| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S PARTS I, II & III

| PART I - COST R | EPORT STATUS | | | | | | | |
|-----------------|------------------|---|---|-------------|--|--|--|--|
| Provider use on | y | 1. [X] Electronically filed cost report Date: 09/25/2018 Time | | Time: 10:47 | | | | |
| | | 2. [] Manually subr | 2. [] Manually submitted cost report | | | | | |
| | | 3. [] If this is an am | 3. [] If this is an amended report enter the number of times the provider resubmitted the cost report | | | | | |
| | | 4. [F] Medicare Util | ization. Enter 'F' for full or 'L' | for low. | | | | |
| Contractor | 5. [] Cost Repor | rt Status | 6. Date Received: | _ | 10. NPR Date: | | | |
| use only | (1) As Submi | tted | 7. Contractor No.: | | 11. Contractor's Vendor Code: | | | |
| | (2) Settled wi | thout audit | 8. [] Initial Report for this Pr | rovider CCN | 12. [] If line 5, column 1 is 4: | | | |
| | (3) Settled wi | th audit | 9. [] Final Report for this Provider CCN | | Enter number of times reopened = $0-9$. | | | |
| | (4) Reopened | | | | | | | |
| | (5) Amended | | | | | | | |

PART II - CERTIFICATION

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

CERTIFICATION BY 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 ST. JOSEPHS REG MED CENTER S. BEND (15-0012) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2017 and ending 06/30/2018, 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.

| Γ | I have read and agree with the above certification statement. | I certify that I intend | my electronic cianature on thic | certification statement to be the legal | v hinding equivalent of my | original cignature |
|-----|---|---------------------------|---------------------------------|---|----------------------------|---------------------|
| -1- | I have read and agree with the above certification statement. | . I certify that I intend | my electronic signature on this | cerneteation statement to be the legal | y omding equivalent of my | Original signature. |

| (Signe | d) | |
|--------|--|---|
| | Chief Financial Officer or Administrator of Provider(s |) |
| | | |
| | Title | |
| | | |
| - | Data | |

PART III - SETTLEMENT SUMMARY

| 1 / 11 1 | TAKI III - GETTEEMENT GUMMAKI | | | | | | | | | |
|----------|------------------------------------|---------|----------|----------|-----|-----------|-----|--|--|--|
| | | | TITLE | XVIII | | | | | | |
| | | TITLE V | PART A | PART B | HIT | TITLE XIX | | | | |
| | | 1 | 2 | 3 | 4 | 5 | | | | |
| 1 | HOSPITAL | | -130,712 | -189,799 | | 7,829 | 1 | | | |
| 2 | SUBPROVIDER - IPF | | | | | | 2 | | | |
| 3 | SUBPROVIDER - IRF | | 33,132 | -525 | | | 3 | | | |
| 4 | SUBPROVIDER (OTHER) | | | | | | 4 | | | |
| 5 | SWING BED - SNF | | | | | | 5 | | | |
| 6 | SWING BED - NF | | | | | | 6 | | | |
| 7 | SKILLED NURSING FACILITY | | | | | | 7 | | | |
| 8 | NURSING FACILITY | | | | | | 8 | | | |
| 9 | HOME HEALTH AGENCY | | | | | | 9 | | | |
| 10 | HEALTH CLINIC - RHC | | | | | | 10 | | | |
| 11 | HEALTH CLINIC - FQHC | | | | | | 11 | | | |
| 12 | OUTPATIENT REHABILITATION PROVIDER | | | | | | 12 | | | |
| 200 | TOTAL | | -97,580 | -190,324 | | 7,829 | 200 | | | |

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

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Atm: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

| | l and Hospital Health Care Complex Address: | | | | | | | | | | | | | |
|---|---|--|--|---|--|--|--|--------------------|----------------|---------------------------|--|--|--|--|
| | Street: 5215 HOLY CROSS PARKWAY | P.O. Box: | | | | | | | | | 1 | | | |
| | City: MISHAWAKA | State: IN | ZIP (| Code: 46545 | | County: SAI | NT JOSEPH | | | | 2 | | | |
| ospita | l and Hospital-Based Component Identification | : | | | | | | Pa | yment Sys | stem | | | | |
| | | | | | | | | | P, T, O, or | | | | | |
| | Component | Component | | CCN | CBSA | Provider | Date | v | XVIII | XIX | | | | |
| | - | Name | | Number | Number | Type | Certified | | | | | | | |
| | 0 | GT LOSEDIJS DEC MED CENTE | ED C DEND | 2 | 3 | 4 | 5 | 6 N | 7 P | 8 P | 3 | | | |
| | Hospital Subprovider - IPF | ST. JOSEPHS REG MED CENTE | EK S. BEND | 15-0012 | 43780 | 1 | 07 / 01 / 1996 | IN | P | P | 4 | | | |
| | Subprovider - IRF | ST JOSEPH REG MED CTR - RE | EHAB | 15-T012 | 43780 | 5 | 06 / 01 / 1983 | N | P | P | 5 | | | |
| | Subprovider - (OTHER) | | | | | | | | | | 6 | | | |
| | Swing Beds - SNF | | | | | | | | | | 7 | | | |
| | Swing Beds - NF | | | | | | - | | | - | 8 | | | |
|) | Hospital-Based SNF Hospital-Based NF | | | | | | - | | | | 9 | | | |
| <u>, </u> | Hospital-Based OLTC | | | | | | 1 | | | | 11 | | | |
| 2 | Hospital-Based HHA | | | | | | | | | | 12 | | | |
| } | Separately Certified ASC | | | | | | | | | | 13 | | | |
| 1 | Hospital-Based Hospice | | | | | | | | | | 14 | | | |
| 5 | Hospital-Based Health Clinic - RHC | | | | | | | | | | 15 | | | |
| <u>5</u> 7 | Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) | | | | | | - | | _ | | 16 17 | | | |
| 3 | Renal Dialysis | | | | | | 1 | | | | 18 | | | |
|) | Other | | | | | | | | | | 19 | | | |
| | | | | | | | | | | | | | | |
| 0 | Cost Reporting Period (mm/dd/yyyy) | From: 07 / 01 / 2017 | 1 | o: 06 / 30 / 20 |)18 | | | | | | 20 | | | |
| | Type of control (see instructions) | 1 | | | | | | | 1 2 | 1 2 | 21 | | | |
| patien | nt PPS Information Does this facility qualify for and receive disp | roportionata shara baspital paymant | a in accordance | with 42 CED | 8412 1062 | In column 1 | antar 'V' for | 1 | 2 | 3 | | | | |
| | yes or 'N' for no. Is this facility subject to 42 | | | | | | | Y | N | | 22 | | | |
| | Did this hospital receive interim uncompensa | | | | | | | | | | • | | | |
| .01 | portion of the cost reporting period occurring | | | | | | | Y | Y | | 22. | | | |
| | occurring on or after October 1. (see instructions) | | | | | | | | | | | | | |
| | Is this a newly merged hospital that requires | | | | | | | | | | II | | | |
| 2.02 | 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 | | | | | | N | N | | 22. | | | | |
| | portion of the cost reporting period on or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by | | | | | | | | | | - | | | |
| | | | | | | | | | | | | | | |
| 2.03 | | | 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 acc | but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no. | | | | | | | N | N | 22. | | | |
| | Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date | | | | | hospital conta | in at least 100 | N | N | N | 22. | | | |
| | 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 | | | | | hospital conta , 2 if census | days, or 3 if date | IN . | | N | | | | |
| 3 | of discharge. Is the method of identifying the | days on lines 24 and/or 25 below? I | nter in column 3 In column 1, ent | instructions) , 'Y' for yes of er 1 if date of | 'N' for no admission | hospital conta , 2 if census | days, or 3 if date | N 3 | N N | N | 22.0 | | | |
| 3 | | days on lines 24 and/or 25 below? I | nter in column 3 In column 1, ent | instructions), 'Y' for yes or er 1 if date of method used | 'N' for no admission in the prior | hospital conta , 2 if census r cost reportin | days, or 3 if date ng period? In | IN . | N | | | | | |
| 3 | of discharge. Is the method of identifying the | days on lines 24 and/or 25 below? I | In column 1, enter in column 1, enter in column 1, enter ifferent from the | instructions) , 'Y' for yes or er 1 if date of method used In-State | admission in the prior | nospital conta , 2 if census or r cost reportin | days, or 3 if date ag period? In Out-of-State | 3 | N | Other | | | | |
| 3 | of discharge. Is the method of identifying the | days on lines 24 and/or 25 below? I | In-State Medicaid | instructions), 'Y' for yes or er 1 if date of method used | admission in the prior | hospital conta ., 2 if census r cost reportin t-of-State Medicaid | days, or 3 if date ng period? In | IN . | N d N | Other fedicaid | | | | |
| 3 | of discharge. Is the method of identifying the | days on lines 24 and/or 25 below? I | In column 1, enter in column 1, enter in column 1, enter ifferent from the | instructions) , 'Y' for yes of er 1 if date of method used In-State Medicai | admission in the prior | nospital conta , 2 if census or r cost reportin | days, or 3 if date ag period? In Out-of-State Medicaid | 3 Medicai | N d N | Other | | | | |
| | of discharge. Is the method of identifying the column 2, enter 'Y' for yes or 'N' for no. | days on lines 24 and/or 25 below? I days in this cost reporting period dis | In-State Medicaid | instructions) , 'Y' for yes or er 1 if date of method used In-State Medicai eligible | admission in the prior | hospital conta ., 2 if census r cost reportin t-of-State Medicaid | days, or 3 if date ng period? In Out-of-State Medicaid eligible | 3 Medicai | N d N | Other fedicaid | 23.0 | | | |
| | of discharge. Is the method of identifying the column 2, enter 'Y' for yes or 'N' for no. If this provider is an IPPS hospital, enter the | days on lines 24 and/or 25 below? I days in this cost reporting period dis- | In-State Medicaid | instructions) , 'Y' for yes or er 1 if date of method used In-State Medicai eligible unpaid da | admission in the prior | hospital conta , 2 if census r cost reportin t-of-State Medicaid aid days | days, or 3 if date ag period? In Out-of-State Medicaid eligible unpaid days | 3 Medicai HMO da | N d N | Other Iedicaid days | | | | |
| | of discharge. Is the method of identifying the column 2, enter 'Y' for yes or 'N' for no. If this provider is an IPPS hospital, enter the column 1, in-state Medicaid eligible unpaid of | days on lines 24 and/or 25 below? I days in this cost reporting period dis- in-state Medicaid paid days in ays in column 2, out-of-state | In column 3 In column 1, enter in column 1, enter from the In-State Medicaid paid days | Instructions) Y for yes or er 1 if date of method used In-State Medicai eligible unpaid da 2 | 'N' for no admission in the prior | hospital conta , 2 if census or r cost reportin t-of-State fedicaid aid days | days, or 3 if date ng period? In Out-of-State Medicaid eligible unpaid days 4 | 3 Medicai HMO day | N d ys M | Other Iedicaid days | 23 | | | |
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| | of discharge. Is the method of identifying the column 2, enter 'Y' for yes or 'N' for no. If this provider is an IPPS hospital, enter the column 1, in-state Medicaid eligible unpaid of Medicaid paid days in column 3, out-of-state | days on lines 24 and/or 25 below? I days in this cost reporting period did in-state Medicaid paid days in ays in column 2, out-of-state Medicaid eligible unpaid days in out unpaid days in column 5, and | In column 3 In column 1, enter in column 1, enter from the In-State Medicaid paid days | Instructions) Y for yes or er 1 if date of method used In-State Medicai eligible unpaid da 2 | 'N' for no admission in the prior | hospital conta , 2 if census or r cost reportin t-of-State fedicaid aid days | days, or 3 if date ng period? In Out-of-State Medicaid eligible unpaid days 4 | 3 Medicai HMO day | N d ys M | Other Iedicaid days | 23 | | | |
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| | of discharge. Is the method of identifying the column 2, enter 'Y' for yes or 'N' for no. If this provider is an IPPS hospital, enter the column 1, in-state Medicaid eligible unpaid of Medicaid paid days in column 3, out-of-state column 4, Medicaid HMO paid and eligible to other Medicaid days in column 6. If this provider is an IRF, enter the in-state M state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid had eligible unpaid days in column 1, out-of-state Medicaid eligible unpaid days in column 1 for urban and '2' for rural. Enter your standard geographic classification column 1, '1' for urban or '2' for rural. If application of the column 1, '1' for urban or '2' for rural. If application of the column 1, '1' for urban or '2' for rural. If application of the column 1, '1' for urban or '2' for rural. If application of the column 1, '1' for urban or '2' for rural. | days on lines 24 and/or 25 below? I days in this cost reporting period did days in this cost reporting period did days in this cost reporting period did days in column 2, out-of-state Medicaid eligible unpaid days in tu unpaid days in column 5, and edicaid paid days in column 1, in-12, out-of-state Medicaid days in tid days in column 4, Medicaid days in column 5. (not wage) status at the beginning of (not wage) status at the end of the column 4 and the column 5. | In column 3 In column 1, enter i | instructions), Y' for yes or er 1 if date of method used In-State Medicai eligible unpaid de 2 2 1, | 'N' for no admission in the prior od d My Prior No Admission in the prior No Admission in the prior No Admission in the prior | hospital conta , 2 if census r cost reportin t-of-State dedicaid aid days 3 | days, or 3 if date ng period? In Out-of-State Medicaid eligible unpaid days 4 | Medicai HMO da; | N N d Mys M495 | Other Iedicaid days | 24 25 | | | |
| | If this provider is an IPPS hospital, enter the column 1, in-state Medicaid eligible unpaid of Medicaid paid days in column 3, out-of-state column 4, Medicaid HMO paid and eligible by other Medicaid days in column 6. If this provider is an IRF, enter the in-state M state Medicaid eligible unpaid days in column 6. If this provider is an IRF, enter the in-state M state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 1, out-of-state Medicaid eligible unpaid and eligible but unpaid days in column 1. Tor urban and '2' for rural. Enter your standard geographic classification column 1, '1' for urban or '2' for rural. If applicolumn 2. | days on lines 24 and/or 25 below? I days in this cost reporting period did days in this cost reporting period did days in this cost reporting period did days in column 2, out-of-state Medicaid eligible unpaid days in the ununpaid days in column 5, and dedicaid paid days in column 1, in-12, out-of-state Medicaid days in days in column 4, Medicaid days in column 5. (not wage) status at the beginning of the column column column column column column days in the days in column days in column | In column 3 In column 1, enter i | instructions), Y' for yes or er 1 if date of method used In-State Medicai eligible unpaid da 2 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1 | r N' for no admission in the prior of d N Prior No. 1 N Prior No. 2 N Pr | hospital contains, 2 if census or cost reportion to-of-State Medicaid aid days 3 43 | days, or 3 if date ng period? In Out-of-State Medicaid eligible unpaid days 4 | Medicai HMO da; | N N d Mys M495 | Other Iedicaid days | 24 25 26 | | | |
| | If this provider is an IPPS hospital, enter the column 1, in-state Medicaid eligible unpaid of Medicaid paid days in column 3, out-of-state column 4, Medicaid HMO paid and eligible to other Medicaid days in column 6. If this provider is an IRF, enter the in-state M state Medicaid eligible unpaid days in column 6. If this provider is an IRF, enter the in-state M state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid hMO paid and eligible but unpaid days in column 1, out-of-state Medicaid eligible unpaid hMO paid and eligible but unpaid classification '1' for urban and '2' for rural. Enter your standard geographic classification column 1, '1' for urban or '2' for rural. If applicolumn 2. If this is a sole community hospital (SCH), er | days on lines 24 and/or 25 below? I days in this cost reporting period did days in this cost reporting period did days in this cost reporting period did days in column 2, out-of-state Medicaid eligible unpaid days in the ununpaid days in column 5, and dedicaid paid days in column 1, in-12, out-of-state Medicaid days in days in column 4, Medicaid days in column 5. (not wage) status at the beginning of the column column column column column column days in the days in column days in column | In column 3 In column 1, enter i | instructions), Y' for yes or er 1 if date of method used In-State Medicai eligible unpaid da 2 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1 | r N' for no admission in the prior of d N Prior No. 1 N Prior No. 2 N Pr | hospital contains, 2 if census or cost reportion to-of-State Medicaid aid days 3 43 | days, or 3 if date ng period? In Out-of-State Medicaid eligible unpaid days 4 | Medicai HMO da; | N N d Mys M495 | Other Iedicaid days | 24 25 26 | | | |
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| 5 | If this provider is an IPPS hospital, enter the column 1, in-state Medicaid eligible unpaid of Medicaid paid days in column 3, out-of-state column 4, Medicaid HMO paid and eligible to other Medicaid days in column 6. If this provider is an IRF, enter the in-state M state Medicaid eligible unpaid days in column 6. If this provider is an IRF, enter the in-state M state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 1, out-of-state Medicaid eligible unpaid in column 2. Enter your standard geographic classification '1' for urban and 2' for rural. Enter your standard geographic classification column 1, '1' for urban or '2' for rural. If applicolumn 2. If this is a sole community hospital (SCH), en period. | days on lines 24 and/or 25 below? I days in this cost reporting period did days in this cost reporting period did days in this cost reporting period did days in column 2, out-of-state Medicaid eligible unpaid days in the ununpaid days in column 5, and dedicaid paid days in column 1, in-12, out-of-state Medicaid days in days in column 4, Medicaid days in column 5. (not wage) status at the beginning of (not wage) status at the end of the coable, enter the effective date of the other the number of periods SCH status of SCH status. Subscript line 36 for the days in this cost of the status of SCH status. Subscript line 36 for the days in this cost of the status of SCH status. | In column 3 In column 1, enter i | instructions), Y' for yes or er 1 if date of method used In-State Medicai eligible unpaid da 2 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1 | r N' for no admission in the prior of d | tospital contains, 2 if census or cost reportion tools and days and days are tools and days are tools and days are tools are tools and days are tools are to | days, or 3 if date ng period? In Out-of-State Medicaid eligible unpaid days 4 | Medicai HMO day | N N d Mys M495 | Other Iedicaid days | 23 24 25 26 27 35 36 | | | |
| | If this provider is an IPPS hospital, enter the column 1, in-state Medicaid eligible unpaid of Medicaid paid days in column 3, out-of-state column 4, Medicaid HMO paid and eligible by other Medicaid days in column 6. If this provider is an IRF, enter the in-state M state Medicaid eligible unpaid days in column 6. If this provider is an IRF, enter the in-state M state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 1, out-of-state Medicaid eligible unpaid and eligible but unpaid days in column 1 'I for urban and '2' for rural. Enter your standard geographic classification column 1, 'I' for urban or '2' for rural. If applicolumn 2. If this is a sole community hospital (SCH), experiod. Enter applicable beginning and ending dates one and enter subsequent dates. If this is a Medicare dependent hospital (MD reporting period. | days on lines 24 and/or 25 below? I days in this cost reporting period did days in this cost reporting period did days in this cost reporting period did days in column 2, out-of-state Medicaid eligible unpaid days in tu unpaid days in column 5, and edicaid paid days in column 1, index out-of-state Medicaid days in days in column 4, Medicaid days in column 4, Medicaid days in column 5. (not wage) status at the beginning of (not wage) status at the end of the coable, enter the effective date of the later the number of periods SCH status. Subscript line 36 for in the company of the periods MDI days in this cost of the status. Subscript line 36 for in the periods MDI days in this cost of periods MDI days in this cost of the status. Subscript line 36 for in the periods MDI days in this cost of the status. | In column 3 In column 1, enter i | instructions), Y' for yes or er 1 if date of method used In-State Medicai eligible unpaid de 2 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1 | r N' for no admission in the prior od My | tospital contains, 2 if census or cost reportion tools and days and days are tools and days are tools and days are tools are tools and days are tools are to | days, or 3 if date ng period? In Out-of-State Medicaid eligible unpaid days 4 | Medicai HMO day | N N d Mys M495 | Other Iedicaid days | 23 24 25 26 27 35 | | | |
| 14 55 56 77 77 | If this provider is an IPPS hospital, enter the column 1, in-state Medicaid eligible unpaid of Medicaid paid days in column 3, out-of-state column 4, Medicaid HMO paid and eligible by other Medicaid eligible unpaid days in column 6. If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 6. If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 7, out-of-state Medicaid eligible but unpaid days in column 1, out-of-state Medicaid eligible unpaid days in column 1. To urban and '2' for rural. Enter your standard geographic classification column 1, '1' for urban or '2' for rural. If applicolumn 2. If this is a sole community hospital (SCH), erperiod. Enter applicable beginning and ending dates one and enter subsequent dates. If this is a Medicare dependent hospital (MD reporting period. Is this hospital a former MDH that is eilgible | days on lines 24 and/or 25 below? I days in this cost reporting period did days in this cost reporting period did days in this cost reporting period did days in column 2, out-of-state Medicaid eligible unpaid days in out unpaid days in column 5, and edicaid paid days in column 1, in-12, out-of-state Medicaid days in did days in column 4, Medicaid dumn 5. (not wage) status at the beginning of (not wage) status at the end of the cable, enter the effective date of the later the number of periods SCH status of SCH status. Subscript line 36 for the MDH transitional payment in for the MDH transitional payment in | In column 3 In column 1, enter i | instructions), Y' for yes or er 1 if date of method used In-State Medicai eligible unpaid de 2 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1 | r N' for no admission in the prior od My | tospital conta | days, or 3 if date ng period? In Out-of-State Medicaid eligible unpaid days 4 | Medicai HMO day | N N d Mys M495 | Other Iedicaid days | 23 24 25 26 27 35 36 37 | | | |
| 5 | If this provider is an IPPS hospital, enter the column 1, in-state Medicaid eligible unpaid of Medicaid paid days in column 3, out-of-state column 4, Medicaid HMO paid and eligible by other Medicaid days in column 6. If this provider is an IRF, enter the in-state M state Medicaid eligible unpaid days in column 6. If this provider is an IRF, enter the in-state M state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 1, out-of-state Medicaid eligible unpaid and eligible but unpaid days in column 1 'I for urban and '2' for rural. Enter your standard geographic classification column 1, 'I' for urban or '2' for rural. If applicolumn 2. If this is a sole community hospital (SCH), experiod. Enter applicable beginning and ending dates one and enter subsequent dates. If this is a Medicare dependent hospital (MD reporting period. | days on lines 24 and/or 25 below? I days in this cost reporting period did days in this cost reporting period did days in this cost reporting period did days in column 2, out-of-state Medicaid eligible unpaid days in the unpaid days in column 5, and dedicaid paid days in column 1, in-12, out-of-state Medicaid days in column 4, Medicaid days in column 4, Medicaid days in column 5. (not wage) status at the beginning of (not wage) status at the end of the column the column the column that the number of periods SCH status of SCH status. Subscript line 36 for in the MDH transitional payment in the column that column the model of the MDH transitional payment in the column that column the status is the status of school of the MDH transitional payment in the column that | In column 3 In column 1, enter i | instructions), Y' for yes or er 1 if date of method used In-State Medicai eligible unpaid da 2 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1 | r N' for no admission in the prior of d Ou My Prior of the state g G Beg | tospital contains, 2 if census or cost reportion tools and days and days are tools and days are tools and days are tools are tools and days are tools are to | days, or 3 if date ng period? In Out-of-State Medicaid eligible unpaid days 4 | Medicai HMO day | N N d Mys M495 | Other Iedicaid days | 23 24 25 26 27 35 36 | | | |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

| | | | | 1 | 2 | |
|---------------------|---|----------------------------|------------------------|-------------------|----------------------------------|--------|
| col | ses this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 C turn 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b) sor 'N' for no. (see instructions) | | | N | N | 39 |
| Is t | this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for dischar 'N' for no in column 2, for discharges on or after October 1. (see instructions) | ges prior to Octobe | r 1. Enter 'Y' for yes | N | N | 40 |
| - 01 | 1 Visit in in establish 2, 151 disentages on of direct decider 1. (see institutions) | V | XVIII | X | IX | \top |
| nective | Payment System (PPS)-Capital | 1 | 2 | | 3 | + |
| | bes this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320? | N | Y | | N . | 45 |
| Is t | this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 12.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. | N | N | | N | 46 |
| | this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no. | N | N | 1 | N | 47 |
| | the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no. | N | N | | N | 48 |
| | | | | | | |
| ching Ho | ospitals | 1 | 2 | | 3 | T |
| | this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no. | Y | | | | 56 |
| If 1 fac this | tine 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this cility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of s cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column s 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable. | N | | | | 57 |
| | tine 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, apter 21, section 2148? If yes, complete Wkst. D-5. | N | | | | 58 |
| | e costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. | N | | | | 59 |
| | | NAHE 413.85 Y/N 1 | Worksheet A Line # | Qualif Criteri | hrough ication a Code 3 | |
| | e you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 R 413.85? (see instructions) | Y | | | <u> </u> | 60 |
| | line 60 is yes, complete columns 2 and 3 for each program. (see instructions) | | 23. | | 1 | 60 |
| 2 If 1 | line 60 is yes, complete columns 2 and 3 for each program. (see instructions) | | 23.02 | | 1 | 60 |
| | | Y/N | IME | | GME | Τ |
| | d your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see | 1 N | 4 | | 5 | 61 |
| ₁ En | tructions) ter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and omitted before March 23, 2010. (see instructions) | | | | | 61 |
| , En | mary care FTEs added under section 5503 of ACA). (see instructions) | | | | | 61 |
| ₂ En | ther the baseline FTE count for primary care and/or general surgery residents, which is used for determining mpliance with the 75% test. (see instructions) | | | | | 61 |
| En rep | ter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost porting period. (see instructions) | | | | | 61 |
| and | ter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care d/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) | | | | | 61 |
| | ter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or neral surgery. (see instructions) | | | | | 61 |

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.

| | Enter in column 2 the program code. Enter in column 3 the livie F1E unweighted count. Enter in column 4, the direct GME F1E unweighted count. | | | | | | | | | |
|--|---|--------------|--------------|------------|------------|---|--|--|--|--|
| | | - | | Unweighted | Unweighted | | | | | |
| | | Program Name | Program Code | IME | Direct GME | ĺ | | | | |
| | | - | | FTE Count | FTE Count | Ĺ | | | | |
| | | 1 | 2 | 3 | 1 | | | | | |

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 direct the GME FTE unweighted count.

| _ACA Pı | rovisions Affecting the Health Resources and Services Administration (HRSA) | | |
|---------|--|--|-------|
| 62 | Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital | | 62 |
| 02 | reseived HRSA PCRE funding (see instructions) | | 62 |
| 62.01 | Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost | | 62.01 |
| 02.01 | reporting period of HRSA THC program (see instructions) | | 02.01 |

| | reporting period of HKSA THC program. (see instructions) | | | 4 |
|-----|---|------|--|----|
| | | | | |
| Tea | ching Hospitals that Claim Residents in Nonprovider Settings | | | |
| 62 | Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for | N | | 62 |
| 63 | no. If yes, complete lines 64 through 67. (see instructions) | IN . | | 63 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

| Earler in column 1, If line 63 is yes, or your facility trained residents in the base year period, the number of unweighted one-primary care resident PTEs that trained in your hospital. Enter in column 3 the ratio of column 1 divided by (column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter is column 2 the program code and the program name. Enter in column 3 the name of unweighted primary care PTE residents surfraubable to renations occurring in all non-provider serings. Enter in column 4 the number of unweighted primary care PTE residents surfraubable to renations occurring in all non-provider serings. Enter in column 4 the number of unweighted primary care PTE residents surfraubable to renations occurring in all non-provider serings. Enter in column 4 the number of unweighted primary care PTE residents surfraubable to renations occurring the Program Code and t | | 5504 of the ACA Base Year FTE Resin or after July 1, 2009 and before June | elents in Nonprovider SettingsThis base year is your cost rep 30, 2010. | orting period that | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 1/ col. 1 + col. 2)) | |
|--|----------|---|--|-------------------------|-------------------------------------|-----------------------------|--|----------|
| 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 4 the number of unweighted FTEs (col. 3/ col. 3/ | | non-primary care resident FTEs attrib number of unweighted non-primary c | nutable to rotations occurring in all nonprovider settings. Enter are resident FTEs that trained in your hospital. Enter in oolun | r in column 2 the | | | | 64 |
| Program Name Program Name Program Code In weighted FTEs (only 3) 1 2 3 4 4 5 5 Section 5504 of the ACA Current Year FTE Residems in Nonprovider Settings—Effective for cost reporting periods beginning for after July 1, 2010 Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs 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 number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the number of unweighted primary care resident FTEs that trained in your hospital for the number of unweighted primary care resident FTEs that trained in your hospital for the number of unweighted primary c | | 3 the number of unweighted primary | care FTE residents attributable to rotations occurring in all no | on-provider settings. E | Enter in column 4 the | | | |
| Enter in Column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your bospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)), (see instructions) Enter in lines 67-67-69, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the mumber 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 FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care FTE residents attributable to column 3 divided by (column 3 - column 4). (see instructions) Program Name Program Code Program Code Program Code Nonprovider Site N | | | | | Unweighted FTEs | | (col. 3/ | |
| Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings—Effective for cost reporting periods beginning or after July 1, 2010 Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted 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) Enter in lines 67-67-39, column 1 the program name. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 - column 4). (see instructions) Enter in lines 67-67-39, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Program Name Program Code Unweighted FTEs Nonprovider Site Unweighted FTEs Nonprovider Site Unweighted FTEs Nonprovider Site Unweighted FTEs Nonprovider Site In Hospital In Program Name Program Code Unweighted FTEs Nonprovider Site Unweighted FTEs Nonprovider Site In Hospital In Ho | | | 1 | 2 | 3 | 4 | 5 | |
| Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted one-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) Enter in lines 67-67-49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 + column 4)), (see instructions) Program Name Program Code Program | ection 5 | | esidents in Nonprovider SettingsEffective for cost reporting | periods beginning | | | (col. 1/ | 65 |
| rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Program Name Program Code Unweighted FTEs (non-provider Site in Hospital) I | | nonprovider settings. Enter in column | 2 the number of unweighted non-primary care resident FTEs | that trained in your | | | , | 66 |
| Program Name Program Name Program Code Program Code Program Code Nonprovider Site Nonprovid | | rotations occurring in all non-provide | r settings. Enter in column 4 the number of unweighted prima | | | | mn 5 the ratio of | |
| patient Psychiatric Facility PPS 1 | | | Program Name | Program Code | | | (col. 3/ | |
| Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for N If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR \$412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) It is 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. If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR \$412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Ong Term Care Hospital PPS Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no. EFRA Providers Is this a new hospital under 42 CFR \$413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no. | | | 1 | 2 | 3 | 4 | | |
| Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no. If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR \$412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1 2 3 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' y for no. If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR \$412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) ong Term Care Hospital PPS O Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no. N D Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no. EFRA Providers Is this a new hospital under 42 CFR \$413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no. | ! | | | | | | | 67 |
| Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no. If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR \$412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) patient Rehabilitation Facility PPS I 2 3 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' y for no. If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR \$412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) ong Term Care Hospital PPS O Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no. N Is this a Long Term Care Hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no. EFRA Providers Is this a new hospital under 42 CFR \$413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no. | natient | Psychiatric Faciltiy PPS | | | 1 | 2 | 3 | |
| Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR \$412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) patient Rehabilitation Facility PPS 1 2 3 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no. If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR \$412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) DOING Term Care Hospital PPS Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no. EFRA Providers Is this a new hospital under 42 CFR \$413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no. N | | | c Facility (IPF), or does it contain an IPF subprovider? Enter | Y' for yes or 'N' for | N | | | 70 |
| Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no. If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Ong Term Care Hospital PPS Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no. EFRA Providers Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no. N | I | Column 1: Ďid the facility have a tea 2004? Enter 'Y' for yes or 'N' for no. Column 2: Ďid this facility train resic §412.424(d)(1)(iii)(D)? Enter 'Y' for | lents in a new teaching program in accordance with 42 CFR yes and 'N' for no. | | | | | 71 |
| Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no. If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Only Term Care Hospital PPS Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no. EFRA Providers Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no. | notiont | Pahabilitation Engility DDS | | | 1 | 2 | 2 | |
| If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) ong Term Care Hospital PPS Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no. EFRA Providers Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no. N | 5 | Is this facility an Inpatient Rehabilita | tion Facility (IRF), or does it contain an IRF subprovider? En | ter 'Y' for yes or 'N' | | 2 | 3 | 75 |
| Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no. EFRA Providers Statistical Statisti | 5 | If line 75 is yes: Column 1: Did the facility have a tea November 15, 2004? Enter 'Y' for ye. Column 2: Did this facility train resic §412.424(d)(1)(iii)(D)? Enter 'Y' for | s or 'N' for no. lents in a new teaching program in accordance with 42 CFR yes and 'N' for no. | , | N | N | | 76 |
| Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no. N EFRA Providers Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no. N | ong Ter | rm Care Hospital PPS | | | | | | |
| Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no. N EFRA Providers Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no. N | 0 | Is this a Long Term Care Hospital (L | | | | N | | 80 |
| 5 Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no. | | | | 'Y' for yes and 'N' fo | or no. | N | | 81 |
| 5 Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no. | EFRA I | Providers | | | | | | |
| | 5 | Is this a new hospital under 42 CFR § | | | | N | | 85 |
| 6 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no. 7 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no. | | | | | | | | 86 87 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

