76. 00 000000 000000 000000 000000 000000			1			
73. 00			1			
76. 00 03020 CARDI OLOGY 0. 319785 76. 00 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0. 000000 90. 10 09001 FAMI LY PRACTI CE CLI NI C 0. 000000 90. 30 09002 HEMATOLOGY ONCOLOGY CLI NI C 2. 144047 90. 50 09004 SLEEP DI SORDERS CLI NI C 0. 294349 91. 00 09100 EMERGENCY 0. 519790 92. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 333538 92. 00 SPECI AL PURPOSE COST CENTERS						
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 90. 00 09000 CLINIC 90. 00 09001 FAMILY PRACTICE CLINIC 0. 000000 90. 10 90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC 2. 144047 90. 30 09004 SLEEP DI SORDERS CLINIC 0. 294349 91. 00 09100 EMERGENCY 0. 519790 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 333538 92. 00 SPECIAL PURPOSE COST CENTERS						
90. 00 09000 CLINIC 0.000000 90. 00 90. 00 90. 10 90. 10 90. 00 90. 10 90. 30 90. 00 90. 50 90. 50 90. 50 90. 00 90. 50 90. 00 90. 00 90. 50 90. 00 90. 00 90. 50 90. 00 90. 00 90. 50 90. 00 90. 00 90. 50 90. 00 90	76.00		0. 319763			78.00
90. 10 09001 FAMILY PRACTICE CLINIC 0.000000 90. 10 09002 HEMATOLOGY ONCOLOGY CLINIC 2.144047 90. 30 09002 SLEEP DISORDERS CLINIC 0.294349 90. 50 09100 EMERGENCY 0.519790 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.333538 SPECIAL PURPOSE COST CENTERS	90 00		0.000000			90.00
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC 2. 144047 90. 30 90. 50 90. 50 91. 00 91. 00 92. 00 92. 00 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 02 93. 03						
90. 50		1 1	•			
91. 00		l l	1			90. 50
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0. 333538 92. 00 SPECIAL PURPOSE COST CENTERS						91.00
	92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 333538			92.00
113. 00 11300 INTEREST EXPENSE 113. 00		SPECIAL PURPOSE COST CENTERS				
	113.00	11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions) 200.00	200.00	Subtotal (see instructions)				200. 00
	201.00	Less Observation Beds				201. 00
202. 00 Total (see instructions)	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 Provi der CCN: 15-0058

					0 12/31/2018	5/29/2019 8:3	
			Ti tl	e XIX	Hospi tal	PPS	o am
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	•	(Wkst. B, Part				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	44, 928, 418	4, 166, 316			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 851, 848	1, 412, 088	9, 439, 760	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	21, 961, 161	2, 266, 056		0	0	54.00
57.00	05700 CT SCAN	2, 566, 819	109, 228			0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 497, 167	159, 081			0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 315, 747	578, 661			0	59. 00
60.00	06000 LABORATORY	14, 532, 644	452, 210	14, 080, 434	. 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	1	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	7, 725, 412	286, 306			0	65. 00
66. 00	06600 PHYSI CAL THERAPY	5, 388, 139				0	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	1, 656, 678	3, 972			0	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	658, 128	1, 530	•		0	66. 10
67. 00	06700 OCCUPATI ONAL THERAPY	3, 190, 534	248, 565			0	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	419, 114	1, 019			0	67. 10
68. 00	06800 SPEECH PATHOLOGY	1, 600, 416	20, 479			0	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	295, 087	684		0	0	68. 10
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 755, 026	725, 710			0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	36, 107, 540	560, 602			0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	47, 307, 435	506, 090			0	73. 00
76. 00	03020 CARDI OLOGY	5, 004, 061	149, 790	4, 854, 271	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS				1	1	
	09000 CLI NI C	0	0) C		1	
	09001 FAMILY PRACTICE CLINIC	0	0	0	_	0	90. 10
	09002 HEMATOLOGY ONCOLOGY CLINIC	2, 045, 027	383, 663			0	90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	1, 236, 753	118, 442			0	90. 50
91.00	09100 EMERGENCY	28, 687, 025	1, 443, 509			-	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 667, 502	1, 333, 070	10, 334, 432	0	0	92. 00
SPECIAL PURPOSE COST CENTERS				440.00			
	11300 INTEREST EXPENSE	272 207 (24	15 400 400	25/ 050 000	_		113.00
200.00		272, 397, 681	15, 438, 699				200.00
201.00		11, 667, 502	1, 333, 070				201. 00
202.00	Total (line 200 minus line 201)	260, 730, 179	14, 105, 629	246, 624, 550	0	1 0	202. 00

Heal th Financial Systems MEMORIAL HOSPITA CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2018	Part II
To 12/31/2018	Date/Time Prepared:
5/29/2019 8:36 am	Provi der CCN: 15-0058

						5/29/2019 8:36 am
			Ti tl	e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,	Cost to Charg	je	
		Operating Cost	Part I, column	Ratio (col.	6	
		Reduction	8)	/ col. 7)		
		6. 00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	44, 928, 418	119, 449, 771	0. 37612	18	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 851, 848	19, 695, 500	0. 55098	31	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	21, 961, 161	124, 302, 346	0. 17667	'5	54. 00
57.00	05700 CT SCAN	2, 566, 819	69, 417, 879	0. 03697	'6	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 497, 167	5, 317, 889	0. 28153	34	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 315, 747	28, 756, 318	0. 11530)5	59.00
60.00	06000 LABORATORY	14, 532, 644	137, 154, 784	0. 10595	18	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0.00000	00	60. 01
65.00	06500 RESPI RATORY THERAPY	7, 725, 412	42, 713, 077	0. 18086	8	65. 00
66.00	06600 PHYSI CAL THERAPY	5, 388, 139	12, 904, 633	0. 41753	55	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	1, 656, 678	4, 030, 393	0. 41104	6	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	658, 128	1, 635, 307	0. 40244	.9	66. 10
67.00	06700 OCCUPATI ONAL THERAPY	3, 190, 534	7, 077, 354	0. 45080	19	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	419, 114	1, 154, 219	0. 36311	5	67. 10
68.00	06800 SPEECH PATHOLOGY	1, 600, 416	4, 355, 272	0. 36746	6	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	295, 087	951, 207		24	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	00	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 755, 026	129, 727, 953	0. 15228	80	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	36, 107, 540				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	47, 307, 435			.9	73. 00
76. 00	03020 CARDI OLOGY	5, 004, 061			3	76. 00
	OUTPATIENT SERVICE COST CENTERS		.,,		1	
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, 045, 027	955, 448	2. 14038	35	90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	1, 236, 753		l .		90. 50
91.00	09100 EMERGENCY	28, 687, 025				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 667, 502		l .		92. 00
	SPECIAL PURPOSE COST CENTERS	11,7001,7000				1 - 1 - 1
113, 00	11300 I NTEREST EXPENSE					113. 00
200.00	1 1	272, 397, 681	1, 237, 962, 583			200. 00
201.00		11, 667, 502				201. 00
202.00	1 1		1, 237, 962, 583			202. 00
202.00	1.553. (1716-200 1111103 17110-201)	200,700,177	1 ., 20,, 702, 500	ı	1	1202.00

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-1						
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co	CN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part I Date/Time Pre 5/29/2019 8:3	pared:
Title XVIII Hospital 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 Cos	i		
	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 & PEDI ATRI CS	10, 633, 452	0	10, 633, 45	52 83, 883	126. 77	30. 00
31.00 INTENSIVE CARE UNIT	1, 329, 024		1, 329, 02			31.00
31.01 NEONATAL INTENSIVE CARE UNIT	1, 165, 826		1, 165, 82	26 8, 919	130. 71	31. 01
40. 00 SUBPROVI DER - I PF	570, 167	0	570, 16	3, 090	184. 52	40. 00
41. 00 SUBPROVI DER - I RF	507, 255	0	507, 25	55 2, 907	174. 49	
43. 00 NURSERY	194, 109		194, 10	09 4, 201	46. 21	43.00
200.00 Total (lines 30 through 199)	14, 399, 833		14, 399, 83	33 112, 208		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	23, 916					30. 00
31.00 INTENSIVE CARE UNIT	2, 261	326, 330				31.00
31.01 NEONATAL INTENSIVE CARE UNIT	0	-				31. 01
40. 00 SUBPROVI DER - I PF	993					40. 00
41. 00 SUBPROVI DER - I RF	1, 180	205, 898				41.00
43. 00 NURSERY	0	-				43.00
200.00 Total (lines 30 through 199)	28, 350	3, 747, 287				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			CN: 15-0058	Peri od:	Worksheet D	
				From 01/01/2018 To 12/31/2018		narod:
				10 12/31/2010	5/29/2019 8: 3	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	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		T	T			
50. 00 05000 OPERATI NG ROOM	4, 166, 316					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 412, 088					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 266, 056					1
57. 00 05700 CT SCAN	109, 228					
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	159, 081					
59. 00 05900 CARDI AC CATHETERI ZATI ON	578, 661					
60. 00 06000 LABORATORY	452, 210					
60. 01 06001 BLOOD LABORATORY	0		0.0000			60. 01
65. 00 06500 RESPI RATORY THERAPY	286, 306					1
66. 00 06600 PHYSI CAL THERAPY	511, 628				l	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	3, 972				0	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	1, 530				0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	248, 565		1			1
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	1, 019				0	67. 10
68. 00 06800 SPEECH PATHOLOGY	20, 479				1	
68. 10 06801 SPEECH THERAPY LIVING CENTER	684	· ·			0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	ļ	0.0000		0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	725, 710					
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	560, 602					
73. 00 07300 DRUGS CHARGED TO PATIENTS	506, 090					
76. 00 03020 CARDI OLOGY	149, 790	15, 847, 504	0. 0094	3, 079, 544	29, 108	76. 00
OUTPATIENT SERVICE COST CENTERS	_	1	1		_	
90. 00 09000 CLI NI C	0	0			0	
90. 10 09001 FAMILY PRACTICE CLINIC	0	0	0.0000		0	
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	383, 663				0	
90. 50 09004 SLEEP DI SORDERS CLINIC	118, 442				0	90. 50
91. 00 09100 EMERGENCY	1, 443, 509					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 333, 070		1		0	
200.00 Total (lines 50 through 199)	15, 438, 699	1, 237, 962, 583	1	208, 446, 878	1, 940, 715	J200. 00

	RIAL HOSPITAL C				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provider Co		eri od:	Worksheet D	
				rom 01/01/2018	Part III	
				o 12/31/2018	Date/Time Pre 5/29/2019 8:3	pared:
		Title	xVIII	Hospi tal	PPS	o ani
Cost Center Description	Nursing School			Allied Health	All Other	
oost ochter beschiptron	Post-Stepdown	ital siring scribble	Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1, 00	2A	2, 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	C	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	l c	0	0	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	31. 01
40. 00 04000 SUBPROVI DER - 1 PF	0	0		0	0	40.00
41. 00 04100 SUBPROVI DER - 1 RF	0	0		0	0	41.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30 through 199)	0	0		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)					
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	83, 883			
31.00 03100 INTENSIVE CARE UNIT		0	9, 208			
31.01 02060 NEONATAL INTENSIVE CARE UNIT		0	8, 919			
40. 00 04000 SUBPROVI DER - I PF	0	0	3, 090			
41. 00 04100 SUBPROVI DER - I RF	0	0	2, 907			
43. 00 04300 NURSERY		0	4, 201			
200.00 Total (lines 30 through 199)		0	112, 208	3	28, 350	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8) 9.00					

30. 00 31. 00 31. 01

40. 00 41. 00 43. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 02060 NEONATAL INTENSIVE CARE UNIT

40.00 | 04000 | SUBPROVI DER - I PF 41.00 | 04100 | SUBPROVI DER - I RF 43.00 | 04300 | NURSERY 200.00 | Total (Lines 30 through 199) Health Financial Systems MEMORIAL HOSPITAL OF SAPPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 15-0058 THROUGH COSTS

			'	0 12/01/2010	5/29/2019 8: 3	
			XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 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 I MAGING (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 BL00D LABORATORY	0	0	(0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
66. 01 06602 PHYSICAL THERAPY EAST BANK	0	0	(0	0	66. 01
66.10 06601 PHYSI CAL 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						
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 DISORDERS CLINIC	0	0	(0	0	90. 50
91. 00 09100 EMERGENCY	0	0	(0	510, 388	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0)	0	92. 00
200.00 Total (lines 50 through 199)	0	0	(0	510, 388	200. 00

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

					12/01/2010	5/29/2019 8: 3	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4.00	5. 00	6. 00	7. 00	8. 00	
	NCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		119, 449, 771		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		19, 695, 500	0.000000	52.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0	0		124, 302, 346		54.00
57. 00 C	05700 CT SCAN	0	0		69, 417, 879	0.000000	57. 00
58. 00 C	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		5, 317, 889	0.000000	58. 00
59.00	05900 CARDIAC CATHETERIZATION	0	0		28, 756, 318	0.000000	59. 00
60.00	06000 LABORATORY	0	0		137, 154, 784	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0.000000	60. 01
65. 00 C	06500 RESPI RATORY THERAPY	0	0		42, 713, 077	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		12, 904, 633	0.000000	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	0		4, 030, 393	0.000000	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0	0		1, 635, 307	0.000000	66. 10
67. 00 C	06700 OCCUPATIONAL THERAPY	0	0		7, 077, 354	0.000000	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0		1, 154, 219	0.000000	67. 10
68.00	06800 SPEECH PATHOLOGY	0	0		4, 355, 272	0.000000	68. 00
68. 10 C	06801 SPEECH THERAPY LIVING CENTER	0	0		951, 207	0.000000	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		o	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		129, 727, 953	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		170, 402, 239	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	O	0		246, 484, 551		
76. 00 C	03020 CARDI OLOGY	O	0		15, 847, 504	0.000000	76. 00
O	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		0	0.000000	90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	o	0		955, 448	0.000000	90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	o	0		4, 265, 617	0.000000	90. 50
91.00	09100 EMERGENCY	0	510, 388	510, 38	56, 382, 343	0.009052	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		34, 980, 979	0.000000	92. 00
200.00	Total (lines 50 through 199)	o	510, 388	510, 38	1, 237, 962, 583		200. 00
	· · · · · · · · · · · · · · · · · · ·	. '				•	•

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0058 Peri od: Worksheet D From 01/01/2018 THROUGH COSTS Part IV 12/31/2018 Date/Time Prepared: 5/29/2019 8:36 am Title XVIII Hospi tal PPS Outpati ent Inpati ent Outpati ent Cost Center Description Inpatient Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col . 12) 13.00 7) x col. 10) 11.00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 20, 437, 219 0 50.00 14, 931, 158 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 26, 947 686 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 12, 337, 795 0 26, 353, 073 54.00 0 05700 CT SCAN 0.000000 7, 724, 597 0 10, 953, 712 57.00 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 1, 468, 405 0 286, 238 58.00 0 05900 CARDI AC CATHETERI ZATI ON 59.00 0.000000 4, 772, 811 0 6, 233, 113 0 59.00 60.00 06000 LABORATORY 0.000000 27, 799, 529 9, 853, 889 0 60.00 0 06001 BLOOD LABORATORY 0.000000 60.01 60 01 0 06500 RESPIRATORY THERAPY 0 727, 278 65.00 0.000000 12, 406, 538 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 2, 117, 613 1, 559, 386 0 66.00 06602 PHYSI CAL THERAPY EAST BANK 0 66.01 0.000000 63, 419 0 66.01 0 06601 PHYSICAL THERAPY LIVING CENTER 0.000000 38, 405 0 66.10 66 10 67.00 06700 OCCUPATIONAL THERAPY 0.000000 1, 119, 458 71, 870 0 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 0.000000 54, 357 67.10 0 67.10 06800 SPEECH PATHOLOGY 10, 709 68 00 0.000000 529, 098 0 68 00 0 68.10 06801 SPEECH THERAPY LIVING CENTER 0.000000 14, 054 0 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 24, 822, 388 11, 359, 531 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 42, 078, 575 72 00 0.000000 18, 248, 117 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 41, 613, 444 44, 080, 782 0 73.00 03020 CARDI OLOGY 0.000000 3, 079, 544 2, 043, 899 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 0.000000 0 09001 FAMILY PRACTICE CLINIC 0 90. 10 0.000000 0 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 0.000000 0 90.30 0 0 09004 SLEEP DISORDERS CLINIC 0.000000 625, 936 90. 50 90. 50 0 0 91. 00 09100 EMERGENCY 6, 112, 917 0.009052 5. 852. 222 52. 974 91.00 55.334 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 3, 908, 011 0 92.00

208, 446, 878

157, 269, 845

52, 974 200. 00

55, 334

Total (lines 50 through 199)

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 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/29/2019 8:36 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 376128 14, 931, 158 5, 616, 027 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 550981 0 0 378 52.00 686 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 176675 26, 353, 073 0 4, 655, 929 54 00 0 0 57.00 05700 CT SCAN 0.036976 10, 953, 712 405, 024 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 281534 286, 238 80, 586 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.115305 6, 233, 113 0 0 718, 709 59.00 06000 LABORATORY 0 60.00 0.105958 9, 853, 889 1, 044, 098 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 06500 RESPIRATORY THERAPY 0 65.00 0.180868 727, 278 0 131, 541 65.00 0 06600 PHYSI CAL THERAPY 1, 559, 386 651, 098 66 00 0 417535 66 00 66.01 06602 PHYSI CAL THERAPY EAST BANK 0.411046 63, 419 26,068 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0.402449 38, 405 0 15, 456 66.10 66.10 06700 OCCUPATIONAL THERAPY 67.00 0.450809 71,870 0 0 0 0 0 0 0 32, 400 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 0 54, 357 67. 10 0.363115 19, 738 67.10 68.00 06800 SPEECH PATHOLOGY 0.367466 10, 709 0 3, 935 68.00 06801 SPEECH THERAPY LIVING CENTER 0. 310224 0 68.10 14,054 4, 360 68.10 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 11, 359, 531 1, 729, 829 71.00 0.152280 640 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 211896 18, 248, 117 0 3, 866, 703 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 8, 460, 380 73.00 0.191929 44, 080, 782 73.00 03020 CARDI OLOGY 76.00 0. 315763 2,043,899 0 645, 388 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 90.00 0 09001 FAMILY PRACTICE CLINIC 0. 000000 90. 10 0 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 2. 140385 0 90.30 90.30 0 09004 SLEEP DISORDERS CLINIC 90.50 0.289935 625, 936 0 181, 481 90.50 91.00 09100 EMERGENCY 0.508794 5, 852, 222 0 2, 977, 575 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 333538 3, 908, 011 0 0 1, 303, 470 92.00 200.00 Subtotal (see instructions) 32, 570, 173 200. 00 157, 269, 845 640 Less PBP Clinic Lab. Services-Program 201.00 0 201.00 Only Charges

157, 269, 845

640

32, 570, 173 202. 00

202.00

Net Charges (line 200 - line 201)

| Peri od: | Worksheet D | From 01/01/2018 | Part V | To 12/21/2019 | Part V | Par Provi der CCN: 15-0058

				To 12/31/2018		epared:
		Title	: XVIII	Hospi tal	PPS	o ani
	Cos					
Cost Center Description	Cost	Cost	1			
· ·	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS			1			
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	0				54. 00 57. 00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	0				57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
60. 01 06000 LABORATORY		0				60.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK		0				66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER		0				66. 10
67. 00 06700 OCCUPATI ONAL THERAPY		0				67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0				67. 10
68. 00 06800 SPEECH PATHOLOGY	o	0				68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	O	0				68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	97	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
76. 00 03020 CARDI OLOGY	0	0				76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	•			90. 00
90. 10 09001 FAMILY PRACTICE CLINIC	0	0				90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0				90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	0	0				90. 50
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Subtotal (see instructions)	97	0				92.00
200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program	9/	0				200. 00 201. 00
Only Charges	١					201.00
202.00 Net Charges (line 200 - line 201)	97	0				202. 00
202. 00 Met ondriges (11 ne 200 11 ne 201)	77	0	I			1202.00