| | | 1 | 17 | 37737 | 1 |
|--|--|--|---|------------------|--|
| | Name : | | V | XIX | |
| | nd XIX Services | | 1 | 2 | |
| 0 | Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column | | N | Y | 90 |
| 1 | Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N applicable column. | I' for no in the | N | N | 91 |
| 2 | Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the app. | licable column | | N | 92 |
| 3 | Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the appli | | N | N | 93 |
| <u> </u> | Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column. | cable column. | N N | N | 94 |
| 5 | If line 94 is 'Y', enter the reduction percentage in the applicable column. | | 11 | IN . | 95 |
| 6 | Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column. | | N | N | 96 |
| 7 | If line 96 is 'Y', enter the reduction percentage in the applicable column. | | 11 | IN . | 97 |
| | Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, | Dt L col 252 | | | |
| 8 | Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | Pt. 1, Col. 25? | Y | Y | 98 |
| 8.01 | Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N | I' for no in column | Y | Y | 98.01 |
| 0.00 | 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, lin | e 89? Enter 'Y' for | v | N/ | 00.00 |
| 8.02 | yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | | Y | Y | 98.02 |
| 8.03 | Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient se 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | ervices cost? Enter | N | N | 98.03 |
| | Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for | or ves or 'N' for no | | | 1 |
| 8.04 | in column 1 for title V, and in column 2 for title XIX. | , | N | N | 98.04 |
| 8.05 | Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter for no in column 1 for title V, and in column 2 for title XIX. | 'Y' for yes or 'N' | Y | Y | 98.05 |
| 8.06 | Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for y | yes or 'N' for no in | Y | Y | 98.06 |
| | column 1 for title V, and in column 2 for title XIX. | | | | |
| ural Pro | viders | | 1 | 2 | |
| 05 | Does this hospital qualify as a CAH? | | N | | 105 |
| 06 | If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instru | ictions) | | | 106 |
| | If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and | | | | |
| 07 | column 1. (see instructions) | | | | 107 |
| | If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete | | | | - |
| 08 | Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for ye | | N | D i t | 108 |
| | Physical If this beautiful mulifier as a CAM are a set as wide and the set of the set o | Occupational | Speech | Respiratory | |
| 09 | If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy. | | | | 109 |
| | outside supplier: Einer 1 for yes of iv for each therapy. | | | 1 | 1 |
| | | | | | |
| | Did this basnital participate in the Pural Community Hasnital Demonstration project (\$4104 Demonstration) for the au | reant aget reporting r | oriod? If you | | |
| 10 | Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the cu | urrent cost reporting p | period? If yes, | N | 110 |
| 110 | Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. | urrent cost reporting p | period? If yes, | | 110 |
| | compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for | nonstration for this n prong of the | | N 2 | 110 |
| | compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration | nonstration for this n prong of the | | | |
| 111 | compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for and/or 'C' for tele-healsh services. | nonstration for this n prong of the | | | |
| 11 Miscellar | compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for and/or 'C' for tele-healsh services. **Reous Cost Reporting Information** Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the | nonstration for this n prong of the additional beds; | | | 111 |
| 11 | compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for and/or 'C' for tele-healsh services. **Recoust Cost Reporting Information** Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) | nonstration for this n prong of the | | | |
| 11 Aiscellar | compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for and/or 'C' for tele-healsh services. **Recoust Cost Reporting Information** Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1. | nonstration for this n prong of the additional beds; | | | 111 |
| 11 Miscellar 15 | compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for and/or 'C' for tele-healsh services. **Reous Cost Reporting Information** Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1. Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no. | nonstration for this n prong of the additional beds; | 1 N | | 111 |
| 11 fiscellar | compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for and/or 'C' for tele-healsh services. **Reous Cost Reporting Information** Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1. Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no. Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no. | nonstration for this n prong of the additional beds; | 1 | | 111 |
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| 1111 115 115 116 117 118.01 118.02 120 121 122 122 122 126 127 | If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for and/or 'C' for tele-healsh services. **Reous Cost Reporting Information** Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1. Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no. Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is claim-made. Enter 2 if the policy is claim-made in the Administrative and General cost center supporting schedule listing cost centers and amounts contained therein. Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amend instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amend instructions). Enter in column 2 'Y' for yes or 'N' for Does the cost report contain state health care related taxes as defined in §198(w)(3) of the Act? Enter 'Y' for yes or 'N' Does the cost report contain state health care related taxes as defined in §198(w)(3) of the Act? Enter 'Y' for yes or 'N'. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included. **Center Information** Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for n | icy is occurrence. Premiums ter? If yes, submit ments? (see tipatient Hold for no. no. I' for no in column ryy) below. olumn 2. umn 2. | N N N 1 Paid Losses N N | 2 Self Insurance | 1111 1115 1116 1117 1118 1118.0 1120 121 122 122 126 127 |
| 1111 115 115 116 117 118 118.01 118.02 20 20 21 22 22 22 26 27 28 | compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for and/or 'C' for tele-healsh services. **Reous Cost Reporting Information** Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1. Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no. Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy amounts of malpractice premiums and paid losses: Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost cent supporting schedule listing cost centers and amounts contained therein. Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amend instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the O Harmless provision in ACA §3121 and applicable amend instructions). Enter in column 1 'Y' for yes or 'N' Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' Does the cost report contain state hea | In prong of the additional beds; N Icy is occurrence. Premiums Iter? If yes, submit ments? (see atpatient Hold for no. In for no in column Iter; If yes occurrence atpatient Hold for no. In for no in column Iter; If yes, submit ments? (see atpatient Hold for no. In for no in column atpatient Hold for no. Iter; If yes, submit ments? (see atpatient Hold for no. Iter; Iter; If yes, submit ments? (see atpatient Hold for no. Iter; Iter | N N N 1 Paid Losses N N | 2 Self Insurance | 111 115 116 117 118 118. 120 121 122 125 126 127 128 |
| 111 111 111 111 111 111 111 111 111 11 | compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for and/or 'C' for tele-healsh services. **Reous Cost Reporting Information** Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1. Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no. Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the pol List amounts of malpractice premiums and paid losses: Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost cent supporting schedule listing cost centers and amounts contained therein. Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amend instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Ot Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' In Jid this is a Medicare | In prong of the additional beds; N Icy is occurrence. Premiums Iter? If yes, submit the state of the prong of the additional beds; Iter? If yes, submit the properties of the state of the properties of the state of the stat | N N N 1 Paid Losses N N | 2 Self Insurance | 1115 1116 1117 1118 1118 1120 121 122 122 123 124 125 126 127 128 129 |
| 1111 1111 1111 1111 1111 1111 1111 1111 1111 | compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for and/or 'C' for tele-healsh services. **Reous Cost Reporting Information** Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1. Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no. Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is claim-made. Enter 2 if the policy schedule listing cost centers and amounts contained therein. Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amend instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Ott Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no. Is this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for bose the cost r | icy is occurrence. Premiums ter? If yes, submit ments? (see atpatient Hold for no. no. I' for no in column yy) below. blumn 2. umn 2. umn 2. umn 2. column 2. | N N N 1 Paid Losses N N | 2 Self Insurance | 1111 1115 1116 1177 118. 118. 118. 120 121 122 125 126 127 128 129 130 |
| 1111 115 116 117 118.02 118.02 120 121 122 122 123 126 127 128 129 130 131 | If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for and/or 'C' for tele-healsh services. **Reporting Information** Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1. Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no. Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the pol. List amounts of malpractice premiums and paid losses: Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost cent supporting schedule listing cost centers and amounts contained therein. Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amend instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' Did this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yy If this i | In prong of the additional beds; In pro | N N N 1 Paid Losses N N | 2 Self Insurance | 1111 1115 1116 1117 1118 1118.1 1120 121 122 122 123 124 127 128 129 129 120 121 121 121 122 123 124 125 126 127 128 129 129 129 129 129 129 129 129 |
| 1111 1111 1115 115 115 115 115 115 115 | compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) dem cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for and/or 'C' for tele-healsh services. **Reous Cost Reporting Information** Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1. Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no. Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is claim-made. Enter 2 if the policy schedule listing cost centers and amounts contained therein. Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amend instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Ott Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no. Is this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for bose the cost r | N icy is occurrence. Premiums ter? If yes, submit ments? (see attpatient Hold for no. no. I' for no in column yy) below. blumn 2. umn 2. umn 2. column 2. column 2. column 2. | N N N 1 Paid Losses N N | 2 Self Insurance | 1111 1115 1116 1177 118. 118. 118. 120 121 122 125 126 127 128 129 130 |

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

| All Provi | ders | | | |
|-----------|---|---|---------|-----|
| | | 1 | 2 | |
| 140 | Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in | v | 15H034 | 140 |
| 140 | column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions) | 1 | 1311034 | 140 |

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143

| OH HHES | 1 mes 142 and 143. | | | | | | |
|---------|---|-------------------------------|---------------------------------|-----------------------|-----------------|-----|-----|
| 141 | Name: ST JOSEPH REG MED CTR | Contractor's Name: WIS | CONSIN PROVIDER SEE | VICES CO Contractor's | s Number: 08102 | 141 | |
| 142 | Street: 5215 HOLY CROSS PARKWAY | P.O. Box: | | | | | 142 |
| 143 | City: MISHAWAKA | State: IN | ZIP Code: 46545 | | | | 143 |
| 144 | Are provider based physicians' costs included in Worksheet A | ? | | | Y | | 144 |
| | If costs for renal services are claimed on Wkst. A, line 74 are t | he costs for inpatient serv | ices only? Enter 'Y' for yes, | or 'N' for no in | | | |
| 145 | column 1. | | | | v | N | 145 |
| 143 | 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 | | | 1 | IN | 143 | |
| | column 2. | | | | | | |
| 146 | Has the cost allocation methodology changed from the previous | isly filed cost report? Ente | er 'Y' for yes and 'N' for no i | n column 1. (see CMS | N | | 146 |
| 140 | Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2. | | | IN | | 140 | |
| | | | | | | | |
| 147 | Was there a change in the statistical basis? Enter 'Y' for yes or | 'N' for no. | | | N | | 147 |
| 148 | 8 Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no. | | N | | 148 | | |
| 149 | Was there a change to the simplified cost finding method? Ent | er 'Y' for yes or 'N' for no. | | | N | | 149 |

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR 8413.13)

| CFK 941 | 5.15) | | | | | |
|---------|---------------------|--------|--------|---------|-----------|--------|
| | | Title | XVIII | | | |
| | | Part A | Part B | Title V | Title XIX | |
| | | 1 | 2 | 3 | 4 | |
| 155 | Hospital | N | N | N | N | 155 |
| 156 | Subprovider - IPF | N | N | N | N | 156 |
| 157 | Subprovider - IRF | N | N | N | N | 157 |
| 158 | Subprovider - Other | | | | | 158 |
| 159 | SNF | N | N | N | N | 159 |
| 160 | HHA | N | N | N | N | 160 |
| 161 | CMHC | | N | N | N | 161 |
| 161.10 | CORF | | | | | 161.10 |

Multicampus

| 165 | Is this hospital part of a multicampus hospital that has one or n different CBSAs? Enter 'Y' for yes or 'N' for no. | nore campuses in N | | | | | 165 |
|-----|--|------------------------------------|----------------------|---------------------|----------------------|------------|-----|
| 166 | If line 165 is yes, for each campus, enter the name in column 0 instructions) | , county in column 1, state in col | umn 2, ZIP in column | 3, CBSA in column 4 | , FTE/campus in colu | mn 5. (see | 166 |
| | Name | County | State | ZIP Code | CBSA | FTE/Campus | |
| | 0 | 1 | 2 | 3 | 4 | 5 | |

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no. 167 If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred 168 168 for the HIT assets. (see instructions) If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under 168.01 168.01 §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions) If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. 169 169 (see instructions) 170 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy) 07 / 01 / 2015 06 / 30 / 2016 170 171 If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 171 I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in 0 Ν column 2. (see instructions)

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
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| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2 PART II

| Gener | al Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. | | | | | |
|--------|--|-----------------------|-------------|---------------|------------|-----|
| COM | IPLETED BY ALL HOSPITALS | | | | | |
| | | | Y/N | Date | | |
| Provid | er Organization and Operation | | 1 | 2 | | |
| 1 | Has the provider changed ownership immediately prior to the beginning of the cost reporting period | d? If yes, enter the | N | | | 1 |
| 1 | date of the change in column 2. (see instructions) | | · | | | 1 |
| | | | Y/N | Date | V/I | |
| | | | 1 | 2 | 3 | |
| 2 | Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the dand in column 3, 'V' for voluntary or T' for involuntary. | ate of termination | N | | | 2 |
| | Is the provider involved in business transactions, including management contracts, with individuals | or entities (e.g., | | | | |
| 3 | chain home offices, drug or medical supply companies) that are related to the provider or its officer | s, medical staff, | N | | | 3 |
| 3 | management personnel, or members of the board of directors through ownership, control, or family | and other similar | IN I | | | 3 |
| | relationships? (see instructions) | | | | | |
| | | | Y/N | Туре | Date | _ |
| Financ | ial Data and Reports | | 1 | 2 | 3 | |
| | Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If | yes, enter 'A' for | | - | | |
| 4 | Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in co | | Y | A | | 4 |
| | instructions). If no, see instructions. | | | | | |
| 5 | Are the cost report total expenses and total revenues different from those in the filed financial states | ments? If yes, | N | | | 5 |
| | submit reconciliation. | | IN . | | | |
| | | | | **** | **** | |
| A | and Educational Activities | | | Y/N 1 | Y/N 2 | |
| | ved Educational Activities Column 1: Are costs claimed for nursing school? | | | 1 | <u> </u> | |
| 6 | Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program? | | | N | | 6 |
| 7 | Are costs claimed for allied health programs? If yes, see instructions. | | | Y | | 7 |
| 8 | Were nursing school and/or allied health programs approved and/or renewed during the cost reporting the cost | ng period? | | N N | | 8 |
| 9 | Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost | | nstructions | Y | | 9 |
| 10 | Was an approved Intern and Resident GME program initiated or renewed in the current cost reporti | | | N | | 10 |
| | Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program | | | | | |
| 11 | instructions. | | | N | | 11 |
| D 1D | | | | | **** | _ |
| Bad D | | | | | Y/N Y | 12 |
| 12 | Is the provider seeking reimbursement for bad debts? If yes, see instructions. If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting periods. | . 49 Tf | | | N N | 13 |
| 14 | If line 12 is yes, and the provider's bad debt conection poncy change during this cost reporting perior. If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. | ou? If yes, submit co | ру. | | N N | 14 |
| 14 | If the 12 is yes, were patient deductions and/of co-payments warved: If yes, see histractions. | | | | IN . | 14 |
| Bed C | omplement | | | | | |
| 15 | Did total beds available change from the prior cost reporting period? If yes, see instructions. | | | | Y | 15 |
| | | | | | | |
| | | | t A | | art B | |
| Da | | Y/N | Date | Y/N | Date | |
| PS&R | Report Data | 1 | 2 | 3 | 4 | + |
| 16 | Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions) | Y | 07/31/2018 | Y | 07/31/2018 | 16 |
| | Was the cost report prepared using the PS&R Report for totals and the provider's records for | | | | | |
| 17 | allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) | N | | N | | 17 |
| | If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that | | | | | |
| 18 | have been billed but are not included on the PS&R Report used to file the cost report? If yes, see | N | | N | | 18 |
| - | instructions. | -, | | -, | | |
| 4.0 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other | | | | | 1.0 |
| 19 | PS&R Report information? If yes, see instructions. | N | | N | | 19 |
| 20 | If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the | N | | > 7 | | 20 |
| 20 | other adjustments: | N | | N | | 20 |
| | Was the cost report prepared only using the provider's records? If yes, see instructions. | N | | N | | 21 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2 PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.

Enter all dates in the mm/dd/yyyy format

| | Enter all dates in the mm/dd/yyyy format. | | | |
|--------|---|---------------------------|--------|--------|
| CON | MPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPIT | ALS) | | |
| | · · | / | | |
| | al Related Cost | | | |
| 22 | Have assets been relifed for Medicare purposes? If yes, see instructions. | | | 22 |
| 23 | Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instruction | ns. | | 23 |
| 24 | Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. | | | 24 |
| 25 | Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions. | | | 25 |
| 26 | Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. | | | 26 |
| 27 | Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions. | | | 27 |
| Intere | st Expense | | | \neg |
| 28 | Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. | | | 28 |
| | With the Woods, mortgage agreements of texter of recent metric more during the cost reporting person. If yes, see institutions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account. | int? If yes see | | - 20 |
| 29 | Did the provider have a funded depreciation account and/of oblid funds (Beof Service Reserve Fund) freated as a funded depreciation according to instructions. | int: If yes, see | | 29 |
| 30 | Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. | | | 30 |
| 31 | Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. | | | 31 |
| Durah | ased Services | | | |
| 32 | Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? | (C : | | 32 |
| 33 | If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. | ir yes, see instructions. | | 33 |
| 33 | If the 52 is yes, were the requirements of Sec. 2153.2 applied pertaining to competitive bloding? If no, see histractions. | | | |
| Provi | der-Based Physicians | | | |
| 34 | Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. | | | 34 |
| 35 | If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting p instructions. | eriod? If yes, see | | 35 |
| | | | | |
| | | Y/N | Date | |
| | Office Costs | 1 | 2 | |
| 36 | Are home office costs claimed on the cost report? | | | 36 |
| 37 | If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. | | | 37 |
| 38 | If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. | | | 38 |
| 39 | If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. | | | 39 |
| 40 | If line 36 is yes, did the provider render services to the home office? If yes, see instructions. | | | 40 |
| Conti | Report Preparer Contact Information | | | |
| 41 | | ANCE - REIMBURSEN | MENT | 41 |
| 41 | Employer: SAINT JOSEPH REGIONAL MEDICAL CENTER | ANCE - KEINIDUKSEI | VIEN I | 41 |
| | | | | |
| 43 | Phone number: (574) 335-4656 E-mail Address: WORKMANT@SJRMC.COM | | | 43 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

| | | | | | | Inp | atient Days / Outp | atient Visits / Tr | ips | |
|-------|--|-----------------------|----------------|-----------------------|--------------|---------|--------------------|--------------------|--------------------------|-------|
| | Component | Wkst A Line No. | No. of Beds | Bed Days Available | CAH Hours | Title V | Title XVIII | Title XIX | Total All Patients | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| 1 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) | 30 | 213 | 77,745 | | | 22,230 | 1,940 | 53,081 | 1 |
| 2 | HMO and other (see instructions) | | | | | | 9,055 | 8,013 | | 2 |
| 3 | HMO IPF Subprovider | | | | | | | | | 3 |
| 4 | HMO IRF Subprovider | | | | | | 30 | | | 4 |
| 5 | Hospital Adults & Peds. Swing Bed SNF | | | | | | | | | 5 |
| 6 | Hospital Adults & Peds. Swing Bed NF | | | | | | | | | 6 |
| 7 | Total Adults & Peds. (exclude observation beds) (see instructions) | | 213 | 77,745 | | | 22,230 | 1,940 | 53,081 | 7 |
| 8 | Intensive Care Unit | 31 | 28 | 10,220 | | | 1,690 | 631 | 5,353 | 8 |
| 9 | Coronary Care Unit | 32 | | | | | | | , | 9 |
| 10 | Burn Intensive Care Unit | 33 | | | | | | | | 10 |
| 11 | Surgical Intensive Care Unit | 34 | | | | | | | | 11 |
| 12 | NEONATAL INTENSIVE CARE UNIT | 35 | 12 | 4,380 | | | | 2,425 | 3,691 | 12 |
| 13 | Nursery | 43 | | | | | | 2,343 | 4,262 | 13 |
| 14 | Total (see instructions) | | 253 | 92,345 | | | 23,920 | 7,339 | 66,387 | 14 |
| 15 | CAH Visits | | | | | | | | | 15 |
| 16 | Subprovider - IPF | 40 | | | | | | | | 16 |
| 17 | Subprovider - IRF | 41 | 40 | 14,600 | | | 1,545 | 358 | 2,806 | 17 |
| 18 | Subprovider I | 42 | | | | | | | | 18 |
| 19 | Skilled Nursing Facility | 44 | | | | | | | | 19 |
| 20 | Nursing Facility | 45 | | | | | | | | 20 |
| 21 | Other Long Term Care | 46 | | | | | | | | 21 |
| 22 | Home Health Agency | 101 | | | | | | | | 22 |
| 23 | ASC (Distinct Part) | 115 | | | | | | | | 23 |
| 24 | Hospice (Distinct Part) | 116 | | | | | | | | 24 |
| 24.10 | Hospice (non-distinct part) | 30 | | | | | | | 126 | 24.10 |
| 25 | CMHC | 99 | | | | | | | - | 25 |
| 26 | RHC | 88 | | | | | | | | 26 |
| 27 | Total (sum of lines 14-26) | | 293 | | | | | | | 27 |
| 28 | Observation Bed Days | | | | | | | 1,141 | 6,118 | 28 |
| 29 | Ambulance Trips | | | | | | | | | 29 |
| 30 | Employee discount days (see instructions) | | | | | | | | 910 | |
| 31 | Employee discount days-IRF | | | | | | | | 45 | 31 |
| 32 | Labor & delivery (see instructions) | | 4 | 1,460 | | | | 413 | 713 | 32 |
| 32.01 | Total ancillary labor & delivery room outpatient | | | | | | | | | 32.01 |
| | days (see instructions) | | | | | | | | | |
| 33 | LTCH non-covered days | | | | | | | | | 33 |
| 33.01 | LTCH site neutral days and discharges | | | | | | | | | 33.01 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

| | | Fu | ll Time Equivaler | nts | | DISCHA | RGES | | |
|-------|--|---------------------------------|----------------------------|--------------------|---------|----------------|--------------|--------------------------|-------|
| | Component | Total Interns & Residents | Employees On Payroll | Nonpaid Workers | Title V | Title XVIII | Title XIX | Total All Patients | |
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) | | | | | 4,967 | 682 | 14,800 | 1 |
| 2 | HMO and other (see instructions) | | | | | 1,943 | 2,045 | | 2 |
| 3 | HMO IPF Subprovider | | | | | | , | | 3 |
| 4 | HMO IRF Subprovider | | | | | | | | 4 |
| 5 | Hospital Adults & Peds. Swing Bed SNF | | | | | | | | 5 |
| 6 | Hospital Adults & Peds. Swing Bed NF | | | | | | | | 6 |
| 7 | Total Adults & Peds. (exclude observation beds) (see instructions) | | | | | | | | 7 |
| 8 | Intensive Care Unit | | | | | | | | 8 |
| 9 | Coronary Care Unit | | | | | | | | 9 |
| 10 | Burn Intensive Care Unit | | | | | | | | 10 |
| 11 | Surgical Intensive Care Unit | | | | | | | | 11 |
| 12 | NEONATAL INTENSIVE CARE UNIT | | | | | | | | 12 |
| 13 | Nursery | | | | | | | | 13 |
| 14 | Total (see instructions) | 31.70 | 1,509.82 | 533.00 | | 4,967 | 682 | 14,800 | 14 |
| 15 | CAH Visits | | | | | | | | 15 |
| 16 | Subprovider - IPF | | | | | | | | 16 |
| 17 | Subprovider - IRF | | 25.92 | | | 120 | 24 | 214 | 17 |
| 18 | Subprovider I | | | | | | | | 18 |
| 19 | Skilled Nursing Facility | | | | | | | | 19 |
| 20 | Nursing Facility | | | | | | | | 20 |
| 21 | Other Long Term Care | | | | | | | | 21 |
| 22 | Home Health Agency | | | | | | | | 22 |
| 23 | ASC (Distinct Part) | | | | | | | | 23 |
| 24 | Hospice (Distinct Part) | | | | | | | | 24 |
| 24.10 | Hospice (non-distinct part) | | | | | | | | 24.10 |
| 25 | CMHC | | | | | | | | 25 |
| 26 | RHC | | | | | | | | 26 |
| 27 | Total (sum of lines 14-26) | 31.70 | 1,535.74 | 533.00 | | | | | 27 |
| 32.01 | Total ancillary labor & delivery room outpatient days (see instructions) | | | | | | | | 32.01 |
| 33 | LTCH non-covered days | | | | | | | | 33 |
| 33.01 | LTCH site neutral days and discharges | | | | | | | | 33.01 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3 PARTS II-III

| Part II | - Wage Data | | | | | | | |
|----------|--|-----------------------|------------------------|--|--|---|--|-------|
| | | Wkst A Line No. | Amount Reported | Reclassif- ication of Salaries (from Worksheet A-6) | Adjusted Salaries (column 2 ± column 3) | Paid Hours Related to Salaries in Column 4 | Average Hourly wage (column 4 ± column 5) | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | |
| | SALARIES | | | | | | | |
| 1 | Total salaries (see instructions) | 200 | 93,537,506 | | 93,537,506 | 3,194,351.60 | 29.28 | 1 |
| 2 | Non-physician anesthetist Part A | | | | | | | 2 |
| 3 | Non-physician anesthetest Part B | | 250 547 | | 250.545 | 1 0 40 00 | 104.45 | 3 |
| 4.01 | Physician-Part A - Administrative | | 359,547 | | 359,547 2,236,531 | 1,849.00 27,857.00 | 194.45 80.29 | 4.01 |
| 5 | Physician-Part A - Teaching Physician-Part B | | 2,236,531 169,223 | | 169,223 | 2,230.00 | 75.88 | 5 |
| 6 | Non-physician-Part B | | 109,223 | | 109,223 | 2,230.00 | 73.66 | 6 |
| 7 | Interns & residents (in an approved program) | 21 | 1,990,759 | -108,889 | 1,881,870 | 56,517.39 | 33.30 | 7 |
| 7.01 | Contracted interns & residents (in an approved program) | | 2,220,102 | 200,000 | 2,002,010 | 2 0,0 2 1 10 2 | | 7.01 |
| 8 | Home office and/or related organization personnel | | | | | | | 8 |
| 9 | SNF | 44 | | | | | | 9 |
| 10 | Excluded area salaries (see instructions) | | 6,911,978 | -210,045 | 6,701,933 | 207,171.95 | 32.35 | 10 |
| | OTHER WAGES & RELATED COSTS | | | | | | | |
| 11 | Contract labor (see instructions) | | 1,824,741 | | 1,824,741 | 29,250.00 | 62.38 | 11 |
| 12 | Contract management and administrative services | | 867,718 | | 967.719 | 5,115.00 | 169.64 | 12 |
| 13 | Contract labor: Physician-Part A - Administrative Home office salaries & wage-related costs | | 807,718 | | 867,718 | 3,113.00 | 109.04 | 14 |
| 14.01 | Home office salaries | | 47,955,859 | | 47,955,859 | 596,622.00 | 80.38 | 14.01 |
| 14.02 | Related organization salaries | | 47,755,057 | | 41,733,037 | 370,022.00 | 00.50 | 14.02 |
| 15 | Home office: Physician Part A - Administrative | | | | | | | 15 |
| 16 | Home office & Contract Physicians Part A - Teaching | | | | | | | 16 |
| | WAGE-RELATED COSTS | | | | | | | |
| 17 | Wage-related costs (core)(see instructions) | | 28,391,737 | | 28,391,737 | | | 17 |
| 18 | Wage-related costs (other)(see instructions) | | 6,646 | | 6,646 | | | 18 |
| 19 | Excluded areas | | 1,427,468 | -43,880 | 1,383,588 | | | 19 |
| 20 | Non-physician anesthetist Part A | | | | | | | 20 |
| 21 | Non-physician anesthetist Part B Physician Part A - Administrative | | 78,022 | | 78.022 | | | 21 22 |
| 22.01 | Physician Part A - Administrative Physician Part A - Teaching | | 485,327 | | 485,327 | | | 22.01 |
| 23 | Physician Part B | | 36,721 | | 36,721 | | | 23 |
| 24 | Wage-related costs (RHC/FOHC) | | 30,721 | | 30,721 | | | 24 |
| 25 | Interns & residents (in an approved program) | | 337,917 | 74,486 | 412,403 | | | 25 |
| 25.50 | Home office wage-related | | 13,290,449 | . , | 13,290,449 | | | 25.50 |
| 25.51 | Related organization wage-related | | | | | | | 25.51 |
| 25.52 | Home office: Physician Part A - Administrative - wage-related | | | | | | | 25.52 |
| 25.53 | Home office & Contract Physicians Part A - Teaching - wage- related | | | | | | | 25.53 |
| | OVERHEAD COSTS - DIRECT SALARIES | | | | | | | |
| 26 | Employee Benefits Department | | 137,458 | | 137,458 | 4,326.95 | 31.77 | 26 |
| 27 | Administrative & General | | 2,632,078 | 265,848 | 2,897,926 | 120,829.59 | 23.98 | 27 |
| 28 29 | Administrative & General under contract (see instructions) | | 335,158 | | 335,158 | 4,246.00 | 78.93 | 28 |
| 30 | Maintenance & Repairs Operation of Plant | | 1,989,129 | | 1,989,129 | 75,046.87 | 26.51 | 30 |
| 31 | Laundry & Linen Service | | 1,989,129 | | 1,989,129 | /3,040.8/ | 20.51 | 31 |
| 32 | Housekeeping | | 1,513,034 | | 1,513,034 | 112,723.53 | 13.42 | 32 |
| 33 | Housekeeping under contract (see instructions) | | 124,800 | | 124,800 | 2,080.00 | 60.00 | 33 |
| 34 | Dietary | | 2,081,310 | -790,898 | 1,290,412 | 90,343.28 | 14.28 | 34 |
| 35 | Dietary under contract (see instructions) | | 256,161 | , | 256,161 | 6,240.00 | 41.05 | 35 |
| 36 | Cafeteria | | | 790,898 | 790,898 | 46,540.55 | 16.99 | 36 |
| 37 | Maintenance of Personnel | | | | | | | 37 |
| 38 | Nursing Administration | | 2,912,468 | | 2,912,468 | 91,069.63 | 31.98 | 38 |
| 39 | Central Services and Supply | | 507,521 | ## 00° | 507,521 | 29,526.53 | 17.19 | 39 |
| 40 | Pharmacy National Pharmacy | | 3,729,554 | -55,803 | 3,673,751 | 84,065.37 | 43.70 | 40 |
| 41 | Medical Records & Medical Records Library Social Service | | 1,968,850 2,034,316 | | 1,968,850 2,034,316 | 83,236.75 56,493.70 | 23.65 36.01 | 41 42 |
| 42 | Other General Service | | 2,034,316 816,574 | | 2,034,316 816,574 | 45,554.53 | 17.93 | 42 |
| +5 | Other General Service | | 010,374 | | 010,374 | 45,554.55 | 17.93 | TJ |

Part III - Hospital Wage Index Summary

| 1 | Net salaries (see instructions) | 89,857,112 | 108,889 | 89,966,001 | 3,120,313.21 | 28.83 | 1 |
|---|---|-------------|----------|-------------|--------------|--------|---|
| 2 | Excluded area salaries (see instructions) | 6,911,978 | -210,045 | 6,701,933 | 207,171.95 | 32.35 | 2 |
| 3 | Subtotal salarles (line 1 minus line 2) | 82,945,134 | 318,934 | 83,264,068 | 2,913,141.26 | 28.58 | 3 |
| 4 | Subtotal other wages & related costs (see instructions) | 50,648,318 | | 50,648,318 | 630,987.00 | 80.27 | 4 |
| 5 | Subtotal wage-related costs (see instructions) | 41,766,854 | | 41,766,854 | | 50.16% | 5 |
| 6 | Total (sum of lines 3 through 5) | 175,360,306 | 318,934 | 175,679,240 | 3,544,128.26 | 49.57 | 6 |
| 7 | Total overhead cost (see instructions) | 21,038,411 | 210,045 | 21,248,456 | 852,323.28 | 24.93 | 7 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

HOSPITAL WAGE RELATED COSTS WORKSHEET S-3 PART IV

Part IV - Wage Related Cost

Part A - Core List

| | | Amount | |
|------|--|------------|----------|
| | DESTRUCTION OF THE PROPERTY OF | Reported | \vdash |
| _ | RETIREMENT COST | 1.001.500 | |
| 1 | 401K Employer Contributions | 1,091,798 | 1 |
| 2 | Tax Sheltered Annuity (TSA) Employer Contribution | | 2 |
| 3 | Nonqualified Defined Benefit Plan Cost (see instructions) | | 3 |
| 4 | Qualified Defined Benefit Plan Cost (see instructions) | 8,321,258 | 4 |
| | PLAN ADMINISTRATIVE COSTS (Paid to External Organization): | | |
| 5 | 401k/TSA Plan Administration Fees | | 5 |
| 6 | Legal/Accounting/Management Fees-Pension Plan | | 6 |
| 7 | Employee Managed Care Program Administration Fees | 393,456 | 7 |
| | HEALTH AND INSURANCE COST | | |
| 8 | Health Insurance (Purchased or Self Funded) | | 8 |
| 8.01 | Health Insurance (Self Funded without a Third Party Administrator) | 1 | 8.01 |
| 8.02 | Health Insurance (Self Funded with a Third Party Administrator) | 10,633,374 | 8.02 |
| 8.03 | Health Insurance (Purchased) | | 8.03 |
| 9 | Prescription Drug Plan | 2,922,642 | 9 |
| 10 | Dental, Hearing and Vision Plan | 591,307 | 10 |
| 11 | Life Insurance (If employee is owner or beneficiary) | 120,171 | 11 |
| 12 | Accident Insurance (If employee is owner or beneficiary) | | 12 |
| 13 | Disability Insurance (If employee is owner or beneficiary) | 588,127 | 13 |
| 14 | Long-Term Care Insurance (If employee is owner or beneficiary) | | 14 |
| 15 | Workers' Compensation Insurance | 253,255 | 15 |
| 16 | Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) | 33,948 | 16 |
| | TAXES | | |
| 17 | FICA-Employers Portion Only | 5,828,762 | 17 |
| 18 | Medicare Taxes - Employers Portion Only | | 18 |
| 19 | Unemployment Insurance | 9,700 | 19 |
| 20 | State or Federal Unemployment Taxes | | 20 |
| | OTHER | | |
| 21 | Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) | | 21 |
| 22 | Day Care Costs and Allowances | | 22 |
| 23 | Tuition Reimbursement | | 23 |
| 24 | Total Wage Related cost (Sum of lines 1-23) | 30,787,799 | 24 |

| Part E | 3 - Other Than Core Related Cost | | | |
|--------|------------------------------------|-------|----|---|
| 25 | OTHER WAGE RELATED COSTS (SPECIEV) | 6 646 | 25 | 1 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3 PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

| _ | Component | Contract Labor | Benefit Cost | |
|----|--|-------------------|-----------------|----|
| | 0 | 1 | 2 | |
| 1 | Total facility contract labor and benefit cost | | | 1 |
| 2 | Hospital | | | 2 |
| 3 | Subprovider - IPF | | | 3 |
| 1 | Subprovider - IRF | | | 4 |
| 5 | Subprovider - (OTHER) | | | 5 |
| 5 | Swing Beds - SNF | | | 6 |
| 7 | Swing Beds - NF | | | 7 |
| 3 | Hospital-Based SNF | | | 8 |
|) | Hospital-Based NF | | | 9 |
| 00 | Hospital-Based OLTC | | | 10 |
| 1 | Hospital-Based HHA | | | 11 |
| 2 | Separately Certified ASC | | | 12 |
| 3 | Hospital-Based Hospice | | | 13 |
| 4 | Hospital-Based Health Clinic - RHC | | | 14 |
| 5 | Hospital-Based Health Clinic - FQHC | | | 15 |
| 6 | Hospital-Based - CMHC | | | 16 |
| .7 | Renal Dialysis | | | 17 |
| 8 | Other | | | 18 |

| - | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

| HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | | | WORKSHEE | ET S-10 |
|--|----------------------------|---------------------|--------------------------|---------------|
| Uncompensated and indigent care cost computation 1 Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8) | | | 0.259470 | 1 |
| 1 Cost to charge ratio (worksheet C, Part I, line 202, column 3 divided by line 202, column 8) | | | 0.239470 | 1 |
| Medicaid (see instructions for each line) | | | | |
| 2 Net revenue from Medicaid | | | 53.831.000 | 2 |
| 3 Did you receive DSH or supplemental payments from Medicaid? | | | Y | 3 |
| 4 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? | | | Y | 4 |
| 5 If line 4 is no, enter DSH and/or supplemental payments from Medicaid | | | | 5 |
| 6 Medicaid charges | | | 194,664,204 | 6 |
| 7 Medicaid cost (line 1 times line 6) | | | 50,509,521 | 7 |
| B Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero. | | | | 8 |
| State Children's Health Insurance Program (SCHIP)(see instructions for each line) | | | | |
| 9 Net revenue from stand-alone SCHIP | | | | 9 |
| 10 Stand-alone SCHIP charges | | | | 10 |
| 11 Stand-alone SCHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). | | | | 11 |
| 12 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero. | | | | 12 |
| I me i i so sono una me o y men entre servici | | | | |
| Other state or local government indigent care program (see instructions for each line) | | | | |
| Net revenue from state or local indigent care program (not included on lines 2, 5, or 9) | | | | 13 |
| 14 Charges for patients covered under state or local indigent care program (not included in lines 6 or 10) | | | | 14 |
| State or local indigent care program cost (line 1 times line 14) | | | | 15 |
| Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero. | | | | 16 |
| If this 13 is less than this 13, then enter zero. | | | | |
| Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each li | ine) | | | |
| 17 Private grants, donations, or endowment income restricted to funding charity care | | | | 17 |
| 18 Government grants, appropriations of transfers for support of hospital operations | | | | 18 |
| 19 Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16) | | | | 19 |
| Uncompensated care (see instructions for each line) | | | | |
| | Uninsured | Insured | TOTAL | |
| | patients | patients | (col. 1 + | |
| | - | - | col. 2) | + |
| | 1 | 2 | 3 | + |
| 20 Charity care charges and uninsured discounts for the entire facility (see instructions) | 11,669,238 | 1,574,784 | 13,244,022 | |
| 21 Cost of patients approved for charity care and uninsured discounts (see instructions) | 3,027,817 | 1,574,784 | 4,602,601 | |
| 22 Payments received from patients for amounts previously written off as charity care 23 Cost of charity care (line 21 minus line 22) | 37,894 2,989,923 | 62,182 1.512,602 | 100,076 4,502,525 | $\overline{}$ |
| 25 Cost of charity care (line 21 minus fine 22) | 2,989,923 | 1,312,002 | 4,302,323 | |
| Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients care program? | s covered by Medicaid or o | other indigent | N | 24 |
| 25 If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit | | | | 25 |
| 26 Total bad debt expense for the entire hospital complex (see instructions) | | | | 26 |
| 27 Medicare reimbursable bad debts for the entire hospital complex (see instructions) | | | | 27 |
| 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) | | | 854,705 | |
| 28 Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) | | | . , , | 28 |
| 29 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) | | | 7,835,530 | |
| 30 Cost of uncompensated care (line 23, column 3 plus line 29) 31 Total unreimbursed and uncompensated care cost (line 19 plus line 30) | | | 12,338,055 12,338,055 | |
| [51] Total unremnoursed and uncompensated care cost (line 19 pius line 50) | | | 12,336,033 | 31 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

| | | COST CENTER DESCRIPTIONS | SALARIES | OTHER | TOTAL (col. 1 + col. 2) | RECLASSI- FICATIONS | RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4) | ADJUST- MENTS | NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6) | |
|----------|----------------|--|------------------------|--------------------------|-------------------------------|---|--|------------------|--|----------------|
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | 00100 | GENERAL SERVICE COST CENTERS | | | | 27.210.050 | 27 210 050 | 2 662 055 | 40.052.505 | |
| 2 | 00100 | Cap Rel Costs-Bldg & Fixt | | | | 37,310,850 -6,950,371 | 37,310,850 -6,950,371 | 3,662,857 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 2 |
| 3 | 00300 | Cap Rel Costs-Mvble Equip Other Cap Rel Costs | | | | -0,930,371 | -0,930,371 | | | 3 |
| 4 | 00400 | Employee Benefits Department | 137,458 | 3,902,872 | 4.040.330 | | 4,040,330 | 680,376 | | 4 |
| 5.01 | 00540 | NONPATIENT TELEPHONES | 233,758 | 56,734 | 290,492 | | 290,492 | 000,570 | | 5.01 |
| 5.04 | 00570 | ADMITTING | 1,088,081 | 331,811 | 1,419,892 | | 1,419,892 | | | 5.04 |
| 5.06 | 00590 | OTHER ADMINISTRATIVE & GENERAL | 1,310,239 | 87,074,978 | 88,385,217 | -18,834,559 | 69,550,658 | -5,761,429 | 63,789,229 | 5.06 |
| 6 | 00600 | Maintenance & Repairs | | | | | | | | 6 |
| 7 | 00700 | Operation of Plant | 1,989,129 | 9,532,883 | 11,522,012 | -622,125 | 10,899,887 | -637,468 | | 7 |
| 8 | 00800 | Laundry & Linen Service Housekeeping | 1,513,034 | 1,090,627 1,481,787 | 1,090,627 2,994,821 | -28,586 -996 | 1,062,041 2,993,825 | | | 9 |
| 10 | 01000 | Dietary | 2,081,310 | 3,216,331 | 5,297,641 | -2,293,041 | 3,004,600 | -147,965 | | 10 |
| 11 | 01100 | Cafeteria | 2,001,310 | 3,210,331 | 3,277,041 | 2,094,506 | 2,094,506 | -2,023,812 | | 11 |
| 12 | 01200 | Maintenance of Personnel | | | | , | ,, | , , , , , , | | 12 |
| 13 | 01300 | Nursing Administration | 2,912,468 | 1,151,351 | 4,063,819 | -551,151 | 3,512,668 | -1,655 | | 13 |
| 14 | 01400 | Central Services & Supply | 507,521 | 381,796 | 889,317 | -8,813 | 880,504 | 1,624 | | 14 |
| 15 | 01500 | Pharmacy Madical Bassada & Library | 3,729,554 | 17,813,178 | 21,542,732 | -17,374,837 | 4,167,895 | -44,456 | | 15 |
| 16 17 | 01600 01700 | Medical Records & Library Social Service | 1,968,850 2,034,316 | 940,312 589,516 | 2,909,162 2,623,832 | -22,107 | 2,887,055 2,623,832 | -183 | | 16 17 |
| 18 | 01700 | STERILE SUPPLY | 816,574 | 1,847,201 | 2,663,775 | -137,917 | 2,525,858 | | | 18 |
| 19 | 01900 | Nonphysician Anesthetists | 010,574 | -,0.7,201 | 2,000,110 | 10,,011 | 2,020,000 | | | 19 |
| 21 | 02100 | I&R Services-Salary & Fringes Apprvd | 1,990,759 | 634,975 | 2,625,734 | -144,635 | 2,481,099 | -2,700 | 2,478,399 2 | 21 |
| 22 | 02200 | I&R Services-Other Prgm Costs Apprvd | 2,464,245 | 666,535 | 3,130,780 | 67,977 | 3,198,757 | -8,209 | | 22 |
| 23 | 02300 | PARAMED ED PRGM-(SPECIFY) | 77,334 | 58,881 | 136,215 | -618 | 135,597 | -10,030 | | 23 |
| 23.02 | 02302 | PHARMACY RESIDENCY PROGRAM | 386,369 | 94,755 | 481,124 | -229,964 | 251,160 | | 251,160 2 | 23.02 |
| | | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | |
| 30 | 03000 | Adults & Pediatrics | 19,073,232 | 7,061,552 | 26,134,784 | -2,531,949 | 23,602,835 | -28,555 | 23,574,280 3 | 30 |
| 31 | 03100 | Intensive Care Unit | 3,726,812 | 1,264,082 | 4,990,894 | -145,136 | 4,845,758 | -48,636 | | 31 |
| 35 | 02060 | NEONATAL INTENSIVE CARE UNIT | 2,084,532 | 852,924 | 2,937,456 | -83,052 | 2,854,404 | , | 2,854,404 3 | 35 |
| 41 | 04100 | Subprovider - IRF | 1,479,528 | 2,221,475 | 3,701,003 | -1,581,073 | 2,119,930 | -118,338 | | 41 |
| 43 | 04300 | Nursery | | | | 2,747,908 | 2,747,908 | | 2,747,908 4 | 43 |
| 50 | 05000 | ANCILLARY SERVICE COST CENTERS Operating Room | 10,069,621 | 39,207,110 | 49,276,731 | -22,872,743 | 26,403,988 | -2,216,365 | 24,187,623 5 | 50 |
| 51 | 05100 | Recovery Room | 1,275,886 | 312,321 | 1,588,207 | -4,795 | 1,583,412 | -2,210,303 | | 51 |
| 52 | 05200 | Delivery Room & Labor Room | 2,645,895 | 812,375 | 3,458,270 | -363,797 | 3,094,473 | | | 52 |
| 54 | 05400 | Radiology-Diagnostic | 3,665,312 | 3,376,494 | 7,041,806 | -1,307,641 | 5,734,165 | -51,231 | 5,682,934 5 | 54 |
| 55 | 05500 | Radiology-Therapeutic | 221,816 | 481,304 | 703,120 | -20,700 | 682,420 | -89,727 | | 55 |
| 57 | 05700 | CT Scan | 752,849 | 748,202 | 1,501,051 | -293,128 | 1,207,923 | | | 57 |
| 58 59 | 05800 05900 | MRI | 2,593,909 | 398,747 | 398,747 | -5,563,165 | 398,747 | -18,270 | | 58 59 |
| 60 | 06000 | Cardiac Catheterization Laboratory | 2,393,909 | 11,775,934 11,436,117 | 14,369,843 11,436,117 | -453,893 | 8,806,678 10,982,224 | -18,270 | | 60 |
| 62.30 | 06250 | BLOOD CLOTTING FOR HEMOPHILIACS | | 11,430,117 | 11,430,117 | -433,673 | 10,762,224 | | | 62.30 |
| 65 | 06500 | Respiratory Therapy | 1,837,414 | 1,600,673 | 3,438,087 | -229,226 | 3,208,861 | -4,000 | | 65 |
| 66 | 06600 | Physical Therapy | 2,550,643 | 998,256 | 3,548,899 | -391,196 | 3,157,703 | -8,686 | | 66 |
| 67 | 06700 | Occupational Therapy | 732,447 | 254,587 | 987,034 | -98,058 | 888,976 | | | 67 |
| 68 | 06800 | Speech Pathology | 403,130 | 84,914 | 488,044 | -17,221 | 470,823 | 1 222 | | 68 |
| 69 71 | 06900 07100 | Electrocardiology Medical Supplies Charged to Patients | 975,602 | 556,739 -579,503 | 1,532,341 -579,503 | -255,063 579,503 | 1,277,278 | 1,332 | | 69 71 |
| 72 | 07200 | Impl. Dev. Charged to Patients | | -517,503 | -317,303 | 24,980,388 | 24,980,388 | | | 72 |
| 73 | 07300 | Drugs Charged to Patients | 346,442 | 390,958 | 737,400 | 17,026,132 | 17,763,532 | | | 73 |
| 74 | 07400 | Renal Dialysis | | 1,112,568 | 1,112,568 | 563 | 1,113,131 | | 1,113,131 7 | 74 |
| 76.97 | 07697 | CARDIAC REHABILITATION | | | | | | | | 76.97 |
| 76.98 | 07698 | HYPERBARIC OXYGEN THERAPY | | | | 55,800 | 55,800 | | | 76.98 |
| 76.99 | 07699 | LITHOTRIPSY OUTDATIENT SERVICE COST CENTERS | | | | | | | 7 | 76.99 |
| 90 | 09000 | OUTPATIENT SERVICE COST CENTERS Clinic | | | | | | | Q | 90 |
| 90.02 | 09001 | MOBILE MEDICAL UNIT | 79,473 | 172,656 | 252,129 | -135,402 | 116,727 | | | 90.02 |
| 90.03 | 09002 | FAMILY MEDICINE CENTER | 701,905 | 886,591 | 1,588,496 | -284,270 | 1,304,226 | -9,960 | | 90.03 |
| 90.04 | 09003 | WOUND HEALING CENTER | 504,278 | 1,295,209 | 1,799,487 | -375,796 | 1,423,691 | | | 90.04 |
| 90.05 | 09004 | OUTPATIENT TREATMENT & INFUSION | 624,346 | 137,232 | 761,578 | 4 | 761,578 | | | 90.05 |
| 90.06 | 09005 | PEDIATRIC SPECIALTY CLINIC | 302,611 | 380,961 | 683,572 | -101,877 | 581,695 | -148,004 | | 90.06 |
| 90.07 | 09006 09007 | SPORTS MED FELLOWSHIP CLINIC PODIATRY RESIDENCY CLINIC | 626,819 74,948 | 287,616 247,612 | 914,435 322,560 | -155,802 -44,464 | 758,633 278,096 | -4,792 -875 | | 90.07 90.08 |
| 90.08 | 09007 | FACULTY PRACTICE CLINIC | 403,814 | 307,249 | 711,063 | -90,787 | 620,276 | -35 | | 90.08 |
| 90.10 | 09009 | OUR LADY OF ROSARY CLINIC | 600,807 | 495,714 | 1,096,521 | -211,662 | 884,859 | -3,035 | | 90.10 |
| 91 | 09100 | Emergency | 4,973,689 | 2,636,057 | 7,609,746 | -40,346 | 7,569,400 | -161,275 | | 91 |
| 92 | 09200 | Observation Beds (Non-Distinct Part) | | | | | | | | 92 |
| | | OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 118 | | SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) | 88,568,759 | 222,081,249 | 310,650,008 | 11,665 | 310,661,673 | -7,203,502 | 303,458,171 1 | 10 |
| 118 | | NONREIMBURSABLE COST CENTERS | 00,300,739 | 222,081,249 | 310,030,008 | 11,005 | 310,001,073 | -1,203,302 | 303,438,1/1 1. | 10 |
| 1 | 1 | 1 TO THE POST OF THE PARTY OF T | | | | | | | | |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

| | | COST CENTER DESCRIPTIONS | SALARIES | OTHER | TOTAL (col. 1 + col. 2) | RECLASSI- FICATIONS | RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4) | ADJUST- MENTS | NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6) | |
|--------|-------|-------------------------------------|------------|-------------|----------------------------|------------------------|--|------------------|--|--------|
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 190 | 19000 | Gift, Flower, Coffee Shop & Canteen | | | | | | | | 190 |
| 192 | 19200 | Physicians' Private Offices | | | | | | | | 192 |
| 192.01 | 19201 | MATERNAL FETAL MEDICINE/LABORIST | 88,558 | 1,528,662 | 1,617,220 | | 1,617,220 | | 1,617,220 | 192.01 |
| 192.02 | 19202 | NEONATOLOGISTS | 1,465,241 | 224,891 | 1,690,132 | | 1,690,132 | | 1,690,132 | 192.02 |
| 192.03 | 19203 | HOSPITALISTS/INTENSIVISTS | 385,331 | 4,988,415 | 5,373,746 | | 5,373,746 | | 5,373,746 | 192.03 |
| 194 | 07950 | SPORTS MED-ATHLETIC TRAINERS | | | | | | | | 194 |
| 194.01 | 07951 | OUTREACH SERVICES | 2,617,300 | 852,946 | 3,470,246 | | 3,470,246 | | 3,470,246 | 194.01 |
| 194.02 | 07952 | KINDRED/OUR LADY OF PEACE | | | | | | | | 194.02 |
| 194.03 | 07953 | ADVANCED SPECIALTIES | | 149,488 | 149,488 | | 149,488 | | 149,488 | 194.03 |
| 194.04 | 07954 | AMBULATORY PHARMACY SERVICES | 412,317 | 90,797 | 503,114 | -11,665 | 491,449 | | 491,449 | 194.04 |
| 200 | | TOTAL (sum of lines 118-199) | 93,537,506 | 229,916,448 | 323,453,954 | | 323,453,954 | -7.203.502 | 316,250,452 | 200 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

| | | CODE | | EASES | T | + | |
|-------|---|--------|--------------------------------|-------|------------------|----------------|-----|
| | EXPLANATION OF RECLASSIFICATION(S) | (1) | COST CENTER | LINE# | SALARY | OTHER | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 1 | NEGATIVE BALANCES | A | Medical Supplies Charged to P | 71 | | 579,503 | |
| 500 | Total reclassifications | | | | | 579,503 | 500 |
| | Code Letter - A | | | | | | |
| 1 | IMPLANTABLE DEVICES | В | Impl. Dev. Charged to Patient | 72 | | 24,980,388 | |
| 2 | IMPLANTABLE DEVICES | В | Impir 201. Charged to I attent | ,,2 | | 21,500,500 | |
| 3 | IMPLANTABLE DEVICES | В | | | | | |
| 4 | IMPLANTABLE DEVICES | В | | | | | |
| 500 | Total reclassifications | | | | | 24,980,388 | 50 |
| | Code Letter - B | | | | | | |
| 1 | DRUGS | С | Drugs Charged to Patients | 73 | | 17,035,084 | |
| 500 | Total reclassifications | | Drugs Charged to Fadents | 7.5 | | 17,035,084 | 50 |
| 200 | Code Letter - C | | | | | 17,055,051 | |
| | | | | | | | |
| 1 | CAFETERIA/DIETARY | D | Cafeteria | 11 | 790,898 | 1,383,022 | |
| 500 | Total reclassifications | | | | 790,898 | 1,383,022 | 50 |
| | Code Letter - D | | | | | | |
| 1 | INTEREST EXPENSE | Е | Cap Rel Costs-Bldg & Fixt | 1 | | 11,525,713 | |
| 2 | INTEREST EXPENSE INTEREST EXPENSE | E | Cup Noi Costo-Diug & FIAt | 1 | - | 11,323,113 | |
| 500 | Total reclassifications | | | | | 11,525,713 | 50 |
| | Code Letter - E | | | | | ,, | |
| | | | | | | | |
| 1 | DEPRECIATION | F | Cap Rel Costs-Bldg & Fixt | 1 | | 25,496,132 | |
| 2 | DEPRECIATION | F | Renal Dialysis | 74 | | 563 | |
| 3 | DEPRECIATION DEPRECIATION | F | | | | | |
| | DEPRECIATION DEPRECIATION | F | | | | | |
| | | F | | | | | |
| 7 | DEPRECIATION | F | | | | | |
| 8 | DEPRECIATION | F | | | | | |
| | DEPRECIATION | F | | | | | |
| | DEPRECIATION | F | | | | | 1 |
| 11 | DEPRECIATION | F | | | | | 1 |
| | DEPRECIATION DEPRECIATION | F F | | | | | 1 |
| 14 | | F | | | | | 1 |
| | DEPRECIATION | F | | | | | 1 |
| | DEPRECIATION | F | | | | | 1 |
| 17 | DEPRECIATION | F | | | | | 1 |
| | DEPRECIATION | F | | | | | 1 |
| | | F | | | | | 1 |
| | DEPRECIATION | F | | | | | 2 |
| 21 | | F | | | | | 2 |
| | DEPRECIATION | F | | | | | |
| | DEPRECIATION | F | | | | | 2 |
| | DEPRECIATION | F | | | | | 2 |
| 26 | DEPRECIATION | F | | | | | - 2 |
| 27 | DEPRECIATION | F | | | | | 2 |
| | DEPRECIATION | F | | | | | 2 |
| | DEPRECIATION | F | | | | | 2 |
| | DEPRECIATION DEPRECIATION | F | | | | | 3 |
| | DEPRECIATION | F | | | | | 3 |
| | DEPRECIATION | F | | | | | 3 |
| 34 | DEPRECIATION | F | | | | | 3 |
| | DEPRECIATION | F | | | | | 3 |
| | DEPRECIATION | F | | | | | 3 |
| | DEPRECIATION | F | | | | | |
| | DEPRECIATION DEPRECIATION | F | | | + | | 3 |
| | DEPRECIATION DEPRECIATION | F | | | + | | |
| | DEPRECIATION DEPRECIATION | F | | | + | | |
| | Total reclassifications | | | | | 25,496,695 | 5 |
| | Code Letter - F | | | | | | |
| | | | | | | | |
| 1 | OB/NURSERY/LABOR ROOM | G | Nursery | 43 | 1,227,254 | 1,158,239 | |
| 500 | Total reclassifications | | | | 1,227,254 | 1,158,239 | 50 |
| | Code Letter - G | | | | - | | |
| | | | I . | 1 1 | | | |
| 1 | HYPERBARIC OXYGEN | н | HYPERBARIC OXYGEN THER APY | 76.98 | 54 762 | 1.038 | |
| 1 500 | HYPERBARIC OXYGEN Total reclassifications | Н | HYPERBARIC OXYGEN THERAPY | 76.98 | 54,762 54,762 | 1,038 1,038 | 50 |

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

| | | INCREASES | | | | | |
|-----|------------------------------------|-------------|-------------------------------|-------|-----------|------------|-----|
| | EXPLANATION OF RECLASSIFICATION(S) | CODE (1) | COST CENTER | LINE# | SALARY | OTHER | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 1 | SBMF CAPITAL | AB | Cap Rel Costs-Bldg & Fixt | 1 | | 289,005 | 1 |
| 500 | Total reclassifications | | | | | 289,005 | 500 |
| | Code Letter - AB | | | | | | |
| 1 | 2ND YR PHARMACY RESIDENTS | AC | OTHER ADMINISTRATIVE & GENERA | 5.06 | 265,848 | 40,345 | 1 |
| 2 | 2ND YR PHARMACY RESIDENTS | AC | | | | | 2 |
| 3 | 2ND YR PHARMACY RESIDENTS | AC | | | | | 3 |
| 500 | Total reclassifications | | | | 265,848 | 40,345 | 500 |
| | Code Letter - AC | | | | | | |
| 1 | OTHER MEDICAL EDUCATION EXPENSES | AD | I&R Services-Other Prgm Costs | 22 | 172,421 | 54,995 | 1 |
| 500 | Total reclassifications | | | | 172,421 | 54,995 | 500 |
| | Code Letter - AD | | | | | | |
| 1 | CLINIC MEDICAL EDUCATION | AE | I&R Services-Salary & Fringes | 21 | 63,532 | 19,249 | 1 |
| 500 | Total reclassifications | | • | | 63,532 | 19,249 | 500 |
| | Code Letter - AE | | | | | | |
| 1 | LABORDELIVERY/NURSERY | AF | Nursery | 43 | 277,392 | 85,023 | 1 |
| 500 | Total reclassifications | | | | 277,392 | 85,023 | 500 |
| | Code Letter - AF | | | | , | , | |
| | GRAND TOTAL (Increases) | | | | 2,852,107 | 82,648,299 | |

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

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

| | | | DECRE | ASES | | | **** | |
|-----|--|----------|---|-------------|-----------|-----------------------|-------------|------------|
| | EXPLANATION OF RECLASSIFICATION(S) | CODE (1) | COST CENTER | LINE# | SALARY | OTHER | Wkst A-7 | |
| | | 1 | 6 | 7 | 8 | 9 | Ref. | |
| 1 | NEGATIVE BALANCES | A | OTHER ADMINISTRATIVE & GENERA | 5.06 | 0 | 579,503 | 10 | 1 |
| 500 | Total reclassifications | | | | | 579,503 | | 500 |
| | Code letter - A | | | | | , | | |
| 1 | IMPLANTABLE DEVICES | В | Operating Room | 50 | | 20,308,373 | | 1 |
| 2 | IMPLANTABLE DEVICES | В | Cardiac Catheterization | 59 | | 4,489,749 | | 2 |
| 3 | IMPLANTABLE DEVICES | В | WOUND HEALING CENTER | 90.04 | | 177,821 | | 3 |
| 500 | IMPLANTABLE DEVICES Total reclassifications | В | Emergency | 91 | | 4,445 24,980,388 | | 500 |
| 300 | Code letter - B | | | | | 24,960,366 | | |
| 1 | DRUGS | С | Pharmacy | 15 | | 17,035,084 | | 1 |
| 500 | Total reclassifications | | | | | 17,035,084 | | 500 |
| | Code letter - C | | | | | | | |
| 1 | CAFETERIA/DIETARY | D | Dietary | 10 | 790,898 | 1,383,022 | | 1 |
| 500 | Total reclassifications Code letter - D | | | | 790,898 | 1,383,022 | | 500 |
| | | - | OTHER ADMINISTRATIVE & CONTRA | 5.00 | | 11.040.155 | 1.1 | |
| 2 | INTEREST EXPENSE INTEREST EXPENSE | E E | OTHER ADMINISTRATIVE & GENERA Subprovider - IRF | 5.06 | | 11,040,155 485,558 | 11 | 1 2 |
| 500 | Total reclassifications | E | Supprovider - INF | 41 | | 11,525,713 | | 500 |
| 200 | Code letter - E | | | | | 11,020,110 | | |
| 1 | DEPRECIATION | F | Cap Rel Costs-Mvble Equip | 2 | | 6,950,371 | 9 | 1 |
| 2 | DEPRECIATION | F | OTHER ADMINISTRATIVE & GENERA | 5.06 | | 7,521,094 | | 2 |
| 3 | DEPRECIATION | F | Operation of Plant | 7 | | 622,125 | | 3 |
| | DEPRECIATION | F | Laundry & Linen Service | 8 | | 28,586 | | 4 |
| | DEPRECIATION | F | Housekeeping | 9 | | 996 | | 5 |
| | DEPRECIATION DEPRECIATION | F F | Dietary | 10 11 | | 119,121 | | 6 7 |
| 7 | DEPRECIATION DEPRECIATION | F | Cafeteria Nursing Administration | 13 | | 79,414 551,151 | | 8 |
| 9 | DEPRECIATION DEPRECIATION | F | Central Services & Supply | 14 | | 8,813 | | 9 |
| | DEPRECIATION | F | Pharmacy | 15 | | 275,189 | | 10 |
| 11 | DEPRECIATION | F | Medical Records & Library | 16 | | 22,107 | | 11 |
| 12 | DEPRECIATION | F | STERILE SUPPLY | 18 | | 137,917 | | 12 |
| 13 | DEPRECIATION | F | I&R Services-Other Prgm Costs | 22 | | 159,439 | | 13 |
| | DEPRECIATION | F | PARAMED ED PRGM-(SPECIFY) | 23 | | 618 | | 14 |
| | DEPRECIATION DEPRECIATION | F F | Adults & Pediatrics Intensive Care Unit | 30 | | 146,456 145,136 | | 15 16 |
| | DEPRECIATION | F | NEONATAL INTENSIVE CARE UNIT | 35 | | 83,052 | | 17 |
| | DEPRECIATION | F | Subprovider - IRF | 41 | | 1,095,515 | | 18 |
| | DEPRECIATION | F | Operating Room | 50 | | 2,564,370 | | 19 |
| 20 | DEPRECIATION | F | Recovery Room | 51 | | 4,795 | | 20 |
| | DEPRECIATION | F | Delivery Room & Labor Room | 52 | | 1,382 | | 21 |
| | DEPRECIATION | F | Radiology-Diagnostic | 54 | | 1,307,641 | | 22 |
| | DEPRECIATION DEPRECIATION | F F | Radiology-Therapeutic CT Scan | 55 57 | | 20,700 | | 23 24 |
| | DEPRECIATION DEPRECIATION | F | C1 Scan Cardiac Catheterization | 59 | | 293,128 1,073,416 | | 25 |
| 26 | DEPRECIATION | F | Laboratory | 60 | | 164,888 | | 26 |
| | DEPRECIATION | F | Respiratory Therapy | 65 | | 229,226 | | 27 |
| 28 | DEPRECIATION | F | Physical Therapy | 66 | | 391,196 | | 28 |
| | DEPRECIATION | F | Occupational Therapy | 67 | | 98,058 | | 29 |
| | DEPRECIATION | F | Speech Pathology | 68 | | 17,221 | | 30 |
| | DEPRECIATION DEPRECIATION | F | Electrocardiology | 69 | | 255,063 | | 31 |
| | DEPRECIATION DEPRECIATION | F | Drugs Charged to Patients MOBILE MEDICAL UNIT | 73 90.02 | | 8,952 135,402 | | 32 33 |
| | DEPRECIATION DEPRECIATION | F | FAMILY MEDICINE CENTER | 90.02 | | 284,270 | | 34 |
| | DEPRECIATION DEPRECIATION | F | WOUND HEALING CENTER | 90.03 | | 142,175 | | 35 |
| | DEPRECIATION | F | PEDIATRIC SPECIALTY CLINIC | 90.06 | | 101,877 | | 36 |
| 37 | DEPRECIATION | F | SPORTS MED FELLOWSHIP CLINIC | 90.07 | | 73,021 | | 37 |
| | DEPRECIATION | F | PODIATRY RESIDENCY CLINIC | 90.08 | | 44,464 | | 38 |
| | DEPRECIATION | F | FACULTY PRACTICE CLINIC | 90.09 | | 90,787 | | 39 |
| | DEPRECIATION DEPRECIATION | F | OUR LADY OF ROSARY CLINIC | 90.10 | | 211,662 | | 40 |
| 500 | DEPRECIATION Total reclassifications | F | Emergency | 91 | | 35,901 25,496,695 | | 500 500 |
| 500 | Code letter - F | | | | | 23,470,073 | | |
| 1 | OB/NURSERY/LABOR ROOM | G | Adults & Pediatrics | 30 | 1,227,254 | 1,158,239 | | 1 |
| 500 | Total reclassifications | | | | 1,227,254 | 1,158,239 | | 500 |
| | Code letter - G | | | | | | | |
| 1 | HYPERBARIC OXYGEN | Н | WOUND HEALING CENTER | 90.04 | 54,762 | 1,038 | | 1 |
| 500 | Total reclassifications | | | | 54,762 | 1,038 | | 500 |
| | Code letter - H | | | | 1 | | | |