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Peri od:	Worksheet D		
		Component	CCN: 15-S058	From 01/01/2018 To 12/31/2018		pared:	
		Ti tl e	Title XVIII		PPS		
	1			I PF			
Cost Center Description	Capi tal	Total Charges			Capital Costs		
		(from Wkst. C,		Program	(column 3 x		
	(from Wkst. B,	·		. Charges	column 4)		
	Part II, col.	8)	2)				
	26)	2.00	2.00	4.00	F 00		
ANCI LLARY SERVI CE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00		
50. 00 05000 OPERATING ROOM	4, 166, 316	119, 449, 771	0. 03487	9 157, 725	5, 501	50.00	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 412, 088		1		0,501	52.00	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	2, 266, 056		•		143		
57. 00 05700 CT SCAN	109, 228				143	1	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	159, 081				172		
59. 00 05900 CARDI AC CATHETERI ZATI ON	578, 661				0	59.00	
60. 00 06000 LABORATORY	452, 210				406		
60. 01 06001 BLOOD LABORATORY	0		0.00000		0	60. 01	
65. 00 06500 RESPI RATORY THERAPY	286, 306		•		0	65. 00	
66. 00 06600 PHYSI CAL THERAPY	511, 628				4, 168		
66. 01 06602 PHYSI CAL THERAPY EAST BANK	3, 972				0	66. 01	
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	1, 530		•	6 0	0	66. 10	
67. 00 06700 OCCUPATI ONAL THERAPY	248, 565				1, 219	67. 00	
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	1, 019				0	67. 10	
68.00 06800 SPEECH PATHOLOGY	20, 479	4, 355, 272	0. 00470	226	1	68. 00	
68. 10 06801 SPEECH THERAPY LIVING CENTER	684	951, 207	0. 00071	9 0	0	68. 10	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0 0	0	70. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	725, 710	129, 727, 953	0. 00559	4 2, 176	12	71. 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	560, 602				6		
73.00 07300 DRUGS CHARGED TO PATIENTS	506, 090				942		
76. 00 03020 CARDI OLOGY	149, 790	15, 847, 504	0.00945	2 150	1	76. 00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0	1			0	1	
90.10 09001 FAMILY PRACTICE CLINIC	0		1 0.0000		0	90. 10	
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	383, 663		1		0	1	
90. 50 09004 SLEEP DISORDERS CLINIC	118, 442				0	90. 50	
91. 00 09100 EMERGENCY	1, 443, 509				52		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	, ,			0		
200.00 Total (lines 50 through 199)	14, 105, 629	1, 237, 962, 583	51	905, 658	12, 633	200. 00	

Health Financial Systems	MEMORI AL	HOSPI TAL OF	SOUTH BEND	, INC			In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE	OTHER PASS	Provi der	CCN: 1	15-0058	Peri od:		Worksheet D
THROUGH COSTS			Component	t CCN:	15-S058	From 01/0 To 12/3		Part IV Date/Time Prepared:
								5/29/2019 8:36 am
			Ti +	1 A Y\/I	111	Subprovi	der -	DDS

		Title	· XVIII	Subprovi der -	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
cost center bescription		Post-Stepdown	livar string scribbi	Post-Stepdown	Airred fiedi tii	
	Cost	Adjustments		Adjustments		
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	<u> </u>		•	1		
50. 00 05000 OPERATING ROOM	0	0	(0	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(o	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(o	0	54.00
57. 00 05700 CT SCAN	0	0		o	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(o	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 RESPIRATORY 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 PHYSI CAL 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
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						
90. 00 09000 CLI NI C	0	0	(0	0	70.00
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	510, 388	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0)	()	0	92. 00
200.00 Total (lines 50 through 199)	0) 0	() 0	510, 388	200. 00

Heal th	Financial Systems MEMO	RIAL HOSPITAL O	F SOUTH BEND,	I NC	In Lie	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	H COSTS		Component	CCN: 15-S058	From 01/01/2018 To 12/31/2018	Part IV Date/Time Prep 5/29/2019 8:30	pared: 6 am
			Ti tl e	XVIII	Subprovi der -	PPS	
					IPF		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
		4.00	F 00	and 4)	7.00	0.00	
	ANOULL ARV CERVI OF COCT OFNITERS	4.00	5. 00	6. 00	7. 00	8. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS	1 0		1	0 110 110 771	0.000000	F0 00
50.00	05000 OPERATING ROOM	0	1		0 119, 449, 771		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 19, 695, 500		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 124, 302, 346		
57. 00	05700 CT SCAN	0	0		0 69, 417, 879		
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 5, 317, 889		
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 28, 756, 318 0 137 154 784		
60.00	06000 LABORATORY 06001 BLOOD LABORATORY	0			.07, .01, 701		
60. 01 65. 00	06500 RESPI RATORY THERAPY	0			0 0 42. 713. 077	0. 000000 0. 000000	
	06600 PHYSI CAL THERAPY	0			0 42, 713, 077 0 12, 904, 633		
66. 00 66. 01	06602 PHYSICAL THERAPY EAST BANK	0			0 4, 030, 393		
66. 10	06601 PHYSICAL THERAPY EAST BANK	0			0 4, 030, 393		
67. 00	06700 OCCUPATIONAL THERAPY				0 7, 077, 354		
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER				0 1, 154, 219		
68. 00	06800 SPEECH PATHOLOGY	0			0 1, 154, 219		
68. 10	06801 SPEECH THERAPY LIVING CENTER				0 4, 355, 272		
70. 00	07000 ELECTROENCEPHALOGRAPHY	0			0 751, 207	0.000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 129, 727, 953		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 170, 402, 239		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	ĺ		0 246, 484, 551		
76. 00	03020 CARDI OLOGY	0			0 15, 847, 504		
70.00	OUTPATIENT SERVICE COST CENTERS				10,017,001	0.000000	70.00
90.00	09000 CLI NI C	T 0	0		0 0	0.000000	90.00
90. 10	09001 FAMILY PRACTICE CLINIC	0			0 0	0. 000000	
	09002 HEMATOLOGY ONCOLOGY CLINIC	0			0 955, 448		
90. 50	09004 SLEEP DI SORDERS CLINIC	0			0 4, 265, 617		
91. 00	09100 EMERGENCY	0	510, 388	510, 38			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1		0 34, 980, 979		
200.00	,	o o		510. 38	88 1, 237, 962, 583		200.00
		1		'		'	•

Health Fina	ncial Systems MEMO	RIAL HOSPITAL OF	SOUTH BEND,	I NC	In Li∈	eu of Form CMS-2	<u> 2552-10</u>
APPORTI ONME	ENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der Co	CN: 15-0058	Peri od:	Worksheet D	
THROUGH COS	STS		Component	CCN: 15-S058	From 01/01/2018 To 12/31/2018		
			Title	XVIII	Subprovi der - PPS		
					IPF		
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	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	
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0. 000000	157, 725		0	1	
	ODELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
54.00 05400	O RADI OLOGY-DI AGNOSTI C	0. 000000	7, 833		0	0	54.00
57. 00 05700	O CT SCAN	0.000000	6, 204		0 0	0	57. 00
58.00 05800	O MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	5, 739		0 0	0	58. 00
59.00 05900	O CARDIAC CATHETERIZATION	0. 000000	0		0 0	0	59. 00
60.00 06000	O LABORATORY	0. 000000	123, 093		0 0	0	60.00
60. 01 06001	1 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
65.00 06500	O RESPI RATORY THERAPY	0. 000000	0		0 0	0	65. 00
66.00 06600	O PHYSI CAL THERAPY	0. 000000	105, 134		0 0	0	66. 00
66. 01 06602	2 PHYSICAL THERAPY EAST BANK	0. 000000	0		0 0	0	66. 01
66. 10 0660°	1 PHYSICAL THERAPY LIVING CENTER	0. 000000	0		0 0	0	66. 10
67. 00 06700	O OCCUPATI ONAL THERAPY	0. 000000	34, 712		0 0	0	67.00
67. 10 0670°	1 OCCUPATIONAL THERAPY LIVING CENTER	0. 000000	0		0 0	0	67. 10
	O SPEECH PATHOLOGY	0. 000000	226		0 0	0	68. 00
	1 SPEECH THERAPY LIVING CENTER	0. 000000	0		o o	0	68. 10
70.00 07000	O ELECTROENCEPHALOGRAPHY	0. 000000	0		o o	0	70.00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2, 176		o o	0	71.00
72.00 07200	OIMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 740		o o	0	72. 00
	DRUGS CHARGED TO PATIENTS	0. 000000	458, 887		0 0	0	73.00
	O CARDI OLOGY	0. 000000	150		0 0	0	76, 00
	ATIENT SERVICE COST CENTERS						
	O CLI NI C	0. 000000	0		0 0	0	90.00
	1 FAMILY PRACTICE CLINIC	0. 000000	0		0 0	0	90. 10
	2 HEMATOLOGY ONCOLOGY CLINIC	0. 000000	0		0 0	0	1
	4 SLEEP DISORDERS CLINIC	0. 000000	0		0 0	0	90. 50
	O EMERGENCY	0. 009052	2, 039		8 0	0	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	2, 007		0 0		
200. 00	Total (lines 50 through 199)	0.00000	905, 658		8 0		200.00
	,	1	, 000	1	-1	,	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10							
Component CN: 15-TOSB To 12/31/2018 Date/Time Prepared: 5/29/2019 8:36 am Title WILLIAM Title WILLIAM Total Charges (From Wast. C. (From Wast. C				CN: 15-0058	Peri od:			
Capital Related Cost Cfrom Wkst. B, Part II, col. Pers. Col. Lary Service Cost Control Related Cost (From Wkst. B, Part II, col. 26) 1.00 2.00 3.00 4.00 5.			Component			Part II Date/Time Pre 5/29/2019 8:3	pared:	
Capital Related Cost (From Wist. B, Part II, col. Capital Related Cost (From Wist. C, Part II, col. C			Title	Title XVIII		PPS		
Related Cost (From Wisst, C. 20)	-							
CFrom Wisst. B, Part II, col. Col. 1 - Col. Charges Column 4) Charges Column 4 Charges	Cost Center Description							
Part II, col. 26)								
ANCI LLARY SERVI CE COST CENTERS					. Charges	column 4)		
ANCILLARY SERVICE COST CENTERS			8)	2)				
ANCI LLARY SERVICE COST CENTERS Service COST CENTERS Service COST CENTERS Service COST CENTERS Service COST CENTERS Service Service COST CENTERS Service Servi			0.00					
50. 00	ANOLILIARY OF BUILDE AGOT OF UTERS	1.00	2.00	3.00	4. 00	5.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 412, 088 19, 695, 500 0. 071696 0 0 52.00		1 1// 01/	440 440 774	0.00403	0 000	445		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 266, 056 124, 302, 346 0. 018230 94, 774 1, 728 54, 00 57. 00 05700 CT SCAN 109, 228 69, 417, 879 0. 001573 33, 839 53 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 159, 081 5, 317, 889 0. 029914 10, 622 318 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 159, 081 5, 317, 889 0. 029134 10, 622 318 58. 00 05900 CARDI AC CATHETERI ZATI ON 578, 661 28, 756, 318 0. 020123 0 0 59. 00 060. 00 06000 LABORATORY 452, 210 137, 154, 784 0. 003297 192, 559 63. 60. 00 06001 06001 08001 08000 LABORATORY 266, 306 42, 713, 077 0. 006703 160, 787 1, 078 65. 00 06500 RESPI RATORY THERAPY 286, 306 42, 713, 077 0. 006703 160, 787 1, 078 65. 00 06602 PHYSI CAL THERAPY EAST BANK 3, 972 4, 030, 393 0. 009986 0 0. 66. 01 06602 PHYSI CAL THERAPY LIVI NG CENTER 1, 530 1, 635, 307 0. 000936 0 0. 66. 10 06700 0CCUPATI ONAL THERAPY LIVI NG CENTER 1, 530 1, 635, 307 0. 000936 0 0. 67. 10 06701 0CCUPATI ONAL THERAPY LIVI NG CENTER 1, 017 1, 154, 219 0. 000883 0 0 67. 10 06800 SPEECH PATHOLOGY 20, 479 4, 355, 272 0. 004702 325, 614 1, 531 68. 00 06800 SPEECH FHERAPY LIVI NG CENTER 684 951, 207 0. 000719 0 0. 000719 0 0. 000710								
57. 00 05700 CT SCAN 109, 228 69, 417, 879 0.001573 33, 839 53 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 159, 081 5, 317, 889 0.029914 10, 622 318 58. 00 69. 00 05900 CARDI AC CATHETERI ZATI ON 578, 661 28, 756, 318 0.020123 0 0 0 59. 00 60. 00 06000 LABORATORY 452, 210 137, 154, 784 0.003297 192, 559 635 60. 00 66. 00 06500 LABORATORY 0 0.000000 0.000000 0 0.0018 66. 00 06500 PHYSI CAL THERAPY 286, 306 42, 713, 077 0.006703 160, 787 1, 078 65. 00 66. 01 06600 PHYSI CAL THERAPY HAST BANK 3, 972 4, 030, 393 0.009986 0 0 06. 01 66. 10 06601 PHYSI CAL THERAPY LIVING CENTER 1, 533 1, 635, 307 0.009986 0 0 0 66. 10 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 159, 081 5, 317, 889 0. 029914 10, 622 318 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 578, 661 28, 756, 318 0. 029123 0 0 59. 00 60. 00 GOOOD CABORATORY 452, 210 137, 154, 784 0. 003297 192, 559 635 60. 00 60. 01 GOOOD CABORATORY 0 0 0. 0000000 0 0. 000000 0 0 60. 01 65. 00 GOSCO RESPI RATIORY THERAPY 286, 306 42, 713, 077 0. 0039647 527, 105 20, 898 65. 00 66. 01 GOGOO PHYSI CAL THERAPY LIVING CENTER 11, 632 12, 904, 633 0. 039647 527, 105 20, 898 60. 00 66. 01 66. 01 GOGOO PHYSI CAL THERAPY LIVING CENTER 1, 530 1, 635, 307 0. 000936 0 0 66. 01 66. 10 GOGOO CUPATI ONAL THERAPY LIVING CENTER 1, 519 1, 154, 219 0. 000938 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
59.00 05900 CARDI AC CATHETERI ZATION 578, 661 28, 756, 318 0.020123 0 0 59.00 60.00 06000 LABORATORY 452, 210 137, 154, 784 0.003297 192, 559 635 60.00 60.01 06000 LABORATORY 0 0.000000 0.000000 0 0 60.00 65.00 06500 RESPI RATORY THERAPY 286, 306 42, 713, 077 0.006703 160, 787 1, 078 65.00 66.01 06600 PHYSI CAL THERAPY 511, 628 12, 904, 633 0.039647 527, 105 20, 898 66.00 66.01 06601 PHYSI CAL THERAPY EAST BANK 3, 972 4, 030, 393 0.000936 0 0 66.01 67.00 06701 DCCUPATI ONAL THERAPY LIVING CENTER 1, 513 1, 513 219 0.035121 503, 569 17, 686 67.00 67.10 06701 OCCUPATI ONAL THERAPY LIVING CENTER 1, 019 1, 154, 219 0.000883 0 0 67.10						l e		
60. 00 06000 LABORATORY 452, 210 137, 154, 784 0.003297 192, 559 635 60.00 60.01 06001 BLOOD LABORATORY 0 0 0.000000 0 0 0 0 0.001 06.001 06.001 06.000 06.0000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0						l		
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0							1	
65. 00 06500 RESPI RATORY THERAPY 286, 306 42, 713, 077 0.006703 160, 787 1, 078 65. 00 66. 00 06600 PHYSI CAL THERAPY 511, 628 12, 904, 633 0.039647 527, 105 20, 898 66. 00 66. 01 06602 PHYSI CAL THERAPY EAST BANK 3, 972 4, 030, 393 0.000986 0 0 66. 10 06601 PHYSI CAL THERAPY LIVING CENTER 1,530 1,635, 307 0.000936 0 0 06. 10 06601 06001 00 00 00 00						l .		
66. 00 06600 PHYSI CAL THERAPY 511, 628 12, 904, 633 0. 039647 527, 105 20, 898 66. 00 66. 01 66. 01 66. 02 PHYSI CAL THERAPY EAST BANK 3, 972 4, 030, 393 0. 000986 0 0 66. 01 66. 0		1						
66. 01 06602 PHYSI CAL THERAPY EAST BANK 3, 972 4, 030, 393 0. 000986 0 0 66. 01 66. 01 66. 01 PHYSI CAL THERAPY LIVING CENTER 1, 530 1, 635, 307 0. 000936 0 0 66. 10 66. 10 67. 00 06700 0CCUPATI ONAL THERAPY LIVING CENTER 1, 530 1, 635, 307 0. 005121 503, 569 17, 686 67. 00 06701 0CCUPATI ONAL THERAPY LIVING CENTER 1, 019 1, 154, 219 0. 000883 0 0 67. 10 68. 00 06800 SPEECH PATHOLOGY 20, 479 4, 355, 272 0. 004702 325, 614 1, 531 68. 00 688 10 06801 SPEECH THERAPY LIVING CENTER 684 951, 207 0. 000719 0 0 68. 10 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0. 000000 0 0 0 0. 000000 0 0 0 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 725, 710 129, 727, 953 0. 005594 94, 664 530 71. 00 72. 00 07300 DRUGS CHARGED TO PATIENTS 560, 602 170, 402, 239 0. 003290 11, 440 38 72. 00 07300 DRUGS CHARGED TO PATIENTS 506, 090 246, 484, 551 0. 002053 596, 767 1, 225 73. 00 07300 DRUGS CHARGED TO PATIENTS 506, 090 246, 484, 551 0. 002053 596, 767 1, 225 73. 00 07400 DYPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0 0 0. 000000 0 0 0 90. 10 90. 10 90. 30 09002 HEMATOLOGY ONCOLOGY CLI NI C 0 0 0. 000000 0 0 0 90. 30 90. 30 09002 HEMATOLOGY ONCOLOGY CLI NI C 0 0 0. 000000 0 0 0 90. 30 90. 30 09002 HEMATOLOGY ONCOLOGY CLI NI C 14, 443, 509 56, 382, 343 0. 025602 0 0 99. 30 99. 20 09200 DSSERVATI ON BEDS (NON-DISTINCT PART) 0 34, 980, 979 0. 000000 0 0 0 92. 00								
66. 10								
67. 00						ľ		
67. 10								
68. 00								
68. 10								
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 725, 710 129, 727, 953 0 005594 94, 664 530 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 560, 602 170, 402, 239 0 003290 11, 440 38 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 506, 090 246, 484, 551 0 002053 596, 767 1, 225 73. 00 76. 00 03020 CARDI OLOGY 149, 790 15, 847, 504 0 0 0 009452 3, 249 31 76. 00 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 0 0 90. 10 09001 FAMI LY PRACTI CE CLI NI C 0 0 0 0 0 90. 30 09002 HEMATOLOGY ONCOLOGY CLI NI C 383, 663 955, 448 0 401553 0 0 90. 30 90. 50 09004 SLEEP DI SORDERS CLI NI C 118, 442 4, 265, 617 0 0 0 0 91. 00 09100 EMERGENCY 1, 443, 509 56, 382, 343 0 025602 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 34, 980, 979 0 0000000 0 0 92. 00 00 0.000000 0 0 0 0 0 0 01 0.000000 0 0 0 0 02 0.0000000 0 0 0 03 0, 0000000 0 0 0 04 0, 0000000 0 0 05 0, 0000000 0 0 06 0, 0000000 0 07 0, 0000000 0 08 0, 0000000 0 09 0, 00000000 0 09 0, 000000000 0 09 0, 0000000000 0 09 0, 00000000000000000000000000000000						1, 531		
71. 00								
72. 00		1						
73. 00 07300 DRUGS CHARGED TO PATIENTS 506, 090 244, 484, 551 0.002053 596, 767 1, 225 73. 00 76. 00 03020 CARDI OLOGY 149, 790 15, 847, 504 0.009452 3, 249 31 76. 00 000 0000 CLI NI C 0 0.000000 0 0 0.000000 90. 10 09001 FAMI LY PRACTI CE CLI NI C 0 0.000000 0 0 90. 10 90. 30 09002 HEMATOLOGY ONCOLOGY CLI NI C 383, 663 955, 448 0.000000 90. 50 09004 SLEEP DI SORDERS CLI NI C 118, 442 4, 265, 617 0.000000 91. 00 09100 EMERGENCY 1, 443, 509 56, 382, 343 0.025602 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 34, 980, 979 0.000000 0 0.000000 0 92. 00 93. 00 00000000000000000000000000000000						•		
76. 00 03020 CARDI OLOGY 149, 790 15, 847, 504 0.009452 3, 249 31 76. 00 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0.000000 0 0 90. 00 90. 10 90								
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE CLINIC OUTPATIENT SERVICE COST COUTPATIENT SERVICE COST COUTPATIENT OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST COUTPATIENT OUTPATIENT SERVICE COUTPATIENT OUTPATIENT SERVICE COST COUTPATIENT OUTPATIENT SERVICE COUTPATIENT OUTPATIENT SERVICE COST COUTPATIENT OUTPATIENT SERVICE COUTPATIENT OUTPATIENT OUTPATIENT SERVICE COUTPATIENT OUTPATIENT SERVICE								
90. 00 09000 CLINIC 0 0.000000 0 0.000000 0 90. 00 90. 00 90. 10 90. 10 90. 30 90. 20 15 10 10 10 10 10 10 1		149, 790	15, 847, 504	0. 00945	2 3, 249	31	76. 00	
90. 10 09001 FAMILY PRACTICE CLINIC 0 0.000000 0 90. 10 90. 30 90. 30 90. 50 90. 4 EMBATOLOGY ONCOLOGY CLINIC 383, 663 955, 448 0.401553 0 90. 30 90. 50 91. 00 91. 00 91. 00 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 34, 980, 979 0.000000 0 92. 00 92. 00 09200		_						
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC 383, 663 955, 448 0. 401553 0 0 90. 30 90. 50 91. 00 09100 EMERGENCY 1, 443, 509 56, 382, 343 0. 025602 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 34, 980, 979 0. 000000 0 92. 00 92. 00 09200 09								
90. 50 09004 SLEEP DI SORDERS CLINI C 118, 442 4, 265, 617 0. 027767 0 0 90. 50 91. 00 09100 EMERGENCY 1, 443, 509 56, 382, 343 0. 025602 0 91. 00 92. 00 09200 09SERVATI ON BEDS (NON-DI STINCT PART) 0 34, 980, 979 0. 000000 0 92. 00 92. 00 09200 09						0		
91. 00 09100 EMERGENCY								
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 34, 980, 979 0.000000 0 92. 00						0		
		1, 443, 509				0		
200.00 Total (lines 50 through 199) 14,105,629 1,237,962,583 2,558,272 45,866 200.00		1						
	200.00 Total (lines 50 through 199)	14, 105, 629	1, 237, 962, 583		2, 558, 272	45, 866	200.00	