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

| | | | DECREA | ASES | | | | |
|-----|------------------------------------|----------|---------------------------------|--------|-----------|------------|---------------------|-----|
| | EXPLANATION OF RECLASSIFICATION(S) | CODE (1) | COST CENTER | LINE# | SALARY | OTHER | Wkst A-7 Ref. | |
| | | 1 | 6 | 7 | 8 | 9 | 10 | |
| 1 | SBMF CAPITAL | AB | Laboratory | 60 | | 289.005 | 9 | |
| 500 | Total reclassifications | Ab | Laboratory | - 00 | | 289,005 | | 50 |
| 300 | Code letter - AB | | | | | 207,003 | | 300 |
| | | | | | | | | |
| 1 | 2ND YR PHARMACY RESIDENTS | AC | Pharmacy | 15 | 55,803 | 8,761 | | |
| 2 | 2ND YR PHARMACY RESIDENTS | AC | PHARMACY RESIDENCY PROGRAM | 23.02 | 199,898 | 30,066 | | |
| 3 | 2ND YR PHARMACY RESIDENTS | AC | AMBULATORY PHARMACY SERVICES | 194.04 | 10,147 | 1,518 | | |
| 500 | Total reclassifications | | | | 265,848 | 40,345 | | 500 |
| | Code letter - AC | | | | | | | |
| 1 | OTHER MEDICAL EDUCATION EXPENSES | AD | I&R Services-Salary & Fringes | 21 | 172,421 | 54,995 | | j |
| 500 | Total reclassifications | | | | 172,421 | 54,995 | | 500 |
| | Code letter - AD | | | | | ,,,,,,, | | |
| 1 | CLINIC MEDICAL EDUCATION | AE | SPORTS MED FELLOWSHIP CLINIC | 90.07 | 63,532 | 19.249 | | |
| 500 | Total reclassifications | AL | SI OKIS MED I ELEOWSIIII CERVIC | 70.07 | 63,532 | 19,249 | | 50 |
| 300 | Code letter - AE | | | | 05,552 | 17,247 | | 300 |
| | | | | | | | | |
| 1 | LABORDELIVERY/NURSERY | AF | Delivery Room & Labor Room | 52 | 277,392 | 85,023 | | 1 |
| 500 | Total reclassifications | | | | 277,392 | 85,023 | | 500 |
| | Code letter - AF | | | | | | | |
| | GRAND TOTAL (Decreases) | | | | 2.852.107 | 82,648,299 | | |

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

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | 1 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

| | | Acquisitions | | | | | | | |
|----|-----------------------------|-----------------------|-------------|----------|-------------|---------------------------------|-------------------|--------------------------------|----|
| | Description | Beginning Balances | Purchases | Donation | Total | Disposals and Retirements | Ending Balance | Fully Depreciated Assets | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 1 | Land | 406,022 | | | | | 406,022 | | 1 |
| 2 | Land Improvements | | | | | | | | 2 |
| 3 | Buildings and Fixtures | 209,167,147 | 96,794,185 | | 96,794,185 | | 305,961,332 | 7,054,625 | 3 |
| 4 | Building Improvements | 4,151,780 | | | | 602,901 | 3,548,879 | | 4 |
| 5 | Fixed Equipment | | | | | | | | 5 |
| 6 | Movable Equipment | 199,289,954 | -86,040,078 | | -86,040,078 | 625,692 | 112,624,184 | 51,052,712 | 6 |
| 7 | HIT-designated Assets | | | | | | | | 7 |
| 8 | Subtotal (sum of lines 1-7) | 413,014,903 | 10,754,107 | | 10,754,107 | 1,228,593 | 422,540,417 | 58,107,337 | 8 |
| 9 | Reconciling Items | | | | | | | | 9 |
| 10 | Total (line 7 minus line 9) | 413,014,903 | 10,754,107 | | 10,754,107 | 1,228,593 | 422,540,417 | 58,107,337 | 10 |

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

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

| 1 /11 | TART III - RECONCIDIATION OF CALITAE COST CENTERS | | | | | | | | | | |
|-------|---|--------------|-----------------------|--|--------------------------------|-----------------------------|-------|---------------------------------|--|---|--|
| | | | COMPUTATION | ON OF RATIOS | | ALLOCATION OF OTHER CAPITAL | | | | | |
| | Description | Gross Assets | Capitalized Leases | Gross Assets for Ratio (col. 1 - col. 2) | Ratio (see instructions) | Insurance | Taxes | Other Capital- Related Costs | Total (sum of cols. 5 through 7) | | |
| * | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | |
| 1 | Cap Rel Costs-Bldg & Fi | | | | 0.000000 | | | | | 1 | |
| 2 | Cap Rel Costs-Mvble Equ | | | | 0.000000 | | | | | 2 | |
| 3 | Total (sum of lines 1-2) | | | | 0.000000 | | | | | 3 | |

| | | | | SUM | MARY OF CAPI | TAL | | | |
|---|---------------------------|--------------|-------|------------|------------------------------------|--------------------------------|--|---|---|
| | Description | Depreciation | Lease | Interest | Insurance (see instructions) | Taxes (see instructions) | Other Capital- Related Costs (see instructions) | Total (2) (sum of cols. 9 through 14) | |
| * | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 | Cap Rel Costs-Bldg & Fixt | 29,447,994 | | 11,525,713 | | | | 40,973,707 | 1 |
| 2 | Cap Rel Costs-Mvble Equip | -6,950,371 | | | | | | -6,950,371 | 2 |
| 3 | Total (sum of lines 1-2) | 22,497,623 | | 11,525,713 | | | | 34,023,336 | 3 |

⁽²⁾ The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

| 2 | Investment income-buildings & fixtures (chapter 2) Investment income-movable equipment (chapter 2) Investment income-other (chapter 2) Trade, quantity, and time discounts (chapter 8) Refunds and rebates of expenses (chapter 8) Rental of provider space by suppliers (chapter 8) Telephone services (pay stations excl) (chapter 21) Television and radio service (chapter 21) Parking lot (chapter 21) Provider-based physician adjustment | BASIS/ CODE (2) 1 B | AMOUNT 2 -313,072 | COST CENTER 3 Cap Rel Costs-Bldg & Fixt Cap Rel Costs-Mvble Equip OTHER ADMINISTRATIVE & GENERAL | LINE# | Wkst. A-7 Ref. 5 | |
|--|---|---------------------------------|---|--|-------|---------------------------|----------------|
| 2 | Investment income-movable equipment (chapter 2) Investment income-other (chapter 2) Trade, quantity, and time discounts (chapter 8) Refunds and rebates of expenses (chapter 8) Rental of provider space by suppliers (chapter 8) Telephone services (pay stations excl) (chapter 21) Television and radio service (chapter 21) Parking lot (chapter 21) | 1 B | | Cap Rel Costs-Bldg & Fixt Cap Rel Costs-Mvble Equip | 1 | | |
| 2 | Investment income-movable equipment (chapter 2) Investment income-other (chapter 2) Trade, quantity, and time discounts (chapter 8) Refunds and rebates of expenses (chapter 8) Rental of provider space by suppliers (chapter 8) Telephone services (pay stations excl) (chapter 21) Television and radio service (chapter 21) Parking lot (chapter 21) | A | -313,072 | Cap Rel Costs-Mvble Equip | | | |
| 3 14 7 15 15 16 16 17 17 17 17 17 17 17 17 17 17 17 17 17 | Investment income-other (chapter 2) Trade, quantity, and time discounts (chapter 8) Refunds and rebates of expenses (chapter 8) Rental of provider space by suppliers (chapter 8) Telephone services (pay stations excl) (chapter 21) Television and radio service (chapter 21) Parking lot (chapter 21) | A | -313,072 | | | | 1 |
| 4 | Trade, quantity, and time discounts (chapter 8) Refunds and rebates of expenses (chapter 8) Rental of provider space by suppliers (chapter 8) Telephone services (pay stations excl) (chapter 21) Television and radio service (chapter 21) Parking lot (chapter 21) | A | -313,072 | OTHER ADMINISTRATIVE & GENERAL | 2 | | 2 |
| 5 1 6 1 7 7 8 7 8 9 1 10 11 12 13 13 14 6 15 15 15 15 15 15 15 | Refunds and rebates of expenses (chapter 8) Rental of provider space by suppliers (chapter 8) Telephone services (pay stations excl) (chapter 21) Television and radio service (chapter 21) Parking lot (chapter 21) | | | CENTERIAL COLINAL | 5.06 | | 3 |
| 6 1 7 7 8 7 8 7 9 1 10 11 12 13 13 14 15 15 15 15 15 15 15 | Rental of provider space by suppliers (chapter 8) Telephone services (pay stations excl) (chapter 21) Television and radio service (chapter 21) Parking lot (chapter 21) | | | | | | 5 |
| 7 8 7 9 11 110 11 11 12 11 13 11 14 (0 115 115 115 115 115 115 115 115 115 11 | Telephone services (pay stations excl) (chapter 21) Television and radio service (chapter 21) Parking lot (chapter 21) | | | | | | 6 |
| 8 7 9 1 10 1 11 2 12 1 13 1 14 (15 1 | Television and radio service (chapter 21) Parking lot (chapter 21) | | | | | | 7 |
| 9 1 10 1 11 2 12 1 13 1 14 (15 1 | Parking lot (chapter 21) | | | | | | 8 |
| 11 S 12 I 13 I 14 G 15 I | Provider-based physician adjustment | | | | | | 9 |
| 12 1 13 1 14 (1 15 1 | | Wkst A-8-2 | -2,658,836 | | | | 10 |
| 13 I 14 (15 I | Sale of scrap, waste, etc. (chapter 23) | | | | | | 11 |
| 14 (15 I | Related organization transactions (chapter 10) | Wkst A-8-1 | 17,654,081 | | | | 12 |
| 15 1 | Laundry and linen service | | | | | | 13 |
| | Cafeteria - employees and guests | В | -1,863,140 | Cafeteria | 11 | | 14 |
| 10 | Rental of quarters to employees & others | | | | | | 15 |
| 17 | Sale of medical and surgical supplies to other than patients | P | 44 450 | Dharmagu | 15 | | 16 |
| | Sale of drugs to other than patients Sale of medical records and abstracts | В | -44,456 | Pharmacy | 15 | | 17 18 |
| | Nursing and allied health education (tuition, fees, books, etc.) | | | | | | 19 |
| | Vending machines | В | -160,672 | Cafeteria | 11 | | 20 |
| | Income from imposition of interest, finance or penalty charges (chapter 21) | | 100,072 | | | | 21 |
| 22] | Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments | | | | | | 22 |
| | Adj for respiratory therapy costs in excess of limitation (chapter 14) | Wkst A-8-3 | | Respiratory Therapy | 65 | | 23 |
| 24 | Adj for physical therapy costs in excess of limitation (chapter 14) | Wkst A-8-3 | | Physical Therapy | 66 | | 24 |
| 25 1 | Util review-physicians' compensation (chapter 21) | A-0-3 | | Utilization Review-SNF | 114 | | 25 |
| | Depreciationbuildings & fixtures | | | Cap Rel Costs-Bldg & Fixt | 1 | | 26 |
| | Depreciationmovable equipment | | | Cap Rel Costs-Mvble Equip | 2 | | 27 |
| | Non-physician anesthetist | | | Nonphysician Anesthetists | 19 | | 28 |
| | Physicians' assistant Adj for occupational therapy costs in excess of limitation (chapter 14) | Wkst | | Occupational Therapy | 67 | | 30 |
| | Adj for speech pathology costs in excess of limitation (chapter 14) | A-8-3 Wkst | | Speech Pathology | 68 | | 31 |
| | CAH HIT Adj for Depreciation | A-8-3 | | | - | | 32 |
| | DONATIONS | A | | | | | 33 |
| | OTHER REVENUE | В | -628,290 | OTHER ADMINISTRATIVE & GENERAL | 5.06 | | 33.01 |
| | OTHER REVENUE | В | -637,468 | Operation of Plant | 7 | | 33.02 |
| 33.03 | OTHER REVENUE | В | -147,965 | Dietary | 10 | | 33.03 |
| | OTHER REVENUE | В | -611 | | 13 | | 33.04 |
| | OTHER REVENUE | В | | Medical Records & Library | 16 | | 33.06 |
| | OTHER REVENUE | В | | I&R Services-Salary & Fringes Apprvd | 21 | | 33.08 |
| | OTHER REVENUE | В | | I&R Services-Other Prgm Costs Apprvd | 22 | | 33.09 |
| | OTHER REVENUE OTHER REVENUE | B B | | PARAMED ED PRGM-(SPECIFY) Adults & Pediatrics | 30 | | 33.10 33.11 |
| | OTHER REVENUE OTHER REVENUE | В | | Subprovider - IRF | 41 | | 33.14 |
| | OTHER REVENUE | В | | Operating Room | 50 | | 33.15 |
| | OTHER REVENUE | В | | Radiology-Diagnostic | 54 | | 33.16 |
| | OTHER REVENUE | В | | Radiology-Therapeutic | 55 | | 33.17 |
| 33.19 | OTHER REVENUE | В | -4,000 | Respiratory Therapy | 65 | | 33.19 |
| | OTHER REVENUE | В | -8,686 | Physical Therapy | 66 | | 33.20 |
| | OTHER REVENUE | В | | Electrocardiology | 69 | | 33.21 |
| | OTHER REVENUE | В | | FAMILY MEDICINE CENTER | 90.03 | | 33.23 |
| | OTHER REVENUE | В | | SPORTS MED FELLOWSHIP CLINIC | 90.07 | | 33.25 |
| | OTHER REVENUE | В | -875 | | 90.08 | | 33.26 |
| | OTHER REVENUE OTHER REVENUE | B B | | FACULTY PRACTICE CLINIC OUR LADY OF ROSARY CLINIC | 90.09 | | 33.27 33.28 |
| | OTHER REVENUE OTHER REVENUE | В | -5,035 | | 90.10 | | 33.29 |
| | MEDICAID PROVIDER BED TAX | A | -17,479,932 | OTHER ADMINISTRATIVE & GENERAL | 5.06 | | 34 |
| | PURCHASE DISCOUNTS | A | 1,,11,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Control of the contro | 2.00 | | 35 |
| | DONATIONS | A | -656,788 | OTHER ADMINISTRATIVE & GENERAL | 5.06 | | 35.01 |
| | PROPERTY TAX | A | | Subprovider - IRF | 41 | | 36 |
| 37 1 | DISCOUNTS | A | 6,760 | OTHER ADMINISTRATIVE & GENERAL | 5.06 | | 37 |
| | DISCOUNTS | A | | Central Services & Supply | 14 | | 37.01 |
| | INTERNATIONAL MEDICINE | A | -955 | OTHER ADMINISTRATIVE & GENERAL | 5.06 | | 38 |
| | OTHER REVENUE | В | | | | | 39 |
| | OTHER REVENUE OTHER REVENUE | B B | | | | | 40 |

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

| | | | | EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED | | | |
|----|---|-------------|------------|--|---------|-------------|----|
| | DESCRIPTION(1) | BASIS/ | AMOUNT | GOOT GENTEED | I INTE# | Wkst. | |
| | DESCRIPTION(1) | CODE (2) | AMOUNT | COST CENTER | LINE# | A-7 Ref. | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 42 | OTHER REVENUE | В | | | | | 42 |
| 43 | OTHER REVENUE | В | | | | | 43 |
| 44 | OTHER REVENUE | В | | | | | 44 |
| 45 | OTHER REVENUE | В | | | | | 45 |
| 46 | OTHER REVENUE | В | | | | | 46 |
| 47 | OTHER REVENEUE | В | | | | | 47 |
| 48 | OTHER REVENUE | В | | | | | 48 |
| 49 | | | | | | | 49 |
| 50 | TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200) | | -7,203,502 | | | | 50 |

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

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

⁽²⁾ Basis for adjustment (see instructions)

B. 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.

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

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

WORKSHEET A-8-1

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

OR CLAIMED HOME OFFICE COSTS:

| | Line No. | Cost Center | Expense Items | Amount of Allowable Cost | Amount Included in Wkst. A column 5 | Net Adjustments (col. 4 minus col. 5)* | Wkst. A-7 Ref. | |
|------|-------------|---|-----------------------------|--------------------------------|--|---|----------------------|------|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 1 | 5.06 | OTHER ADMINISTRATIVE & GENERAL | HO NON CAPITAL COSTS | 53,917,370 | 43,369,641 | 10,547,729 | | 1 |
| 2 | 4 | Employee Benefits Department | WORKERS COMP | 253,255 | 471,058 | -217,803 | | 2 |
| 3 | 5.06 | OTHER ADMINISTRATIVE & GENERAL | INSURANCE | 1,277,401 | 2,499,000 | -1,221,599 | | 3 |
| 3.01 | 5.06 | OTHER ADMINISTRATIVE & GENERAL | PENSION | 8,321,258 | 4,336,540 | 3,984,718 | | 3.01 |
| 3.02 | 4 | Employee Benefits Department | RETIREE HEALTH COSTS | 33,948 | -864,231 | 898,179 | | 3.02 |
| 3.03 | 1 | Cap Rel Costs-Bldg & Fixt | HO CAPITAL COSTS | 3,662,857 | | 3,662,857 | 9 | 3.03 |
| 4 | | | | | | | - | 4 |
| 5 | TOTAL | S (sum of lines 1-4) Transfer column 6, line 5 to Works | heet A-8, column 2, line 12 | 67,466,089 | 49,812,008 | 17,654,081 | | 5 |

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

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

| | | | | Related Orga | anization(s) and/or | Home Office | |
|----|------------|------------------------|-------------------------------|--------------------|-------------------------------|----------------------|----|
| | Symbol (1) | Name | Percentage of Ownership | Name | Percentage of Ownership | Type of Business | |
| | 1 | 2 | 3 | 4 | 5 | 6 | |
| 6 | G | | | CHE TRINTIY HEALTH | | HO OF PARENT COMPANY | 6 |
| 7 | G | | | SJRMC - INC | | PARENT COMPANY | 7 |
| 8 | G | SJRMC- PLYMOUTH CAMPUS | | | | HOSPITAL | 8 |
| 9 | | | | | | | 9 |
| 10 | | | | | | | 10 |

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

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

| | Wkst A Line # | Cost Center/ Physician Identifier | Total Remun- eration | Professional Component | Provider Component | RCE Amount | Physician/ Provider Component Hours | Unadjusted RCE Limit | 5 Percent of Unadjusted RCE Limit | |
|-----|------------------|---|----------------------------|---------------------------|-----------------------|---------------|--|-------------------------|--|-----|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
| 1 | 13 | Nursing Administrati NURSING ADMINIS | 1,819 | | 1,819 | 179,000 | 9 | 775 | 39 | 1 |
| 2 | | | | | | | | | | 2 |
| 3 | | | | | | | | | | 3 |
| 4 | 31 | Intensive Care Unit INTENSIVE CARE | 93,730 | | 93,730 | 179,000 | 524 | 45,094 | 2,255 | 4 |
| 5 | 50 | Operating Room OPERATING ROOM | 2,299,381 | 2,155,619 | 143,762 | 246,400 | 701 | 83,041 | 4,152 | 5 |
| 6 | 54 | Radiology-Diagnostic RADIOLOGY-DIAGN | 68,146 | 31,481 | 36,665 | 271,900 | 167 | 21,830 | 1,092 | 6 |
| 7 | | | | | | | | | | 7 |
| - 8 | 59 | Cardiac Catheterizat CARDIAC CATHETE | 29,974 | | 29,974 | 179,000 | 136 | 11,704 | 585 | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | 90.06 | PEDIATRIC SPECIALTY PEDIATRIC SPECI | 148,004 | 148,004 | | 169,700 | 222 | 18,112 | 906 | 10 |
| 11 | | | | | | | | | | 11 |
| 12 | 91 | Emergency EMERGENCY | 334,885 | | 334,885 | 179,000 | 2,088 | 179,688 | 8,984 | 12 |
| 13 | 30 | Adults & Pediatrics ADULTS & PEDIAT | 27,429 | 24,071 | 3,358 | 237,100 | 24 | 2,736 | 137 | 13 |
| 14 | 69 | Electrocardiology ELECTROCARDIOLO | 680 | | 680 | 179,000 | 4 | 344 | 17 | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | | | | | | | | | | 18 |
| 19 | | | | | | | | | | 19 |
| 20 | | | | | | | | | | 20 |
| 200 | | TOTAL | 3,004,048 | 2,359,175 | 644,873 | | 3,875 | 363,324 | 18,167 | 200 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

| | Wkst A Line # | Cost Center/ Physician Identifier | Cost of Memberships & Continuing Education | Provider Component Share of col. 12 | Physician Cost of Malpractice Insurance | Provider Component Share of col. 14 | Adjusted RCE Limit | RCE Disallowance | Adjustment | |
|-----|------------------|---|---|--|--|--|-----------------------|---------------------|------------|-----|
| | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | |
| 1 | 13 | Nursing Administrati NURSING ADMINIS | | | | | 775 | 1,044 | 1,044 | 1 |
| 2 | | | | | | | | | | 2 |
| 3 | | | | | | | | | | 3 |
| 4 | 31 | Intensive Care Unit INTENSIVE CARE | | | | | 45,094 | 48,636 | 48,636 | 4 |
| 5 | 50 | Operating Room OPERATING ROOM | | | | | 83,041 | 60,721 | 2,216,340 | 5 |
| 6 | 54 | Radiology-Diagnostic RADIOLOGY-DIAGN | | | | | 21,830 | 14,835 | 46,316 | 6 |
| 7 | | | | | | | | | | 7 |
| 8 | 59 | Cardiac Catheterizat CARDIAC CATHETE | | | | | 11,704 | 18,270 | 18,270 | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | 90.06 | PEDIATRIC SPECIALTY PEDIATRIC SPECI | | | | | 18,112 | | 148,004 | 10 |
| 11 | | | | | | | | | | 11 |
| 12 | 91 | Emergency EMERGENCY | | | | | 179,688 | 155,197 | 155,197 | 12 |
| 13 | 30 | Adults & Pediatrics ADULTS & PEDIAT | | | | | 2,736 | 622 | 24,693 | 13 |
| 14 | 69 | Electrocardiology ELECTROCARDIOLO | | | | | 344 | 336 | 336 | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | | | | | | | | | | 18 |
| 19 | | | | | | | | | | 19 |
| 20 | | | | | | | | | | 20 |
| 200 | | TOTAL | | | | | 363,324 | 299,661 | 2,658,836 | 200 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COST ALLOCATION - GENERAL SERVICE COSTS

| | COST CENTER DESCRIPTIONS | NET EXP FOR COST ALLOCATION (from Wkst A, col.7) | CAP BLDGS & FIXTURES | CAP MOVABLE EQUIPMENT | EMPLOYEE BENEFITS DEPARTMENT | NON- PATIENT TELEPHONES | ADMITTING 5.04 | |
|----------|--|--|----------------------------|-----------------------------|------------------------------------|-------------------------------|-----------------|----------|
| | GENERAL SERVICE COST CENTERS | Ü | 1 | | - | 3.01 | 3.04 | |
| 1 | Cap Rel Costs-Bldg & Fixt | 40,973,707 | 40,973,707 | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | -6,950,371 | 24.45 | -6,950,371 | 4.5.45.050 | | | 2 |
| 5.01 | Employee Benefits Department NONPATIENT TELEPHONES | 4,720,706 290,492 | 26,647 41,151 | | 4,747,353 11,881 | 343,524 | | 5.01 |
| 5.04 | ADMITTING | 1,419,892 | 157,353 | | 55,305 | 4,775 | 1,637,325 | 5.04 |
| 5.06 | OTHER ADMINISTRATIVE & GENERAL | 63,789,229 | 5,158,490 | | 80,109 | 44,195 | 1,007,020 | 5.06 |
| 6 | Maintenance & Repairs | | , , | | , | , | | 6 |
| 7 | Operation of Plant | 10,262,419 | 10,558,910 | | 101,103 | 10,406 | | 7 |
| 8 | Laundry & Linen Service | 1,062,041 | | | | 612 | | 8 |
| 9 | Housekeeping | 2,993,825 | 509,162 | | 76,904 | 2,081 | | 9 |
| 10 11 | Dietary Cafeteria | 2,856,635 70,694 | 722,507 981,895 | | 69,821 35,968 | 2,938 2,571 | | 10 11 |
| 12 | Maintenance of Personnel | 70,094 | 901,093 | | 33,906 | 2,371 | | 12 |
| 13 | Nursing Administration | 3,511,013 | 160,304 | | 148,035 | 3,428 | | 13 |
| 14 | Central Services & Supply | 882,128 | , | | 25,796 | 367 | | 14 |
| 15 | Pharmacy | 4,123,439 | 560,770 | | 186,729 | 6,978 | | 15 |
| 16 | Medical Records & Library | 2,886,872 | 82,218 | | 100,073 | 5,387 | | 16 |
| 17 | Social Service | 2,623,832 | 50,005 | | 103,400 | 4,407 | | 17 |
| 18 | STERILE SUPPLY | 2,525,858 | 649,481 | | 41,505 | 1,347 | | 18 |
| 19 21 | Nonphysician Anesthetists I&R Services-Salary & Fringes Apprvd | 2,478,399 | 75,894 | | 95,652 | | | 19 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | 3,190,548 | 75,094 | | 134,016 | 4,285 | | 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | 125,567 | | | 3,931 | 735 | | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | 251,160 | | | 9,478 | 367 | | 23.02 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 23,574,280 | 9,595,907 | | 907,096 | 67,087 | 182,982 | 30 |
| 31 | Intensive Care Unit | 4,797,122 | 1,206,540 | | 189,426 | 5,509 | 35,413 | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 2,854,404 | 426,860 | | 105,953 | 2,571 | 17,968 | 35 |
| 41 | Subprovider - IRF Nursery | 2,001,592 2,747,908 | | | 75,201 76,478 | 10,529 | 7,504 7,720 | 41 |
| 43 | ANCILLARY SERVICE COST CENTERS | 2,747,908 | | | /0,4/8 | | 7,720 | 43 |
| 50 | Operating Room | 24,187,623 | 4,028,687 | | 511,819 | 30,606 | 337,441 | 50 |
| 51 | Recovery Room | 1,583,412 | 266,977 | | 64,851 | 4,530 | 29,932 | 51 |
| 52 | Delivery Room & Labor Room | 3,094,473 | , | | 120,386 | | 23,525 | 52 |
| 54 | Radiology-Diagnostic | 5,682,934 | 1,137,983 | | 186,300 | 17,262 | 93,095 | |
| 55 | Radiology-Therapeutic | 592,693 | 142.061 | | 11,274 | 1.102 | 1,575 | |
| 57 | CT Scan MRI | 1,207,923 | 143,861 | | 38,266 | 1,102 | 115,785 | 57 58 |
| 58 59 | Cardiac Catheterization | 398,747 8,788,408 | 1,236,813 | | 131,843 | 1,592 9,549 | 9,378 92,465 | 59 |
| 60 | Laboratory | 10,982,224 | 165,954 | | 131,043 | 4,775 | 175,033 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | 20,702,221 | | | | 3,7.74 | | 62.30 |
| 65 | Respiratory Therapy | 3,204,861 | 302,816 | | 93,392 | 4,775 | 27,828 | 65 |
| 66 | Physical Therapy | 3,149,017 | 274,398 | | 129,644 | 6,733 | 22,991 | 66 |
| 67 | Occupational Therapy | 888,976 | | | 37,229 | 1,102 | 8,285 | 67 |
| 68 | Speech Pathology | 470,823 | 227 828 | | 20,490 | 490 | 4,744 | 68 |
| 69 71 | Electrocardiology Medical Supplies Charged to Patients | 1,278,610 | 226,838 | | 49,588 | 3,918 | 37,937 | 69 71 |
| 72 | Impl. Dev. Charged to Patients | 24,980,388 | | | | | 123.085 | 72 |
| 73 | Drugs Charged to Patients | 17,763,532 | 39,465 | | 17,609 | 735 | 142,329 | |
| 74 | Renal Dialysis | 1,113,131 | 95,542 | | ., | 122 | 2,638 | |
| 76.97 | CARDIAC REHABILITATION | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 55,800 | | | 2,783 | 245 | 1,665 | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | 76.99 |
| 00 | OUTPATIENT SERVICE COST CENTERS | | | | | | | 00 |
| 90.02 | Clinic MOBILE MEDICAL UNIT | 116,727 | | | 4,039 | | 849 | 90.02 |
| 90.02 | FAMILY MEDICINE CENTER | 1,294,266 | | | 35,676 | 6,856 | 4,723 | |
| 90.04 | WOUND HEALING CENTER | 1,423,691 | | | 22,848 | 1,836 | 7,618 | |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 761,578 | 130,537 | | 31,734 | 1,469 | 7,588 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 433,691 | | | 15,381 | 2,081 | 502 | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 753,841 | | | 28,631 | 857 | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 277,221 | | | 3,809 | 1,959 | 2.240 | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC OUR LADY OF ROSARY CLINIC | 620,241 881,824 | | | 20,525 30,538 | | 2,248 | 90.09 |
| 90.10 | Emergency | 7,408,125 | 1,782,657 | | 252,803 | 17,262 | 104,082 | 90.10 |
| 92 | Observation Beds (Non-Distinct Part) | 7,700,123 | 1,702,037 | | 232,003 | 17,202 | 104,002 | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | |
| | SUBTOTALS (sum of lines 1-117) | 303,458,171 | 40,796,622 | | 4,495,318 | 300,431 | 1,628,928 | 118 |
| 118 | | | .,,. | | | | | |
| 118 | NONREIMBURSABLE COST CENTERS Gift, Flower, Coffee Shop & Canteen | | 158,786 | | | 612 | | 190 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COST ALLOCATION - GENERAL SERVICE COSTS

| | | NET EXP | | | | | | |
|--------|----------------------------------|-------------|------------|------------|------------|------------|-----------|--------|
| | | FOR COST | CAP | CAP | EMPLOYEE | NON- | | |
| | COST CENTER DESCRIPTIONS | ALLOCATION | BLDGS & | MOVABLE | BENEFITS | PATIENT | | |
| | | (from Wkst | FIXTURES | EQUIPMENT | DEPARTMENT | TELEPHONES | ADMITTING | |
| | | A, col.7) | | | | | | |
| | | 0 | 1 | 2 | 4 | 5.01 | 5.04 | |
| 192.01 | MATERNAL FETAL MEDICINE/LABORIST | 1,617,220 | 8,517 | | 4,501 | | 180 | 192.01 |
| 192.02 | NEONATOLOGISTS | 1,690,132 | | | 74,475 | 367 | 2,288 | 192.02 |
| 192.03 | HOSPITALISTS/INTENSIVISTS | 5,373,746 | | | 19,586 | 1,469 | 1,290 | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | | | 194 |
| 194.01 | OUTREACH SERVICES | 3,470,246 | | | 133,032 | 5,632 | 4,639 | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | | | | | 2,326 | | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | 149,488 | | | | | | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | 491,449 | | | 20,441 | | | 194.04 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | -6,950,371 | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 316,250,452 | 40,973,707 | -6,950,371 | 4,747,353 | 343,524 | 1,637,325 | 202 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COST ALLOCATION - GENERAL SERVICE COSTS

| | COST CENTER DESCRIPTIONS | SUBTOTAL (cols.0-4) 4A | 5.06 | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE 8 | HOUSE- KEEPING | DIETARY 10 | |
|----------|--|---|---|-----------------------|------------------------------------|-------------------|---------------|----------|
| | GENERAL SERVICE COST CENTERS | 771 | 5.00 | , | · · | , | 10 | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | 4 |
| 5.01 | NONPATIENT TELEPHONES | | | | | | | 5.01 |
| 5.04 | ADMITTING | 60,072,022 | 60,072,022 | | | | | 5.04 |
| 5.06 | OTHER ADMINISTRATIVE & GENERAL Maintenance & Repairs | 69,072,023 | 69,072,023 | | | | | 5.06 |
| 7 | Operation of Plant | 20,932,838 | 5,692,246 | 26,625,084 | | | | 7 |
| 8 | Laundry & Linen Service | 1,062,653 | 288,966 | 20,023,004 | 1,351,619 | | | 8 |
| 9 | Housekeeping | 3,581,972 | 974.042 | 541,584 | 1,551,017 | 5,097,598 | | 9 |
| 10 | Dietary | 3,651,901 | 993,058 | 768,515 | | 150,194 | 5,563,668 | 10 |
| 11 | Cafeteria | 1,091,128 | 296,709 | 1,044,420 | | 204,115 | , | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | 3,822,780 | 1,039,525 | 170,512 | | 33,324 | | 13 |
| 14 | Central Services & Supply | 908,291 | 246,991 | | | | | 14 |
| 15 | Pharmacy | 4,877,916 | 1,326,447 | 596,478 | | 116,572 | | 15 |
| 16 | Medical Records & Library | 3,074,550 | 836,059 | 87,454 | | 17,091 | | 16 |
| 17 | Social Service | 2,781,644 | 756,410 | 53,190 | | 10,395 | | 17 |
| 18 | STERILE SUPPLY | 3,218,191 | 875,119 | 690,838 | | 135,013 | | 18 |
| 19 21 | Nonphysician Anesthetists I&R Services-Salary & Fringes Apprvd | 2,649,945 | 720,597 | 80,726 | | 15,777 | | 19 |
| 22 | I&R Services-Salary & Fringes Apprvd I&R Services-Other Prgm Costs Apprvd | 3,328,849 | 905,211 | 6U, /20 | | 15,/// | | 21 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | 130,233 | 35,414 | | | | | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | 261,005 | 70,975 | | | | | 23.02 |
| 23.02 | INPATIENT ROUTINE SERV COST CENTERS | 201,003 | 10,713 | | | | | 23.02 |
| 30 | Adults & Pediatrics | 34,327,352 | 9,334,699 | 10,206,954 | 150,986 | 1,994,785 | 4,437,901 | 30 |
| 31 | Intensive Care Unit | 6,234,010 | 1,695,208 | 1,283,370 | 29,220 | 250,814 | 266,201 | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 3,407,756 | 926,668 | 454,041 | 14,826 | 88,735 | 12,442 | 35 |
| 41 | Subprovider - IRF | 2,094,826 | 569,644 | | 6,192 | | 320,834 | 41 |
| 43 | Nursery | 2,832,106 | 770,132 | | 6,370 | | | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | 29,096,176 | 7,912,094 | 4,285,225 | 279,032 | 837,478 | | 50 |
| 51 | Recovery Room | 1,949,702 | 530,181 | 283,977 | 24,698 | 55,499 | | 51 |
| 52 | Delivery Room & Labor Room | 3,238,384 | 880,611 | 1 210 447 | 19,411 | 226.562 | | 52 |
| 54 | Radiology-Diagnostic | 7,117,574 | 1,935,475 164,664 | 1,210,447 | 76,817 1,300 | 236,562 | | 54 |
| 55 57 | Radiology-Therapeutic CT Scan | 605,542 1,506,937 | 409,780 | 153,021 | 95,539 | 29,906 | | 57 |
| 58 | MRI | 409,717 | 111,414 | 133,021 | 7,738 | 29,900 | | 58 |
| 59 | Cardiac Catheterization | 10,259,078 | 2,789,741 | 1,315,571 | 76,297 | 257,107 | | 59 |
| 60 | Laboratory | 11,327,986 | 3,080,408 | 176,522 | 144,426 | 34,498 | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | , | -,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | , . | , | , , , , , | | 62.30 |
| 65 | Respiratory Therapy | 3,633,672 | 988,101 | 322,098 | 22,962 | 62,949 | | 65 |
| 66 | Physical Therapy | 3,582,783 | 974,263 | 291,871 | 18,971 | 57,041 | | 66 |
| 67 | Occupational Therapy | 935,592 | 254,415 | | 6,836 | | | 67 |
| 68 | Speech Pathology | 496,547 | 135,026 | | 3,915 | | | 68 |
| 69 | Electrocardiology | 1,596,891 | 434,241 | 241,282 | 31,303 | 47,155 | | 69 |
| 71 | Medical Supplies Charged to Patients | 25 102 452 | 6.006.060 | | 101.562 | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 25,103,473 | 6,826,362 | 41.070 | 101,563 | 0.204 | | 72 |
| 73 74 | Drugs Charged to Patients Renal Dialysis | 17,963,670 1,211,433 | 4,884,843 329,424 | 41,978 101,626 | 117,441 2,177 | 8,204 19,861 | | 73 |
| 76.97 | CARDIAC REHABILITATION | 1,211,433 | 329,424 | 101,020 | 2,177 | 19,001 | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 60,493 | 16,450 | | 1,374 | | | 76.98 |
| 76.99 | LITHOTRIPSY | 00,123 | 10,430 | | 1,574 | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 90 | Clinic | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 121,615 | | | 701 | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 1,341,521 | 364,798 | | 3,897 | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 1,455,993 | 395,927 | | 6,286 | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 932,906 | 253,684 | 138,849 | 6,261 | 27,136 | 6,649 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 451,655 | 122,818 | | 414 | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 783,329 | 213,010 | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 282,989 | 76,953 | | 1.055 | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 643,014 | 174,854 | | 1,855 | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC Emergency | 912,362 9,564,929 | 248,098 2,600,982 | 1,896,173 | 85,882 | 370,576 | | 90.10 |
| 92 | Observation Beds (Non-Distinct Part) | 7,304,729 | 2,000,762 | 1,070,173 | 05,002 | 370,370 | | 91 |
| 12 | OTHER REIMBURSABLE COST CENTERS | | | | | | | <u> </u> |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 309,927,932 | 65,462,737 | 26,436,722 | 1,344,690 | 5,060,787 | 5,044,027 | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | |
| 190 | Gift, Flower, Coffee Shop & Canteen | 159,398 | 43,345 | 168,898 | | 33,008 | | 190 |
| 192 | Physicians' Private Offices | 42,469 | 11,549 | 10,405 | | 2,033 | | 192 |
| 192.01 | MATERNAL FETAL MEDICINE/LABORIST | 1,630,418 | 443,358 | 9,059 | 148 | 1,770 | | 192.01 |
| 192.02 | NEONATOLOGISTS | 1,767,262 | 480,570 | | 1,888 | | | 192.02 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COST ALLOCATION - GENERAL SERVICE COSTS

| | | | | OPERATION | LAUNDRY | HOUSE- | DIETARY | |
|--------|------------------------------|-------------|------------|------------|-----------|-----------|-----------|--------|
| | COST CENTER DESCRIPTIONS | SUBTOTAL | | OF PLANT | & LINEN | KEEPING | | |
| | | (cols.0-4) | | | SERVICE | | | |
| | | 4A | 5.06 | 7 | 8 | 9 | 10 | |
| 192.03 | HOSPITALISTS/INTENSIVISTS | 5,396,091 | 1,467,354 | | 1,065 | | | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | | | 194 |
| 194.01 | OUTREACH SERVICES | 3,613,549 | 982,629 | | 3,828 | | | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | 2,326 | 633 | | | | 519,641 | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | 149,488 | 40,650 | | | | | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | 511,890 | 139,198 | | | | | 194.04 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | -6,950,371 | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 316,250,452 | 69,072,023 | 26,625,084 | 1,351,619 | 5,097,598 | 5,563,668 | 202 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COST ALLOCATION - GENERAL SERVICE COSTS

| | COST CENTER DESCRIPTIONS | CAFETERIA 11 | NURSING ADMINIS- TRATION 13 | CENTRAL SERVICES & SUPPLY 14 | PHARMACY 15 | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | |
|----------------|---|-------------------|--------------------------------------|---------------------------------------|----------------|---------------------------------|----------------------|----------------|
| | GENERAL SERVICE COST CENTERS | | 10 | | 10 | 10 | 1, | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 2 | Cap Rel Costs-Myble Equip | | | | | | | 2 |
| 5.01 | Employee Benefits Department NONPATIENT TELEPHONES | | | | | | | 5.01 |
| 5.04 | ADMITTING | | | | | | | 5.04 |
| 5.04 | OTHER ADMINISTRATIVE & GENERAL | | | | | | | 5.06 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | | | | | | | 7 |
| 8 | Laundry & Linen Service | | | | | | | 8 |
| 9 | Housekeeping Dietary | | | | | | | 9 |
| 11 | Cafeteria | 2,636,372 | | | | | | 11 |
| 12 | Maintenance of Personnel | 2,030,372 | | | | | | 12 |
| 13 | Nursing Administration | 82,728 | 5,148,869 | | | | | 13 |
| 14 | Central Services & Supply | 28,484 | 57,431 | 1,241,197 | | | | 14 |
| 15 | Pharmacy | 80,356 | 162,020 | | 7,159,789 | | | 15 |
| 16 | Medical Records & Library | 79,631 | 160,559 | | 5.242 | 4,255,344 | 2.7// 22/ | 16 |
| 17 18 | Social Service STERILE SUPPLY | 52,795 44,340 | 106,449 89,401 | | 5,343 | | 3,766,226 | 17 18 |
| 19 | Nonphysician Anesthetists | 44,540 | 89,401 | | 1 | | | 19 |
| 21 | I&R Services-Salary & Fringes Apprvd | 59,405 | 119,777 | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | 32,634 | 65,800 | | | | | 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | 2,438 | 4,915 | | | | | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | 4,085 | 8,236 | | | | | 23.02 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | .= : | | |
| 30 | Adults & Pediatrics | 644,184 | 1,298,864 229,104 | 138,650 | 561 | 475,574 92,038 | 3,347,756 376,623 | 30 |
| 31 35 | Intensive Care Unit NEONATAL INTENSIVE CARE UNIT | 113,627 59,910 | 120,796 | 26,833 13,615 | 85 2 | 92,038 46,699 | 41,847 | 31 35 |
| 41 | Subprovider - IRF | 50,137 | 101,091 | 5,686 | 2 | 19,504 | 41,047 | 41 |
| 43 | Nurserv | 48,271 | 97,327 | 5,850 | 800 | 20,066 | | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | 312,793 | 630,679 | 256,241 | 42,722 | 876,920 | | 50 |
| 51 | Recovery Room | 39,969 | 80,589 | 22,680 | 6 | 77,794 | | 51 |
| 52 | Delivery Room & Labor Room | 69,946 | 141,032 | 17,826 | 225 242 | 61,142 | | 52 |
| 54 55 | Radiology-Diagnostic Radiology-Therapeutic | 113,012 6,501 | 227,864 13,107 | 70,541 1,194 | 235,343 | 241,957 4,094 | | 54 55 |
| 57 | CT Scan | 21,127 | 42,597 | 87,733 | 59,187 | 300,927 | | 57 |
| 58 | MRI | 21,127 | 42,377 | 7,106 | 37,107 | 24,374 | | 58 |
| 59 | Cardiac Catheterization | 69,353 | 139,836 | 70,063 | 104,761 | 240,319 | | 59 |
| 60 | Laboratory | | | 132,626 | | 454,912 | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 56,814 | 114,552 | 21,086 | 31 | 72,326 | | 65 |
| 66 67 | Physical Therapy Occupational Therapy | 65,686 18,162 | 132,441 36,619 | 17,421 6,278 | 826 72 | 59,753 21,533 | | 66 67 |
| 68 | Speech Pathology | 9,136 | 18,420 | 3,595 | 12 | 12,331 | | 68 |
| 69 | Electrocardiology | 29,735 | 59,955 | 28,746 | 388 | 98,599 | | 69 |
| 71 | Medical Supplies Charged to Patients | | , | - ,, | | , | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | 93,265 | | 319,900 | | 72 |
| 73 | Drugs Charged to Patients | 9,575 | 19,306 | 107,846 | 6,588,300 | 369,915 | | 73 |
| 74 | Renal Dialysis | | | 1,999 | | 6,857 | | 74 |
| 76.97 76.98 | CARDIAC REHABILITATION HYDERARIC OVYGEN THERARY | 1,867 | 3,764 | 1,262 | 15 | 4,327 | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY LITHOTRIPSY | 1,00/ | 3,704 | 1,202 | 15 | 4,327 | | 76.98 76.99 |
| , 0.,,, | OUTPATIENT SERVICE COST CENTERS | | | | | | | , 5.77 |
| 90 | Clinic | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 2,943 | 5,934 | 643 | | 2,207 | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 32,283 | 65,091 | 3,579 | 37,163 | 12,276 | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 15,395 | 31,040 | 5,772 | 14,350 | 19,799 | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION PEDIATRIC SPECIALTY CLINIC | 9,377 | 35,690 18,908 | 5,750 380 | 322 | 19,721 1,304 | | 90.05 |
| 90.06 | SPORTS MED FELLOWSHIP CLINIC | 9,377 | 18,908 | 380 | 4,770 | 1,304 | | 90.06 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 10,036 | 20,236 | | 1,307 | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 8,697 | 17,535 | 1,703 | 23,872 | 5,842 | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | 16,383 | 33,033 | | 14,084 | | | 90.10 |
| 91 | Emergency | 168,025 | 338,786 | 78,865 | 19 | 270,510 | | 91 |
| 92 | Observation Beds (Non-Distinct Part) OTHER REIMBURSABLE COST CENTERS SPECIAL DURDOSE COST CENTERS | | | | | | | 92 |
| 118 | SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) | 2,497,050 | 4,867,957 | 1,234,834 | 7,134,330 | 4,233,520 | 3,766,226 | 118 |
| 110 | NONREIMBURSABLE COST CENTERS | 2,497,030 | 7,007,737 | 1,234,034 | 7,134,330 | 7,233,320 | 3,700,220 | 110 |
| 190 | Gift, Flower, Coffee Shop & Canteen | | | | | | | 190 |
| 192 | Physicians' Private Offices | | | | | | | 192 |
| 192.01 | MATERNAL FETAL MEDICINE/LABORIST | 549 | 1,107 | 136 | | 467 | | 192.01 |
| 192.02 | NEONATOLOGISTS | 15,197 | 30,642 | 1,734 | | 5,947 | | 192.0 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COST ALLOCATION - GENERAL SERVICE COSTS

| | | CAFETERIA | NURSING | CENTRAL | PHARMACY | MEDICAL | SOCIAL | |
|--------|------------------------------|-----------|-----------|------------|-----------|-----------|-----------|--------|
| | COST CENTER DESCRIPTIONS | | ADMINIS- | SERVICES & | | RECORDS & | SERVICE | |
| | | | TRATION | SUPPLY | | LIBRARY | | |
| | | 11 | 13 | 14 | 15 | 16 | 17 | |
| 192.03 | HOSPITALISTS/INTENSIVISTS | 4,173 | 8,413 | 978 | | 3,353 | | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | | | 194 |
| 194.01 | OUTREACH SERVICES | 112,595 | 227,023 | 3,515 | 25,459 | 12,057 | | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | | | | | | | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | | | | | | | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | 6,808 | 13,727 | | | | | 194.04 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 2,636,372 | 5,148,869 | 1,241,197 | 7,159,789 | 4,255,344 | 3,766,226 | 202 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COST ALLOCATION - GENERAL SERVICE COSTS

| | COST CENTER DESCRIPTIONS | OTHER GENERAL SERVICE 18 | I&R SALARY & FRINGES 21 | I&R PROGRAM COSTS 22 | PARAMED EDUCATION 23 | 23.02 | SUBTOTAL 24 | |
|-----------|--|-----------------------------------|----------------------------------|-------------------------------|----------------------------|---|-------------------------|----------|
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | 2 |
| 4 5.01 | Employee Benefits Department | | | | | | | 4 |
| 5.01 | NONPATIENT TELEPHONES ADMITTING | | | | | | | 5.01 |
| 5.06 | OTHER ADMINISTRATIVE & GENERAL | | | | | | | 5.06 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | | | | | | | 7 |
| 8 | Laundry & Linen Service | | | | | | | 8 |
| 9 | Housekeeping | | | | | | | 9 |
| 10 | Dietary | | | | | | | 10 |
| 11 | Cafeteria | | | | | | | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | | | | | | | 13 |
| 14 15 | Central Services & Supply | | | | | | | 14 15 |
| 16 | Pharmacy Medical Records & Library | | | | | | | 16 |
| 17 | Social Service | | | | | | | 17 |
| 18 | STERILE SUPPLY | 5.052.903 | | | | | | 18 |
| 19 | Nonphysician Anesthetists | 3,032,703 | | | | | | 19 |
| 21 | I&R Services-Salary & Fringes Apprvd | 1 | 3,646,227 | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | 1 | 5,040,227 | 4,332,494 | | | | 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | | | 1,242,171 | 173,000 | | | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | | | | | 344,301 | | 23.02 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 82,861 | 2,023,398 | 2,404,229 | | | 70,868,754 | 30 |
| 31 | Intensive Care Unit | 766 | 190,015 | 225,778 | | | 11,013,692 | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 4,312 | 51,355 | 61,021 | | | 5,304,025 | |
| 41 | Subprovider - IRF | 13,021 | | | | | 3,180,935 | 41 |
| 43 | Nursery | | 231,099 | 274,595 | | | 4,286,616 | 43 |
| 50 | ANCILLARY SERVICE COST CENTERS | 4.500.056 | 112.002 | 124.246 | | | 10.266.611 | 50 |
| 50 | Operating Room | 4,590,056 | 112,982 | 134,246 | | | 49,366,644 | 50 51 |
| 51 52 | Recovery Room Delivery Room & Labor Room | | 25,678 | 30,511 | | | 3,065,095 4,484,541 | 52 |
| 54 | Radiology-Diagnostic | 4,454 | 25,678 | 30,511 | | | 11,526,235 | 54 |
| 55 | Radiology-Therapeutic | 4,434 | 23,076 | 30,311 | | | 796,402 | |
| 57 | CT Scan | | | | | | 2,706,754 | |
| 58 | MRI | | | | | | 560,349 | |
| 59 | Cardiac Catheterization | 24,680 | | | | | 15,346,806 | 59 |
| 60 | Laboratory | | | | | | 15,351,378 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 9,390 | | | | | 5,303,981 | 65 |
| 66 | Physical Therapy | | | | | | 5,201,056 | 66 |
| 67 | Occupational Therapy | | | | | | 1,279,507 | 67 |
| 68 | Speech Pathology | | | | | | 678,970 | 68 |
| 69 | Electrocardiology | | 87,304 | 103,736 | | | 2,759,335 | 69 |
| 71 | Medical Supplies Charged to Patients | | | | | | 22 111 562 | 71 |
| 72 73 | Impl. Dev. Charged to Patients | | | | | 344,301 | 32,444,563 | 72 73 |
| 74 | Drugs Charged to Patients Renal Dialysis | | 15,407 | 18,306 | | 344,301 | 30,455,379 1,707,090 | 74 |
| | CARDIAC REHABILITATION | + | 13,40/ | 10,500 | | | 1,707,090 | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | 89,552 | |
| 76.99 | LITHOTRIPSY | 1 | | | | | 07,552 | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 90 | Clinic | | 662,483 | 787,171 | | | 1,449,654 | 90 |
| 90.02 | MOBILE MEDICAL UNIT | | | | | | 134,043 | |
| 90.03 | FAMILY MEDICINE CENTER | 26,155 | | | | | 1,886,763 | |
| 90.04 | WOUND HEALING CENTER | 18,127 | | | | | 1,962,689 | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | | | | | | 1,444,347 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | | | | | | 605,178 | |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 1,277 | | | | | 1,031,068 | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 900 | | | | | 391,521 | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC OUR LADY OF ROSARY CLINIC | 823 | | | | | 878,195 1,223,960 | 90.09 |
| 90.10 | Emergency | 4,454 | 220,828 | 262,390 | 173.000 | | 16,035,419 | 90.10 |
| 92 | Observation Beds (Non-Distinct Part) | 4,434 | 220,028 | 202,390 | 173,000 | | 10,033,419 | 91 |
| <i>7=</i> | OTHER REIMBURSABLE COST CENTERS | | | | | | | 12 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | |
| | | 4 790 276 | 3,646,227 | 4,332,494 | 173,000 | 344,301 | 304,820,496 | 118 |
| 118 | SUBTOTALS (sum of lines 1-117) | 4,780,376 | 3,040,227 | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS | 4,780,376 | 3,040,227 | 1,002,101 | | | | |
| 190 | NONREIMBURSABLE COST CENTERS Gift, Flower, Coffee Shop & Canteen | 4,780,376 | 3,040,227 | 1,552,151 | , | ,,,,,, | 404,649 | |
| | NONREIMBURSABLE COST CENTERS | 4,780,370 | 3,040,221 | 1,552,171 | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | , , | 192 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COST ALLOCATION - GENERAL SERVICE COSTS

| | COST CENTER DESCRIPTIONS | OTHER GENERAL | I&R SALARY & | I&R PROGRAM | PARAMED EDUCATION | | | |
|--------|------------------------------|------------------|-----------------|----------------|----------------------|---------|-------------|--------|
| | | SERVICE | FRINGES | COSTS | | | SUBTOTAL | |
| | | 18 | 21 | 22 | 23 | 23.02 | 24 | |
| 192.03 | HOSPITALISTS/INTENSIVISTS | | | | | | 6,881,427 | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | | | 194 |
| 194.01 | OUTREACH SERVICES | 195,282 | | | | | 5,175,937 | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | | | | | | 522,600 | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | 77,245 | | | | | 267,383 | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | | | | | | 671,623 | 194.04 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | -6,950,371 | 201 |
| 202 | TOTAL (sum of lines 118-201) | 5,052,903 | 3,646,227 | 4,332,494 | 173,000 | 344,301 | 316,250,452 | 202 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COST ALLOCATION - GENERAL SERVICE COSTS

| | COST CENTER DESCRIPTIONS | I&R COST & POST STEP- DOWN ADJS 25 | TOTAL 26 | | |
|----------|---|---|-------------|---|-------|
| | GENERAL SERVICE COST CENTERS | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | 2 |
| 4 | Employee Benefits Department | | | | 4 |
| 5.01 | NONPATIENT TELEPHONES | | | | 5.01 |
| 5.04 | ADMITTING OTHER ADMINISTRATING & GENERAL | | | | 5.04 |
| 5.06 | OTHER ADMINISTRATIVE & GENERAL | | | | 5.06 |
| 7 | Maintenance & Repairs | | | | 6 7 |
| 8 | Operation of Plant Laundry & Linen Service | | | | 8 |
| 9 | Housekeeping | | | | 9 |
| 10 | Dietary | | | | 10 |
| 11 | Cafeteria | | | | 11 |
| 12 | Maintenance of Personnel | | | | 11 12 |
| 13 | Nursing Administration | | | | 13 |
| 14 | Central Services & Supply | | | | 13 |
| 15 | Pharmacy | | | | 15 |
| 16 | Medical Records & Library | | | | 16 |
| 17 | Social Service | | | | 17 |
| 18 | STERILE SUPPLY | | | | 18 |
| 19 | Nonphysician Anesthetists | | | | 19 |
| 21 | I&R Services-Salary & Fringes Apprvd | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | | | 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | | | | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | | | | 23.02 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | 35.02 |
| 30 | Adults & Pediatrics | -4,427,627 | 66,441,127 | | 30 |
| 31 | Intensive Care Unit | -415,793 | 10,597,899 | | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | -112,376 | 5,191,649 | | 35 |
| 41 | Subprovider - IRF | | 3,180,935 | | 41 |
| 43 | Nursery | -505,694 | 3,780,922 | | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | |
| 50 | Operating Room | -247,228 | 49,119,416 | | 50 |
| 51 | Recovery Room | | 3,065,095 | | 51 |
| 52 | Delivery Room & Labor Room | -56,189 | 4,428,352 | | 52 |
| 54 | Radiology-Diagnostic | -56,189 | 11,470,046 | | 54 |
| 55 | Radiology-Therapeutic | | 796,402 | | 55 |
| 57 | CT Scan | | 2,706,754 | | 57 |
| 58 | MRI | | 560,349 | | 58 |
| 59 | Cardiac Catheterization | | 15,346,806 | | 59 |
| 60 | Laboratory | | 15,351,378 | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | # 202 004 | | 62.30 |
| 65 | Respiratory Therapy | | 5,303,981 | | 65 |
| 66 | Physical Therapy | | 5,201,056 | | 66 |
| 67 | Occupational Therapy | | 1,279,507 | | 67 |
| 68 | Speech Pathology | 101.040 | 678,970 | | 68 |
| 69 | Electrocardiology Madical Supplies Channel to Patients | -191,040 | 2,568,295 | | |
| 71 72 | Medical Supplies Charged to Patients Impl. Dev. Charged to Patients | | 32,444,563 | | 71 72 |
| 73 | Drugs Charged to Patients | | 30,455,379 | | 73 |
| 74 | Renal Dialysis | -33,713 | 1,673,377 | + | 73 |
| | CARDIAC REHABILITATION | -33,/13 | 1,073,377 | + | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | 89,552 | | 76.98 |
| 76.99 | LITHOTRIPSY | | 07,332 | | 76.99 |
| 70.77 | OUTPATIENT SERVICE COST CENTERS | | | | 70.57 |
| 90 | Clinic | -1,449,654 | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 1,115,054 | 134,043 | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | | 1,886,763 | | 90.03 |
| 90.04 | WOUND HEALING CENTER | | 1,962,689 | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | | 1,444,347 | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | | 605,178 | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | 1,031,068 | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | 391,521 | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | | 878,195 | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | 1,223,960 | | 90.10 |
| 91 | Emergency | -483,218 | 15,552,201 | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | |
| | SPECIAL PURPOSE COST CENTERS | | | | |
| | 21 10 11 10 11 10 11 10 11 11 11 11 11 11 | | 204044.555 | | 118 |
| 118 | SUBTOTALS (sum of lines 1-117) | -7,978,721 | 296,841,775 | | 110 |
| | SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS | -7,978,721 | | | |
| 190 | SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS Gift, Flower, Coffee Shop & Canteen | -7,978,721 | 404,649 | | 190 |
| | SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS | -7,978,721 | | | |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COST ALLOCATION - GENERAL SERVICE COSTS

| | | I&R COST & | | | |
|--------|------------------------------|------------|-------------|--|--------|
| | COST CENTER DESCRIPTIONS | POST STEP- | | | |
| | | DOWN ADJS | TOTAL | | |
| | | 25 | 26 | | |
| 192.03 | HOSPITALISTS/INTENSIVISTS | | 6,881,427 | | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | 194 |
| 194.01 | OUTREACH SERVICES | | 5,175,937 | | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | | 522,600 | | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | | 267,383 | | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | | 671,623 | | 194.04 |
| 200 | Cross Foot Adjustments | | | | 200 |
| 201 | Negative Cost Centers | | -6,950,371 | | 201 |
| 202 | TOTAL (sum of lines 118-201) | -7,978,721 | 308,271,731 | | 202 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ALLOCATION OF CAPITAL-RELATED COSTS

| | COST CENTER DESCRIPTIONS | DIR ASSGND CAP-REL COSTS | CAP BLDGS & FIXTURES 1 | CAP MOVABLE EQUIPMENT 2 | SUBTOTAL 2A | EMPLOYEE BENEFITS DEPARTMENT 4 | NON- PATIENT TELEPHONES 5.01 | |
|----------|--|--------------------------------|---------------------------------|----------------------------------|----------------------|---|---------------------------------------|----------------|
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 2 | Cap Rel Costs-Myble Equip | | | | | | | 2 |
| 4 | Employee Benefits Department | | 26,647 | | 26,647 | 26,647 | 41.010 | 4 |
| 5.01 | NONPATIENT TELEPHONES ADMITTING | | 41,151 | | 41,151 | 67 | 41,218 | 5.01 |
| 5.04 | OTHER ADMINISTRATIVE & GENERAL | | 157,353 5,158,490 | | 157,353 5,158,490 | 310 449 | 573 5,303 | 5.04 5.06 |
| 6 | Maintenance & Repairs | | 3,136,490 | | 3,136,490 | 442 | 3,303 | 6 |
| 7 | Operation of Plant | | 10,558,910 | | 10,558,910 | 567 | 1,249 | 7 |
| 8 | Laundry & Linen Service | | 23,000,720 | | 20,000,20 | | 73 | 8 |
| 9 | Housekeeping | | 509,162 | | 509,162 | 431 | 250 | 9 |
| 10 | Dietary | | 722,507 | | 722,507 | 391 | 353 | 10 |
| 11 | Cafeteria | | 981,895 | | 981,895 | 202 | 308 | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | | 160,304 | | 160,304 | 830 | 411 | 13 |
| 14 | Central Services & Supply | | 5.00.770 | | 5.00.770 | 145 | 44 | 14 |
| 15 16 | Pharmacy Medical Records & Library | | 560,770 82,218 | | 560,770 82,218 | 1,047 561 | 837 646 | 15 16 |
| 17 | Social Service | | 50,005 | | 50,005 | 580 | 529 | 17 |
| 18 | STERILE SUPPLY | | 649,481 | | 649,481 | 233 | 162 | 18 |
| 19 | Nonphysician Anesthetists | | 042,401 | | 042,401 | 233 | 102 | 19 |
| 21 | I&R Services-Salary & Fringes Apprvd | | 75,894 | | 75,894 | 536 | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | 75,074 | | 70,074 | 751 | 514 | 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | | | | | 22 | 88 | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | | | | | 53 | 44 | 23.02 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | | 9,595,907 | | 9,595,907 | 5,111 | 8,051 | 30 |
| 31 | Intensive Care Unit | | 1,206,540 | | 1,206,540 | 1,062 | 661 | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | | 426,860 | | 426,860 | 594 | 308 | 35 |
| 41 | Subprovider - IRF | | | | | 422 | 1,263 | 41 |
| 43 | Nursery | | | | | 429 | | 43 |
| 50 | ANCILLARY SERVICE COST CENTERS Operating Room | | 4,028,687 | | 4,028,687 | 2.970 | 3,672 | 50 |
| 51 | Recovery Room | | 266,977 | | 266,977 | 2,870 364 | 5,672 | 51 |
| 52 | Delivery Room & Labor Room | | 200,977 | | 200,977 | 675 | 344 | 52 |
| 54 | Radiology-Diagnostic | | 1,137,983 | | 1,137,983 | 1,045 | 2,071 | 54 |
| 55 | Radiology-Therapeutic | | 1,137,703 | | 1,137,703 | 63 | 2,071 | 55 |
| 57 | CT Scan | | 143,861 | | 143,861 | 215 | 132 | 57 |
| 58 | MRI | | , | | , | | 191 | 58 |
| 59 | Cardiac Catheterization | | 1,236,813 | | 1,236,813 | 739 | 1,146 | 59 |
| 60 | Laboratory | | 165,954 | | 165,954 | | 573 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | | 302,816 | | 302,816 | 524 | 573 | 65 |
| 66 | Physical Therapy | | 274,398 | | 274,398 | 727 | 808 | 66 |
| 67 68 | Occupational Therapy | | | | | 209 115 | 132 59 | 67 68 |
| 69 | Speech Pathology Electrocardiology | | 226,838 | | 226,838 | 278 | 470 | 69 |
| 71 | Medical Supplies Charged to Patients | | 220,636 | | 220,636 | 278 | 470 | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | | | 72 |
| 73 | Drugs Charged to Patients | | 39,465 | | 39,465 | 99 | 88 | 73 |
| 74 | Renal Dialysis | | 95,542 | | 95,542 | | 15 | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | 16 | 29 | |
| 76.99 | LITHOTRIPSY | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 90 | Clinic MODILE MEDICAL LINET | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | | | | | 23 | 922 | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER WOUND HEALING CENTER | | | | | 200 128 | 823 220 | 90.03 90.04 |
| 90.04 | OUTPATIENT TREATMENT & INFUSION | | 130,537 | | 130,537 | 178 | 176 | 90.04 |
| 90.05 | PEDIATRIC SPECIALTY CLINIC | | 130,337 | | 130,337 | 86 | 250 | 90.05 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | 161 | 103 | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | 21 | 235 | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | | | | | 115 | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | | 171 | | 90.10 |
| 91 | Emergency | | 1,782,657 | | 1,782,657 | 1,418 | 2,071 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 110 | SPECIAL PURPOSE COST CENTERS | | 40.704.402 | | 40.704.402 | 25.222 | 26.012 | 110 |
| 118 | SUBTOTALS (sum of lines 1-117) | | 40,796,622 | | 40,796,622 | 25,233 | 36,048 | 118 |
| 190 | NONREIMBURSABLE COST CENTERS Gift, Flower, Coffee Shop & Canteen | | 158,786 | | 158,786 | | 72 | 190 |
| 190 | Physicians' Private Offices | | 9,782 | | 9,782 | | 3,922 | |
| 192.01 | MATERNAL FETAL MEDICINE/LABORIST | | 8,517 | | 8,517 | 25 | 3,722 | 192.01 |
| 192311 | | | | | | | | |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ALLOCATION OF CAPITAL-RELATED COSTS