Health Financial Systems	MEMORIAL HOSPITA	L OF SOUTH BEND), 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 01/01/2018	Worksheet D Part IV
Timodell' eeers		Componen	t CCN: 15-T058	To 12/31/2018	Date/Time Prepared: 5/29/2019 8:36 am
		Tit	tle XVIII	Subprovi der -	PPS

		Title	xVIII	Subprovi der -	PPS	
	N 51	N : 6 1 1	h	IRF		
Cost Center Description			Nursing School	Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	1.00	Adjustments 2A	2.00	Adjustments 3A	3. 00	
ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	SA	3.00	
50, 00 05000 OPERATING ROOM	٥	0	1	0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	٥	0]		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	ام	0		0	0	54.00
57. 00 05700 CT SCAN	ol ol	0	l o	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	ol	0	i d	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	ol	0	o d	0	0	59. 00
60. 00 06000 LABORATORY	o	0	d	0	0	60.00
60. 01 06001 BLOOD LABORATORY	o	0	d c	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	o	0	o c	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	o	0	o c	0	0	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	o	0	o c	0	0	66. 01
66. 10 06601 PHYSI CAL 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
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) 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	<u>C</u>	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS	T		ı			
90. 00 09000 CLI NI C	0	0	C	0	0	70.00
90. 10 09001 FAMILY PRACTICE CLINIC	0	0	Q C	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	510, 388	1
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	_]	510, 200	92.00
200.00 Total (lines 50 through 199)	[0	ıl C	0	510, 388	J200. 00

		RIAL HOSPITAL C				eu of Form CMS-2	<u> 2552-10</u>
APPORTI THROUGH	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF I COSTS	RVICE OTHER PAS:			Peri od: From 01/01/2018		
			Component	CCN: 15-T058	To 12/31/2018	Date/Time Pre 5/29/2019 8:3	
			Ti tl e	XVIII	Subprovi der -	PPS	
	Cost Contar Decement on	All Othor	Total Cost	Total	I RF	Doti o of Coot	
	Cost Center Description	All Other Medical	(sum of cols.	Outpatient	(from Wkst. C,	Ratio of Cost to Charges	
		Education Cost	`	Cost (sum of		(col. 5 ÷ col.	
		Luucati on cost	1, 2, 3, and 4)	col s. 2, 3,	8)	7)	
			")	and 4)	0)	,,	
		4.00	5.00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	<u> </u>	•	•	•		
50. 00	05000 OPERATING ROOM	0	C		0 119, 449, 771	0.000000	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	o c	1	0 19, 695, 500	0.000000	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	O)	0 124, 302, 346	0.000000	54. 00
57.00	05700 CT SCAN	0	0)	0 69, 417, 879	0.000000	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0 5, 317, 889		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0)	0 28, 756, 318		59. 00
	06000 LABORATORY	0	0)	0 137, 154, 784	0.000000	
	06001 BLOOD LABORATORY	0	0)	0	0.000000	
	06500 RESPI RATORY THERAPY	0	0)	0 42, 713, 077		1
	06600 PHYSI CAL THERAPY	0	0)	0 12, 904, 633		1
	06602 PHYSI CAL THERAPY EAST BANK	0	0		0 4, 030, 393		
	06601 PHYSICAL THERAPY LIVING CENTER	0	0	1	0 1, 635, 307		
	06700 OCCUPATI ONAL THERAPY	0	0	1	0 7, 077, 354	l .	
	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	1	0 1, 154, 219		
	06800 SPEECH PATHOLOGY	0		1	0 4, 355, 272		
	06801 SPEECH THERAPY LIVING CENTER	0		1	0 951, 207		1
	07000 ELECTROENCEPHALOGRAPHY	0			0 100 707 050	0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 129, 727, 953 0 170, 402, 239		1
	07200 TMPL. DEV. CHARGED TO PATTENTS 07300 DRUGS CHARGED TO PATTENTS	0			0 170, 402, 239 0 246, 484, 551		1
	03020 CARDI OLOGY		ļ	1	0 15, 847, 504		
	OUTPATIENT SERVICE COST CENTERS			1	0 15, 647, 504	0.000000	70.00
	09000 CLINIC	T 0	O		0 0	0.000000	90.00
	09001 FAMILY PRACTICE CLINIC	0			0 0		
	09002 HEMATOLOGY ONCOLOGY CLINIC	0			0 955, 448		1
	09004 SLEEP DISORDERS CLINIC	0	l o	,	0 4, 265, 617		1
	09100 EMERGENCY	0	510, 388	510, 38			1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 34, 980, 979		
200.00	Total (lines 50 through 199)	0	510, 388	510, 38	88 1, 237, 962, 583		200.00
	· · · · · · · · · · · · · · · · · · ·		•	•	•		-

Heal th Fi	inancial Systems MEMO	RIAL HOSPITAL OF	SOUTH BEND,	I NC	In Li€	eu of Form CMS-2	<u> 2552-10</u>
APPORTI OI	NMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der Co	CN: 15-0058	Peri od:	Worksheet D	
THROUGH (COSTS		Component (CCN: 15-T058	From 01/01/2018 To 12/31/2018		
			Title	XVIII	Subprovi der -	PPS	
					I RF		
	Cost Center Description	Outpati ent	Inpati 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.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13.00	
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	0. 000000	3, 283		0	_	
	5200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	0. 000000	94, 774		0 0	0	54.00
57. 00 05	5700 CT SCAN	0. 000000	33, 839		0 0	0	57. 00
58. 00 05	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	10, 622		0 0	0	58. 00
59.00 05	5900 CARDIAC CATHETERIZATION	0. 000000	0		0 0	0	59. 00
60.00 06	6000 LABORATORY	0. 000000	192, 559		0	0	60.00
60. 01 06	6001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
65. 00 06	5500 RESPIRATORY THERAPY	0. 000000	160, 787		0 0	0	65. 00
66.00 06	6600 PHYSI CAL THERAPY	0. 000000	527, 105		0 0	0	66. 00
66. 01 06	6602 PHYSICAL THERAPY EAST BANK	0. 000000	0	i	0 0	0	66. 01
66. 10 06	6601 PHYSICAL THERAPY LIVING CENTER	0. 000000	0		0 0	0	66. 10
67. 00 06	5700 OCCUPATIONAL THERAPY	0. 000000	503, 569		0 0	0	67. 00
67. 10 06	5701 OCCUPATIONAL THERAPY LIVING CENTER	0. 000000	0		0 0	0	67. 10
	SPEECH PATHOLOGY	0. 000000	325, 614		0 0	0	68. 00
	5801 SPEECH THERAPY LIVING CENTER	0. 000000	0		0 0	0	
70.00 07	7000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71. 00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	94, 664		0 0	0	71. 00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	11, 440		0 0	0	72. 00
	7300 DRUGS CHARGED TO PATIENTS	0. 000000	596, 767		0 0	0	73. 00
	3020 CARDI OLOGY	0. 000000	3, 249		0	0	76. 00
	JTPATIENT SERVICE COST CENTERS						
	9000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 10 09	9001 FAMILY PRACTICE CLINIC	0. 000000	0		0 0	0	90. 10
	9002 HEMATOLOGY ONCOLOGY CLINIC	0. 000000	0		0 0	0	1
	9004 SLEEP DISORDERS CLINIC	0. 000000	0		0	Ō	1
	9100 EMERGENCY	0. 009052	0		0	0	
4	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	o o	1
200.00	Total (lines 50 through 199)		2, 558, 272			_	200. 00
	,	1	-,,	1	-1	'	

Health Financial Systems MEMO	RIAL HOSPITAL O	F SOUTH BEND,	I NC	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co	CN: 15-0058	Peri od: Worksheet From 01/01/2018 Part I To 12/31/2018 Date/Time		
			10 12/31/20			pared: 6 am
		Ti tl	e XIX	Hospi tal		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cos			
	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	10, 633, 452					
31.00 INTENSIVE CARE UNIT	1, 329, 024		1, 329, 0			
31.01 NEONATAL INTENSIVE CARE UNIT	1, 165, 826		1, 165, 8			31. 01
40. 00 SUBPROVI DER - I PF	570, 167	0	570, 10	3, 090	184. 52	40. 00
41. 00 SUBPROVI DER - I RF	507, 255	0	507, 2	55 2, 907	174. 49	
43. 00 NURSERY	194, 109		194, 10	09 4, 201	46. 21	43. 00
200.00 Total (lines 30 through 199)	14, 399, 833		14, 399, 8	33 112, 208		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 501	317, 052				30. 00
31.00 INTENSIVE CARE UNIT	0	-				31.00
31.01 NEONATAL INTENSIVE CARE UNIT	338					31. 01
40. 00 SUBPROVI DER - I PF	65					40. 00
41. 00 SUBPROVI DER - I RF	11					41. 00
43. 00 NURSERY	161	7, 440				43. 00
200.00 Total (lines 30 through 199)	3, 076	382, 585				200. 00

Health Financial Systems ME	MORIAL HOSPITAL C	OF SOUTH BEND,	INC	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provider C		Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 8:3	pared: 6 am
			e XIX	Hospi tal	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)	0.00	0.00	4.00	F 00	
ANOLLI ADV. CEDVILOE, COCT. CENTERC	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	4.4// 04/	440 440 774	0.0040	70 40 000 004	/00 404	
50. 00 O5000 OPERATI NG ROOM	4, 166, 316					
52. 00 05200 DELI VERY ROOM & LABOR ROOM	1, 412, 088		1			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 266, 056					
57. 00 05700 CT SCAN	109, 228					
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	159, 081		1			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	578, 661		1			
60. 00 06000 LABORATORY	452, 210				1	
60. 01 06001 BLOOD LABORATORY	0	_	0.0000		0	60. 01
65. 00 06500 RESPIRATORY THERAPY	286, 306				74, 721	65.00
66. 00 06600 PHYSI CAL THERAPY	511, 628		1			
66. 01 06602 PHYSI CAL THERAPY EAST BANK	3, 972				1	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	1, 530				0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	248, 565		1			
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	1, 019					67. 10
68. 00 06800 SPEECH PATHOLOGY	20, 479				1	
68. 10 06801 SPEECH THERAPY LIVING CENTER	684				0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	_	0.0000		0	70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	725, 710					
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	560, 602				0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	506, 090					
76. 00 03020 CARDI OLOGY	149, 790	15, 847, 504	0. 00945	1, 187, 310	11, 222	76. 00
OUTPATIENT SERVICE COST CENTERS		ı	1			
90. 00 09000 CLI NI C	0	0			0	
90. 10 09001 FAMILY PRACTICE CLINIC	0		0.0000		0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	383, 663		1			
90. 50 09004 SLEEP DI SORDERS CLINIC	118, 442				0	90. 50
91. 00 09100 EMERGENCY	1, 443, 509				1	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 333, 070		1		0	
200.00 Total (lines 50 through 199)	15, 438, 699	1, 237, 962, 583	1	108, 872, 916	2, 012, 130	J200. 00

Health Financial Systems MEM APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER I	ORIAL HOSPITAL C PASS THROUGH COS		CN: 15-0058 F	In Lie Period: From 01/01/2018 To 12/31/2018		pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdown		Medi cal	
	Adjustments		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	0	30.00
31. 00 03100 NTENSI VE CARE UNIT	0			0	0	31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT					0	31. 01
40. 00 04000 SUBPROVI DER - PF		íl ő			Ő	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)						200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Dotiont	Per Diem (col.	Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.		5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Days	3 - (01. 6)	Program bays	
	instructions)					
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS		\	83, 883	0.00	2, 501	30.00
	0)				
31. 00 03100 INTENSIVE CARE UNIT			9, 208			31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT			8, 919			31. 01
40. 00 04000 SUBPROVI DER - I PF	0		3, 090			40. 00
41. 00 04100 SUBPROVI DER - I RF	0) 0	2, 907			41.00
43. 00 04300 NURSERY		0	4, 201			
200.00 Total (lines 30 through 199)		0	112, 208	3	3, 076	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
INDATIENT DOUTINE SERVICE COST CENTERS	9. 00					

30. 00 31. 00 31. 01

40. 00 41. 00 43.00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 02060 REONATAL INTENSIVE CARE UNIT

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

						5/29/2019 8: 30	5 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician			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	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)	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 RESPIRATORY 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	0)	0	0	66. 10
67.00	06700 OCCUPATI ONAL THERAPY	o	0)	0	0	67.00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	o	0)	0	0	67. 10
68. 00	06800 SPEECH PATHOLOGY	o	0)	0	0	68.00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0	0	,	0	o	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0)	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	,	0	o	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	,	0	o	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				-		
90.00		0	O		0 0	0	90.00
90. 10	09001 FAMILY PRACTICE CLINIC	0	0	,	0	0	90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	O	0)	0	0	90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	O	0)	0	0	90. 50
91.00	09100 EMERGENCY	O	0)	0	510, 388	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	ol			o	0	92.00
200.00		o	0		0	510, 388	
				•	•		

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 8:36 am
 Heal th Financial
 Systems
 MEMORIAL HOSPITAL OF STANDARD OF THE PASS
 MEMORIAL HOSPITAL OF SOUTH BEND, INC Provider CCN: 15-0058 THROUGH COSTS

					5/29/2019 8: 3	6 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	(119, 449, 771		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(19, 695, 500		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(124, 302, 346		
57. 00 05700 CT SCAN	0	0	(69, 417, 879	0.000000	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	(5, 317, 889		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(28, 756, 318	0.000000	59. 00
60. 00 06000 LABORATORY	0	0	(137, 154, 784	0.000000	60. 00
60. 01 06001 BLOOD LABORATORY	0	0	(0	0.000000	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0	(42, 713, 077		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(12, 904, 633	0.000000	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0	0	(4, 030, 393	0.000000	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	(1, 635, 307	0.000000	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(7, 077, 354	0.000000	67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	(1, 154, 219	0.000000	67. 10
68.00 06800 SPEECH PATHOLOGY	0	0		4, 355, 272	0.000000	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0	0	(951, 207	0.000000	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(129, 727, 953	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	0		170, 402, 239	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(246, 484, 551	0.000000	73. 00
76. 00 03020 CARDI OLOGY	O	0		15, 847, 504	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		0	0.000000	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	o	0		955, 448	0.000000	90. 30
90. 50 09004 SLEEP DISORDERS CLINIC	o	0		4, 265, 617	0.000000	90. 50
91. 00 09100 EMERGENCY	o	510, 388	510, 388	56, 382, 343	0.009052	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		34, 980, 979	0.000000	92. 00
200.00 Total (lines 50 through 199)	o	510, 388	510, 388	1, 237, 962, 583		200. 00
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0058 Peri od: Worksheet D From 01/01/2018 THROUGH COSTS Part IV 12/31/2018 Date/Time Prepared: 5/29/2019 8:36 am Title XIX Hospi tal PPS Outpati ent Outpati ent Cost Center Description Inpatient I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col. (col. 6 ÷ col Costs (col. 8 x col . 12) 13.00 7) x col. 10) 11.00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 19, 880, 836 0 0 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 9, 945, 694 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 7, 923, 242 0 54.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05700 CT SCAN 0.000000 4, 121, 914 0 57.00 57.00 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 835, 083 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0.000000 1, 881, 745 0 59.00 60.00 06000 LABORATORY 0.000000 20, 706, 816 0 0 60.00 0 06001 BLOOD LABORATORY 0.000000 60.01 60 01 0 0 06500 RESPIRATORY THERAPY 11, 147, 461 65.00 0.000000 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 931, 446 0 66.00 0 66.01 06602 PHYSICAL THERAPY EAST BANK 0.000000 679 0 66.01 0 06601 PHYSICAL THERAPY LIVING CENTER 0.000000 0 66.10 66 10 67.00 06700 OCCUPATIONAL THERAPY 0.000000 690,072 0 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 0.000000 0 67.10 499 0 67.10 0 06800 SPEECH PATHOLOGY 68 00 0.000000 308, 518 0 68 00 0 68.10 06801 SPEECH THERAPY LIVING CENTER 0.000000 0 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 C 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 343, 946 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72 00 0.000000 Ω 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 24, 404, 432 0 73.00 03020 CARDI OLOGY 0.000000 1, 187, 310 0 0 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0.000000 0 0 0 90.00 09001 FAMILY PRACTICE CLINIC 0 90. 10 0.000000 0 0 0 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 0.000000 0 0 90.30 16, 448 09004 SLEEP DISORDERS CLINIC 0.000000 90. 50 90. 50 0 0

0.009052

0.000000

4, 546, 775

108, 872, 916

41, 157

41, 157

91.00

0 200. 00

0

0 92.00

0

91. 00 09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

92.00

Health Financial Systems MEMOD	RIAL HOSPITAL C	OF SOUTH BEND,	I NC	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0058	Peri od:	Worksheet D	
		Component	CCN: 15-S058	From 01/01/2018 To 12/31/2018		pared: 6 am
		Ti tI	e XIX	Subprovi der -	PPS	
				. I PF		
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)					
ANOLLI ADV. CEDVI OF COCT. CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	4 1// 21/	110 440 771	0.00403	22.050	025	F0 00
50. 00 05000 OPERATI NG ROOM	4, 166, 316				835	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 412, 088				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 266, 056					54.00
57. 00 05700 CT SCAN	109, 228				l e	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	159, 081				0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	578, 661				0	
60. 00 06000 LABORATORY	452, 210				l e	1
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	_	0.00000		0 36	60. 01 65. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	286, 306					
66. 01 06600 PHYSI CAL THERAPY EAST BANK	511, 628 3, 972				1, 468 0	1
	1, 530		1		0	
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER 67. 00 06700 OCCUPATI ONAL THERAPY	248, 565				895	66. 10 67. 00
67. 10 06700 OCCUPATIONAL THERAPY LIVING CENTER	1, 019		1		0 0	
68. 00 06800 SPEECH PATHOLOGY	20, 479		1		0	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	684				0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	004		1		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	725, 710				0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	560, 602				0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	506, 090					1
76. 00 03020 CARDI OLOGY	149, 790				0	
OUTPATIENT SERVICE COST CENTERS	147,770	13,047,304	0.00743	2		70.00
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC	0	_	1		1	
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	383, 663	_			Ö	
90. 50 09004 SLEEP DI SORDERS CLINIC	118, 442				o o	1
91. 00 09100 EMERGENCY	1, 443, 509		1		332	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0.002	1
200.00 Total (lines 50 through 199)	-	1, 237, 962, 583		373, 528	1	200. 00
	1		1	1 2:27 020	., 200	, ,