| | T | T | | | | | | |
|--------|------------------------------|------------|------------|------------|------------|------------|------------|--------|
| | | DIR ASSGND | CAP | CAP | | EMPLOYEE | NON- | |
| | COST CENTER DESCRIPTIONS | CAP-REL | BLDGS & | MOVABLE | | BENEFITS | PATIENT | |
| | | COSTS | FIXTURES | EQUIPMENT | SUBTOTAL | DEPARTMENT | TELEPHONES | |
| | | 0 | 1 | 2 | 2A | 4 | 5.01 | |
| 192.03 | HOSPITALISTS/INTENSIVISTS | | | | | 110 | 176 | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | | | 194 |
| 194.01 | OUTREACH SERVICES | | | | | 746 | 676 | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | | | | | | 279 | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | | | | | | | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | | | | | 115 | | 194.04 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | -6,950,371 | -6,950,371 | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | | 40,973,707 | -6,950,371 | 34,023,336 | 26,647 | 41,218 | 202 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ALLOCATION OF CAPITAL-RELATED COSTS

| | COST CENTER DESCRIPTIONS | ADMITTING | 506 | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | HOUSE- KEEPING | DIETARY | |
|----------|---|--------------|------------------------|--------------------------|-------------------------------|---------------------|-----------|----------------------|
| | GENERAL SERVICE COST CENTERS | 5.04 | 5.06 | 7 | 8 | 9 | 10 | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 2 | Cap Rel Costs-Myble Equip | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | 4 |
| 5.01 | NONPATIENT TELEPHONES | | | | | | | 5.01 |
| 5.04 | ADMITTING | 158,236 | | | | | | 5.04 |
| 5.06 | OTHER ADMINISTRATIVE & GENERAL | | 5,164,242 | | | | | 5.06 |
| 7 | Maintenance & Repairs | | 125 596 | 10.986.312 | | | | 7 |
| 8 | Operation of Plant Laundry & Linen Service | | 425,586 21,605 | 10,986,312 | 21,678 | | | 8 |
| 9 | Housekeeping | | 72,825 | 223,474 | 21,078 | 806,142 | | 9 |
| 10 | Dietary | | 74,247 | 317,112 | | 23,752 | 1,138,362 | 10 |
| 11 | Cafeteria | | 22,184 | 430,959 | | 32,279 | -,, | 11 |
| 12 | Maintenance of Personnel | | , | , | | | | 12 |
| 13 | Nursing Administration | | 77,721 | 70,358 | | 5,270 | | 13 |
| 14 | Central Services & Supply | | 18,466 | | | | | 14 |
| 15 | Pharmacy | | 99,173 | 246,125 | | 18,435 | | 15 |
| 16 | Medical Records & Library | | 62,509 | 36,086 | | 2,703 | | 16 |
| 17 | Social Service | | 56,554 | 21,948 | | 1,644 | | 17 |
| 18 19 | STERILE SUPPLY Nonphysician Apacthetists | + | 65,429 | 285,061 | | 21,351 | | 18 19 |
| 21 | Nonphysician Anesthetists I&R Services-Salary & Fringes Apprvd | | 53,876 | 33,310 | | 2,495 | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | 67,679 | 33,310 | | 2,493 | | 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | | 2,648 | | | | | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | | 5,306 | | | | | 23.02 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 17,733 | 697,931 | 4,211,699 | 2,441 | 315,457 | 908,023 | 30 |
| 31 | Intensive Care Unit | 3,432 | 126,744 | 529,557 | 473 | 39,664 | 54,466 | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 1,741 | 69,283 | 187,351 | 240 | 14,033 | 2,546 | 35 |
| 41 | Subprovider - IRF | 727 | 42,590 | | 100 | | 65,645 | 41 |
| 43 | Nursery | 748 | 57,580 | | 103 | | | 43 |
| 50 | ANCILLARY SERVICE COST CENTERS Operating Room | 32,263 | 591,554 | 1,768,213 | 4,335 | 132,440 | | 50 |
| 51 | Recovery Room | 2,901 | 39,639 | 117,178 | 399 | 8,777 | | 51 |
| 52 | Delivery Room & Labor Room | 2,280 | 65,840 | 117,170 | 314 | 0,777 | | 52 |
| 54 | Radiology-Diagnostic | 9,022 | 144,707 | 499,467 | 1,242 | 37,410 | | 54 |
| 55 | Radiology-Therapeutic | 153 | 12,311 | .,,,,,,, | 21 | 2.,, | | 55 |
| 57 | CT Scan | 11,221 | 30,638 | 63,141 | 1,545 | 4,729 | | 57 |
| 58 | MRI | 909 | 8,330 | | 125 | | | 58 |
| 59 | Cardiac Catheterization | 8,961 | 208,577 | 542,844 | 1,234 | 40,659 | | 59 |
| 60 | Laboratory | 16,962 | 230,309 | 72,838 | 2,335 | 5,456 | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | 2 (07 | #2.0#¢ | 422.00 | 274 | 0.055 | | 62.30 |
| 65 66 | Respiratory Therapy | 2,697 | 73,876 | 132,907 120,435 | 371 307 | 9,955 9,021 | | 65 66 |
| 67 | Physical Therapy Occupational Therapy | 2,228 803 | 72,842 19,022 | 120,455 | 111 | 9,021 | | 67 |
| 68 | Speech Pathology | 460 | 10,095 | | 63 | | | 68 |
| 69 | Electrocardiology | 3,676 | 32,466 | 99,560 | 506 | 7,457 | | 69 |
| 71 | Medical Supplies Charged to Patients | | , , , , , | , | | ., | | 71 |
| 72 | Impl. Dev. Charged to Patients | 11,928 | 510,379 | | 1,642 | | | 72 |
| 73 | Drugs Charged to Patients | 13,793 | 365,219 | 17,321 | 1,899 | 1,297 | | 73 |
| 74 | Renal Dialysis | 256 | 24,630 | 41,934 | 35 | 3,141 | | 74 |
| 76.97 | CARDIAC REHABILITATION | 121 | 1.220 | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 161 | 1,230 | | 22 | | | 76.98 |
| 76.99 | LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS | | | | | | | 76.99 |
| 90 | Clinic | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 82 | | | 11 | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 458 | 27,274 | | 63 | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 738 | 29,602 | | 102 | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 735 | 18,967 | 57,293 | 101 | 4,291 | 1,360 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 49 | 9,183 | | 7 | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | 15,926 | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 210 | 5,753 | | 22 | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 218 | 13,073 | | 30 | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC Emergency | 10,087 | 18,549 194,465 | 782,418 | 1,389 | 58,604 | | 90.10 |
| 92 | Observation Beds (Non-Distinct Part) | 10,007 | 174,403 | /04,418 | 1,369 | 30,004 | | 91 |
| /2 | OTHER REIMBURSABLE COST CENTERS | | | | | | | / |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 157,422 | 4,894,392 | 10,908,589 | 21,566 | 800,320 | 1,032,040 | 118 |
| 220 | NONREIMBURSABLE COST CENTERS | | | | | | | 1 |
| | | | | | | | | |
| 190 | Gift, Flower, Coffee Shop & Canteen | | 3,241 | 69,692 | | 5,220 | | 190 |
| | | 17 | 3,241 863 33,148 | 69,692 4,293 3,738 | 2 | 5,220 322 280 | | 190 192 192.01 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ALLOCATION OF CAPITAL-RELATED COSTS

| | COST CENTER DESCRIPTIONS | ADMITTING | | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | HOUSE- KEEPING | DIETARY | |
|--------|------------------------------|-----------|-----------|-----------------------|-------------------------------|-------------------|-----------|--------|
| | | 5.04 | 5.06 | 7 | 8 | 9 | 10 | |
| 192.03 | HOSPITALISTS/INTENSIVISTS | 125 | 109,708 | | 17 | | | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | | | 194 |
| 194.01 | OUTREACH SERVICES | 450 | 73,467 | | 62 | | | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | | 47 | | | | 106,322 | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | | 3,039 | | | | | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | | 10,407 | | | | | 194.04 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 158,236 | 5,164,242 | 10,986,312 | 21,678 | 806,142 | 1,138,362 | 202 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ALLOCATION OF CAPITAL-RELATED COSTS

| | COST CENTER DESCRIPTIONS | CAFETERIA 11 | NURSING ADMINIS- TRATION 13 | CENTRAL SERVICES & SUPPLY 14 | PHARMACY 15 | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | |
|----------|---|-----------------|--------------------------------------|---------------------------------------|----------------|---------------------------------|-------------------|----------|
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | 4 |
| 5.01 | NONPATIENT TELEPHONES | | | | | | | 5.01 |
| 5.04 | ADMITTING | | | | | | | 5.04 |
| 5.06 | OTHER ADMINISTRATIVE & GENERAL | | | | | | | 5.06 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 8 | Operation of Plant | | | | | | | 7 |
| 9 | Laundry & Linen Service Housekeeping | | | | | | | 9 |
| 10 | Dietary | | | | | | | 10 |
| 11 | Cafeteria | 1,467,827 | | | | | | 11 |
| 12 | Maintenance of Personnel | 1,407,627 | | | | | | 12 |
| 13 | Nursing Administration | 46,059 | 360,953 | | | | | 13 |
| 14 | Central Services & Supply | 15,859 | 4.026 | 38,540 | | | | 14 |
| 15 | Pharmacy | 44,739 | 11,358 | 36,340 | 982,484 | | | 15 |
| 16 | Medical Records & Library | 44,335 | 11,256 | | 702,101 | 240,314 | | 16 |
| 17 | Social Service | 29,394 | 7,462 | | 733 | 2.0,511 | 168,849 | 17 |
| 18 | STERILE SUPPLY | 24,687 | 6,267 | | , , , , | | 130,017 | 18 |
| 19 | Nonphysician Anesthetists | 2.,007 | 0,237 | | | | | 19 |
| 21 | I&R Services-Salary & Fringes Apprvd | 33,074 | 8,397 | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | 18,169 | 4,613 | | | | | 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | 1,357 | 345 | | | | | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | 2,274 | 577 | | | | | 23.02 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 358,662 | 91,055 | 4,369 | 77 | 26,856 | 150,088 | 30 |
| 31 | Intensive Care Unit | 63,263 | 16,061 | 846 | 12 | 5,198 | 16,885 | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 33,356 | 8,468 | 429 | | 2,637 | 1,876 | 35 |
| 41 | Subprovider - IRF | 27,914 | 7,087 | 179 | | 1,101 | | 41 |
| 43 | Nursery | 26,875 | 6,823 | 184 | 110 | 1,133 | | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | 174,151 | 44,213 | 7,501 | 5,862 | 49,532 | | 50 |
| 51 | Recovery Room | 22,253 | 5,650 | 715 | 1 | 4,393 | | 51 |
| 52 | Delivery Room & Labor Room | 38,943 | 9,887 | 562 | | 3,453 | | 52 |
| 54 | Radiology-Diagnostic | 62,921 | 15,974 | 2,223 | 32,294 | 13,664 | | 54 |
| 55 57 | Radiology-Therapeutic | 3,619 11,762 | 919 2,986 | 2,765 | 8,122 | 231 16,994 | | 55 57 |
| 58 | CT Scan MRI | 11,/02 | 2,980 | 2,763 | 8,122 | 1,376 | | 58 |
| 59 | Cardiac Catheterization | 38,613 | 9,803 | 2,208 | 14,376 | 13,571 | | 59 |
| 60 | Laboratory | 36,013 | 9,803 | 4,179 | 14,370 | 25,689 | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | 4,179 | | 23,069 | | 62.30 |
| 65 | Respiratory Therapy | 31,632 | 8,030 | 664 | 4 | 4,084 | | 65 |
| 66 | Physical Therapy | 36,571 | 9,285 | 549 | 113 | 3,374 | | 66 |
| 67 | Occupational Therapy | 10,112 | 2,567 | 198 | 10 | 1,216 | | 67 |
| 68 | Speech Pathology | 5,086 | 1,291 | 113 | | 696 | | 68 |
| 69 | Electrocardiology | 16,555 | 4,203 | 906 | 53 | 5,568 | | 69 |
| 71 | Medical Supplies Charged to Patients | .,,,,,, | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | 2,939 | | 18,065 | | 72 |
| 73 | Drugs Charged to Patients | 5,331 | 1,353 | 3,398 | 904,062 | 20,890 | | 73 |
| 74 | Renal Dialysis | | | 63 | | 387 | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 1,039 | 264 | 40 | 2 | 244 | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | 76.99 |
| L | OUTPATIENT SERVICE COST CENTERS | | | | | | | 0.7 |
| 90 | Clinic | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 1,638 | 416 | 20 | | 125 | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 17,974 | 4,563 | 113 | 5,100 | 693 | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 8,571 | 2,176 | 182 | 1,969 | 1,118 | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 9,855 | 2,502 | 181 | 4. | 1,114 | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 5,221 | 1,325 | 12 | 44 | 74 | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 5,294 5,588 | 1,344 1,419 | | 655 179 | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | 1,419 | 54 | | 330 | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC OUR LADY OF ROSARY CLINIC | 4,842 9,121 | 2,316 | 34 | 3,276 1,933 | 330 | | 90.09 |
| 90.10 | Emergency | 93,550 | 23,750 | 2,485 | 1,933 | 15,276 | | 90.10 |
| 92 | Observation Beds (Non-Distinct Part) | 95,530 | 23,730 | 2,463 | 3 | 13,270 | | 92 |
| 12 | OTHER REIMBURSABLE COST CENTERS | | | | | | | 12 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 1,390,259 | 341,260 | 38,339 | 978,990 | 239,082 | 168,849 | 118 |
| | NONREIMBURSABLE COST CENTERS | -,-,0,00 | 211,200 | 30,009 | , , , , , , , | | 2 30,0 17 | |
| 190 | Gift, Flower, Coffee Shop & Canteen | | | | | | | 190 |
| | Physicians' Private Offices | | | | | | | 192 |
| 192 | | | | | | | | 102.01 |
| 192.01 | MATERNAL FETAL MEDICINE/LABORIST | 306 | 78 | 4 | | 26 | | 192.01 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ALLOCATION OF CAPITAL-RELATED COSTS

| | COST CENTER DESCRIPTIONS | CAFETERIA | NURSING ADMINIS- | CENTRAL SERVICES & | PHARMACY | MEDICAL RECORDS & | SOCIAL SERVICE | |
|--------|------------------------------|-----------|---------------------|-----------------------|----------|----------------------|-------------------|--------|
| | | | TRATION | SUPPLY | | LIBRARY | | |
| | | 11 | 13 | 14 | 15 | 16 | 17 | |
| 192.03 | HOSPITALISTS/INTENSIVISTS | 2,323 | 590 | 31 | | 189 | | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | | | 194 |
| 194.01 | OUTREACH SERVICES | 62,688 | 15,915 | 111 | 3,494 | 681 | | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | | | | | | | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | | | | | | | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | 3,790 | 962 | | | | | 194.04 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 1,467,827 | 360,953 | 38,540 | 982,484 | 240,314 | 168,849 | 202 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ALLOCATION OF CAPITAL-RELATED COSTS

| | COST CENTER DESCRIPTIONS | OTHER GENERAL SERVICE | I&R SALARY & FRINGES | I&R PROGRAM COSTS | PARAMED EDUCATION | | SUBTOTAL | |
|----------------|---|-----------------------------|----------------------------|-------------------------|----------------------|-------|-------------------|----------------|
| | | 18 | 21 | 22 | 23 | 23.02 | 24 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | 4 |
| 5.01 | NONPATIENT TELEPHONES ADMITTING | | | | | | | 5.01 |
| 5.04 | OTHER ADMINISTRATIVE & GENERAL | | | | | | | 5.04 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | | | | | | | 7 |
| 8 | Laundry & Linen Service | | | | | | | 8 |
| 9 | Housekeeping | | | | | | | 9 |
| 10 | Dietary | | | | | | | 10 |
| 11 | Cafeteria | | | | | | | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | | | | | | | 13 |
| 14 | Central Services & Supply | | | | | | | 14 |
| 15 | Pharmacy Madical Passada & Library | | | | | | | 15 |
| 16 | Medical Records & Library | | | | | | | 16 17 |
| 17 18 | Social Service STERILE SUPPLY | 1,052,671 | | | | | | 18 |
| 19 | Nonphysician Anesthetists | 1,052,071 | | | | | | 19 |
| 21 | I&R Services-Salary & Fringes Apprvd | | 207,582 | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | -0.,532 | 91,726 | | | | 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | | | | 4,460 | | | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | | | | | 8,254 | | 23.02 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 17,263 | | | | | 16,410,723 | 30 |
| 31 | Intensive Care Unit | 160 | | | | | 2,065,024 | |
| 35 | NEONATAL INTENSIVE CARE UNIT | 898 | | | | | 750,620 | |
| 41 | Subprovider - IRF Nursery | 2,713 | | | | | 149,741 93,985 | 41 43 |
| 43 | ANCILLARY SERVICE COST CENTERS | | | | | | 93,983 | 43 |
| 50 | Operating Room | 956,246 | | | | | 7,801,539 | 50 |
| 51 | Recovery Room | 750,240 | | | | | 469,791 | 51 |
| 52 | Delivery Room & Labor Room | | | | | | 121,954 | |
| 54 | Radiology-Diagnostic | 928 | | | | | 1,960,951 | |
| 55 | Radiology-Therapeutic | | | | | | 17,355 | |
| 57 | CT Scan | | | | | | 298,111 | |
| 58 | MRI | | | | | | 11,155 | |
| 59 | Cardiac Catheterization | 5,142 | | | | | 2,124,686 | |
| 60 | Laboratory | | | | | | 524,295 | |
| 62.30 65 | BLOOD CLOTTING FOR HEMOPHILIACS Respiratory Therapy | 1,956 | | | | | 570,089 | 62.30 |
| 66 | Physical Therapy | 1,930 | | | | | 530,658 | |
| 67 | Occupational Therapy | | | | | | 34,380 | |
| 68 | Speech Pathology | | | | | | 17,978 | |
| 69 | Electrocardiology | | | | | | 398,536 | |
| 71 | Medical Supplies Charged to Patients | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | | 544,953 | |
| 73 | Drugs Charged to Patients | | | | | | 1,374,215 | 73 |
| 74 | Renal Dialysis | | | | | | 166,003 | 74 |
| | CARDIAC REHABILITATION HYDERD A RIC OVYGEN THER A RY | | | | | | 2.047 | 76.97 |
| 76.98 76.99 | HYPERBARIC OXYGEN THERAPY LITHOTRIPSY | + | | | | | 3,047 | 76.98 76.99 |
| 70.77 | OUTPATIENT SERVICE COST CENTERS | | | | | | | 70.99 |
| 90 | Clinic | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | | | | | | 2,315 | |
| 90.03 | FAMILY MEDICINE CENTER | 5,449 | | | | | 62,710 | |
| 90.04 | WOUND HEALING CENTER | 3,776 | | | | | 48,582 | |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | | | | | | 227,290 | |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | _ | | | | | 16,251 | |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 266 | | | | | 23,749 | |
| 90.08 | PODIATRY RESIDENCY CLINIC FACULTY PRACTICE CLINIC | 171 | | | | | 13,195 | |
| 90.09 | OUR LADY OF ROSARY CLINIC | 1/1 | | | | | 23,338 32,090 | |
| 91.10 | Emergency | 928 | | | | | 2,969,101 | 91.10 |
| 92 | Observation Beds (Non-Distinct Part) | 728 | | | | | 2,707,101 | 92 |
| | OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 995,896 | | | | | 39,858,410 | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | |
| 190 | Gift, Flower, Coffee Shop & Canteen | | | | | | 237,012 | |
| 192 | Physicians' Private Offices | | | | | | 19,182 | |
| 192.01 | MATERNAL FETAL MEDICINE/LABORIST | | | | | | | 192.01 |
| 192.02 | NEONATOLOGISTS | | | | | | 47,645 | 192.02 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ALLOCATION OF CAPITAL-RELATED COSTS

| | | OTHER | I&R | I&R | PARAMED | | | |
|--------|------------------------------|-----------|----------|---------|-----------|-------|------------|--------|
| | COST CENTER DESCRIPTIONS | GENERAL | SALARY & | PROGRAM | EDUCATION | | | |
| | | SERVICE | FRINGES | COSTS | | | SUBTOTAL | |
| | | 18 | 21 | 22 | 23 | 23.02 | 24 | |
| 192.03 | HOSPITALISTS/INTENSIVISTS | | | | | | 113,269 | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | | | 194 |
| 194.01 | OUTREACH SERVICES | 40,683 | | | | | 198,973 | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | | | | | | 106,648 | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | 16,092 | | | | | 19,131 | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | | | | | | 15,274 | 194.04 |
| 200 | Cross Foot Adjustments | | 207,582 | 91,726 | 4,460 | 8,254 | 312,022 | 200 |
| 201 | Negative Cost Centers | | | | | | -6,950,371 | 201 |
| 202 | TOTAL (sum of lines 118-201) | 1,052,671 | 207,582 | 91,726 | 4,460 | 8,254 | 34,023,336 | 202 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ALLOCATION OF CAPITAL-RELATED COSTS

| | COST CENTER DESCRIPTIONS | I&R COST & POST STEP- DOWN ADJS 25 | TOTAL 26 | | | |
|----------------------|---|---|-------------------|-------------|---|---------------|
| | GENERAL SERVICE COST CENTERS | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | 2 |
| 4 | Employee Benefits Department | | | | | 4 |
| 5.01 | NONPATIENT TELEPHONES | | | | | 5.01 |
| 5.04 | ADMITTING | | | | | 5.04 |
| 5.06 | OTHER ADMINISTRATIVE & GENERAL | | | | | 5.06 |
| 6 | Maintenance & Repairs | | | | | 6 7 |
| 7 | Operation of Plant Laundry & Linen Service | | | | | 8 |
| 9 | Housekeeping | | | | | 9 |
| 10 | Dietary | | | | | 10 |
| 11 | Cafeteria | | | | | 11 |
| 12 | Maintenance of Personnel | | | | | 12 |
| 13 | Nursing Administration | | | | | 13 |
| 14 | Central Services & Supply | | | | | 14 |
| 15 | Pharmacy | | | | | 15 |
| 16 | Medical Records & Library | | | | | 16 |
| 17 | Social Service | | | | | 17 |
| 18 | STERILE SUPPLY | | | | | 18 |
| 19 | Nonphysician Anesthetists | | | | | 19 |
| 21 | I&R Services-Salary & Fringes Apprvd | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | | | | 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | | | | | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | | | | | 23.02 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | |
| 30 | Adults & Pediatrics | | 16,410,723 | | | 30 |
| 31 | Intensive Care Unit | | 2,065,024 | | | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | | 750,620 | | | 35 |
| 41 | Subprovider - IRF | | 149,741 | | | 41 |
| 43 | Nursery | | 93,985 | | | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | | |
| 50 | Operating Room | | 7,801,539 | | | 50 |
| 51 | Recovery Room | | 469,791 | | | 51 |
| 52 | Delivery Room & Labor Room | | 121,954 | | | 52 |
| 54 | Radiology-Diagnostic | | 1,960,951 | | | 54 |
| 55 | Radiology-Therapeutic | | 17,355 | | | 55 |
| 57 | CT Scan | | 298,111 | | | 57 |
| 58 | MRI | | 11,155 | | | 58 |
| 59 | Cardiac Catheterization | | 2,124,686 | | | 59 |
| 60 | Laboratory | | 524,295 | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | ##O 000 | | | 62.30 |
| 65 | Respiratory Therapy | | 570,089 | | | 65 |
| 66 | Physical Therapy | | 530,658 34,380 | | | 66 |
| 67 68 | Occupational Therapy Speech Pathology | | 17,978 | | | 68 |
| 69 | Electrocardiology | | 398,536 | | | 69 |
| 71 | Medical Supplies Charged to Patients | | 390,330 | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | 544,953 | | + | 72 |
| 73 | Drugs Charged to Patients | | 1.374.215 | | | 73 |
| 74 | Renal Dialysis | | 166,003 | <u> </u> | | 74 |
| | CARDIAC REHABILITATION | | 100,003 | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | 3,047 | | | 76.98 |
| 76.99 | LITHOTRIPSY | | 5,017 | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | , 5.57 |
| 90 | Clinic | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | | 2,315 | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | | 62,710 | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | | 48,582 | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | | 227,290 | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | | 16,251 | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | 23,749 | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | 13,195 | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | | 23,338 | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | 32,090 | | | 90.10 |
| 91 | Emergency | | 2,969,101 | | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | |
| | SPECIAL PURPOSE COST CENTERS | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | | 39,858,410 | | | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | |
| 100 | | 1 | 237,012 | | 1 | 190 |
| 190 | Gift, Flower, Coffee Shop & Canteen | | | | | |
| 190 192 192.01 | Physicians' Private Offices MATERNAL FETAL MEDICINE/LABORIST | | 19,182 46,141 | | | 192 192.01 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ALLOCATION OF CAPITAL-RELATED COSTS

| | | I&R COST & | | | | |
|--------|------------------------------|------------|------------|--|--|--------|
| | COST CENTER DESCRIPTIONS | POST STEP- | | | | |
| | | DOWN ADJS | TOTAL | | | |
| | | 25 | 26 | | | |
| 192.03 | HOSPITALISTS/INTENSIVISTS | | 113,269 | | | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | 194 |
| 194.01 | OUTREACH SERVICES | | 198,973 | | | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | | 106,648 | | | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | | 19,131 | | | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | | 15,274 | | | 194.04 |
| 200 | Cross Foot Adjustments | | 312,022 | | | 200 |
| 201 | Negative Cost Centers | | -6,950,371 | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | | 34.023,336 | | | 202 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