Health Financial Systems	MEMORI AL	HOSPI TAL OF	SOUTH BEND	, INC			In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE	OTHER PASS	Provi der	CCN: 1		Peri od:		Worksheet D
THROUGH COSTS			Componen	t CCN:		From 01/ To 12/		Date/Time Prepared:
								5/29/2019 8:36 am
			Ti	tla VI	Υ	Subprov	ıi der -	DDS

		Ti tI	e XIX	Subprovider -	PPS	
Cook Cooks Doors at a	Nama Dharai ai an	N: C-11	Ni	I PF	All:! !!! +!-	
Cost Center Description	Anesthetist			Allied Health	Allied Health	
	Cost	Post-Stepdown		Post-Stepdown		
	1.00	Adjustments 2A	2.00	Adjustments 3A	3. 00	
ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	JA.	3.00	
50. 00 05000 OPERATI NG ROOM	1			0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM					0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0				,	54.00
57. 00 05700 CT SCAN	0				,	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0				0	59.00
60. 00 06000 LABORATORY	0			0	0	60.00
60. 01 06001 BLOOD LABORATORY	0			o o	Ō	60. 01
65. 00 06500 RESPIRATORY THERAPY	0			o	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	O		0	0	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0	l c		0	0	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	0	0) (o	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0	0) (o	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						
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	510, 388	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	_))	0	92. 00
200.00 Total (lines 50 through 199)) 0] 0)J () O	510, 388	J200. 00

Health Financial Systems MEM	ORIAL HOSPITAL O	F SOUTH BEND	LNC	In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S				Peri od:	Worksheet D	2002 10
THROUGH COSTS		Component	CCN: 15-S058	From 01/01/2018 To 12/31/2018	Part IV Date/Time Pre 5/29/2019 8:3	pared: 6 am
		Ti tl	e XIX	Subprovi der -	PPS	
C+ C+ D	ALL OH	T-+-1 C+	T-4-1	I PF	D-+:6 C+	
Cost Center Description	All Other Medical	Total Cost (sum of cols.	Total Outpatient	(from Wkst. C,	Ratio of Cost to Charges	
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
	Education Cost	1, 2, 3, and 4)	col s. 2, 3,	8)	7)	
		4)	and 4)	0)	')	
	4. 00	5.00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	0	0		0 119, 449, 771	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 19, 695, 500		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 124, 302, 346	0. 000000	
57. 00 05700 CT SCAN	0	l o		0 69, 417, 879	0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	l c		0 5, 317, 889	0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	l c		0 28, 756, 318	0.000000	59. 00
60. 00 06000 LABORATORY	0	0		0 137, 154, 784	0.000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0.000000	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	0		0 42, 713, 077	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 12, 904, 633	0. 000000	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0	0)	0 4, 030, 393	0.000000	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	0	0)	0 1, 635, 307	0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0)	0 7, 077, 354		
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0)	0 1, 154, 219		
68. 00 06800 SPEECH PATHOLOGY	0	0		0 4, 355, 272	0. 000000	
68. 10 06801 SPEECH THERAPY LIVING CENTER	0	0)	0 951, 207	0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0)	0	0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0 129, 727, 953	0. 000000	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0)	0 170, 402, 239		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1		0 246, 484, 551	0.000000	
76. 00 03020 CARDI OLOGY	0	0)	0 15, 847, 504	0. 000000	76. 00
OUTPATIENT SERVICE COST CENTERS					0.000000	00 00
90. 00 09000 CLINIC	0	1		0 0	0.000000	
90. 10 09001 FAMILY PRACTICE CLINIC 90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0		0 955, 448	0. 000000 0. 000000	
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC 90. 50 09004 SLEEP DI SORDERS CLINIC	0			0 4, 265, 617		
91. 00 09100 EMERGENCY	0	510, 388	510, 38			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1	310, 38	0 34, 980, 979		
200.00 Total (lines 50 through 199)		1	510.39	34, 960, 979		200.00
200.00 10tal (111163 30 till ough 177)	1	1 310, 300	η 510, 3C	1, 231, 702, 303	I	1200.00

Heal th	Financial Systems MEMO	RIAL HOSPITAL OF	SOUTH BEND,	I NC	In Lie	eu of Form CMS-	<u>2552-10</u>
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der Co	CN: 15-0058	Peri od:	Worksheet D	
THROUG	H COSTS		Component	CCN: 15-S058	From 01/01/2018 To 12/31/2018		epared: 86 am
			Ti tl	e XIX	Subprovi der -	PPS	
					I PF		
	Cost Center Description	Outpati ent	Inpati 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.	8	Costs (col. 9	
		7)		x col. 10)		x col . 12)	
	ANOLULARY OFRICAS COOT OFFITERS	9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS		00.050	1			
50. 00	05000 OPERATI NG ROOM	0. 000000	23, 950		0 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	3, 696		0 0	0	
57. 00	05700 CT SCAN	0. 000000	2, 068	•	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	
60.00	06000 LABORATORY	0. 000000	72, 750		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0. 000000	5, 425		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	37, 027	1	0 0	0	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0. 000000	0		0	0	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0. 000000	0		0	0	66. 10
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	25, 497		0	0	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0. 000000	0		0	0	67. 10
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	
68. 10	06801 SPEECH THERAPY LIVING CENTER	0. 000000	0		0	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	190, 138		0	0	73. 00
76. 00	03020 CARDI OLOGY	0. 000000	0		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0	0	
90. 10	09001 FAMILY PRACTICE CLINIC	0. 000000	0		0	0	
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	0. 000000	0		0	0	1
90. 50	09004 SLEEP DI SORDERS CLINIC	0. 000000	0		0	0	90. 50
91. 00	09100 EMERGENCY	0. 009052	12, 977	1	17 0	0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	
200.00	Total (lines 50 through 199)		373, 528	1	17 0	0	200.00

Health Financial Systems MEMO	RIAL HOSPITAL O	OF SOUTH BEND,	I NC	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der Co	CN: 15-0058	Peri od:	Worksheet D	
		Component		From 01/01/2018 To 12/31/2018		pared: 6 am
		Ti tl	e XIX	Subprovi der -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 O5000 OPERATING ROOM	4, 166, 316	119, 449, 771	0. 03487	9 1, 029	36	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 412, 088			•	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 266, 056				469	
57. 00 05700 CT SCAN	109, 228				14	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	159, 081				176	
59. 00 05900 CARDI AC CATHETERI ZATI ON	578, 661				0	
60. 00 06000 LABORATORY	452, 210				174	1
60. 01 06001 BLOOD LABORATORY	0		0.00000		0	60. 01
65. 00 06500 RESPIRATORY THERAPY	286, 306	42, 713, 077			79	65. 00
66. 00 06600 PHYSI CAL THERAPY	511, 628	12, 904, 633	0. 03964	7 162, 962	6, 461	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	3, 972	4, 030, 393	0.00098	6 0	0	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	1, 530	1, 635, 307	0.00093	6 0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	248, 565	7, 077, 354	0. 03512	1 151, 313	5, 314	67. 00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	1, 019	1, 154, 219	0. 00088	3 0	0	67. 10
68. 00 06800 SPEECH PATHOLOGY	20, 479	4, 355, 272	0.00470	2 106, 539	501	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	684	951, 207			0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	_	0.0000		0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	725, 710				325	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	560, 602				0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	506, 090		1		412	
76. 00 03020 CARDI OLOGY	149, 790	15, 847, 504	0. 00945	2 496	5	76. 00
OUTPATIENT SERVICE COST CENTERS	_	_	1		_	
90. 00 09000 CLI NI C	0					
90. 10 09001 FAMILY PRACTICE CLINIC	0	·			0	
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	383, 663				0	90. 30
90. 50 09004 SLEEP DISORDERS CLINIC	118, 442				0	90. 50
91. 00 09100 EMERGENCY	1, 443, 509					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (lines 50 through 199)	14 105 620	34, 980, 979 1, 237, 962, 583	1	787, 738	12 007	92. 00 200. 00
200.00 Total (Titles 30 tillough 199)	14, 100, 629	1,237,702,383	T .	101,138	13, 997	J200. 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		CCN: 15-0058	Peri od: From 01/01/2018	
		Componen	T CCN: 15-1058	10 12/31/2018	Date/Time Prepared: 5/29/2019 8:36 am
		Ti	tle XIX	Subprovi der -	PPS

			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 Siring Scribbi	Post-Stepdown	Airred near til	
		Cost	Adjustments		Adjustments		
		1.00	2A	2, 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0	C	0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
57. 00	05700 CT SCAN	0	0	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
	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 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
	07300 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						
	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	01	90. 30
	09004 SLEEP DISORDERS CLINIC	0	0	C	0	0	90. 50
	09100 EMERGENCY	0	0	0	0	510, 388	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92. 00
200.00	Total (lines 50 through 199)	0	0	(C	0	510, 388	200. 00

Heal th	Financial Systems MEMO	RIAL HOSPITAL O	F SOUTH BEND,	I NC	In Lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C	CN: 15-0058	Peri od:	Worksheet D	
THROUG	H COSTS		Component	CCN: 15-T058	From 01/01/2018 To 12/31/2018	Part IV Date/Time Prep 5/29/2019 8:30	pared: 6 am
			Ti tl	e XIX	Subprovi der -	PPS	
					I RF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum o	f Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	_		0 119, 449, 771		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 19, 695, 500	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 124, 302, 346		
57.00	05700 CT SCAN	0	0		0 69, 417, 879	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0 5, 317, 889		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0 28, 756, 318		59. 00
60.00	06000 LABORATORY	0	0	1	0 137, 154, 784	0.000000	
60. 01	06001 BLOOD LABORATORY	0	0)	0 0	0.000000	
65.00	06500 RESPI RATORY THERAPY	0	0		0 42, 713, 077	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 12, 904, 633	0.000000	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	0		0 4, 030, 393	0.000000	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	1	0 1, 635, 307	0.000000	66. 10
67.00	06700 OCCUPATI ONAL THERAPY	0	0	1	0 7, 077, 354	0.000000	
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	1	0 1, 154, 219		
68.00	06800 SPEECH PATHOLOGY	0	0)	0 4, 355, 272	0.000000	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0	0	1	0 951, 207		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0)	0 0	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0 129, 727, 953	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0 170, 402, 239		
73.00	07300 DRUGS CHARGED TO PATIENTS	0		1	0 246, 484, 551		
76.00	03020 CARDI OLOGY	0	0		0 15, 847, 504	0.000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	1	0	0.000000	
90. 10	09001 FAMILY PRACTICE CLINIC	0	0)	0	0.000000	
	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	1	0 955, 448		
90. 50	09004 SLEEP DISORDERS CLINIC	0	0	1	0 4, 265, 617	0.000000	90. 50
91. 00	09100 EMERGENCY	0	510, 388	510, 38			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-	1	0 34, 980, 979		
200.00	Total (lines 50 through 199)	0	510, 388	510, 3	38 1, 237, 962, 583		200. 00

Health Financial Systems ME	MORIAL HOSPITAL OF	SOUTH BEND,	I NC	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S		Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-T058	From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Subprovi der -	PPS	
				I RF		
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	1, 029		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	25, 747		0 0	0	54.00
57. 00 05700 CT SCAN	0. 000000	9, 207		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	5, 884		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	52, 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	11, 846		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	162, 962		0 0	0	66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0. 000000	0		0 0	0	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	0. 000000	0		o o	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	151, 313		o o	0	67.00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0. 000000	0		o o	0	67. 10
68. 00 06800 SPEECH PATHOLOGY	0. 000000	106, 539		o o	0	68.00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0. 000000	0		o o	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	58, 156		o o	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	200, 526		0 0	0	73. 00
76. 00 03020 CARDI OLOGY	0. 000000	496		0 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS	2, 22222		<u> </u>	-1		
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC	0. 000000	0	•	o o		
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	0. 000000	0		0 0	0	90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	0. 000000	0		o o	0	90. 50
91. 00 09100 EMERGENCY	0. 009052	1, 230		1 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 230		o o	0	
200.00 Total (lines 50 through 199)	3. 333000	787, 738		1 0	1	200. 00
	1	, , , , ,	'	1 9	,	, ,

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: 15-0058	Peri od: From 01/01/2018	Worksheet D-1	
			Date/Time Pre 5/29/2019 8:3	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

		T: 11 20/11		5/29/2019 8: 3	6 am
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	cost center bescription			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			83, 883	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day	<i>3</i> ,	vata room dave	83, 883 65, 478	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only pri	vate room days,	05, 478	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		7, 889	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	om days) through Decembe	31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private room	om days) after December 3	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 roor	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	adys) through becomber	or or the cost	· ·	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	23, 916	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Join days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, er				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	Conly (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	Conty (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye			_	
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period	through Docombon 21 of	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			93, 067, 817	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	⁻ 31 of the cost reporti	ng period (line	0	24. 00
25. 00	X Time 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or the cost ropertring	po ou (o	Ü	20.00
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)		93, 067, 817	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Congral inpatient routing service charges (eveluding swing box	d and observation had ch	argos)	185, 120, 476	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed cha	i ges)	161, 657, 819	
30. 00	Semi-private room charges (excluding swing-bed charges)			23, 462, 657	
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 502742	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)			2, 468. 89	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			2, 974. 10	
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 line Reivate room cost differential ediustment (line 3 x line 35)	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 a	and private room cost di	fferential (line	0 93, 067, 817	36. 00 37. 00
57.00	27 minus line 36)	and private room cost ur	Si Sinti di Ci i le	75, 557, 517	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 109. 50	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line			26, 534, 802 0	39. 00 40. 00
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		26, 534, 802	
11.00	1.52a Sgram general impactions routine service cost (Title 37		ı	20, 004, 002	1 00

Heal th	Financial Systems MEMOR	RIAL HOSPITAL (OF SOUTH BEND,	INC	In Lie	eu of Form CMS-	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
					From 01/01/2018 To 12/31/2018		
			Title	xVIII	Hospi tal	PPS	o alli
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	·	Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4.00	4) 5. 00	
42 00	NURSERY (title V & XIX only)	1.00	2.00		4.00		42. 00
42.00	Intensive Care Type Inpatient Hospital Units		,	0.0	5		42.00
43.00	INTENSIVE CARE UNIT	16, 055, 706	9, 208	1, 743. 6	7 2, 261	3, 942, 438	43. 00
43. 01	NEONATAL INTENSIVE CARE UNIT	12, 338, 402	8, 919	1, 383. 3	0	0	
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
47.00	Cost Center Description						47.00
						1. 00	
48. 00	Program inpatient ancillary service cost (Wks					42, 762, 128	
49. 00	Total Program inpatient costs (sum of lines	41 through 48)	(see instructio	ns)		73, 239, 368	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	ationt routino	sorvices (from	Wkst D sum	of Darte L and	3, 358, 161	50.00
50.00	Pass through costs applicable to Program The	acrone routine	SCIVICES (IIOII	I MINGE. D, SUIII	or runts I allu	3, 330, 101	30.00
51.00	Pass through costs applicable to Program inpa	atient ancilla	ry services (fr	om Wkst. D, su	um of Parts II	1, 996, 049	51.00
	and IV)						
52.00	Total Program excludable cost (sum of lines!		-1-41		4:-4	5, 354, 210	1
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		erated, non-pny	sician anestne	etist, and	67, 885, 158	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)				>	0	
57. 00	Difference between adjusted inpatient operati	ing cost and to	arget amount (I	ine 56 minus I	ine 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period	ending 1996 u	indated and cor	mounded by the	-	
37.00	market basket	por tring period	charing 1770, c	ipaatea ana eo	iipodriaca by the	0.00	37.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	
61. 00	If line 53/54 is less than the lower of lines					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see i		ts (Tines 54 X	60), OF 1% OF	the target		
62. 00	Relief payment (see instructions)	instructions)				0	62. 00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instr	uctions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dec	ember 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the c	ost reporting	period (See	0	65. 00
	instructions) (title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66. 00
47.00	CAH (see instructions)	o costs through	n Docombor 21 a	f the cost re	porting ported	0	67. 00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	c costs till ougl	n pecellipet 31 C	n the cost rep	or tring period		07.00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after l	December 31 of	the cost repor	rting period	0	68. 00
	(line 13 x line 20)		(1) (7)	(0)		_	/6.5-
69. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facili						70. 00
71. 00	Adjusted general inpatient routine service of	•					71. 00
72. 00	Program routine service cost (line 9 x line						72. 00
	Medically necessary private room cost applica						73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient i	•			art II column		74. 00 75. 00
73.00	26, line 45)	TOUTTHE SELVICE	COSES (IIOIII W	orksheet b, Po	art II, COLUMII		73.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78.00	Inpatient routine service cost (line 74 minus		arovidor rese	le)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				ıs line 79)		79.00
81. 00	Inpatient routine service costs for compa		Jose Timi tati Oli	. (1116 70 111111	///		81.00
82. 00	Inpatient routine service cost limitation (li		1)				82. 00
83. 00	Reasonable inpatient routine service costs (ns)				83. 00
84.00	Program inpatient ancillary services (see ins		anc)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55. 50	PART IV - COMPUTATION OF OBSERVATION BED PASS		Jugii 00)			<u> </u>	1 30.00

10, 516 87. 00 1, 109. 50 88. 00 11, 667, 502 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 CO		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	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	10, 633, 452	93, 067, 817	0. 11425	5 11, 667, 502	1, 333, 070	90.00
91.00 Nursing School cost	0	93, 067, 817	0.00000	11, 667, 502	0	91.00
92.00 Allied health cost	0	93, 067, 817	0.00000	11, 667, 502	0	92.00
93.00 All other Medical Education	0	93, 067, 817	0. 000000	11, 667, 502	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: 15-005	8 Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-SC	58 To 12/31/2018	Date/Time Prepared: 5/29/2019 8:36 am
	Title XVIII	Subprovi der -	PPS

		II the Aviii	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 090	
2.00	Inpatient days (including private room days, excluding swing-berivate room days (excluding swing-bed and observation bed day			3, 090	
3.00	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, 090	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	R1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember e	or or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n davs) after December 31	of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	days) at tel becember 31	or the cost	U	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	993	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	oly (including private re	om dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Joili days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (Therdaing private	e room days)	U	12.00
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 ye			0	14. 00
15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	dii (excluding swing-bed c	lays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		2.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
19. 00	reporting period	through December 21 of	the cost	0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through becember 31 or	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		3, 776, 341	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0, 770, 311	22. 00
	5 x line 17)	04 6 11			
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 reportir	ng period (line	0	24. 00
25 00	7 x line 19))1 -6 thtt!		0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	or 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, 776, 341	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3,	0	
30.00	Semi -private room charges (excluding swing-bed charges)	1. 00)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3)	- line 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34. 00	Average per diem private room charge differential (line 32 mir	, ,	i ons)	0. 00	
35.00	Average per diem private room cost differential (line 34 x line 35)	ne 31)		0.00	35. 00 36. 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 a	and private room cost dif	ferential (line	0 3, 776, 341	
	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			1, 222. 12	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 213, 565	39. 00
40.00	Medically necessary private room cost applicable to the Progra	•		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ IINE 4U)		1, 213, 565	41.00

IIIIPU I	ATION OF INPATIENT OPERATING COST		Component	CN: 15-0058 CCN: 15-S058	Peri od: From 01/01/2018 To 12/31/2018 Subprovi der -		epared:
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0.	00 0) 0	42.00
6. 00 6. 01 6. 00 6. 00 7. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description	0	C	1		1	
	1					1. 00	
i. 00 i. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ons)		225, 261 1, 438, 826	
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine s	ervices (from	n Wkst D su	m of Parts L and	183, 228	50.00
. 00	Pass through costs applicable to Program inpart and IV)		•			12, 651	
. 00 . 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclumedical education costs (line 49 minus line!	ding capital rel	ated, non-phy	vsician anest	hetist, and	195, 879 1, 242, 947	1
00	TARGET AMOUNT AND LIMIT COMPUTATION	•]
. 00	Program discharges Target amount per discharge					0 00	54.00
. 00	Target amount (line 54 x line 55)					0.00	1
. 00	Difference between adjusted inpatient operati	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost reparket basket	porting period e	enaing 1996, l	ipaatea ana c	ompounaea by tne	0.00	59.00
. 00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	1
. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payment		rtions)				62.00
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mistruc	, trons)			0	03.00
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost report	ing period (See	0	64. 00
. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)</pre>	ts after Decembe	er 31 of the d	cost reportin	g period (See	0	65. 00
. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line 6	4 plus line 6	5)(title XVI	II only). For	0	66. 00
. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 d	of the cost r	eporting period	0	67. 00
. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
. 00	Skilled nursing facility/other nursing facili	ity/ICF/IID rout	ine service d	cost (line 37)		70.00
. 00	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71. 00
. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		(line 14 v li	ne 35)			72. 00
. 00	Total Program general inpatient routine servi		•	,			74.00
. 00	Capital-related cost allocated to inpatient				Part II, column		75. 0
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 0
	Program capital-related costs (line 9 x line						77. 0
. 00							78. 0
. 00	Aggregate charges to beneficiaries for excess			*.			79. 0
. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		st limitation	ı (ııne 78 mi	nus iine 79)		80.0
. 00	Inpatient routine service cost per drem itml						82.00
. 00	Reasonable inpatient routine service costs (s						83. 0
. 00	Program inpatient ancillary services (see in		`				84. 0
. 00	Utilization review - physician compensation						85. 0
i. UU	Total Program inpatient operating costs (sum		ougn 85)				86. 0
	PART IV - COMPUTATION OF OBSERVATION BED PAS						
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87.0

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		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2018 To 12/31/2018		
		Title	XVIII	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	570, 167	3, 776, 341	0. 15098	4 0	0	90.00
91.00 Nursing School cost	0	3, 776, 341	0.00000	0	0	91.00
92.00 Allied health cost	0	3, 776, 341	0.00000	0	0	92.00
93.00 All other Medical Education	0	3, 776, 341	0.00000	0 0	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: 15-0058	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-T058		
	Title XVIII	Subprovi der -	PPS

		litle XVIII	I RF	PPS	
	Cost Center Description		110		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		2, 907	1. 00
2.00				2, 907	2. 00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	ivate room days,	1, 471	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed davs)		1, 436	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	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 December	31 OF the COST	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	m 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)	m days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 180	9. 00
	newborn days)		aming are and	,,	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII on		nom davs) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		Join days) arter	G	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	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	V only (including privat	o room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			U	13.00
14.00	Medically necessary private room days applicable to the Progra			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			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
.,. 00	reporting period	o till dagi. Doddingdi di di		0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		3, 440, 710	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0, 110, 710	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	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 440, 710	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		,		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)	7, 672, 079	
30.00	Semi-private room charges (excluding swing-bed charges)			3, 988, 126 3, 683, 953	
31. 00	General inpatient routine service cost/charge ratio (line 27	+ line 28)		0. 448472	1
32. 00	Average private room per diem charge (line 29 ÷ line 3)			2, 711. 17	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 22) (:	+!>	2, 565. 43	
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		tions)	145. 74 65. 36	34. 00 35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	(51)		96, 145	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 344, 565	•
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMFNTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 183. 59	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			1, 396, 636	39. 00
40.00	Medically necessary private room cost applicable to the Progra			1 204 424	
41.00	Total Program general inpatient routine service cost (line 39	+ ITTIE 40)	ı	1, 396, 636	41.00

		RIAL HOSPITAL OF				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058 Period: From 01/01/2018 To 12/31/2018		Worksheet D-1		
					Date/Time Pre 5/29/2019 8:3		
			Ti tl e	: XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
	Innerent control of the control of t	1.00	2.00	3. 00	4. 00	5. 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	0	0. (00 0	0	43. 00
43. 01 44. 00	NEONATAL INTENSIVE CARE UNIT	0	0	0. (00	0	43. 01 44. 00
45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						45.00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1. 00	
48.00	Program inpatient ancillary service cost (Wk			>		771, 534	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(S	ee instructio	ins)		2, 168, 170	49.00
50.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, sur	n of Parts I and	205, 898	50.00
51. 00	<pre> </pre>	ationt ancillary	sarvicas (fr	om Wkst D s	cum of Darte II	45, 866	51.00
51.00	and IV)	,	301 VI CE3 (II	om with D, 3	Jam Or ruits II	45, 500	31.00
52.00	Total Program excludable cost (sum of lines		atad ===='	rol ol on arrell	notict and	251, 764	1
53. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line	9 1	ateu, non-phy	sician anestr	ietist, and	1, 916, 406	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	•					ļ
	Program discharges Target amount per discharge					0 00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					0.00	1
57.00	00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0		
58.00	8.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the				0.00	58. 00 59. 00	
	market basket						
60. 00 61. 00					0.00		
01.00	which operating costs (line 53) are less that						01.00
42.00	amount (line 56), otherwise enter zero (see	instructions)					62. 00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)				63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST					_	
64. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reportino	g period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 6	4 nlus line 6	5)(title XVII	I only) For	0	66. 00
00.00	CAH (see instructions)	`	·		3,		
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost repo	orting period	0	68. 00
(0.00	(line 13 x line 20)		: /7 !:	(0)			40.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rout	ine service c	ost (line 37)			70.00
71. 00 72. 00						71. 00 72. 00	
73. 00	Medically necessary private room cost applic	able to Program					73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II column		74. 00 75. 00
75.00	26, line 45)	Toutine service	COSIS (IIOIII W	OIKSHEEL B, F	art II, Corumn		75.00
76.00	Per diem capital related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from pr		•			79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st limitation	ı(line 78 mir	nus line 79)		80. 00 81. 00
82. 00	1 .						82. 00
83.00	Reasonable inpatient routine service costs ()				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
8/ 1111	protein observation bed days (see instructions	,					1 07.00
87. 00 88. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	diem (line 27 ÷	line 2)				88. 00 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 01/01/2018 To 12/31/2018		pared: 6 am
		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	507, 255	3, 440, 710	0. 14742	7 0	0	90.00
91.00 Nursing School cost	0	3, 440, 710	0.00000	0	0	91.00
92.00 Allied health cost	0	3, 440, 710	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 440, 710	0. 00000	0 0	0	93. 00

Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058	Peri od: From 01/01/2018	Worksheet D-1	
			To 12/31/2018	Date/Time Pre 5/29/2019 8:3	pared: 6 am
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

PART 1. ALL PROVIDES CONCENDENTS PART 1. ALL PROVIDES CONCENDENTS			Title XIX	Hospi tal	PPS	
Inpatient days (Including private room days and seing-bed days, excluding newborn) 83,883 1.00 Impatient days (Including private room days, sectuding sating-bed and reaction days) 1.00 Impatient days (Including private room days, sectuding sating-bed and reaction days) 1.00		Cost Center Description		-	1 00	
Impattent days (including private room days and swing-bed days, excluding newborn) 83,883 2.00 Inpattent days (excluding private room days, excluding swing-bed and observation bed days) 17 you have only private room days (excluding swing-bed and observation bed days) 17 you have only private room days 2.00 3.00		PART I - ALL PROVIDER COMPONENTS		L	1.00	
Inpatient days (including private room days, excluding swing-bed and newborn days) 1.7 you have only private room days, cock uding swing-bed and observation bed days) 1.7 you have only private room days, on 3.0 or not complete this line. 3.0 or this line. 3.0						
Private room days (excluding swing-bed and observation bed days). If you have only private room days, decluding swing-bed and observation bed days) Semi-private room days (excluding swing-bed and observation bed days) Semi-private room days (excluding swing-bed and observation bed days) Semi-private room days (excluding swing-bed with the swing observation bed days) From the swing-bed SM type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 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) 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) Total lapsified days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) Total brough December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total brough December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total brough December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total brough December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total brough December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total brough December 31 of the cost reporting period (if a swing-bed SMF services applicable to services through December 31 of the cost reporting period (if a swing-bed SMF services applicable to s						
do not complete this line. 4. 00 Sell-private room days (excluding swing-bed and observation bed days) 1. Total swing-bed SW type inpattent days (including private room days) after December 31 of the cost period period period period period period period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed Fype inpattent days (including private room days) through December 31 of the cost period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed Fype inpattent days (including private room days) through December 31 of the cost period reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed Fype inpattent days (including private room days) after December 31 of the cost period reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpattent days including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line) 10. 00 Swing-bed SW type inpattent days applicable to this line) 10. 00 Swing-bed SW type inpattent days applicable to the Program (excluding private room days) through December 31 of the cost period (if calendar year, enter 0 on this line) 10. 00 Swing-bed SW type inpattent days applicable to this swing with the period days after days applicable to this swing with through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 00 Swing-bed SW type inpattent days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 00 Total surveys days (title V or XIX only) 10. 01 Total surveys days (title V or XIX only) 10. 02 Swing-bed NF type inpattent days applicable to swing-bed swing-bed days) 10. 02 Total surveys days (title V or XIX only) 10. 03 Total surveys days (title V or XIX only) 10. 04 Swing-bed NF type inpattent days applicable to services after December 31 of the cost reporting period (in calendar year, enter 0 on this line) 10. 05 Swing-bed NF type inpattent day				vate room days	· ·	
Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SkF type inpatient days (including private room days) after December 31 of the cost of the swing-bed SkF type inpatient days (including private room days) after December 31 of the cost of the swing-bed NF type inpatient days (including private room days) after December 31 of the cost open financing private NF type inpatient days (including private room days) after December 31 of the cost of the cost of the swing-bed NF type inpatient days (including private room days) after December 31 of the cost of the cost of the cost of the swing-bed NF type inpatient days (including private room days) after December 31 of the cost of the	3.00		ys). The you have only pri	vate room days,	O	3.00
reporting period (1 cal calary (including private room days) after December 31 of the cost of coporting period (1 calardar year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (1 calardar year, enter 0 on this line) 8. 00 Total inpatient days (including private room days) after December 31 of the cost reporting period (1 calardar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and involved private room days) after of through December 31 of the cost reporting period (see instructions) 11. 00 Swing-bed SNF type inpatient days applicable to till to XVII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12. 00 Swing-bed SNF type inpatient days applicable to till to XVII only (including private room days) after through December 31 of the cost reporting period (see instructions) 13. 00 Swing-bed NF type inpatient days applicable to till to XVII only (including private room days) after December 31 of the cost reporting period (see instructions) 14. 00 Medically necessary private room days applicable to till to XVII only (including private room days) 15. 00 Intell nursery days (till to V or XX only) 16. 00 Nursery days (till to V or XX only) 17. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18. 00 Medical reporting period 18. 00 Medical reporting period (see applicable to services after December 31 of the cost reporting period (see applicable to services through December 31 of the cost reporting period (see applicable to SNF type services through December 31 of the cost reporting period (line on the period swing-bed SNF services after December 31 of the cost reporting period (line on the period swing-bed SNF services af	4.00		ed days)		73, 367	4. 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cellendar years, enter 0 on this line)	5.00		om days) through December	31 of the cost	0	5. 00
reporting period (if Calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 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 swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 9.01 Total swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) of through December 31 of the cost reporting period (id calendar year, enter 0 on this line) 9.02 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (id calendar year, enter 0 on this line) 9.12.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.12.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.13.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 New Common Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 4.201 15.00 New Common Swing-bed NF type services applicable to services through December 31 of the cost 0.00 17.00 New Common Swing-bed SWF services applicable to services after December 31 of the cost 0.00 17.00 New Common Swing-bed NF services applicable to services after December 31 of the cost 0.00 17.00 New Common Swing-bed NF services applicable to services after December 31 of the cost 0.00 17.00 New Common Swing-bed NF services applicable to services after December 31 o	/ 00			1 -6	0	/ 00
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x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Fri vate room charges (excluding swing-bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room charge differential (line 3 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 93,067,817) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 8 x line 31) 38.00 Average per diem private room cost differential (line 8 x line 35) 38.00 Average per diem private room cost differential (line 8 x line 35) 39.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Seneral inpatient routine service cost per diem (see instructions) 30.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00	·	31 of the cost reporting	period (line 6	0	23. 00
7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 93,067,817) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 93,067,817) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Medically necessary private room cost (line 9 x line 38) 2, 774,860 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 do 0. 00			`			
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x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 97 inus line 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 30. 00 31. 00 32. 00 32. 00 32. 00 32. 00 32. 00 33. 00 34. 00 34. 00 34. 00 35. 00 36. 00 37. 00 36. 00 37. 00 38. 00 39. 00 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	25 00		21 of the cost reporting	noried (line 9	0	25 00
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38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,109.50 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,109.50 38.00 2,774,860 39.00 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2,774,860 39.00 40.00	00.05				4 100 ==	00.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	•			
		1 3 3 1	,			

OMPUT	ATION OF INPATIENT OPERATING COST		Provider Co	CN: 15-0058	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Pre 5/29/2019 8:3	pared:
			Ti tl	e XIX	Hospi tal	PPS	o am
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	2, 719, 737	4, 201	647.	161	104, 231	42. 00
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	16, 055, 706	9, 208	1, 743. 0	57 0	0	43.00
3. 01	NEONATAL INTENSIVE CARE UNIT	12, 338, 402					
1. 00	CORONARY CARE UNIT						44. 00
5. 00	BURN INTENSIVE CARE UNIT						45. 00
6.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
7.00	Cost Center Description						47.00
						1. 00	
8. 00	Program inpatient ancillary service cost (Wk					27, 524, 242	
9. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ns)		30, 870, 915	49. 00
0. 00	Pass through costs applicable to Program inpa	atient routine	services (from	ı Wkst. D. sun	n of Parts I and	368, 672	50.00
	III)		·				
. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	2, 053, 287	51.00
2. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				2, 421, 959	52.00
3. 00	Total Program inpatient operating cost exclusion		lated, non-phy	sician anesth	netist, and	28, 448, 956	
	medical education costs (line 49 minus line]
	TARGET AMOUNT AND LIMIT COMPUTATION						
. 00	Program discharges Target amount per discharge	0.00					
. 00	Target amount (line 54 x line 55)					0.00	1
. 00	Difference between adjusted inpatient operati	ing cost and ta	rget amount (I	ine 56 minus	line 53)	Ö	
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, u	ipdated and co	ompounded by the	0.00	59.00
. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. un	dated by the m	arket basket		0.00	60.00
. 00	If line 53/54 is less than the lower of lines				the amount by	0	1
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
2. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive payment	ent (see instru	ictions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST		·				
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reporti	ng period (See	0	64. 00
5. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	or 21 of the c	ost roporting	norind (Soo	0	65.00
. 00	instructions) (title XVIII only)	ts after becenik	iei 31 di the c	ost reporting	g perrou (see		05.00
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
	CAH (see instructions)		D 1 04	6.11			/7.00
. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 d	of the cost re	eporting period	0	67. 00
3. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	ortina period	0	68. 00
	(line 13 x line 20)			•	3 1		
. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil		•		<u> </u>		70.00
. 00	Adjusted general inpatient routine service of	-					71.00
. 00	Program routine service cost (line 9 x line	71)					72. 00
. 00	Medically necessary private room cost applications		•				73.00
. 00	Total Program general inpatient routine servi	•			Oort II column		74.00
. 00	Capital-related cost allocated to inpatient 26, line 45)	TOULTHE SELVICE	COSIS (IIOII W	OLINSHEEL B, F	art II, COLUMN		75. 00
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
. 00	Program capital-related costs (line 9 x line						77. 00
. 00	Inpatient routine service cost (line 74 minu:		unavil dam :	la)			78.00
9. 00 0. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			· .	nus line 70)		79. 00 80. 00
	TOTAL TIOULANI FOUTING SELVICE COSTS TOL COND	ar i 3011 tO tHC t	ost rimitatiOH	. (11110 /0 11111	143 IIIIC /7/	1	1 00.00

81.00

82.00

83.00

84.00

85.00

86.00

10, 516 87. 00 1, 109. 50 88. 00 11, 667, 502 89. 00

84.00

85.00

86.00

81.00 Inpatient routine service cost per diem limitation

Total observation bed days (see instructions)

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

83.00 Reasonable inpatient routine service costs (see instructions)

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

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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	MEMORIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 01/01/2018	Worksheet D-1	
				Γο 12/31/2018		
		Ti tl	e XIX	Hospi tal	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 THRO	DUGH COST					
90.00 Capital-related cost	10, 633, 452	93, 067, 817	0. 11425!	11, 667, 502	1, 333, 070	90.00
91.00 Nursing School cost	0	93, 067, 817	0. 000000	11, 667, 502	0	91.00
92.00 Allied health cost	0	93, 067, 817	0. 000000	11, 667, 502	0	92.00
93.00 All other Medical Education	0	93, 067, 817	0. 000000	11, 667, 502	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	Provider CCN: 15-0058	Period: From 01/01/2018	Worksheet D-1
	Component CCN: 15-S058		
	Title XIX	Subprovi der -	PPS

		litie XIX	Subprovider -	PPS	
	Cost Center Description			l	
	T			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		3, 090	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			3, 090	
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		. 21 -6 +6	3, 090	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roof reporting period	om days) through becembe	a 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	•			
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei 3	i or the cost	O	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	65	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		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		nom days) after	0	11. 00
00	December 31 of the cost reporting period (if calendar year, er		dayo, artor	· ·	00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	/		0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar years)			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(4, 201	
16. 00	Nursery days (title V or XIX only)			161	16. 00
47.00	SWING BED ADJUSTMENT		6.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	T the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00
20.00	reporting period	s arter becember 51 or t	THE COST	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			3, 776, 341	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23. 00
23.00	x line 18)	31 of the cost reportin	g perrou (Trile o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)				05 00
25. 00	Swing-bed cost applicable to NF type services after December (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, 776, 341	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	: 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 line 25)	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 a	and private room cost di	fferential (line	3, 776, 341	36. 00 37. 00
200	27 minus line 36)				27.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 000 10	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 222. 12 79, 438	
40. 00	Medically necessary private room cost applicable to the Progra			77, 430	
	Total Program general inpatient routine service cost (line 39			79, 438	

		RIAL HOSPITAL OF				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST			CN: 15-0058 CCN: 15-S058	Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
			Ti tl	e XIX	Subprovi der -	5/29/2019 8: 3 PPS	6 am
	Cost Center Description	Total Inpatient Costli	Total npatient Davs	Average Pei Diem (col. 1		Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4.00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units		_			I -	
43. 00 43. 01	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	0	C	1	00 0	l .	43. 00 43. 01
44. 00	CORONARY CARE UNIT			0.			44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
17.00	Cost Center Description						17.00
40.00	Drogram i mosti ent ancillary comi es cost (WIII)	o+ D 2 ool 2	line 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		88, 669 168, 107	1
	PASS THROUGH COST ADJUSTMENTS	J / \					
50. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from	n Wkst. D, su	m of Parts I and	11, 994	50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	4, 383	51. 00
52.00	Total Program excludable cost (sum of lines					16, 377	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phy	sician anest	hetist, and	151, 730	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	<i>32)</i>					
54.00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57.00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting poriod o	nding 1004 i	undated and a	ampounded by the	0	58. 00 59. 00
39.00	market basket	portring perrou e	naring 1996, t	ipuateu anu c	oliipourided by trie	0.00	39.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by						60. 00 61. 00
62. 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) Relief payment (see instructions)						62. 00
63. 00	Allowable Inpatient cost plus incentive paym	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	e cost report	ina period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	· ·		·			65. 00
66. 00	instructions)(title XVIII only) 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 routin (line 12 x line 19)	e costs through	December 31 c	of the cost r	eporting period	0	67. 00
68. 00	1 '	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					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil)		70.00
71.00	Adjusted general inpatient routine service c	ost per diem (li					71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(line 14 x li	ne 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)	ŕ			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from V	lorksheet B,	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovi der record	ls)			78. 00 79. 00
80.00	Total Program routine service costs for comp			*.	nus line 79)		80. 00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)	,				84. 00
85. 00 86. 00	Utilization review - physician compensation						85. 00 86. 00
ou. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougii 85)				86.00
87. 00	Total observation bed days (see instructions)					87. 00
88.00	Adjusted general inpatient routine cost per Observation hed cost (line 87 x line 88) (see	•	line 2)			l .	88. 00 89. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				0	89