WORKSHEET B-1

COST ALLOCATION - STATISTICAL BASIS

| | COST CENTER DESCRIPTIONS | CAP BLDGS & FIXTURES SQUARE FEET | CAP MOVABLE EQUIPMENT SQUARE FEET | EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES | NON- PATIENT TELEPHONES PHONE EXTE NSIONS | ADMITTING GROSS REVE NUE | RECON- CILIATION | |
|-------|--|--|---|---|---|--------------------------------------|---------------------|------------|
| | | 1 | 2 | 4 | 5.01 | 5.04 | 5A.06 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | 485,895 | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | 216 | 485,895 | 02 400 040 | | | | 2 |
| 4 | Employee Benefits Department | 316 | 316 | 93,400,048 | 2.906 | | | 4 |
| 5.01 | NONPATIENT TELEPHONES | 488 | 488 | 233,758 | 2,806 | 1 140 026 200 | | 5.01 |
| 5.04 | ADMITTING OTHER ADMINISTRATIVE & GENERAL | 1,866 61,173 | 1,866 61,173 | 1,088,081 1,576,087 | 39 361 | 1,149,926,299 | -69,072,023 | 5.04 |
| 6 | Maintenance & Repairs | 01,173 | 01,173 | 1,370,087 | 301 | | -09,072,023 | 5.06 |
| 7 | Operation of Plant | 125,215 | 125,215 | 1.989.129 | 85 | | | 7 |
| 8 | Laundry & Linen Service | 123,213 | 123,213 | 1,909,129 | 5 | | | 8 |
| 9 | Housekeeping | 6,038 | 6,038 | 1,513,034 | 17 | | | 9 |
| 10 | Dietary | 8,568 | 8,568 | 1,373,665 | 24 | | | 10 |
| 11 | Cafeteria | 11,644 | 11,644 | 707,645 | 21 | | | 11 |
| 12 | Maintenance of Personnel | | | , | | | | 12 |
| 13 | Nursing Administration | 1,901 | 1,901 | 2,912,468 | 28 | | | 13 |
| 14 | Central Services & Supply | , , , | ,, , | 507,521 | 3 | | | 14 |
| 15 | Pharmacy | 6,650 | 6,650 | 3,673,751 | 57 | | | 15 |
| 16 | Medical Records & Library | 975 | 975 | 1,968,850 | 44 | | | 16 |
| 17 | Social Service | 593 | 593 | 2,034,316 | 36 | | | 17 |
| 18 | STERILE SUPPLY | 7,702 | 7,702 | 816,574 | 11 | | | 18 |
| 19 | Nonphysician Anesthetists | | | | | | | 19 |
| 21 | I&R Services-Salary & Fringes Apprvd | 900 | 900 | 1,881,870 | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | | 2,636,666 | 35 | | | 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | | | 77,334 | 6 | | | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | | | 186,471 | 3 | | | 23.02 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | .= | | | | |
| 30 | Adults & Pediatrics | 113,795 | 113,795 | 17,845,978 | 548 | 128,498,757 | | 30 |
| 31 | Intensive Care Unit | 14,308 | 14,308 | 3,726,812 | 45 | 24,868,507 | | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 5,062 | 5,062 | 2,084,532 | 21 | 12,617,860 | | 35 |
| 41 | Subprovider - IRF | | | 1,479,528 | 86 | 5,269,952 | | 41 |
| 43 | Nursery ANCILLARY SERVICE COST CENTERS | | | 1,504,646 | | 5,421,672 | | 43 |
| 50 | Operating Room | 47,775 | 47,775 | 10,069,621 | 250 | 237,085,405 | | 50 |
| 51 | Recovery Room | 3,166 | 3,166 | 1,275,886 | 37 | 21,019,694 | | 51 |
| 52 | Delivery Room & Labor Room | 3,100 | 3,100 | 2,368,503 | 31 | 16,520,410 | | 52 |
| 54 | Radiology-Diagnostic | 13,495 | 13,495 | 3,665,312 | 141 | 65,376,018 | | 54 |
| 55 | Radiology-Therapeutic | 13,493 | 13,493 | 221,816 | 141 | 1,106,282 | | 55 |
| 57 | CT Scan | 1,706 | 1,706 | 752,849 | 9 | 81,309,758 | | 57 |
| 58 | MRI | 1,700 | 1,700 | 752,047 | 13 | 6,585,826 | | 58 |
| 59 | Cardiac Catheterization | 14,667 | 14,667 | 2,593,909 | 78 | 64,933,575 | | 59 |
| 60 | Laboratory | 1,968 | 1,968 | _,,,,,,,, | 39 | 122,916,084 | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | 2,700 | 2,700 | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | 62.30 |
| 65 | Respiratory Therapy | 3,591 | 3,591 | 1,837,414 | 39 | 19,542,373 | | 65 |
| 66 | Physical Therapy | 3,254 | 3,254 | 2,550,643 | 55 | 16,145,158 | | 66 |
| 67 | Occupational Therapy | | | 732,447 | 9 | 5,818,195 | | 67 |
| 68 | Speech Pathology | | | 403,130 | 4 | 3,331,722 | | 68 |
| 69 | Electrocardiology | 2,690 | 2,690 | 975,602 | 32 | 26,641,164 | | 69 |
| 71 | Medical Supplies Charged to Patients | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | 86,436,232 | | 72 |
| 73 | Drugs Charged to Patients | 468 | 468 | 346,442 | 6 | 99,950,061 | | 73 |
| 74 | Renal Dialysis | 1,133 | 1,133 | | 1 | 1,852,636 | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | 54,762 | 2 | 1,169,251 | | 76.98 |
| 76.99 | LITHOTRIPSY OUTEDATE SERVICE COST CENTEERS | | | | | | | 76.99 |
| 00 | OUTPATIENT SERVICE COST CENTERS | | | | | | | 00 |
| 90 | Clinic MOBILE MEDICAL LINIT | | | 70.472 | | 507.242 | 101 (15 | 90 |
| 90.02 | MOBILE MEDICAL UNIT | | | 79,473 701,905 | 5.0 | 596,242 | -121,615 | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER WOUND HEALING CENTER | + | | 701,905 449,516 | 56 15 | 3,316,865 5,349,636 | | 90.03 |
| 90.04 | OUTPATIENT TREATMENT & INFUSION | 1,548 | 1,548 | 624,346 | 12 | 5,349,636 | | 90.04 |
| 90.05 | PEDIATRIC SPECIALTY CLINIC | 1,348 | 1,348 | 302,611 | 17 | 352,245 | | 90.05 |
| 90.00 | SPORTS MED FELLOWSHIP CLINIC | | | 563,287 | 7 | 332,243 | | 90.00 |
| 90.07 | PODIATRY RESIDENCY CLINIC | | | 74,948 | 16 | | | 90.07 |
| 90.08 | FACULTY PRACTICE CLINIC | | | 403,814 | 10 | 1,578,368 | | 90.08 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | 600,807 | | 1,570,500 | | 90.10 |
| 91 | Emergency | 21,140 | 21,140 | 4,973,689 | 141 | 73,091,073 | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 21,140 | 21,1-40 | .,,,,,,,,,,, | 1-71 | , 5,071,075 | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 483,795 | 483,795 | 88,441,448 | 2,454 | 1,144,029,706 | -69,193,638 | 118 |
| 110 | | , | | | , | | , | |
| 110 | NONREIMBURSABLE COST CENTERS | | | | | | | |
| 190 | NONREIMBURSABLE COST CENTERS Gift, Flower, Coffee Shop & Canteen | 1,883 | 1,883 | | 5 | | | 190 |
| | | 1,883 116 101 | 1,883 116 | | 5 267 | | | 190 192 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| | | | | | | | | _ |
|--------|--|------------|-----------|------------|------------|------------|-----------|--------|
| | | CAP | CAP | EMPLOYEE | NON- | | | |
| | | BLDGS & | MOVABLE | BENEFITS | PATIENT | | RECON- | |
| | COST CENTER DESCRIPTIONS | FIXTURES | EQUIPMENT | DEPARTMENT | TELEPHONES | ADMITTING | CILIATION | |
| | | SQUARE | SQUARE | GROSS | PHONE EXTE | GROSS REVE | | |
| | | FEET | FEET | SALARIES | NSIONS | NUE | | |
| | | 1 | 2 | 4 | 5.01 | 5.04 | 5A.06 | |
| 192.02 | NEONATOLOGISTS | | | 1,465,241 | 3 | 1,606,882 | | 192.02 |
| 192.03 | HOSPITALISTS/INTENSIVISTS | | | 385,331 | 12 | 905,991 | | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | | | 194 |
| 194.01 | OUTREACH SERVICES | | | 2,617,300 | 46 | 3,257,641 | | 194.0 |
| 194.02 | KINDRED/OUR LADY OF PEACE | | | | 19 | | | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | | | | | | | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | | | 402,170 | | | | 194.04 |
| 200 | Cross foot adjustments | | | | | | | 200 |
| 201 | Negative cost centers | | | | | | | 201 |
| 202 | Cost to be allocated (Per Wkst. B, Part I) | 40,973,707 | | 4,747,353 | 343,524 | 1,637,325 | | 202 |
| 203 | Unit Cost Multiplier (Wkst. B, Part I) | 84.326258 | | 0.050828 | 122.424804 | 0.001424 | | 203 |
| 204 | Cost to be allocated (Per Wkst. B, Part II) | | | 26,647 | 41,218 | 158,236 | | 204 |
| 205 | Unit Cost Multiplier (Wkst. B, Part II) | | | 0.000285 | 14.689237 | 0.000138 | | 205 |
| 206 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | | 206 |
| 207 | NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV) | | | | | | | 207 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| | COST CENTER DESCRIPTIONS | ACCUM COST 5.06 | OPERATION OF PLANT SQUARE FEET 7 | LAUNDRY & LINEN SERVICE GROSS REVE NUE 8 | HOUSE- KEEPING SQUARE FEET 9 | MEALS SERVED | CAFETERIA FTES | |
|----------------|--|------------------------|--|---|--|-----------------|----------------|----------------|
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 4 | Cap Rel Costs-Myble Equip | | | | | | | 4 |
| 5.01 | Employee Benefits Department NONPATIENT TELEPHONES | | | | | | | 5.01 |
| 5.04 | ADMITTING | | | | | | | 5.04 |
| 5.06 | OTHER ADMINISTRATIVE & GENERAL | 254,007,185 | | | | | | 5.06 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | 20,932,838 | 296,837 | | | | | 7 |
| 8 | Laundry & Linen Service | 1,062,653 | 6.020 | 1,149,926,299 | 200 700 | | | 8 |
| 9 | Housekeeping Dietary | 3,581,972 3,651,901 | 6,038 8,568 | | 290,799 8,568 | 227,604 | | 9 |
| 11 | Cafeteria | 1,091,128 | 11,644 | | 11,644 | 227,004 | 120,047 | 11 |
| 12 | Maintenance of Personnel | 1,051,120 | 11,011 | | 11,011 | | 120,017 | 12 |
| 13 | Nursing Administration | 3,822,780 | 1,901 | | 1,901 | | 3,767 | 13 |
| 14 | Central Services & Supply | 908,291 | | | | | 1,297 | 14 |
| 15 | Pharmacy | 4,877,916 | 6,650 | | 6,650 | | 3,659 | 15 |
| 16 | Medical Records & Library | 3,074,550 | 975 | | 975 | | 3,626 | 16 |
| 17 18 | Social Service STERILE SUPPLY | 2,781,644 3,218,191 | 593 7,702 | | 593 7,702 | | 2,404 2,019 | 17 18 |
| 19 | Nonphysician Anesthetists | 3,218,191 | 7,702 | | 7,702 | | 2,019 | 18 |
| 21 | I&R Services-Salary & Fringes Apprvd | 2,649,945 | 900 | | 900 | | 2,705 | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | 3,328,849 | 200 | | 700 | | 1,486 | 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | 130,233 | | | | | 111 | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | 261,005 | | | | | 186 | 23.02 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 34,327,352 | 113,795 | 128,498,757 | 113,795 | 181,550 | 29,333 | 30 |
| 31 35 | Intensive Care Unit NEONATAL INTENSIVE CARE UNIT | 6,234,010 3,407,756 | 14,308 5,062 | 24,868,507 12,617,860 | 14,308 5,062 | 10,890 509 | 5,174 2,728 | 31 35 |
| 41 | Subprovider - IRF | 2,094,826 | 3,062 | 5,269,952 | 3,062 | 13,125 | 2,728 | 41 |
| 43 | Nursery | 2,832,106 | | 5,421,672 | | 13,123 | 2,198 | 43 |
| | ANCILLARY SERVICE COST CENTERS | 2,032,100 | | 5,121,072 | | | 2,170 | |
| 50 | Operating Room | 29,096,176 | 47,775 | 237,085,405 | 47,775 | | 14,243 | 50 |
| 51 | Recovery Room | 1,949,702 | 3,166 | 21,019,694 | 3,166 | | 1,820 | 51 |
| 52 | Delivery Room & Labor Room | 3,238,384 | | 16,520,410 | | | 3,185 | 52 |
| 54 | Radiology-Diagnostic | 7,117,574 605,542 | 13,495 | 65,376,018 1,106,282 | 13,495 | | 5,146 296 | 54 55 |
| 55 57 | Radiology-Therapeutic CT Scan | 1,506,937 | 1,706 | 81,309,758 | 1,706 | | 962 | 57 |
| 58 | MRI | 409,717 | 1,700 | 6,585,826 | 1,700 | | 902 | 58 |
| 59 | Cardiac Catheterization | 10,259,078 | 14,667 | 64,933,575 | 14,667 | | 3,158 | 59 |
| 60 | Laboratory | 11,327,986 | 1,968 | 122,916,084 | 1,968 | | -, | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 3,633,672 | 3,591 | 19,542,373 | 3,591 | | 2,587 | 65 |
| 66 | Physical Therapy | 3,582,783 | 3,254 | 16,145,158 | 3,254 | | 2,991 | 66 |
| 67 68 | Occupational Therapy Speech Pathology | 935,592 496,547 | | 5,818,195 3,331,722 | | | 827 416 | 67 68 |
| 69 | Speech Pathology Electrocardiology | 1,596,891 | 2,690 | 26,641,164 | 2,690 | | 1,354 | 69 |
| 71 | Medical Supplies Charged to Patients | 1,570,071 | 2,000 | 20,041,104 | 2,070 | | 1,554 | 71 |
| 72 | Impl. Dev. Charged to Patients | 25,103,473 | | 86,436,232 | | | | 72 |
| 73 | Drugs Charged to Patients | 17,963,670 | 468 | 99,950,061 | 468 | | 436 | |
| 74 | Renal Dialysis | 1,211,433 | 1,133 | 1,852,636 | 1,133 | | | 74 |
| 76.97 | CARDIAC REHABILITATION | 50.400 | | 1.170.051 | | | 0.5 | 76.97 |
| 76.98 76.99 | HYPERBARIC OXYGEN THERAPY LITHOTRIPSY | 60,493 | | 1,169,251 | | | 85 | 76.98 76.99 |
| 70.99 | OUTPATIENT SERVICE COST CENTERS | | | | | | | 70.99 |
| 90 | Clinic | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | | | 596,242 | | | 134 | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 1,341,521 | | 3,316,865 | | | 1,470 | 90.03 |
| 90.04 | WOUND HEALING CENTER | 1,455,993 | | 5,349,636 | | | 701 | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 932,906 | 1,548 | 5,328,685 | 1,548 | 272 | 806 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 451,655 | | 352,245 | | | 427 | 90.06 |
| 90.07 90.08 | SPORTS MED FELLOWSHIP CLINIC PODIATRY RESIDENCY CLINIC | 783,329 282,989 | | | | | 433 457 | 90.07 |
| 90.08 | FACULTY PRACTICE CLINIC | 643,014 | | 1,578,368 | | | 396 | 90.08 |
| 90.10 | OUR LADY OF ROSARY CLINIC | 912,362 | | 1,570,500 | | | 746 | 90.10 |
| 91 | Emergency | 9,564,929 | 21,140 | 73,091,073 | 21,140 | | 7,651 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 110 | SPECIAL PURPOSE COST CENTERS | 246 724 25 | 201.85 | 1 144 020 70 | 200 100 | 20121 | 110.55 | 116 |
| 118 | SUBTOTALS (sum of lines 1-117) | 240,734,294 | 294,737 | 1,144,029,706 | 288,699 | 206,346 | 113,703 | 118 |
| 190 | NONREIMBURSABLE COST CENTERS Gift, Flower, Coffee Shop & Canteen | 159,398 | 1,883 | | 1,883 | | | 190 |
| 192 | Physicians' Private Offices | 42,469 | 116 | | 116 | | | 192 |
| | MATERNAL FETAL MEDICINE/LABORIST | 1,630,418 | 101 | 126,079 | 101 | | | 192.01 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| | | | OPERATION | LAUNDRY | HOUSE- | DIETARY | CAFETERIA | |
|--------|--|------------|------------|------------|-----------|-----------|-----------|--------|
| | | | OF PLANT | & LINEN | KEEPING | | | |
| | COST CENTER DESCRIPTIONS | | | SERVICE | | | | |
| | | ACCUM | SQUARE | GROSS REVE | SQUARE | MEALS | FTES | |
| | | COST | FEET | NUE | FEET | SERVED | | |
| | | 5.06 | 7 | 8 | 9 | 10 | 11 | |
| 192.02 | NEONATOLOGISTS | 1,767,262 | | 1,606,882 | | | 692 | 192.02 |
| 192.03 | HOSPITALISTS/INTENSIVISTS | 5,396,091 | | 905,991 | | | 190 | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | | | 194 |
| 194.01 | OUTREACH SERVICES | 3,613,549 | | 3,257,641 | | | 5,127 | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | 2,326 | | | | 21,258 | | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | 149,488 | | | | | | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | 511,890 | | | | | 310 | 194.04 |
| 200 | Cross foot adjustments | | | | | | | 200 |
| 201 | Negative cost centers | | | | | | | 201 |
| 202 | Cost to be allocated (Per Wkst. B, Part I) | 69,072,023 | 26,625,084 | 1,351,619 | 5,097,598 | 5,563,668 | 2,636,372 | 202 |
| 203 | Unit Cost Multiplier (Wkst. B, Part I) | 0.271929 | 89.695975 | 0.001175 | 17.529627 | 24.444509 | 21.961165 | 203 |
| 204 | Cost to be allocated (Per Wkst. B, Part II) | 5,164,242 | 10,986,312 | 21,678 | 806,142 | 1,138,362 | 1,467,827 | 204 |
| 205 | Unit Cost Multiplier (Wkst. B, Part II) | 0.020331 | 37.011262 | 0.000019 | 2.772162 | 5.001503 | 12.227103 | 205 |
| 206 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | | 206 |
| 207 | NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV) | | | | | | | 207 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

| | COST CENTER DESCRIPTIONS | NURSING ADMINIS- TRATION FTES | CENTRAL SERVICES & SUPPLY GROSS REVE NUE | PHARMACY COSTED REQUIS. | MEDICAL RECORDS & LIBRARY GROSS REVE NUE | SOCIAL SERVICE TIME SPENT | OTHER GENERAL SERVICE TIME SPENT | |
|----------|--|--|--|--------------------------|--|------------------------------------|--|----------|
| | | 13 | 14 | 15 | 16 | 17 | 18 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | 2 |
| 5.01 | Employee Benefits Department NONPATIENT TELEPHONES | | | | | | | 5.01 |
| 5.04 | ADMITTING | | | | | | | 5.04 |
| 5.06 | OTHER ADMINISTRATIVE & GENERAL | | | | | | | 5.06 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | | | | | | | 7 |
| 8 | Laundry & Linen Service | | | | | | | 8 |
| 9 | Housekeeping | | | | | | | 9 |
| 10 | Dietary | | | | | | | 10 |
| 11 | Cafeteria | | | | | | | 11 |
| 12 | Maintenance of Personnel Nursing Administration | 116,280 | | | | | | 12 |
| 14 | Central Services & Supply | 1,297 | 1,149,926,299 | | | | | 14 |
| 15 | Pharmacy | 3,659 | 1,149,920,299 | 18,515,486 | | | | 15 |
| 16 | Medical Records & Library | 3,626 | | 10,010,100 | 1,149,926,299 | | | 16 |
| 17 | Social Service | 2,404 | | 13,817 | , | 90 | | 17 |
| 18 | STERILE SUPPLY | 2,019 | | 3 | | | 178,123 | 18 |
| 19 | Nonphysician Anesthetists | | | | | | | 19 |
| 21 | I&R Services-Salary & Fringes Apprvd | 2,705 | | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | 1,486 | | | | | | 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | 111 | | | | | | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM INPATIENT ROUTINE SERV COST CENTERS | 186 | | | | | | 23.02 |
| 30 | Adults & Pediatrics | 29,333 | 128,498,757 | 1,452 | 128,498,757 | 80 | 2,921 | 30 |
| 31 | Intensive Care Unit | 5,174 | 24,868,507 | 221 | 24,868,507 | 9 | 27 | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 2,728 | 12,617,860 | 5 | 12,617,860 | 1 | 152 | 35 |
| 41 | Subprovider - IRF | 2,283 | 5,269,952 | | 5,269,952 | | 459 | 41 |
| 43 | Nursery | 2,198 | 5,421,672 | 2,070 | 5,421,672 | | | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | 14,243 | 237,085,405 | 110,481 | 237,085,405 | | 161,807 | 50 |
| 51 | Recovery Room | 1,820 | 21,019,694 | 15 | 21,019,694 | | | 51 |
| 52 | Delivery Room & Labor Room | 3,185 | 16,520,410 | 600.606 | 16,520,410 | | 1.57 | 52 |
| 54 55 | Radiology-Diagnostic | 5,146 296 | 65,376,018 1,106,282 | 608,606 | 65,376,018 1,106,282 | | 157 | 54 55 |
| 57 | Radiology-Therapeutic CT Scan | 962 | 81,309,758 | 153,060 | 81,309,758 | | | 57 |
| 58 | MRI | 902 | 6,585,826 | 133,000 | 6,585,826 | | | 58 |
| 59 | Cardiac Catheterization | 3,158 | 64,933,575 | 270,915 | 64,933,575 | | 870 | 59 |
| 60 | Laboratory | -, | 122,916,084 | , | 122,916,084 | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 2,587 | 19,542,373 | 79 | 19,542,373 | | 331 | 65 |
| 66 | Physical Therapy | 2,991 | 16,145,158 | 2,137 | 16,145,158 | | | 66 |
| 67 | Occupational Therapy | 827 | 5,818,195 | 185 | 5,818,195 | | | 67 |
| 68 | Speech Pathology | 416 | 3,331,722 | 1.004 | 3,331,722 | | | 68 |
| 69 71 | Electrocardiology Medical Supplies Charged to Patients | 1,354 | 26,641,164 | 1,004 | 26,641,164 | | | 69 71 |
| 72 | Impl. Dev. Charged to Patients | | 86,436,232 | | 86,436,232 | | | 72 |
| 73 | Drugs Charged to Patients | 436 | 99,950,061 | 17,037,587 | 99,950,061 | | | 73 |
| 74 | Renal Dialysis | .50 | 1,852,636 | .,, | 1,852,636 | | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 85 | 1,169,251 | 40 | 1,169,251 | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | 76.99 |
| 00 | OUTPATIENT SERVICE COST CENTERS | | | | | | | 00 |
| 90 | Clinic MODII E MEDICAL LINIT | 124 | 500.040 | | 507.242 | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT FAMILY MEDICINE CENTER | 134 1,470 | 596,242 3,316,865 | 96,106 | 596,242 3,316,865 | | 922 | 90.02 |
| 90.03 | WOUND HEALING CENTER | 701 | 5,349,636 | 37,110 | 5,349,636 | | 639 | 90.03 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 806 | 5,328,685 | 37,110 | 5,328,685 | | 039 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 427 | 352,245 | 833 | 352,245 | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 433 | | 12,335 | | | 45 | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 457 | | 3,380 | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 396 | 1,578,368 | 61,735 | 1,578,368 | | 29 | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | 746 | #0 004 0F- | 36,422 | #0.004.0F | | | 90.10 |
| 91 | Character Pada (Non Distinct Port) | 7,651 | 73,091,073 | 49 | 73,091,073 | | 157 | 91 |
| 92 | Observation Beds (Non-Distinct Part) OTHER REIMBURSABLE COST CENTERS | | | | | | | 92 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 109,936 | 1,144,029,706 | 18,449,647 | 1,144,029,706 | 90 | 168,516 | 118 |
| | NONREIMBURSABLE COST CENTERS | 107,750 | -,,020,700 | 10, 17,017 | -,- : :,022,700 | ,,, | 130,310 | |
| 190 | Gift, Flower, Coffee Shop & Canteen | | | | | | | 190 |
| 192 | Physicians' Private Offices | | | | | | | 192 |
| 192.01 | MATERNAL FETAL MEDICINE/LABORIST | 25 | 126,079 | | 126,079 | | | 192.01 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

| | | NURSING | CENTRAL | PHARMACY | MEDICAL | SOCIAL | OTHER | |
|--------|--|-----------|------------|-----------|------------|---------------|-----------|--------|
| | | ADMINIS- | SERVICES & | | RECORDS & | SERVICE | GENERAL | |
| | COST CENTER DESCRIPTIONS | TRATION | SUPPLY | | LIBRARY | | SERVICE | |
| | | FTES | GROSS REVE | COSTED | GROSS REVE | TIME | TIME | |
| | | | NUE | REQUIS. | NUE | SPENT | SPENT | |
| | | 13 | 14 | 15 | 16 | 17 | 18 | |
| 192.02 | NEONATOLOGISTS | 692 | 1,606,882 | | 1,606,882 | | | 192.02 |
| 192.03 | HOSPITALISTS/INTENSIVISTS | 190 | 905,991 | | 905,991 | | | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | | | 194 |
| 194.01 | OUTREACH SERVICES | 5,127 | 3,257,641 | 65,839 | 3,257,641 | | 6,884 | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | | | | | | | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | | | | | | 2,723 | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | 310 | | | | | | 194.04 |
| 200 | Cross foot adjustments | | | | | | | 200 |
| 201 | Negative cost centers | | | | | | | 201 |
| 202 | Cost to be allocated (Per Wkst. B, Part I) | 5,148,869 | 1,241,197 | 7,159,789 | 4,255,344 | 3,766,226 | 5,052,903 | 202 |
| 203 | Unit Cost Multiplier (Wkst. B, Part I) | 44.279919 | 0.001079 | 0.386692 | 0.003701 | 41,846.955556 | 28.367493 | 203 |
| 204 | Cost to be allocated (Per Wkst. B, Part II) | 360,953 | 38,540 | 982,484 | 240,314 | 168,849 | 1,052,671 | 204 |
| 205 | Unit Cost Multiplier (Wkst. B, Part II) | 3.104171 | 0.000034 | 0.053063 | 0.000209 | 1,876.100000 | 5.909798 | 205 |
| 206 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | | 206 |
| 207 | NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV) | | | | | | | 207 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

| | I&R | I&R | PARAMED | | | |
|--------------------------|----------|----------|-----------|------------|--|--|
| | SALARY & | PROGRAM | EDUCATION | | | |
| COST CENTER DESCRIPTIONS | FRINGES | COSTS | | | | |
| | ASSIGNED | ASSIGNED | ASSIGNED | PATIENT DA | | |
| | TIME | TIME | TIME | YS | | |
| | 21 | 22 | 23 | 23.02 | | |

| | GENERAL SERVICE COST CENTERS | | | | | | |
|-------------|---|-----------|-----------|-----|-----|---|----------|
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | 4 5.01 |
| 5.01 | NONPATIENT TELEPHONES ADMITTING | | | | | | 5.01 |
| 5.04 | OTHER ADMINISTRATIVE & GENERAL | | | | | | 5.06 |
| 6 | Maintenance & Repairs | | | | | | 6 |
| 7 | Operation of Plant | | | | | | 7 |
| 8 | Laundry & Linen Service | | | | | | 8 |
| 9 | Housekeeping | | | | | | 9 |
| 10 | Dietary | | | | | | 10 |
| 11 | Cafeteria Maintenance of Personnel | | | | | | 11 |
| 13 | Nursing Administration | | | | | | 13 |
| 14 | Central Services & Supply | | | | | | 14 |
| 15 | Pharmacy | | | | | | 15 |
| 16 | Medical Records & Library | | | | | | 16 |
| 17 | Social Service | | | | | | 17 |
| 18 19 | STERILE SUPPLY Nonphysician Anesthetists | | | | | | 18 19 |
| 21 | I&R Services-Salary & Fringes Apprvd | 710 | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | ,10 | 710 | | | | 22 |
| 23 | PARAMED ED PRGM-(SPECIFY) | | | 100 | | | 23 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | | | | 100 | | 23.02 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | |
| 30 | Adults & Pediatrics Intensive Care Unit | 394 37 | 394 37 | | | | 30 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 10 | 10 | | | | 35 |
| 41 | Subprovider - IRF | 10 | 10 | | | | 41 |
| 43 | Nursery | 45 | 45 | | | | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50 | Operating Room | 22 | 22 | | | | 50 |
| 51 | Recovery Room | - | - | | | | 51 |
| 52 54 | Delivery Room & Labor Room Radiology-Diagnostic | 5 | 5 | | | | 52 54 |
| 55 | Radiology-Therapeutic | 3 | | | | | 55 |
| 57 | CT Scan | | | | | | 57 |
| 58 | MRI | | | | | | 58 |
| 59 | Cardiac Catheterization | | | | | | 59 |
| 60 | Laboratory | | | | | | 60 |
| 62.30 65 | BLOOD CLOTTING FOR HEMOPHILIACS Respiratory Therapy | | | | | | 62.30 |
| 66 | Physical Therapy | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | 67 |
| 68 | Speech Pathology | | | | | | 68 |
| 69 | Electrocardiology | 17 | 17 | | | | 69 |
| 71 | Medical Supplies Charged to Patients | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | 100 | | 72 |
| 73 74 | Drugs Charged to Patients Renal Dialysis | 3 | 3 | | 100 | | 73 74 |
| 76.97 | CARDIAC REHABILITATION | 3 | 3 | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | ļ |
| 90 | Clinic MODIL E MEDICAL LIDIT | 129 | 129 | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT FAMILY MEDICINE CENTER | | | | | | 90.02 |
| 90.03 | WOUND HEALING CENTER | | | | | | 90.03 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | | | | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | | | | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC Emergency | 43 | 43 | 100 | | | 90.10 |
| 92 | Observation Beds (Non-Distinct Part) | 43 | 43 | 100 | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | Ľ |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 710 | 710 | 100 | 100 | | 118 |
| 100 | NONREIMBURSABLE COST CENTERS | | | | | | 100 |
| 190 | Gift, Flower, Coffee Shop & Canteen | | | | | 1 | 190 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
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| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

| | | I&R | I&R | PARAMED | | | |
|--------|--|--------------|--------------|--------------|--------------|--|--------|
| | COST CENTED DESCRIPTIONS | SALARY & | PROGRAM | EDUCATION | | | |
| | COST CENTER DESCRIPTIONS | FRINGES | COSTS | | D | | |
| | | ASSIGNED | ASSIGNED | ASSIGNED | PATIENT DA | | |
| | | TIME | TIME | TIME | YS | | |
| | | 21 | 22 | 23 | 23.02 | | |
| 192 | Physicians' Private Offices | | | | | | 192 |
| 192.01 | MATERNAL FETAL MEDICINE/LABORIST | | | | | | 192.01 |
| 192.02 | NEONATOLOGISTS | | | | | | 192.02 |
| 192.03 | HOSPITALISTS/INTENSIVISTS | | | | | | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | | 194 |
| 194.01 | OUTREACH SERVICES | | | | | | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | | | | | | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | | | | | | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | | | | | | 194.04 |
| 200 | Cross foot adjustments | | | | | | 200 |
| 201 | Negative cost centers | | | | | | 201 |
| 202 | Cost to be allocated (Per Wkst. B, Part I) | 3,646,227 | 4,332,494 | 173,000 | 344,301 | | 202 |
| 203 | Unit Cost Multiplier (Wkst. B, Part I) | 5,135.530986 | 6,102.104225 | 1,730.000000 | 3,443.010000 | | 203 |
| 204 | Cost to be allocated (Per Wkst. B, Part II) | 207,582 | 91,726 | 4,460 | 8,254 | | 204 |
| 205 | Unit Cost Multiplier (Wkst. B, Part II) | 292.369014 | 129.191549 | 44.600000 | 82.540000 | | 205 |
| 206 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | 206 |
| 207 | NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV) | | | | | | 207 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

POST STEPDOWN ADJUSTMENTS WORKSHEET B-2

| | WORKSHEET | | | |
|-------------|-----------|----------|--------|--|
| DESCRIPTION | CODE | LINE NO. | AMOUNT | |
| 1 | 2 | 3 | 4 | |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COMPUTATION OF RATIO OF COST TO CHARGES

| | | | | T | ao ama | | 1 |
|-------|--|---|--------------------------|----------------|--------------------------|----------------|-------|
| | | T . 10 . | | | COSTS | | |
| | COST CENTER DESCRIPTIONS | Total Cost (from Wkst. B, Part I, | Therapy Limit Adj. | Total Costs | RCE Dis- allowance | Total Costs | |
| | | col. 26) | 2 | 3 | 4 | 5 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | 1 | <u>Z</u> | 3 | 4 | | |
| 30 | Adults & Pediatrics | 66,441,127 | | 66,441,127 | 622 | 66,441,749 | 30 |
| 31 | Intensive Care Unit | 10,597,899 | | 10,597,899 | 48,636 | 10,646,535 | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 5,191,649 | | 5,191,649 | 40,030 | 5,191,649 | 35 |
| 41 | Subprovider - IRF | 3,180,935 | | 3,180,935 | | 3,180,935 | 41 |
| 43 | Nursery | 3,780,933 | | 3,780,922 | | 3,780,922 | 43 |
| 13 | ANCILLARY SERVICE COST CENTERS | 3,760,922 | | 3,700,722 | | 3,700,722 | 13 |
| 50 | Operating Room | 49,119,416 | | 49,119,416 | 60,721 | 49,180,137 | 50 |
| 51 | Recovery Room | 3.065.095 | | 3,065,095 | 00,721 | 3,065,095 | 51 |
| 52 | Delivery Room & Labor Room | 4,428,352 | | 4,428,352 | | 4,428,352 | 52 |
| 54 | Radiology-Diagnostic | 11.470.046 | | 11,470,046 | 14,835 | 11,484,881 | 54 |
| 55 | Radiology-Therapeutic | 796,402 | | 796,402 | 1 1,055 | 796,402 | 55 |
| 57 | CT Scan | 2,706,754 | | 2,706,754 | | 2,706,754 | 57 |
| 58 | MRI | 560,349 | | 560,349 | | 560,349 | 58 |
| 59 | Cardiac Catheterization | 15,346,806 | | 15,346,806 | 18,270 | 15,365,076 | 59 |
| 60 | Laboratory | 15,351,378 | | 15,351,378 | 10,270 | 15,351,378 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | 15,551,570 | | 10,001,070 | | 10,001,070 | 62.30 |
| 65 | Respiratory Therapy | 5,303,981 | | 5,303,981 | | 5,303,981 | 65 |
| 66 | Physical Therapy | 5,201,056 | | 5,201,056 | | 5,201,056 | 66 |
| 67 | Occupational Therapy | 1,279,507 | | 1,279,507 | | 1,279,507 | 67 |
| 68 | Speech Pathology | 678,970 | | 678,970 | | 678,970 | 68 |
| 69 | Electrocardiology | 2,568,295 | | 2,568,295 | 336 | 2,568,631 | 69 |
| 71 | Medical Supplies Charged to Patients | 2,500,255 | | 2,5 00,255 | 220 | 2,500,051 | 71 |
| 72 | Impl. Dev. Charged to Patients | 32,444,563 | | 32,444,563 | | 32,444,563 | 72 |
| 73 | Drugs Charged to Patients | 30,455,379 | | 30,455,379 | | 30,455,379 | 73 |
| 74 | Renal Dialysis | 1,673,377 | | 1,673,377 | | 1,673,377 | 74 |
| 76,97 | CARDIAC REHABILITATION | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | ,,,,,,, | | ,, | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 89,552 | | 89,552 | | 89,552 | 76.98 |
| 76.99 | LITHOTRIPSY | 07,002 | | ***** | | ***** | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90 | Clinic | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 134,043 | | 134,043 | | 134,043 | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 1,886,763 | | 1,886,763 | | 1,886,763 | 90.03 |
| 90.04 | WOUND HEALING CENTER | 1,962,689 | | 1,962,689 | | 1,962,689 | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 1,444,347 | | 1,444,347 | | 1,444,347 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 605,178 | | 605,178 | | 605,178 | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 1,031,068 | | 1,031,068 | | 1,031,068 | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 391,521 | | 391,521 | | 391,521 | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 878,195 | | 878,195 | | 878,195 | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | 1,223,960 | | 1,223,960 | | 1,223,960 | 90.10 |
| 91 | Emergency | 15,552,201 | | 15,552,201 | 155,197 | 15,707,398 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 6,866,537 | | 6,866,537 | | 6,866,537 | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 200 | Subtotal (sum of lines 30 thru 199) | 303,708,312 | | 303,708,312 | 298,617 | 304,006,929 | 200 |
| 201 | Less Observation Beds | 6,866,537 | | 6,866,537 | | 6,866,537 | 201 |
| 202 | Total (line 200 minus line 201) | 296,841,775 | | 296,841,775 | | 297,140,392 | 202 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COMPUTATION OF RATIO OF COST TO CHARGES