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 CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2018 To 12/31/2018		
		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.	1
					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	570, 167	3, 776, 341	0. 15098	4 0	0	90.00
91.00 Nursing School cost	0	3, 776, 341	0.00000	0	0	91.00
92.00 Allied health cost	0	3, 776, 341	0.00000	0	0	92.00
93.00 All other Medical Education	0	3, 776, 341	0.00000	o o	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	Provider CCN: 15-0058		Worksheet D-1
	Component CCN: 15-T058	From 01/01/2018 To 12/31/2018	
	Title XIX	Subprovi der -	PPS
		, I DE	

Cost Center Description PART _ All PROWINDER COMPONENTS 1.00 PART _ All PROWINDER COMPONENTS			Title XIX	Subprovi der - I RF	PPS	
INSMITTER LATE ROWINGER COMPONENTS		Cost Center Description		TRI		
Impartient Day's 1.00 Impartient days (including private room days, excluding newborn) 2.907 2.00 Impartient days (including private room days, excluding seing-bed and newborn days) 2.907 2.00 2		PART I - ALL PROVIDER COMPONENTS			1. 00	
2.907 2.00 Inipatient days (including private room days, excluding swing-bed and nestorn days) 2.907 2.00 3.00 According to the continuation of the cost complete this line. 3.00 According to the cost cost cost cost cost cost cost cost						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this lice. Unding swing-bed and observation bed days). 2,900 do not complete this lice. Unding swing-bed and observation bed days). 5,001 reporting period. 1,002 lotal swing-bed SNF type inpatient days. (Including private room days) through December 31 of the cost reporting period. 1,002 lotal swing-bed SNF type inpatient days. (Including private room days) through December 31 of the cost reporting period (I calendar year, enter 0 on this line). 1,003 lotal swing-bed MF type inpatient days. (Including private room days) through December 31 of the cost reporting period (I calendar year, enter 0 on this line). 1,004 lotal lapatient days including private room days applicable to the Program (excluding swing-bed and non-born days). 1,005 lotal lapatient days including private room days palpicable to the Program (excluding swing-bed and non-born days). 1,006 lotal lapatient days including private room days palpicable to the Program (excluding swing-bed and non-born days). 1,007 lotal swing-bed SNF type inpatient days applicable to title XVIII only (Including private room days) after December 31 of the cost reporting period (I calendar year, enter 0 on this line). 2,003 long-bed SNF type inpatient days applicable to title XVIII only (Including private room days). 1,004 long-beckers 31 of the cost reporting period (I calendar year, enter 0 on this line). 2,005 long-bed SNF type inpatient days applicable to title XVIII only (Including private room days). 1,006 long-beckers 31 of the cost reporting period (I calendar year, enter 0 on this line). 2,007 long-beckers 31 of the cost reporting period (I calendar year, enter 0 on this line). 3,007 long-beckers 31 of the cost reporting period (I calendar year, enter 0 on this line). 3,007 long-beckers 31 of the cost reporting period (I calendar year, enter 0 on this line). 3,008 long-bed SNF services applicable to services through December 31 o						
do not complete this line. 4. 00 Semi-private room days (sectualing swing-bed and observation bed days) 5.00 Intait swing-bed SW type inpatient days. (Including private room days) after December 31 of the cost period interesting period of the cost reporting period (If calendar year, enter 0 on this line) 7.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 7.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 7.00 Total swing-bed W type inpatient days (Including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 7.00 Swing-bed SW type inpatient days applicable to the Program (excluding private room days) 7.00 Swing-bed SW type inpatient days applicable to the Will enter of the cost reporting period (If calendar year, enter 0 on this line) 7.00 Swing-bed SW type inpatient days applicable to the Will enter of the SW type inpatient days applicable to the Will enter of the SW type inpatient days applicable to the Will enter of the SW type inpatient days applicable to the Will enter of the Will enter of the William of the Cost reporting period (If calendar year, enter 0 on this line) 7.00 Swing-bed SW type inpatient days applicable to the Program (excluding private room days) 7.01 Swing-bed Net type inpatient days applicable to the Program (excluding private room days) 7.02 Swing-bed Net type inpatient days applicable to the Will enter of the Cost reporting period (If calendar year, enter 0 on this line) 7.01 Swing-bed Net type inpatient days applicable to SW type services applicable to services through December 31 of the cost reporting period (In cost reporting period (In cost reporting period (In cost report				ivata room days		
Semi-private room days (excluding swing-bed and observation bed days) 2,907 4,00	3.00	, , , , , , , , , , , , , , , , , , , ,	ys). IT you have only pr	ivate room days,	U	3.00
reporting period (if calendar year, enter 0 on this line) 7.00 lotal 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 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 (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 nextorn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after SNIII only (including private room days) after December 31 of the cost reporting period (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 14.00 Medically necessary rivate room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 SNEED ADJOINTENANCE 17.00 SNEED ADJOINTENANCE 18.00 Medicars rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days applicable to services after December	4.00	!	ed days)		2, 907	4. 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) 7.00 7	5.00		om days) through Decembe	r 31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 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 Exempting 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 newborn days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medical (ly necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.10 New SNF	6 00		om days) after December	31 of the cost	0	6 00
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Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost on this line) 10 10 10 10 10 10 10 1	7.00		m days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 12.00 through December 31 of the cost reporting period (including private room days) 13.00 swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 after December 31 of the cost reporting period (including private room days) 14.00 after December 31 of the cost reporting period (including private room days) 15.00 lotal nursery days (title V or XIX only) 16.00 lotal nurse	9 00	1	m days) after December 3	1 of the cost	0	9 00
10.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 0.00 1	8.00		ii days) ai tei beceiibei 3	i oi the cost	Ü	6.00
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x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 32. 00 Average private room per diem charge (line 29 ± line 3) 33. 00 Average semi-private room per diem charge (line 30 ± line 4) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 440, 710) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 440, 710) 38. 00 Agisted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 26. 00 27. 00 28. 00 28. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20	25 00	,	31 of the cost reporting	period (line 8	0	25 00
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PRI VATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Pri vate room charges (excluding swing-bed charges) 30. 00 Semi-pri vate room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average pri vate room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem pri vate room cost differential (line 34 x line 31) 36. 00 Pri vate room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 3, 440, 710) 38. 00 Ajusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 10 28. 00 29. 00 20. 00 30		, ,	(1)			
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 440, 710) 30.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 31.00 Semi-private room charges (excluding swing-bed charges) 32.00 Average per ivate room charges (line 27 ÷ line 28) 33.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 3, 440, 710) 35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 440, 710) 37.00 Average per diem private room cost per diem (see instructions) 38.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 38.00 Average per diem private room cost applicable to the Program (line 14 x line 35)	27.00		(line 21 minus line 26)		3, 440, 710	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 440, 710) 37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00		d and observation bed ch	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 440, 710) 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 (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.000 0000000000000000000000000000000	29. 00	Private room charges (excluding swing-bed charges)				
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 440, 710) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00			11 00)			
33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 440, 710) 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 (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,	÷ 11 ne 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 440, 710) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 .00 34.00 37.00 35.00 37.00 36.00 37.00 37.00 37.0		, , , , , , , , , , , , , , , , , , , ,				
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 440, 710 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 37.00	34.00	Average per diem private room charge differential (line 32 mi)		tions)	0.00	34.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 Adv. 710 37.00 37		, , ,	ne 31)		0.00	
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 183.59 38.00 Program general inpatient routine service cost (line 9 x line 38) 13,019 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			and private room cost di	fferential (line	3, 440. 710	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 183.59 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00	27 minus line 36)	p	3. 3	5, 110, 710	37.00
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 183.59 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1, 183.59 38.00 40.00			ICTUENTO			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 13,019 39.00 40.00	38 00				1 102 50	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 13,019 41.00					0	40. 00
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		13, 019	41. 00

		RIAL HOSPITAL OF				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Peri od: From 01/01/2018	Worksheet D-1	
			Component	CCN: 15-T058	To 12/31/2018	Date/Time Pre 5/29/2019 8:3	
			Ti tl	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
	I	1.00	2.00	3. 00	4. 00	5. 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	O	•		l e	
43. 01 44. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0.0	00	0	43. 01 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1.00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ins)		238, 420 251, 439	
171.00	PASS THROUGH COST ADJUSTMENTS	<u> </u>		,			
50. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	ı Wkst. D, sun	n of Parts I and	1, 919	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	14, 008	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				15 007	52. 00
52.00	Total Program excludable cost (sum of lines in Total Program inpatient operating cost excluding		ated, non-phy	sician anesth	netist, and	15, 927 235, 512	
	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					l	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	net amount (L	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	9			,	0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period e	ndi ng 1996, ເ	pdated and co	ompounded by the	0.00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upd	ated by the m	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(TITIES 54 X	00), 01 1% 01	the target		
62.00	Relief payment (see instructions)		+!>			l e	62.00
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			<u> </u>	63. 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 reportino	period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line 6	4 plus line 6	5)(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 routing	e costs after De	cember 31 of	the cost repo	ortina period	0	68. 00
	(line 13 x line 20)			•	9		
69.00	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	ost (line 37))		70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ 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 services tall-related cost allocated to inpatient				Part II column		74. 00 75. 00
75.00	Capital-related cost allocated to inpatient 26, line 45)	TOUTTHE SETVICE	CUSIS (IIOIII V	ioi kaileet B, F	art II, COLUMN		/ 5.00
76.00	Per diem capital related costs (line 75 ÷ line						76. 00 77. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						78.00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from pr		•	III 76`		79. 00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		st IImitatior	ı (Iıne 78 mir	nus IIne 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs ()				83. 00 84. 00
85.00	Program inpatient ancillary services (see in: Utilization review - physician compensation		s)				85.00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	 87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00
	Observation bed cost (line 87 x line 88) (see	e instructions)				1 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 CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2018 To 12/31/2018		pared: 6 am
		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	507, 255	3, 440, 710	0. 14742	7 0	0	90.00
91.00 Nursing School cost	0	3, 440, 710	0.00000	0	0	91.00
92.00 Allied health cost	0	3, 440, 710	0. 00000	0 0	0	92. 00
93.00 All other Medical Education	0	3, 440, 710	0. 00000	0 0	0	93. 00

Health Financial Systems	MEMORIAL HOSPITAL OF S	OUTH BEND, INC	In Lie	u of Form CMS-2552-10
INDATIENT ANCILLARY SERVICE COST ADDODTIC	NIMENT	Drovidor CCN: 15 0050	Pori od:	Workshoot D 2

Health Financial Systems MEMORIAL HOSPITAL OF S	OUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0058	Peri od: From 01/01/2018	Worksheet D-3	
			To 12/31/2018	Date/Time Pre 5/29/2019 8:3	
	Title	xVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			67, 693, 267		30.00
31. 00 03100 INTENSIVE CARE UNIT			10, 962, 494		31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT			0		31. 01
40. 00 04000 SUBPROVI DER - 1 PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 37627		7, 690, 055	
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 55252		14, 889	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17699		2, 183, 716	
57. 00 05700 CT SCAN		0. 03697		285, 625	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 28153		413, 406	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 11587		553, 049	
60. 00 06000 LABORATORY		0. 10598		2, 946, 361	
60. 01 06001 BLOOD LABORATORY		0.00000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY		0. 18086			
66. 00 06600 PHYSI CAL THERAPY		0. 41872		886, 706	
66. 01 06602 PHYSI CAL THERAPY EAST BANK		0. 41104		0	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER		0.40244		0	66. 10
67. 00 06700 OCCUPATIONAL THERAPY		0. 45080			1
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 36311		104 426	67. 10
68. 00 06800 SPEECH PATHOLOGY		0. 36746			1
68. 10 06801 SPEECH THERAPY LIVING CENTER 70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 31022		0	68. 10
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		-	70. 00 71. 00
72. 00 07100 MPL. DEV. CHARGED TO PATIENTS		0. 15228 0. 21189		8, 916, 282	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 21169			73.00
76. 00 03020 CARDI OLOGY		0. 19192		984, 792	76.00
OUTPATI ENT SERVI CE COST CENTERS		0.31976	3,077,344	704, 772	70.00
90. 00 09000 CLI NI C		0.00000	0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC		0. 00000		ő	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC		2. 14404		Ö	90. 30
90. 50 09004 SLEEP DI SORDERS CLINI C		0. 29434		Ö	90. 50
91. 00 09100 EMERGENCY		0. 51979		3, 177, 433	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 33353		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			208, 446, 878	42, 762, 128	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			208, 446, 878		202. 00

Health Financial Systems MEMORIAL HOSPITAL OF INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			In Lie Period:	wof Form CMS-2 Worksheet D-3	
THE ATTENT AND LEARLY SERVICE GOST ATTORTTONNENT			From 01/01/2018 Fo 12/31/2018	Date/Time Pre	pared:
	Ti +I /	e XVIII	Subprovi der -	5/29/2019 8: 3 PPS	6 am
	11 (1)	ZVIII	I PF	FF3	
Cost Center Description		Ratio of Cost	•	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT			0		31. 01
40. 00 04000 SUBPROVI DER - I PF			1, 194, 503		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 37627	7 157, 725	59, 348	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 55252	1 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 176994	7, 833	1, 386	54.00
57. 00 05700 CT SCAN		0. 036976	6, 204	229	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 281534	5, 739	1, 616	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 11587!	5 0	0	59.00
60. 00 06000 LABORATORY		0. 105986	5 123, 093	13, 046	60.00
60. 01 06001 BLOOD LABORATORY		0.000000	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY		0. 180868	3 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 418729	9 105, 134	44, 023	66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK		0. 411046	6 0	0	
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER		0. 402449		0	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 45080	9 34, 712	15, 648	67.00
67. 10 06701 OCCUPATI ONAL THERAPY LIVING CENTER		0. 36311!		0	
68. 00 O6800 SPEECH PATHOLOGY		0. 367466		l e	
68. 10 06801 SPEECH THERAPY LIVING CENTER		0. 310224		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 000000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 152280		l	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 211890	1	l	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 191929	1	88, 074	
76. 00 03020 CARDI 0L0GY		0. 31978!	5 150	48	76. 00
OUTPATIENT SERVICE COST CENTERS			-1		
90. 00 09000 CLI NI C		0.000000		0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC		0.000000		-	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC		2. 14404		0	90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC		0. 294349		0	90. 50
91. 00 09100 EMERGENCY		0. 519790		1, 060	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 333538			
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1	905, 658	225, 261	1/しし ()

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)

905, 658

225, 261 200. 00

201. 00

202. 00

200.00 201.00

202.00

	Financial Systems MEMORIAL HOSP ENT ANCILLARY SERVICE COST APPORTIONMENT	PITAL OF SOUTH BEND,	CN: 15-0058	Peri od:	worksheet D-3	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0058	From 01/01/2018		
		Component	CCN: 15-T058	To 12/31/2018		
		Ti tl d	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	9	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 & PEDI ATRI CS			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			3, 151, 003		41.0
43. 00	04300 NURSERY					43.0
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 3762	77 3, 283	1, 235	50.0
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 5525	21 0	0	52.0
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1769	94, 774	16, 774	54.0
57. 00	05700 CT SCAN		0. 0369	76 33, 839		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 2815			
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 1158		0	
50.00	06000 LABORATORY		0. 1059			1
60. 01	06001 BLOOD LABORATORY		0.0000		0	
55.00	06500 RESPI RATORY THERAPY		0. 1808			
66.00	06600 PHYSI CAL THERAPY		0. 4187		220, 714	
6. 01	06602 PHYSI CAL THERAPY EAST BANK		0. 4110		0	
6. 10	06601 PHYSI CAL THERAPY LI VI NG CENTER		0. 4024		0	
57. 00 57. 10	O6700 OCCUPATIONAL THERAPY O6701 OCCUPATIONAL THERAPY LIVING CENTER		0. 4508 0. 3631		227, 013 0	1
8. 00	06800 SPEECH PATHOLOGY		0. 3674		119, 652	
8. 10	06801 SPEECH THERAPY LIVING CENTER		0. 3102		0	1
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 0000		0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1522		-	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2118			
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 1919	·		1
76. 00	03020 CARDI OLOGY		0. 3197			
	OUTPATIENT SERVICE COST CENTERS			2,217	., ., .,	1 - `
90. 00	09000 CLI NI C		0.0000	00 0	0	90.0
90. 10	09001 FAMILY PRACTICE CLINIC		0.0000		0	90.
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC		2. 1440	47 0	0	90. 3
90. 50	09004 SLEEP DI SORDERS CLINIC		0. 2943	49 0	0	90. 5
	09100 EMERGENCY		0. 5197			
92 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.3335	38 0	0	92 0

0. 294349 0. 519790 0. 333538

2, 558, 272

2, 558, 272

92. 00 0

201. 00

202. 00

771, 534 200. 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 S	SOUTH BE	ND, INC	3	l r	n Lieu o	f Form	CMS-2552-10
					T			

Health Financial Systems MEMORIAL HOSPITAL OF S	SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0058	Peri od:	Worksheet D-3	
			From 01/01/2018	Doto/Time Dro	nanad.
			To 12/31/2018	Date/Time Pre 5/29/2019 8:3	pareu: 6 am
	Ti tl	e XIX	Hospi tal	PPS	<u> </u>
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDI ATRI CS		I	38, 862, 766		30.00
31. 00 03100 NTENSI VE CARE UNIT			12, 057, 010		31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT			17, 246, 154		31.00
40. 00 04000 SUBPROVI DER - 1 PF			17, 240, 134		40.00
41. 00 04100 SUBPROVI DER - 1 RF			0		41. 00
43. 00 04300 NURSERY			2, 463, 855		43.00
ANCI LLARY SERVI CE COST CENTERS			2, 403, 633		43.00
50. 00 05000 OPERATING ROOM		0. 37627	7 19, 880, 836	7, 480, 701	50.00
52. 00 O5200 DELIVERY ROOM & LABOR ROOM		0. 55252		5, 495, 205	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17699		1, 402, 366	1
57. 00 05700 CT SCAN		0. 03697		152, 412	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)		0. 28153		235, 104	1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 11587		218, 047	59. 00
60. 00 06000 LABORATORY		0. 10598		2, 194, 633	1
60. 01 06001 BLOOD LABORATORY		0.00000		2, 171, 000	60. 01
65. 00 06500 RESPIRATORY THERAPY		0. 18086		2, 016, 219	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 41872		390, 023	l
66. 01 06602 PHYSI CAL THERAPY EAST BANK		0. 41104		279	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER		0. 40244		0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY		0. 45080		311, 091	67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 36311		181	67. 10
68. 00 06800 SPEECH PATHOLOGY		0. 36746		113, 370	
68. 10 06801 SPEECH THERAPY LIVING CENTER		0. 31022		0	68. 10
70. 00 O7000 ELECTROENCEPHALOGRAPHY		0. 00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 15228		52, 376	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 21189		0.0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 19192		4, 683, 918	
76. 00 03020 CARDI OLOGY		0. 31978		379, 684	76. 00
OUTPATIENT SERVICE COST CENTERS		0.31770	1, 107, 310	377,004	70.00
90. 00 09000 CLI NI C		0.00000	00	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC		0.00000		0	90. 10
90. 30 O9002 HEMATOLOGY ONCOLOGY CLINIC		2. 14404		35, 265	1
90. 50 09004 SLEEP DI SORDERS CLINI C		0. 29434		0	90. 50
91. 00 09100 EMERGENCY		0. 51979		2, 363, 368	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 33353		2, 300, 300	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			108, 872, 916	27, 524, 242	1
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)	1	0	, 52., 212	201.00
202.00 Net charges (line 200 minus line 201)	()		108, 872, 916		202.00
				1	

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0058 CCN: 15-S058	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Pre 5/29/2019 8:3	pared:
		Ti t	e XIX	Subprovi der – I PF	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	LANDATI ENT. DOUTLANE CERVILOE COCT. CENTERO		1.00	2. 00	3. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		T		I	20.6
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT			0		30.0
31. 00	02060 NEONATAL INTENSIVE CARE UNIT			0		31.0
40. 00	04000 SUBPROVI DER - I PF			537, 075		40.0
41. 00	04100 SUBPROVI DER - I RF			007,070		41. 0
13. 00	04300 NURSERY			0		43. (
	ANCILLARY SERVICE COST CENTERS		•	•	•	
0.00	05000 OPERATING ROOM		0. 3762	77 23, 950	9, 012	50.
2.00	05200 DELIVERY ROOM & LABOR ROOM		0. 55252	21 0	0	52.
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 17699		654	1
7. 00	05700 CT SCAN		0. 0369		76	1
8. 00	05800 MAGNETI C RESONANCE MAGING (MRI)		0. 28153		0	
9.00	05900 CARDI AC CATHETERI ZATI ON		0. 11587		0	59.
0.00	06000 LABORATORY		0. 10598		7, 710	1
0. 01 5. 00	06001 BL00D LABORATORY 06500 RESPI RATORY THERAPY		0. 00000 0. 18086		0 981	60.
6. 00	06600 PHYSI CAL THERAPY		0. 41872		15, 504	
6. 01	06602 PHYSI CAL THERAPY EAST BANK		0. 41104		0	1
6. 10	06601 PHYSI CAL THERAPY LIVING CENTER		0. 4024		0	66.
7. 00	06700 OCCUPATI ONAL THERAPY		0. 45080		11, 494	1
7. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 3631		0	1
8. 00	06800 SPEECH PATHOLOGY		0. 36746	56 0	0	68.
8. 10	06801 SPEECH THERAPY LIVING CENTER		0. 31022	24 0	0	68.
0.00	07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 15228		0	1
2. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 21189		0	72.
	07300 DRUGS CHARGED TO PATIENTS		0. 19192		l	1
6. 00	03020 CARDI OLOGY		0. 31978	35 0	0	76.
0. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		0.0000	00	0	90.
90. 00			0.00000		0	
90. 10	09002 HEMATOLOGY ONCOLOGY CLINIC		2. 14404		0	
	09004 SLEEP DI SORDERS CLINI C		0. 29434		0	1
	09100 EMEDGENCY		0. 2743		6 745	

0. 294349 0. 519790 0. 333538

91. 00

201. 00

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0 92.00

88, 669 200. 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)

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0058 CCN: 15-T058	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Pre 5/29/2019 8:3	pared:
		Titl	e XIX	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)	
	LANDATI SATE DOUTLAND OFFICE COOK OFFICE CO		1.00	2. 00	3. 00	
00 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
30.00	03000 ADULTS & PEDIATRICS			0		30.0
31. 00 31. 01	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT			0		31. 0 31. 0
40. 00	04000 SUBPROVI DER - I PF			0		40.0
41. 00	04100 SUBPROVI DER - I RF			932, 134		41. (
13. 00	04300 NURSERY			0		43. (
	ANCILLARY SERVICE COST CENTERS		1			
0.00	05000 OPERATING ROOM		0. 3762	77 1, 029	387	50.
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 55252	21 0	0	52.
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1769	94 25, 747	4, 557	54.
7. 00	05700 CT SCAN		0. 0369	76 9, 207	340	57.
8. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 2815		1, 657	
9. 00	05900 CARDI AC CATHETERI ZATI ON		0. 1158		0	59.
0.00	06000 LABORATORY		0. 10598		5, 596	
0. 01	06001 BLOOD LABORATORY		0.00000		0	60.
5. 00	06500 RESPI RATORY THERAPY		0. 1808		2, 143	
6. 00	06600 PHYSI CAL THERAPY 06602 PHYSI CAL THERAPY EAST BANK		0. 41872 0. 41104		68, 237	66. 66.
6. 10	06601 PHYSI CAL THERAPY LIVING CENTER		0.4110		0 0	66.
7. 00	06700 OCCUPATI ONAL THERAPY		0. 45080		68, 213	
7. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 3631		00, 219	
8. 00	06800 SPEECH PATHOLOGY		0. 3674		39, 149	
8. 10	06801 SPEECH THERAPY LIVING CENTER		0. 3102		0	
0. 00	07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70.
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 15228	58, 156	8, 856	71.
2. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 21189	96 0	0	72.
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 1919:	29 200, 526	38, 487	73.
6. 00	03020 CARDI OLOGY		0. 31978	35 496	159	76.
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		0. 00000		0	90.
90. 10	09001 FAMILY PRACTICE CLINIC		0.00000		0	
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC		2. 1440		0	90.
	09004 SLEEP DI SORDERS CLINIC		0. 2943		0	
a 1 (1(1)	INO INDIEMERIEMI'V			aru - 1 220		

0. 294349 0. 519790 0. 333538

238, 420 200. 00

639 0 92.00

91.00

201. 00

202. 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)

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 01/01/2018 Part A To 12/31/2018 Date/Time Prepared:

			10 12/31/2018	Date/IIme Pre 5/29/2019 8:3	
		Title XVIII	Hospi tal	PPS	<u> </u>
	DADT A LANDATI ENT HOCOLITAL CEDIM OFC HADED LDDC			1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring instructions)	ng prior to October 1 (see	36, 704, 564	1
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see				1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	orior 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
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			2, 643, 208	
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repor	rting period (see instru	ctions)	21, 554, 567 370. 95	3. 00 4. 00
F 00	Indirect Medical Education Adjustment			4/ 7/	
5. 00	FTE count for allopathic and osteopathic programs for the most or 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 that meet the new programs in accordance with 42 CFR 413.79(e)	ne criteria for an add-o	n to the cap for	0.00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified u			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 CFR §412. 105(f)(1)(i	/)(B)(2) If the	0.00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopar affiliated programs in accordance with 42 CFR 413.75(b), 413.1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slope report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	3. 00	8. 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	es (8, 8,01 and 8,02) (9	see	19. 76	9. 00
10. 00	instructions) FTE count for allopathic and osteopathic programs in the curre	ent vear from vour recor	ds	27. 15	10.00
11. 00	FTE count for residents in dental and podiatric programs.			0.00	
12.00	Current year allowable FTE (see instructions)			19. 76	12. 00
13.00	Total allowable FTE count for the prior year.			19. 76	13. 00
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ar ended on or after Sep	tember 30, 1997,	19. 76	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			19. 76	15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
17.00	Adjustment for residents displaced by program or hospital clos	sure		0.00	17. 00
18.00	Adjusted rolling average FTE count			19. 76	18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4)).		0. 053269	19. 00
20.00	Prior year resident to bed ratio (see instructions)			0. 054796	20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 053269	
22. 00	IME payment adjustment (see instructions)			1, 380, 782	
22. 01	IME payment adjustment - Managed Care (see instructions)	C 11 MMA		618, 077	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 Number of additional allopathic and osteopathic IME FTE reside	ent cap slots under 42 C	FR 412. 105	0.00	23. 00
24.00	(f)(1)(iv)(C).			7 20	24.00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the I	ower of line 23 or line	24 (see	7. 39 0. 00	1
24 00	instructions)			0.000000	24 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	1
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	
	IME add-on adjustment amount (see instructions)		0	1	
			1 200 702		
29. 01			1, 380, 782 618, 077	1	
	Di sproporti onate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	5. 12	
31. 00	Percentage of Medicaid patient days (see instructions)			33. 82	
	Sum of lines 30 and 31			38. 94	
33.00	Allowable disproportionate share percentage (see instructions))		21.34	
34. UU	0 Disproportionate share adjustment (see instructions) 2,568,9				

Heal th	Financial Systems MEMORIAL HOSPITAL OF S	OUTH REND INC	In lie	eu of Form CMS-:	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0058	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A	pared:
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment				
35. 00	Total uncompensated care amount (see instructions)			8, 272, 872, 447	
35. 01	Factor 3 (see instructions)		0. 000810874	l	
35. 02	Hospital uncompensated care payment (If line 34 is zero, enter instructions)	zero on this line) (se			35. 02
35. 03	Pro rata share of the hospital uncompensated care payment amou		4, 103, 926		1
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		5, 472, 053		36. 00
40.00	Additional payment for high percentage of ESRD beneficiary dis				40.00
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding c 652, 682, 683, 684 and 685 (see instructions)	n scharges for MS-DRGS	0		40.00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68 instructions)	33, 684 an 685. (see	0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-E an 685. (see instructions)	DRGs 652, 682, 683, 684	0		41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qualif	v for adjustment)	0.00		42. 00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682 instructions)		0	l	43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0. 000000		44. 00
45. 00	days) 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.		0.00		46. 00
47. 00	Subtotal (see instructions)	01)	60, 217, 796		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, sm	nall rural hospitals	00, 217, 770		48. 00
10.00	only. (see instructions)	iar i ar ar meepr tare			10.00
				Amount	
10.00				1.00	10.00
49. 00	Total payment for inpatient operating costs (see instructions)			60, 835, 873	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			4, 575, 559	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0 071 407	51. 00 52. 00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, lir Nursing and Allied Health Managed Care payment	le 49 see Instructions).		871, 697 27, 539	
54. 00	Special add-on payments for new technologies			1, 575	
54. 00	Islet isolation add-on payment			1, 3/3	54. 00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69))		0	55. 00
56. 00	Cost of physicians' services in a teaching hospital (see intru			0	56.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. II		arough 35)	0	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt. I		ii ougii 55).	55, 334	
59. 00	Total (sum of amounts on lines 49 through 58)	., 551. 11 11110 200)		66, 367, 577	1
60. 00	Primary payer payments			68, 572	
61. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		66, 299, 005	
62. 00	Deductibles billed to program beneficiaries			4, 958, 020	1
63. 00	Coinsurance billed to program beneficiaries			207, 257	
64. 00	Allowable bad debts (see instructions)			540, 007	
65.00	Adjusted reimbursable bad debts (see instructions)			351, 005	1
66. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		157, 553	66. 00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	-		61, 484, 733	67. 00
68 00	Credits received from manufacturers for real aced devices for a	l o	68 00		

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

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

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

70.00 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

0 68.00

69.00

70.00

70.88

70.89

70. 90

0

0 70.50

0 70.87

0

0 70. 91

0 70. 92 22 70. 93

-27, 510 70. 94

0 70.95

-41, 122

70.87

70. 90

Health Financial Systems	MEMORIAL HOSPITAL OF S	OUTH BEND, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF DELMOUDCEMENT CETTLEMENT		D: J CON 15 0050	D!!	Wasaliala a 4 F

	ATION OF REIMBURSEMENT SETTLEMENT	Provider Co		Peri od: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70. 97
70.00	the corresponding federal year for the period ending on or af	ter 10/1)				70.00
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)	(0 0 70)			0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			61, 416, 101	
71. 01	Sequestration adjustment (see instructions)				1, 228, 322	
71. 02	Demonstration payment adjustment amount after sequestration				(0 (77 105	71. 02
72.00	Interim payments				60, 677, 105	
73.00	Tentative settlement (for contractor use only)	12 72 and			400 224	73.00
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0 73)				-489, 326	
75. 00	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	ance with			0	75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sumplus 2.04 (see instructions)	of 2.03			0	90. 00
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instr				0	92. 00
93.00	Capital outlier reconciliation adjustment amount (see instruc	ctions)			0	93. 00
94. 00	The rate used to calculate the time value of money (see instr				0. 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 instruc	ctions)			0	96. 00
				Prior to 10/1 1.00	0n/After 10/1 2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0. 9991073745		
102.00	HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0	0	102. 00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0. 9995	0. 9995	103. 00
104.00	HRR adjustment amount for HSP bonus payment (see instructions			0	0	104. 00
	Rural Community Hospital Demonstration Project (§410A Demonstration by this the first year of the current 5-year demonstration pe	ration) Adju		0		104. 00 200. 00
	Rural Community Hospital Demonstration Project (§410A Demonstration per List this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	ration) Adju		0		
200. 00	Rural Community Hospital Demonstration Project (§410A Demonstration pet this the first year of the current 5-year demonstration pet Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ration) Adju eriod under t		0		200. 00
200.00	Rural Community Hospital Demonstration Project (§410A Demonstration pet this the first year of the current 5-year demonstration pet Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin.	ration) Adju eriod under t		0		200. 00 201. 00
200. 00 201. 00 202. 00	Rural Community Hospital Demonstration Project (§410A Demonstration per List this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, linemedicare discharges (see instructions)	ration) Adju eriod under t				200. 00 201. 00 202. 00
200. 00 201. 00 202. 00	Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project Its this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	ration) Adju eriod under t ne 49)	he 21st			200. 00 201. 00
200. 00 201. 00 202. 00	Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project Pro	ration) Adju eriod under t ne 49)	he 21st			200. 00 201. 00 202. 00
200. 00 201. 00 202. 00 203. 00	Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project Pro	ration) Adju eriod under t ne 49)	he 21st		ration	200. 00 201. 00 202. 00 203. 00
200. 00 201. 00 202. 00 203. 00 204. 00	Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project Pro	ration) Adju eriod under t ne 49)	he 21st		ration	200. 00 201. 00 202. 00 203. 00 204. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project In this the first year of the current 5-year demonstration percentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	eration) Adju eriod under t ne 49) u first year	he 21st		crati on	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	Rural Community Hospital Demonstration Project (§410A Demonstration by this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	eration) Adju eriod under t ne 49) u first year	he 21st		crati on	200. 00 201. 00 202. 00 203. 00 204. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	Rural Community Hospital Demonstration Project (§410A Demonstration by this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	eration) Adju eriod under t ne 49) u first year	he 21st		crati on	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00	Rural Community Hospital Demonstration Project (§410A Demonstration by this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	ration) Adju eriod under t me 49) i first year	he 21st		trati on	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	Rural Community Hospital Demonstration Project (§410A Demonstration per List this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin. Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	ration) Adju eriod under t me 49) i first year	he 21st		ration	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	ration) Adju eriod under t me 49) i first year	he 21st		rati on	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, linemedicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ration) Adju eriod under t ne 49) i first year cructions) line 59)	he 21st		rati on	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Rural Community Hospital Demonstration Project (§410A Demonstration by this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ration) Adju eriod under t ne 49) i first year cructions) line 59)	he 21st		rati on	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00	Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, linemedicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ration) Adju eriod under t me 49) i first year cructions) line 59)	he 21st		cration	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00 212. 00	Rural Community Hospital Demonstration Project (§410A Demonstration by this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line 100)	ration) Adju eriod under t me 49) i first year cructions) line 59)	he 21st		tration	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00 212. 00 213. 00	Rural Community Hospital Demonstration Project (§410A Demonstration by this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ration) Adju eriod under t me 49) in first year cructions) line 59)	of the currer		tration	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00 212. 00 213. 00	Rural Community Hospital Demonstration Project (§410A Demonstration by this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line Low-volume adjustment (see instructions)	ration) Adju eriod under t me 49) in first year cructions) line 59)	of the currer		tration	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00

Health Financial Systems	MEMORIAL HOSPITAL OF S	OUTH BEND, INC	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0058	From 01/01/2018	Worksheet E Part B Date/Time Prepared:

Date/Time Prepared: 5/29/2019 8:36 am Title XVIII Hospi tal PPS 1.00 PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) 97 Medical and other services reimbursed under OPPS (see instructions) 32, 517, 199 2.00 2.00 3.00 OPPS payments 29, 456, 220 3 00 4.00 Outlier payment (see instructions) 437, 349 4.00 4.01 Outlier reconciliation amount (see instructions) 4.01 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 6.00 Line 2 times line 5 Ω 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. IV, col. 13, line 200 52.974 9 00 10.00 Organ acquisitions 0 10.00 Total cost (sum of lines 1 and 10) (see instructions) 97 11.00 11.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 640 12.00 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 13.00 Total reasonable charges (sum of lines 12 and 13) 14.00 640 14.00 Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 16.00 had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 18.00 Total customary charges (see instructions) 640 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 543 19.00 instructions) 20 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 20 00 0 instructions) 97 21 00 Lesser of cost or charges (see instructions) 21 00 0 22.00 Interns and residents (see instructions) 22.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 23.00 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 29, 946, 543 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions) 25, 00 128 25, 00 26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 5, 158, 757 26.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 24, 787, 755 27.00 27.00 instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 369, 749 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 0 25, 157, 504 30.00 Subtotal (sum of lines 27 through 29) 30.00 31.00 Primary payer payments 3, 389 31.00 32.00 Subtotal (line 30 minus line 31) 25, 1<u>54, 115</u> 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) 33 00 33 00 0 34.00 Allowable bad debts (see instructions) 818, 593 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 532, 085 35.00 539, 123 36, 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 36, 00 25, 686, 200 37.00 Subtotal (see instructions) 37.00 38.00 MSP-LCC reconciliation amount from PS&R -240 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 0 Subtotal (see instructions) 25, 686, 440 40.00 40 00 40.01 Sequestration adjustment (see instructions) 513, 729 40.01 40.02 Demonstration payment adjustment amount after sequestration Ω 40 02 41.00 25, 216, 825 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) Λ 42 00 Balance due provider/program (see instructions) -44, 114 43.00 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 0 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 92 00 0 00 92 00 93.00 Time Value of Money (see instructions) 0 93.00 94.00 Total (sum of lines 91 and 93) 0 94.00

8.00

Part I

From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 8:36 am 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 60, 640, 405 25, 135, 725 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 04/27/2018 36, 700 04/27/2018 81, 100 3.01 3.02 3.02 3.03 3.03 0 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 Λ 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 36, 700 81, 100 3.99 3.50-3.98) 60, 677, 105 25, 216, 825 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 0 6.01 SETTLEMENT TO PROGRAM 489, 326 6 02 44, 114 6.02 7.00 Total Medicare program liability (see instructions) 60, 187, 779 25, 172, 711 7.00 Contractor NPR Date (Mo/Day/Yr) Number 0 1 00 2 00

Provider CCN: 15-0058

Peri od:

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	Subprovider - IPF	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		851, 24	8	0	1. 00 2. 00
3. 00	services rendered in the cost reporting period. If none, write "NONE" or enter a zero 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			0	0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3. 04 3. 05				0	0	3. 04 3. 05
3.05	Provider to Program			U	U	3. 05
3.50	ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 51				Ö	o	3. 51
3.52				o	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		851, 24	0	0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		051, 24	0		4.00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					- 04
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02 5. 03				0	0	5. 02 5. 03
5.05	Provider to Program			0	0	3. 03
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				o	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		5, 89	4	0	6. 01
6.02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		857, 14		NDD Doto	7. 00
)	Contractor Number	NPR Date (Mo/Day/Yr)	
8. 00	Name of Contractor		J	1. 00	2. 00	8. 00
3.00	Inalie of contractor			1		0.00

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	Subprovider - IRF	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	Total interim payments paid to provider		1, 930, 46		0	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 02	ADJUSTIMENTS TO PROVIDER			0		3. 01
3. 03				Ö	ا	3. 02
3.04				O	0	3. 04
3.05				0	0	3.05
	Provider to Program			_		
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51 3. 52				0	0	3. 51 3. 52
3. 52				0		3. 52
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			Ö	o o	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 930, 46	6	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			1		5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			_1	_	
5. 01	TENTATIVE TO PROVIDER			0	0	5. 01
5. 02 5. 03				0		5. 02 5. 03
5.05	Provider to Program			<u> </u>	0	3. 03
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				О	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
4 00	5. 50-5. 98)					4 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			o	o	6. 01
6. 02	SETTLEMENT TO PROGRAM		34, 04	2	Ö	6. 02
7.00	Total Medicare program liability (see instructions)		1, 896, 42	_	0	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor	()	1.00	2.00	8. 00
5.00	name of contractor			I	1	0.00

Heal th	Financial Systems MEMORIAL HOSPITAL OF	SOUTH BEND, INC	In Lie	u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0058 Period: W					
			From 01/01/2018			
			To 12/31/2018	Date/Time Pre 5/29/2019 8:3		
		Title XVIII	Hospi tal	PPS	o an	
				1.00		
	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	e 14		1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00	
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
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	
31.00	Other Adjustment (specify)				31. 00	
22 00	Delenes due provider (line 0 (en line 10) minus line 20 and l	ing 21) (cas instruction	·~\		22 00	

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

30. 00 31. 00 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 01/01/2018	
		Component CCN: 15-S058	To 12/31/2018	Date/Time Prepared:
		·		5/29/2019 8:36 am
		Title XVIII	Subprovi der -	PPS
			IPF	

	I PF		
	PART II - MEDICARE PART A SERVICES - IPF PPS	1.00	
1. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	887, 232	1. 00
2.00	Net IPF PPS Outlier Payments	36, 718	2. 00
3.00	Net IPF PPS ECT Payments	18, 604	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
	15, 2004. (see instructions)		
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
7 00	teaching program" (see instuctions)	0.00	7 00
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	7. 00
8. 00	teaching program" (see instuctions) Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8. 00
9.00	Average Daily Census (see instructions)	8. 465753	9. 00
10.00	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)	942, 554	12. 00
13. 00	Nursing and Allied Health Managed Care payment (see instruction)	0	13. 00
14.00	Organ acqui si ti on (DO NOT USE THIS LINE)		14.00
15.00		l ol	15. 00
16.00	Subtotal (see instructions)	942, 554	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	942, 554	18.00
19.00	Deducti bl es	68, 268	19.00
20.00	Subtotal (line 18 minus line 19)	874, 286	20.00
21. 00	Coi nsurance	5, 665	
22. 00	Subtotal (line 20 minus line 21)	868, 621	
23. 00		9, 224	
24. 00	1 7	5, 996	
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2, 680	
26. 00	Subtotal (sum of lines 22 and 24)	874, 617	
27. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27. 00
28. 00	Other pass through costs (see instructions)	18	28. 00
29. 00	Outlier payments reconciliation	0	29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30. 50 30. 99	Pioneer ACO demonstration payment adjustment (see instructions)		30. 50 30. 99
31. 00	Demonstration payment adjustment amount before sequestration Total amount payable to the provider (see instructions)	874, 635	31. 00
31. 00	Sequestration adjustment (see instructions)	17, 493	31. 00
31. 01		17, 493	31. 01
32. 00	Interim payments	851, 248	
33. 00	Tentative settlement (for contractor use only)	031, 240	33. 00
34. 00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	5, 894	
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	35. 00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	36, 718	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	52. 00
53.00	Time Value of Money (see instructions)	0	53.00

Health Financial Systems	MEMORIAL HOSPITAL OF SO	OUTH BEND, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0058		Worksheet E-3
		Component CCN: 15-T058	From 01/01/2018 To 12/31/2018	
		Title XVIII	Subprovi der - I RF	PPS

	IRF		
		1 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1. 00	
1. 00	Net Federal PPS Payment (see instructions)	1, 789, 252	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0508	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	112, 723	3. 00
4.00	Outlier Payments	38, 643	4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	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	0. 00	5. 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)		
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
8. 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)	7. 964384	10. 00
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12. 00	Teaching Adjustment (see instructions)	0.000000	12. 00
13. 00	Total PPS Payment (see instructions)	1, 940, 618	
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)	o	16. 00
17.00	Subtotal (see instructions)	1, 940, 618	17. 00
18.00	Primary payer payments	0	18. 00
19.00	Subtotal (line 17 less line 18).	1, 940, 618	19.00
20. 00	Deducti bl es	8, 040	
21. 00	Subtotal (line 19 minus line 20)	1, 932, 578	
22. 00	Coi nsurance	0	22. 00
23. 00	Subtotal (line 21 minus line 22)	1, 932, 578	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3, 922	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	2, 549	
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)		26. 00
27. 00	Subtotal (sum of lines 23 and 25)	1, 935, 127	27. 00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
30.00	Other pass through costs (see instructions)	0	29. 00 30. 00
31. 00	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31. 50
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32. 00	Total amount payable to the provider (see instructions)	1, 935, 127	
32. 01	Sequestration adjustment (see instructions)	38, 703	
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
33. 00	Interim payments	1, 930, 466	33. 00
34.00	Tentative settlement (for contractor use only)	0	34. 00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-34, 042	35. 00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36.00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Wkst. E-3, Pt. III, line 4	38, 643	
	Outlier reconciliation adjustment amount (see instructions)	0	51.00
	The rate used to calculate the Time Value of Money	0.00	
55.00	Time Value of Money (see instructions)	ı ol	53. 00

	Financial Systems MEMORIAL HOSPITAL OF GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der Co		Peri od:	Worksheet E-4	
EDI CAL	. EDUCATION COSTS			From 01/01/2018 To 12/31/2018		
		Title	: XVIII	Hospi tal	5/29/2019 8: 30 PPS	o alli
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
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. (
	Unweighted FTE resident cap add-on for new programs per 42 CF Amount of reduction to Direct GME cap under section 422 of MN		1) (see instr	ructions)	0. 00 0. 00	1
01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)		§413.79 (m).	(see	0.00	1
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.
	ACA Section 5503 increase to the Direct GME FTE Cap (see inst 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)	s (see inst	ructions for	cost reporting	3. 00	4.
00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus l	ines 4.01 and	27. 76	5.
00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	27. 15	
00	Enter the lesser of line 5 or line 6		Primary Care	e Other	27. 15 Total	7.
			1. 00	2. 00	3. 00	
	Weighted FTE count for physicians in an allopathic and osteop program for the current year.	athi c	27. 1	5 0.00	27. 15	8.
	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6.		27. 1	0.00	27. 15	9
	Weighted dental and podiatric resident FTE count for the curr	,		0.00		10
1	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	irrent year	27. 1	0. 00 0. 00		10
	Total weighted resident FTE count for the prior cost reporting instructions)	ng year (see	26. 5			12
00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	eporting	26. 6	0.00		13
	Rolling average FTE count (sum of lines 11 through 13 divided	l by 3).	26. 7			14
	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p	rograme	0. C 0. C			15 15
	Adjustment for residents displaced by program or hospital clo		0.0			16
	Unweighted adjustment for residents displaced by program or h		0.0			16
	Adjusted rolling average FTE count		26. 7			17
- 1	Per resident amount Approved amount for resident costs		119, 314. 0 3, 192, 84		3, 192, 843	18 19
					1. 00	
00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots rec	eived under 42	0. 00	20
	Direct GME FTE unweighted resident count over cap (see instru	,			0. 00	
	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a	,	nstructions)		0. 00 0. 00	
	Multiply line 22 time line 23	illiourit (see i	nstructions)		0.00	1
	Total direct GME amount (sum of lines 19 and 24)				3, 192, 843	
			Inpatient Par A	t Managed care		
			1.00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		20.25	0 44 440		\
	Inpatient Days (see instructions) Total Inpatient Days (see instructions)		28, 35 98, 22			26 27
	Ratio of inpatient days to total inpatient days		0. 28862			28
	Program direct GME amount		921, 51			29
. 00	Reduction for direct GME payments for Medicare Advantage			52, 645		30
	Net Program direct GME amount		I .	1	1, 241, 446	1 21

Heal th	Financial Systems MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	u of Form CMS-2	2552-10	
DI RECT	DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 15-0058 Period:					
MEDI CA	L EDUCATION COSTS		From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 8:30		
		Title XVIII	Hospi tal	PPS		
				1. 00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	•		CAL		
32.00	, , , , , , , , , , , , , , , , , , , ,	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00	
	and 94)					
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I		74 and 94)		33. 00	
	Ratio of direct medical education costs to total charges (line	e 32 ÷ line 33)		0. 000000		
	Medicare outpatient ESRD charges (see instructions)	24 1: 25)		0		
36.00	Medicare outpatient ESRD direct medical education costs (line APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII			0	36. 00	
	Part A Reasonable Cost	UNLY				
27 00	Reasonable cost (see instructions)			76, 846, 364	27 00	
38. 00	,			70, 840, 304		
	Cost of physicians' services in a teaching hospital (see insti	ructions)		0		
	Primary payer payments (see instructions)	1 40 (1 0113)		68, 572		
	Total Part A reasonable cost (sum of lines 37 through 39 minus	s line 40)		76, 777, 792		
	Part B Reasonable Cost		Į.			
42.00	Reasonable cost (see instructions)			32, 570, 270	42.00	
43.00				3, 389	43.00	
44.00	Total Part B reasonable cost (line 42 minus line 43)			32, 566, 881	44.00	
45.00	Total reasonable cost (sum of lines 41 and 44)			109, 344, 673	45. 00	
46.00	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line 45)		0. 702163	46. 00	
47.00	Ratio of Part B reasonable cost to total reasonable cost (line			0. 297837	47. 00	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	RT B				
	Total program GME payment (line 31)			1, 241, 446		
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)			871, 697		
50. 00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		369, 749	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: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 8: 36 am

OH y)					5/29/2019 8: 3	<u>6 am</u>
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
4 00	CURRENT ASSETS	2 (04 000	J			4 00
1. 00 2. 00	Cash on hand in banks Temporary investments	-3, 694, 000 12, 000		_	1	
3.00	Notes receivable	12,000		_	0	3.00
4. 00	Accounts receivable	125, 865, 763	1	0	0	
5. 00	Other recei vabl e	48, 580, 000		0	Ö	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-28, 808, 763		0	Ō	6. 00
7.00	Inventory	17, 814, 000	0	0	0	7. 00
8.00	Prepai d expenses	1, 774, 000	0	0	0	
9.00	Other current assets	0	0	0	0	9. 00
10. 00	Due from other funds	0	5, 758, 000		0	10. 00
11. 00	Total current assets (sum of lines 1-10)	161, 543, 000	5, 758, 000	0	0	11. 00
40.00	FI XED ASSETS	04 504 000				40.00
12.00	Land	21, 501, 000	0	_	-	12.00
13. 00 14. 00	Land improvements Accumulated depreciation	0		_		13. 00 14. 00
15. 00	Buildings	504, 886, 000	1	0	0	15. 00
16. 00	Accumulated depreciation	-460, 418, 000		0	Ö	16. 00
17. 00	Leasehold improvements	0	o o	Ö	o o	17. 00
18. 00	Accumulated depreciation	0	ō	0	Ō	18. 00
19.00	Fi xed equipment	294, 503, 000	0	0	0	19. 00
20.00	Accumul ated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Maj or movable equipment	0	0	0	0	23. 00
24. 00	Accumulated depreciation	0	0	0	0	24. 00
25. 00	Mi nor equipment depreciable	0	0	0	0	25. 00
26. 00	Accumulated depreciation HIT designated Assets	0	0	0	0	26. 00 27. 00
27. 00 28. 00	Accumulated depreciation	0		0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e			_	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	360, 472, 000	1	_		30.00
00.00	OTHER ASSETS	1 000/1/2/000	,			00.00
31.00	Investments	11, 184, 000	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	0	0	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	11, 184, 000		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	533, 199, 000	5, 758, 000	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	43, 776, 000	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	43, 776, 000		0	1	38.00
39. 00	Payroll taxes payable			0	0	
40. 00	Notes and Loans payable (short term)	5, 179, 000		0	ő	
41. 00	Deferred income	0	ō	0	Ō	41. 00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5, 469, 000	0	0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	54, 424, 000	0	0	0	45. 00
	LONG TERM LIABILITIES	T	_		г	
46.00	Mortgage payable	0	0	_	1	
47. 00	Notes payable	152, 350, 000	0	_		
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	14, 051, 000		_	l	48. 00 49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	166, 401, 000		_	l	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	220, 825, 000		_	l	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	312, 374, 000				52. 00
53.00	Specific purpose fund		5, 758, 000			53.00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted		1	0		55. 00
56. 00	Governing body created - endowment fund balance			0	l	56. 00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,		1		0	58. 00
E0 00	replacement, and expansion	212 274 000	E 750 000	_	_	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	312, 374, 000 533, 199, 000			0	
00.00	[59]	333, 177, 000	3, 730, 000			00.00
	1 - 1	1	1	ļ	1	1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10 MEMORIAL HOSPITAL OF SOUTH BEND, INC Provider CCN: 15-0058 Peri od: Worksheet G-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 8:36 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) 1.00 290, 987, 000 1.00 6, 814, 000 2.00 120, 105, 000 2.00 3.00 3.00 Total (sum of line 1 and line 2) 411, 092, 000 6, 814, 000

4.00	CAPI TAL CONTRIBUTIONS	0		-1, 056, 000		0	4.00
5.00	NET ASSETS RELEASED FROM RESTRICTION	1, 155, 000		0		0	5.00
6.00		0		0		ol	6.00
7.00		0		0		ol	7.00
8.00		0		0		o	8. 00
9.00		0		0		o	9. 00
10.00	Total additions (sum of line 4-9)		1, 155, 000		-1, 056, 000		10.00
11.00	Subtotal (line 3 plus line 10)		412, 247, 000		5, 758, 000		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		ol	12.00
13.00		0		0		o	13.00
14.00	TRANSFER TO BEACON HEALTH SYSTEM	99, 873, 000		0		o	14.00
15.00		0		0		o	15.00
16.00		0		0		o	16.00
17.00		0		0		ol	17.00
18.00	Total deductions (sum of lines 12-17)		99, 873, 000		0		18.00
19.00	Fund balance at end of period per balance		312, 374, 000		5, 758, 000		19.00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
	T	6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0		0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)	_		_			2. 00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	CAPI TAL CONTRI BUTI ONS		0				4. 00
5.00							5.00
	NET ASSETS RELEASED FROM RESTRICTION		0				
6.00	NET ASSETS RELEASED FROM RESTRICTION		0				6. 00
7.00	NET ASSETS RELEASED FROM RESTRICTION		0 0 0				6. 00 7. 00
7. 00 8. 00	NET ASSETS RELEASED FROM RESTRICTION		0 0 0 0				6. 00 7. 00 8. 00
7. 00 8. 00 9. 00			0 0 0 0				6. 00 7. 00 8. 00 9. 00
7.00 8.00 9.00 10.00	Total additions (sum of line 4-9)	O	0 0 0 0	O			6. 00 7. 00 8. 00 9. 00 10. 00
7. 00 8. 00 9. 00 10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0	0 0 0 0	0			6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Total additions (sum of line 4-9)	0	0 0 0 0 0	0			6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0	0			6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0	0 0 0 0 0	0			6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0	0			6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0	0 0			6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) TRANSFER TO BEACON HEALTH SYSTEM	0	0 0 0 0 0	0 0			6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) TRANSFER TO BEACON HEALTH SYSTEM Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0 0 0	0 0			6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) TRANSFER TO BEACON HEALTH SYSTEM Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0	0 0 0 0 0 0 0 0	0 0 0			6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) TRANSFER TO BEACON HEALTH SYSTEM Total deductions (sum of lines 12-17)	0 0 0	0 0 0 0 0 0 0 0	0 0			6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00

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

			То	12/31/2018	Date/Time Prep 5/29/2019 8:30	
	Cost Center Description	Inpatient		Outpati ent	Total	J dill
		1. 00		2. 00	3. 00	
	PART I - PATIENT REVENUES				2. 22	
	General Inpatient Routine Services					
1.00	Hospi tal	237, 361, 64	10		237, 361, 640	1. 00
2.00	SUBPROVI DER - I PF	3, 858, 67			3, 858, 674	2. 00
3.00	SUBPROVIDER - IRF	7, 990, 35			7, 990, 356	3. 00
4.00	SUBPROVI DER	, , , , , ,			, ,	4. 00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY				_	7. 00
8.00	NURSING FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	249, 210, 67	70		249, 210, 670	
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	47, 961, 56	59		47, 961, 569	11. 00
11. 01	NEONATAL INTENSIVE CARE UNIT	28, 892, 74			28, 892, 740	
12. 00	CORONARY CARE UNIT					12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL I NTENSI 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	76, 854, 30)9		76, 854, 309	16. 00
	11-15)	7 07 00 17 00	"		, 0, 00 , 00 ,	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	326, 064, 97	79		326, 064, 979	17. 00
18. 00	Ancillary services	630, 298, 63		0	630, 298, 638	18. 00
19. 00	Outpati ent servi ces		0	618, 353, 495	618, 353, 495	19. 00
20. 00	RURAL HEALTH CLINIC	1	0	0.0,000,170	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY			Ĭ	· ·	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	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	956, 363, 61	17	618 353 495	1, 574, 717, 112	28. 00
20.00	G-3, line 1)	700,000,01	' '	010, 000, 170	1, 0, 1, , 1, , 112	20.00
	PART II - OPERATING EXPENSES	1				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			447, 626, 907		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	Ĭ		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)(transfer			447, 626, 907		43. 00
	to Wkst. G-3, line 4)					
		•	,	'		

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

STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0058	Peri od: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prep 5/29/2019 8:30	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		1, 574, 717, 112	1.00
2.00	Less contractual allowances and discounts on patients' accounts				2.00
3.00	Net patient revenues (line 1 minus line 2)			543, 838, 213	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 4	3)		447, 626, 907	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			96, 211, 306	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			122, 439	7. 00
8. 00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9. 00	Revenue from television and radio service			0	9. 00
	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			1, 583, 399	
	Parking Lot receipts			324, 563	
	Revenue from laundry and linen service			0	13.00
	Revenue from meals sold to employees and guests			1, 617, 322	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other th	an patients		0	16. 00
	00 Revenue from sale of drugs to other than patients			0	17. 00
	00 Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
	Rental of vending machines			0	21. 00
	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			2, 458, 789	
	MI SC OTHER REVENUE			16, 158, 929	
	Total other income (sum of lines 6-24)			22, 265, 441	
	Total (line 5 plus line 25)			118, 476, 747	
	UNREALIZED LOSS ON SWAP			-1, 628, 253	
	Total other expenses (sum of line 27 and subscripts)			-1, 628, 253	
29. 00	Net income (or loss) for the period (line 26 minus line 28)			120, 105, 000	29. 00

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CM						
CALCULATION OF CAPITAL PAYMENT Provider CCN: 15-0058 Period: From 01/01/2018 To 12/31/2018			Worksheet L Parts I-III Date/Time Prepared: 5/29/2019 8:36 am			
	Title XVIII Hospital					
			110001 141	PPS		
				1. 00		
	PART I - FULLY PROSPECTIVE METHOD					
	CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier			3, 892, 956	1.00	
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01	
2.00	Capital DRG outlier payments			277, 735	2. 00	
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01	
3.00	Total inpatient days divided by number of days in the cost re	porting period (see inst	ructions)	256. 54	3. 00	
4.00	Number of interns & residents (see instructions)			19. 76	4.00	
5.00	Indirect medical education percentage (see instructions)			2. 19	5. 00	
6.00	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)	sum of lines 1 and 1.01	, columns 1 and	85, 256	6. 00	
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line				7. 00	
0.00	30) (see instructions)					
8.00					8. 00	
9. 00 10. 00	Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions	38. 94 8. 21	1			
11. 00	Disproportionate share adjustment (see instructions)	8. 21 319. 612	•			
12.00	Total prospective capital payments (see instructions)	4, 575, 559				
12.00	Total prospective capital payments (see mistructions)		4, 575, 559	12.00		
				1. 00		
	PART II - PAYMENT UNDER REASONABLE COST					
1.00	Program inpatient routine capital cost (see instructions)			0		
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00	
3.00	Total inpatient program capital cost (line 1 plus line 2)				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	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00		
1.00					1.00	
2.00	Program inpatient capital costs for extraordinary circumstance	es (see instructions)		0	2.00	
3. 00	Net program inpatient capital costs (line 1 minus line 2)	(,		0	1	
4. 00	Applicable exception percentage (see instructions)			0.00		
5. 00	Capital cost for comparison to payments (line 3 x line 4)				5. 00	
6. 00	Percentage adjustment for extraordinary circumstances (see in	structions)		0.00	1	
7. 00	Adjustment to capital minimum payment level for extraordinary		line 6)	0		
8. 00	Capital minimum payment level (line 5 plus line 7)		/	0		
9. 00					9. 00	
10.00	Current year comparison of capital minimum payment level to c	less line 9)	0	10. 00		
44 00						

11.00

0 12.00

0 13.00 0 14.00

0 15.00 0 16.00 0 17.00

10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)
11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year

12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)

14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period

Worksheet L, Part III, line 14)

(if line 12 is negative, enter the amount on this line)

17.00 Current year exception offset amount (see instructions)

15.00 Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)