| | | | CHARGES | | | | | 1 |
|-------|---|--------------------------|--------------------------|--------------------------------------|------------------------|-----------------------------|---------------------------|----------|
| | COST CENTER DESCRIPTIONS | Inpatient | Outpatient | Total (column 6 + column 7) | Cost or Other Ratio | TEFRA Inpatient Ratio | PPS Inpatient Ratio | |
| | | 6 | 7 | 8 | 9 | 10 | 11 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 121,036,246 | | 121,036,246 | | | | 30 |
| 31 | Intensive Care Unit | 24,868,507 | | 24,868,507 | | | | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 12,617,860 | | 12,617,860 | | | | 35 |
| 41 | Subprovider - IRF | 5,269,952 | | 5,269,952 | | | | 41 |
| 43 | Nursery | 5,421,672 | | 5,421,672 | | | | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | 113,781,919 | 123,303,486 | 237,085,405 | 0.207180 | 0.207180 | 0.207436 | 50 |
| 51 | Recovery Room | 8,763,335 | 12,256,359 | 21,019,694 | 0.145820 | 0.145820 | 0.145820 | 51 |
| 52 | Delivery Room & Labor Room | 15,337,216 | 1,183,194 | 16,520,410 | 0.268053 | 0.268053 | 0.268053 | 52 |
| 54 | Radiology-Diagnostic | 13,861,831 | 51,514,186 | 65,376,017 | 0.175447 | 0.175447 | 0.175674 | 54 |
| 55 | Radiology-Therapeutic | 921,538 | 184,744 | 1,106,282 | 0.719891 | 0.719891 | 0.719891 | 55 |
| 57 | CT Scan | 23,535,887 | 57,773,871 | 81,309,758 | 0.033289 | 0.033289 | 0.033289 | 57 |
| 58 | MRI | 4,878,648 | 1,707,178 | 6,585,826 | 0.085084 | 0.085084 | 0.085084 | 58 |
| 59 | Cardiac Catheterization | 27,675,000 | 37,258,575 | 64,933,575 | 0.236346 | 0.236346 | 0.236628 | 59 |
| 60 | Laboratory | 72,586,830 | 50,329,254 | 122,916,084 | 0.124893 | 0.124893 | 0.124893 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | 12 (74 444 | 6 967 020 | 10.542.272 | 0.271400 | 0.271400 | 0.271400 | 62.30 |
| 65 | Respiratory Therapy | 12,674,444 | 6,867,929 | 19,542,373 | 0.271409 0.322143 | 0.271409 | 0.271409 | 65 |
| 66 | Physical Therapy | 5,952,758 | 10,192,399 | 16,145,157 | | 0.322143 0.219915 | 0.322143 0.219915 | 66 67 |
| | Occupational Therapy | 4,332,289 2,501,932 | 1,485,906 829,790 | 5,818,195 | 0.219915 0.203790 | 0.219915 | 0.219915 | 68 |
| 68 | Speech Pathology Electrocardiology | 10.042.134 | 16.599.030 | 3,331,722 26,641,164 | 0.203790 | 0.203790 | 0.203790 | 69 |
| | 62 | 10,042,134 | 10,399,030 | 20,041,104 | 0.096403 | 0.090403 | 0.090410 | 71 |
| 71 | Medical Supplies Charged to Patients | (2.502.410 | 22 042 012 | 86,436,232 | 0.275250 | 0.275250 | 0.375358 | 72 |
| 72 | Impl. Dev. Charged to Patients Drugs Charged to Patients | 62,592,419 53,562,931 | 23,843,813 46,387,130 | 99,950,061 | 0.375358 0.304706 | 0.375358 0.304706 | 0.375358 | 73 |
| 74 | Renal Dialysis | 1,477,962 | 374.674 | 1.852.636 | 0.304706 | 0.304706 | 0.304706 | 74 |
| 76.97 | CARDIAC REHABILITATION | 1,477,902 | 3/4,0/4 | 1,832,030 | 0.903241 | 0.903241 | 0.903241 | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 16,008 | 1,153,243 | 1,169,251 | 0.076589 | 0.076589 | 0.076589 | 76.98 |
| 76.98 | LITHOTRIPSY | 10,008 | 1,133,243 | 1,109,231 | 0.070389 | 0.076389 | 0.070389 | 76.98 |
| 70.99 | OUTPATIENT SERVICE COST CENTERS | | | | | | | 70.99 |
| 90 | Clinic | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 418 | 595.824 | 596,242 | 0.224813 | 0.224813 | 0.224813 | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 547.892 | 2,768,973 | 3,316,865 | 0.568839 | 0.568839 | 0.568839 | 90.03 |
| 90.03 | WOUND HEALING CENTER | 62,729 | 5,286,907 | 5,349,636 | 0.366883 | 0.366883 | 0.366883 | 90.03 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 106,070 | 5,222,615 | 5,328,685 | 0.271051 | 0.271051 | 0.271051 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 298 | 351.947 | 352.245 | 1.718060 | 1.718060 | 1.718060 | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 270 | 331,747 | 332,273 | 1.710000 | 1.710000 | 1.710000 | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 214,015 | 1,364,353 | 1,578,368 | 0.556394 | 0.556394 | 0.556394 | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | == .,,,10 | -,00.,000 | -,,500 | | | | 90.10 |
| 91 | Emergency | 17,768,194 | 55,322,879 | 73,091,073 | 0.212778 | 0.212778 | 0.214902 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 2,577,723 | 4,884,788 | 7,462,511 | 0.920138 | 0.920138 | 0.920138 | 92 |
| | OTHER REIMBURSABLE COST CENTERS | -,,.20 | .,, | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | , | T . |
| 200 | Subtotal (sum of lines 30 thru 199) | 624,986,657 | 519.043.047 | 1.144.029.704 | | | | 200 |
| 201 | Less Observation Beds | . ,,,,,,,,, | , , , | , ,,,,,,,,, | | | | 201 |
| 202 | Total (line 200 minus line 201) | 624,986,657 | 519,043,047 | 1,144,029,704 | | | | 202 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

| | | | | | COSTS | | |
|-------|--|--|--------------------------|----------------|--------------------------|----------------|-------|
| | COST CENTER DESCRIPTIONS | Total Cost (B Part I col 26 plus sum of cols 21 & 22) | Therapy Limit Adj. | Total Costs | RCE Dis- allowance | Total Costs | |
| | | 1 | 2 | 3 | 4 | 5 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30 | Adults & Pediatrics | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | | | ļ | | | 35 |
| 41 | Subprovider - IRF | | | | | | 41 |
| 43 | Nursery | | | | | | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50 | Operating Room | | | | | | 50 |
| 51 | Recovery Room | | | 1 | | | 51 |
| 52 | Delivery Room & Labor Room | | | | | | 52 |
| 54 | Radiology-Diagnostic | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | 55 |
| 57 | CT Scan | | | | | | 57 |
| 58 | MRI | | | | | | 58 |
| 59 | Cardiac Catheterization | | | | | | 59 |
| 60 | Laboratory | | | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | 62.30 |
| 65 | Respiratory Therapy | | | | | | 65 |
| 66 | Physical Therapy | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | 67 |
| 68 | Speech Pathology | | | | | | 68 |
| 69 | Electrocardiology | | | | | | 69 |
| 71 | Medical Supplies Charged to Patients | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | | 72 |
| 73 | Drugs Charged to Patients | | | | | | 73 |
| 74 | Renal Dialysis | | | | | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90 | Clinic | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | | | | | <u> </u> | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | | | | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | | | | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | | | | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | | | | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | | <u> </u> | 90.10 |
| 91 | Emergency | | | | | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 200 | Subtotal (sum of lines 30 thru 199) | | | | | | 200 |
| 201 | Less Observation Beds | | | | | | 201 |
| 202 | Total (line 200 minus line 201) | | | T | | | 202 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

| | | | CHARGES | | | | | |
|-------|--|-------------|-------------|-----------------------------------|------------------------|-----------------------------|---------------------------|-------|
| | COST CENTER DESCRIPTIONS | Inpatient | Outpatient | Total (column 6 + column 7) | Cost or Other Ratio | TEFRA Inpatient Ratio | PPS Inpatient Ratio | |
| | | 6 | 7 | 8 | 9 | 10 | 11 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 121,036,246 | | 121,036,246 | | | | 30 |
| 31 | Intensive Care Unit | 24,868,507 | | 24,868,507 | | | | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 12,617,860 | | 12,617,860 | | | | 35 |
| 41 | Subprovider - IRF | 5,269,952 | | 5,269,952 | | | | 41 |
| 43 | Nursery | 5,421,672 | | 5,421,672 | | | | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | 113,781,919 | 123,303,486 | 237,085,405 | | | | 50 |
| 51 | Recovery Room | 8,763,335 | 12,256,359 | 21,019,694 | | | | 51 |
| 52 | Delivery Room & Labor Room | 15,337,216 | 1,183,194 | 16,520,410 | | | | 52 |
| 54 | Radiology-Diagnostic | 13,861,831 | 51,514,186 | 65,376,017 | | | | 54 |
| 55 | Radiology-Therapeutic | 921,538 | 184,744 | 1,106,282 | | | | 55 |
| 57 | CT Scan | 23,535,887 | 57,773,871 | 81,309,758 | | | | 57 |
| 58 | MRI | 4,878,648 | 1,707,178 | 6,585,826 | | | | 58 |
| 59 | Cardiac Catheterization | 27,675,000 | 37,258,575 | 64,933,575 | | | | 59 |
| 60 | Laboratory | 72,586,830 | 50,329,254 | 122,916,084 | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 12,674,444 | 6,867,929 | 19,542,373 | | | | 65 |
| 66 | Physical Therapy | 5,952,758 | 10,192,399 | 16,145,157 | | | | 66 |
| 67 | Occupational Therapy | 4,332,289 | 1,485,906 | 5,818,195 | | | | 67 |
| 68 | Speech Pathology | 2,501,932 | 829,790 | 3,331,722 | | | | 68 |
| 69 | Electrocardiology | 10,042,134 | 16,599,030 | 26,641,164 | | | | 69 |
| 71 | Medical Supplies Charged to Patients | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 62,592,419 | 23,843,813 | 86,436,232 | | | | 72 |
| 73 | Drugs Charged to Patients | 53,562,931 | 46,387,130 | 99,950,061 | | | | 73 |
| 74 | Renal Dialysis | 1,477,962 | 374,674 | 1,852,636 | | | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 16,008 | 1,153,243 | 1,169,251 | | | | 76.98 |
| 76.99 | LITHOTRIPSY | · | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 90 | Clinic | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 418 | 595,824 | 596,242 | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 547,892 | 2,768,973 | 3,316,865 | | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 62,729 | 5,286,907 | 5,349,636 | | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 106,070 | 5,222,615 | 5,328,685 | | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 298 | 351,947 | 352,245 | | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 214,015 | 1,364,353 | 1,578,368 | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | | | | 90.10 |
| 91 | Emergency | 17,768,194 | 55,322,879 | 73,091,073 | | | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 2,577,723 | 4,884,788 | 7,462,511 | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 200 | Subtotal (sum of lines 30 thru 199) | 624,986,657 | 519,043,047 | 1,144,029,704 | | | | 200 |
| 201 | Less Observation Beds | | | | | | | 201 |
| 202 | Total (line 200 minus line 201) | 624,986,657 | 519,043,047 | 1,144,029,704 | | | | 202 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

| | | | | | COSTS | | |
|-------|--|---|--------------------------|----------------|--------------------------|----------------|-------|
| | COST CENTER DESCRIPTIONS | Total Cost (B Part I col 26 plus sum of cols 21 & 22) | Therapy Limit Adj. | Total Costs | RCE Dis- allowance | Total Costs | |
| | | 1 | 2 | 3 | 4 | 5 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30 | Adults & Pediatrics | 66,441,127 | | 66,441,127 | 622 | 66,441,749 | 30 |
| 31 | Intensive Care Unit | 10,597,899 | | 10,597,899 | 48,636 | 10,646,535 | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 5,191,649 | | 5,191,649 | | 5,191,649 | 35 |
| 41 | Subprovider - IRF | 3,180,935 | | 3,180,935 | | 3,180,935 | 41 |
| 43 | Nursery | 3,780,922 | | 3,780,922 | | 3,780,922 | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50 | Operating Room | 49,119,416 | | 49,119,416 | 60,721 | 49,180,137 | 50 |
| 51 | Recovery Room | 3,065,095 | | 3,065,095 | | 3,065,095 | 51 |
| 52 | Delivery Room & Labor Room | 4,428,352 | | 4,428,352 | | 4,428,352 | 52 |
| 54 | Radiology-Diagnostic | 11,470,046 | | 11,470,046 | 14,835 | 11,484,881 | 54 |
| 55 | Radiology-Therapeutic | 796,402 | | 796,402 | | 796,402 | 55 |
| 57 | CT Scan | 2,706,754 | | 2,706,754 | | 2,706,754 | 57 |
| 58 | MRI | 560,349 | | 560,349 | | 560,349 | 58 |
| 59 | Cardiac Catheterization | 15,346,806 | | 15,346,806 | 18,270 | 15,365,076 | 59 |
| 60 | Laboratory | 15,351,378 | | 15,351,378 | | 15,351,378 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | 62.30 |
| 65 | Respiratory Therapy | 5,303,981 | | 5,303,981 | | 5,303,981 | 65 |
| 66 | Physical Therapy | 5,201,056 | | 5,201,056 | | 5,201,056 | 66 |
| 67 | Occupational Therapy | 1,279,507 | | 1,279,507 | | 1,279,507 | 67 |
| 68 | Speech Pathology | 678,970 | | 678,970 | | 678,970 | 68 |
| 69 | Electrocardiology | 2,568,295 | | 2,568,295 | 336 | 2,568,631 | 69 |
| 71 | Medical Supplies Charged to Patients | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 32,444,563 | | 32,444,563 | | 32,444,563 | 72 |
| 73 | Drugs Charged to Patients | 30,455,379 | | 30,455,379 | | 30,455,379 | 73 |
| 74 | Renal Dialysis | 1,673,377 | | 1,673,377 | | 1,673,377 | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 89,552 | | 89,552 | | 89,552 | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90 | Clinic | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 134,043 | | 134,043 | | 134,043 | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 1,886,763 | | 1,886,763 | | 1,886,763 | 90.03 |
| 90.04 | WOUND HEALING CENTER | 1,962,689 | | 1,962,689 | | 1,962,689 | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 1,444,347 | | 1,444,347 | | 1,444,347 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 605,178 | | 605,178 | | 605,178 | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 1,031,068 | | 1,031,068 | | 1,031,068 | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 391,521 | | 391,521 | | 391,521 | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 878,195 | | 878,195 | | 878,195 | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | 1,223,960 | | 1,223,960 | | 1,223,960 | 90.10 |
| 91 | Emergency | 15,552,201 | | 15,552,201 | 155,197 | 15,707,398 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 6,866,537 | | 6,866,537 | **,*** | 6,866,537 | 92 |
| | OTHER REIMBURSABLE COST CENTERS | 7,53,000 | | .,,. | | .,, | |
| 200 | Subtotal (sum of lines 30 thru 199) | 303,708,312 | | 303,708,312 | 298,617 | 304,006,929 | 200 |
| 201 | Less Observation Beds | 6,866,537 | | 6,866,537 | | 6,866,537 | 201 |
| 202 | Total (line 200 minus line 201) | 296,841,775 | | 296,841,775 | 298,617 | 297,140,392 | 202 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

| | | | CHARGES | | | | | |
|----------------|---|-------------|-------------|-----------------------------------|------------------------|-----------------------|---------------------------|-------|
| | COST CENTER DESCRIPTIONS | Inpatient | Outpatient | Total (column 6 + column 7) | Cost or Other Ratio | TEFRA Inpatient Ratio | PPS Inpatient Ratio | |
| | | 6 | 7 | 8 | 9 | 10 | 11 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 121,036,246 | | 121,036,246 | | | | 30 |
| 31 | Intensive Care Unit | 24,868,507 | | 24,868,507 | | | | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 12,617,860 | | 12,617,860 | | | | 35 |
| 41 | Subprovider - IRF | 5,269,952 | | 5,269,952 | | | | 41 |
| 43 | Nursery | 5,421,672 | | 5,421,672 | | | | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | 113,781,919 | 123,303,486 | 237,085,405 | 0.207180 | 0.207180 | 0.207436 | 50 |
| 51 | Recovery Room | 8,763,335 | 12,256,359 | 21,019,694 | 0.145820 | 0.145820 | 0.145820 | 51 |
| 52 | Delivery Room & Labor Room | 15,337,216 | 1,183,194 | 16,520,410 | 0.268053 | 0.268053 | 0.268053 | 52 |
| 54 | Radiology-Diagnostic | 13,861,831 | 51,514,186 | 65,376,017 | 0.175447 | 0.175447 | 0.175674 | 54 |
| 55 | Radiology-Therapeutic | 921,538 | 184,744 | 1,106,282 | 0.719891 | 0.719891 | 0.719891 | 55 |
| 57 | CT Scan | 23,535,887 | 57,773,871 | 81,309,758 | 0.033289 | 0.033289 | 0.033289 | 57 |
| 58 | MRI | 4,878,648 | 1,707,178 | 6,585,826 | 0.085084 | 0.085084 | 0.085084 | 58 |
| 59 | Cardiac Catheterization | 27,675,000 | 37,258,575 | 64,933,575 | 0.236346 | 0.236346 | 0.236628 | 59 |
| 60 | Laboratory | 72,586,830 | 50,329,254 | 122,916,084 | 0.124893 | 0.124893 | 0.124893 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | 72,200,020 | 00,027,201 | 122,>10,001 | 0.12.055 | 0.12.055 | 0.1210/5 | 62.30 |
| 65 | Respiratory Therapy | 12,674,444 | 6,867,929 | 19,542,373 | 0.271409 | 0.271409 | 0.271409 | 65 |
| 66 | Physical Therapy | 5,952,758 | 10,192,399 | 16,145,157 | 0.322143 | 0.322143 | 0.322143 | 66 |
| 67 | Occupational Therapy | 4,332,289 | 1,485,906 | 5,818,195 | 0.219915 | 0.219915 | 0.219915 | 67 |
| 68 | Speech Pathology | 2,501,932 | 829,790 | 3,331,722 | 0.203790 | 0.203790 | 0.203790 | 68 |
| 69 | Electrocardiology Electrocardiology | 10,042,134 | 16,599,030 | 26,641,164 | 0.096403 | 0.096403 | 0.203790 | 69 |
| 71 | Medical Supplies Charged to Patients | 10,042,134 | 10,399,030 | 20,041,104 | 0.090403 | 0.090403 | 0.090410 | 71 |
| 72 | Impl. Dev. Charged to Patients | 62,592,419 | 23,843,813 | 86,436,232 | 0.375358 | 0.375358 | 0.375358 | 72 |
| 73 | Drugs Charged to Patients | 53,562,931 | 46,387,130 | 99,950,061 | 0.304706 | 0.373336 | 0.304706 | 73 |
| 74 | Renal Dialysis | 1,477,962 | 374.674 | 1,852,636 | 0.903241 | 0.903241 | 0.304706 | 74 |
| 76.97 | CARDIAC REHABILITATION | 1,477,962 | 3/4,0/4 | 1,832,030 | 0.903241 | 0.903241 | 0.903241 | 76.97 |
| | | 16,000 | 1 152 242 | 1 160 251 | 0.076590 | 0.076590 | 0.07(500 | |
| 76.98 76.99 | HYPERBARIC OXYGEN THERAPY | 16,008 | 1,153,243 | 1,169,251 | 0.076589 | 0.076589 | 0.076589 | 76.98 |
| /6.99 | LITHOTRIPSY OUTPA THENT SERVICE COST CENTERS | | | | | | | 76.99 |
| 90 | OUTPATIENT SERVICE COST CENTERS Clinic | | | | | | | 90 |
| 90.02 | | 418 | 505 924 | 506 242 | 0.224912 | 0.224912 | 0.224912 | 90.02 |
| | MOBILE MEDICAL UNIT | - | 595,824 | 596,242 | 0.224813 | 0.224813 | 0.224813 | |
| 90.03 | FAMILY MEDICINE CENTER | 547,892 | 2,768,973 | 3,316,865 | 0.568839 | 0.568839 | 0.568839 | 90.03 |
| 90.04 | WOUND HEALING CENTER | 62,729 | 5,286,907 | 5,349,636 | 0.366883 | 0.366883 | 0.366883 | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 106,070 | 5,222,615 | 5,328,685 | 0.271051 | 0.271051 | 0.271051 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 298 | 351,947 | 352,245 | 1.718060 | 1.718060 | 1.718060 | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 214.015 | 1 264 252 | 1 570 240 | 0.556204 | 0.556204 | 0.556204 | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 214,015 | 1,364,353 | 1,578,368 | 0.556394 | 0.556394 | 0.556394 | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | 15.500.100 | FF 222 0F- | ## 001 0#F | 0.212== | 0.212==5 | 0.24.405 | 90.10 |
| 91 | Emergency | 17,768,194 | 55,322,879 | 73,091,073 | 0.212778 | 0.212778 | 0.214902 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 2,577,723 | 4,884,788 | 7,462,511 | 0.920138 | 0.920138 | 0.920138 | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 200 | Subtotal (sum of lines 30 thru 199) | 624,986,657 | 519,043,047 | 1,144,029,704 | | | | 200 |
| 201 | Less Observation Beds | | | | | | | 201 |
| 202 | Total (line 200 minus line 201) | 624,986,657 | 519,043,047 | 1,144,029,704 | | | | 202 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

| | COST CENTER DESCRIPTIONS | Total Cost (Wkst B, Part I, | Capital Cost (Wkst B, Part II, | Operating Cost Net of Capital Cost | Capital Reduction | |
|-------|--------------------------------------|-----------------------------------|--------------------------------------|--|----------------------|-------|
| | | col. 26) | col. 26 | (col. 1 - col. 2) | | |
| | | 1 | 2 | 3 | 4 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | |
| 50 | Operating Room | 49,119,416 | 7,801,539 | 41,317,877 | | 50 |
| 51 | Recovery Room | 3,065,095 | 469,791 | 2,595,304 | | 51 |
| 52 | Delivery Room & Labor Room | 4,428,352 | 121,954 | 4,306,398 | | 52 |
| 54 | Radiology-Diagnostic | 11,470,046 | 1,960,951 | 9,509,095 | | 54 |
| 55 | Radiology-Therapeutic | 796,402 | 17,355 | 779,047 | | 55 |
| 57 | CT Scan | 2,706,754 | 298,111 | 2,408,643 | | 57 |
| 58 | MRI | 560,349 | 11,155 | 549,194 | | 58 |
| 59 | Cardiac Catheterization | 15,346,806 | 2,124,686 | 13,222,120 | | 59 |
| 60 | Laboratory | 15,351,378 | 524,295 | 14,827,083 | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | , | , , | | 62.30 |
| 65 | Respiratory Therapy | 5,303,981 | 570,089 | 4,733,892 | | 65 |
| 66 | Physical Therapy | 5,201,056 | 530,658 | 4,670,398 | | 66 |
| 67 | Occupational Therapy | 1,279,507 | 34,380 | 1,245,127 | | 67 |
| 68 | Speech Pathology | 678,970 | 17,978 | 660,992 | | 68 |
| 69 | Electrocardiology | 2,568,295 | 398,536 | 2,169,759 | | 69 |
| 71 | Medical Supplies Charged to Patients | ,,,,,,, | , | ,, | | 71 |
| 72 | Impl. Dev. Charged to Patients | 32,444,563 | 544,953 | 31,899,610 | | 72 |
| 73 | Drugs Charged to Patients | 30,455,379 | 1,374,215 | 29,081,164 | | 73 |
| 74 | Renal Dialysis | 1,673,377 | 166,003 | 1,507,374 | | 74 |
| 76.97 | CARDIAC REHABILITATION | 5,0.0,0 | | 3,000,000 | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 89,552 | 3,047 | 86,505 | | 76.98 |
| 76.99 | LITHOTRIPSY | 07,032 | 5,017 | 00,000 | | 76.99 |
| 70.77 | OUTPATIENT SERVICE COST CENTERS | | | | | 70.55 |
| 90 | Clinic | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 134,043 | 2,315 | 131,728 | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 1,886,763 | 62,710 | 1,824,053 | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 1,962,689 | 48,582 | 1,914,107 | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 1,444,347 | 227,290 | 1,217,057 | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 605,178 | 16,251 | 588,927 | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 1,031,068 | 23,749 | 1,007,319 | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 391,521 | 13,195 | 378,326 | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 878,195 | 23,338 | 854,857 | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | 1,223,960 | 32,090 | 1,191,870 | | 90.10 |
| 91 | Emergency | 15,552,201 | 2,969,101 | 12,583,100 | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 6,866,537 | 1,695,993 | 5,170,544 | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | 2,000,007 | -,,//0 | 2,2.2,011 | | 1- |
| 200 | Subtotal | 214,515,780 | 22,084,310 | 192,431,470 | | 200 |
| 201 | Less Observation Beds | 6,866,537 | 1,695,993 | 5,170,544 | | 201 |
| 202 | Total | 207.649.243 | 20.388.317 | 187,260,926 | | 202 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

| | COST CENTER DESCRIPTIONS | Operating Cost Reduction Amount | Cost Net of Capital and Operating Cost Reduction | Total Charges (Wkst C, Part I, col. 8) | Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7) | |
|-------|--|---------------------------------------|---|--|---|----------|
| | ANOTA A DAY OF DAY OF COOK OF STANFARD | 5 | 6 | / | 8 | |
| 50 | ANCILLARY SERVICE COST CENTERS | | 40 110 416 | 227 005 405 | 0.207100 | 50 |
| 50 | Operating Room | | 49,119,416 | 237,085,405 21,019,694 | 0.207180 0.145820 | 50 |
| 51 | Recovery Room | | 3,065,095 | | | 51 |
| 52 | Delivery Room & Labor Room | | 4,428,352 | 16,520,410 | 0.268053 | 52 |
| 54 | Radiology-Diagnostic | | 11,470,046 | 65,376,017 | 0.175447 | 54 |
| 55 | Radiology-Therapeutic | | 796,402 | 1,106,282 | 0.719891 | 55 |
| 57 | CT Scan | | 2,706,754 | 81,309,758 | 0.033289 | 57 |
| 58 | MRI | | 560,349 | 6,585,826 | 0.085084 | 58 |
| 59 | Cardiac Catheterization | | 15,346,806 | 64,933,575 | 0.236346 | 59 |
| 60 | Laboratory | | 15,351,378 | 122,916,084 | 0.124893 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | 62.30 |
| 65 | Respiratory Therapy | | 5,303,981 | 19,542,373 | 0.271409 | 65 |
| 66 | Physical Therapy | | 5,201,056 | 16,145,157 | 0.322143 | 66 |
| 67 | Occupational Therapy | | 1,279,507 | 5,818,195 | 0.219915 | 67 |
| 68 | Speech Pathology | | 678,970 | 3,331,722 | 0.203790 | 68 |
| 69 | Electrocardiology | | 2,568,295 | 26,641,164 | 0.096403 | 69 |
| 71 | Medical Supplies Charged to Patients | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | 32,444,563 | 86,436,232 | 0.375358 | 72 |
| 73 | Drugs Charged to Patients | | 30,455,379 | 99,950,061 | 0.304706 | 73 |
| 74 | Renal Dialysis | | 1,673,377 | 1,852,636 | 0.903241 | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | 89,552 | 1,169,251 | 0.076589 | 76.98 |
| 76.99 | LITHOTRIPSY | | · | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | |
| 90 | Clinic | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | | 134,043 | 596,242 | 0.224813 | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | | 1,886,763 | 3,316,865 | 0.568839 | 90.03 |
| 90.04 | WOUND HEALING CENTER | | 1,962,689 | 5,349,636 | 0.366883 | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | | 1,444,347 | 5,328,685 | 0.271051 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | | 605,178 | 352,245 | 1.718060 | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | 1.031.068 | ,210 | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | 391,521 | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | | 878,195 | 1,578,368 | 0.556394 | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | 1,223,960 | -,, | | 90.10 |
| 91 | Emergency | | 15,552,201 | 73,091,073 | 0.212778 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | 6,866,537 | 7,462,511 | 0.920138 | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | 0,000,337 | 7,402,311 | 0.220130 | <u> </u> |
| 200 | Subtotal | | 214,515,780 | 974,815,467 | | 200 |
| 201 | Less Observation Beds | | 6,866,537 | 7.462.511 | | 201 |
| 202 | Total | | 207,649,243 | 967,352,956 | | 202 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

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

| | | Capital Related Cost (from Wkst. B, Part II, (col. 26) | Swing Bed Adjust- ment | Reduced Capital Related Cost (col. 1 minus col. 2) | Total Patient Days | Per Diem (col. 3 ÷ col. 4) | Inpatient Program Days | Inpatient Program Capital Cost (col. 5 x col. 6) | |
|-----|---|--|---------------------------------|--|--------------------------|-------------------------------------|------------------------------|---|-----|
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | |
| 30 | Adults & Pediatrics General Routine Care) | 16,410,723 | | 16,410,723 | 59,199 | 277.21 | 22,230 | 6,162,378 | 30 |
| 31 | Intensive Care Unit | 2,065,024 | | 2,065,024 | 5,353 | 385.77 | 1,690 | 651,951 | 31 |
| 32 | Coronary Care Unit | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | 34 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 750,620 | | 750,620 | 3,691 | 203.36 | | | 35 |
| 40 | Subprovider - IPF | | | | | | | | 40 |
| 41 | Subprovider - IRF | 149,741 | | 149,741 | 2,806 | 53.36 | 1,545 | 82,441 | 41 |
| 42 | Subprovider I | | | | | | | | 42 |
| 43 | Nursery | 93,985 | | 93,985 | 4,262 | 22.05 | | | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | 45 |
| 200 | Total (lines 30-199) | 19,470,093 | | 19,470,093 | 75,311 | | 25,465 | 6,896,770 | 200 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0012

WORKSHEET D PART II

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

| | | Capital Related | Total Charges | Ratio of | | Capital | |
|-------|---------------------------------|----------------------|------------------|-----------|-------------|-----------|-------|
| | | Cost | (from | Cost to | Inpatient | Costs | |
| | | (from | Wkst. C, | Charges | Program | (col. 3 | |
| | | Wkst. B, | Part I, | (col. 1 ÷ | Charges | x col. 4) | |
| | | Part II (col. 26) | (col. 8) | col. 2) | | , | |
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50 | Operating Room | 7,801,539 | 237,085,405 | 0.032906 | 41,331,889 | 1,360,067 | 50 |
| 51 | Recovery Room | 469,791 | 21,019,694 | 0.022350 | 3,407,933 | 76,167 | 51 |
| 52 | Delivery Room & Labor Room | 121,954 | 16,520,410 | 0.007382 | 38,971 | 288 | 52 |
| 54 | Radiology-Diagnostic | 1,960,951 | 65,376,017 | 0.029995 | 5,906,729 | 177,172 | 54 |
| 55 | Radiology-Therapeutic | 17,355 | 1,106,282 | 0.015688 | 340,330 | 5,339 | 55 |
| 57 | CT Scan | 298,111 | 81,309,758 | 0.003666 | 10,185,397 | 37,340 | 57 |
| 58 | MRI | 11,155 | 6,585,826 | 0.001694 | 2,613,962 | 4,428 | 58 |
| 59 | Cardiac Catheterization | 2,124,686 | 64,933,575 | 0.032721 | 9,814,562 | 321,142 | 59 |
| 60 | Laboratory | 524,295 | 122,916,084 | 0.004265 | 29,966,487 | 127,807 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | 62.30 |
| 65 | Respiratory Therapy | 570,089 | 19,542,373 | 0.029172 | 5,418,139 | 158,058 | 65 |
| 66 | Physical Therapy | 530,658 | 16,145,157 | 0.032868 | 1,980,029 | 65,080 | 66 |
| 67 | Occupational Therapy | 34,380 | 5,818,195 | 0.005909 | 1,413,607 | 8,353 | 67 |
| 68 | Speech Pathology | 17,978 | 3,331,722 | 0.005396 | 734,224 | 3,962 | 68 |
| 69 | Electrocardiology | 398,536 | 26,641,164 | 0.014959 | 4,391,117 | 65,687 | 69 |
| 71 | Medical Supplies Charged to Pat | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 544,953 | 86,436,232 | 0.006305 | 23,899,213 | 150,685 | |
| 73 | Drugs Charged to Patients | 1,374,215 | 99,950,061 | 0.013749 | 20,298,215 | 279,080 | |
| 74 | Renal Dialysis | 166,003 | 1,852,636 | 0.089604 | 670,766 | 60,103 | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 3,047 | 1,169,251 | 0.002606 | 16,008 | 42 | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90 | Clinic | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 2,315 | 596,242 | 0.003883 | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 62,710 | 3,316,865 | 0.018906 | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 48,582 | 5,349,636 | 0.009081 | 34,255 | 311 | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 227,290 | 5,328,685 | 0.042654 | 104,084 | 4,440 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 16,251 | 352,245 | 0.046136 | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 23,749 | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 13,195 | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 23,338 | 1,578,368 | 0.014786 | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | 32,090 | | | | | 90.10 |
| 91 | Emergency | 2,969,101 | 73,091,073 | 0.040622 | 7,577,898 | 307,829 | 91 |
| 92 | Observation Beds (Non-Distinct | 1,695,993 | 7,462,511 | 0.227268 | 1,404,926 | 319,295 | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 200 | Total (sum of lines 50-199) | 22,084,310 | 974,815,467 | | 171,548,741 | 3,532,675 | 200 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

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

| | | Nursing School Post- Stepdown Adjustments | Nursing School | Allied Health Post- Stepdown Adjustments | Allied Health Cost | All Other Medical Education Cost | Swing-Bed Adjust- ment Amount (see instruct- ions) | Total Costs (sum of cols. 1 through 3 minus col 4.) | |
|-----|---|---|-------------------|--|--------------------------|---|--|---|-----|
| (A) | Cost Center Description | 1A | 1 | 2A | 2 | 3 | 4 | 5 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | |
| 30 | Adults & Pediatrics General Routine Care) | | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | | 31 |
| 32 | Coronary Care Unit | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | 34 |
| 35 | NEONATAL INTENSIVE CARE UNIT | | | | | | | | 35 |
| 40 | Subprovider - IPF | | | | | | | | 40 |
| 41 | Subprovider - IRF | | | | | | | | 41 |
| 42 | Subprovider I | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | 45 |
| 200 | TOTAL (lines 30-199) | | | | | | | | 200 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

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

| | | Total Patient Days | Per Diem (col. 5÷ col. 6) | Inpatient Program Days | Inpatient Program Pass- Through Cost (col. 7 x col. 8) | |
|-----|--|--------------------------|---------------------------------|------------------------------|--|-----|
| (A) | Cost Center Description | 6 | 7 | 8 | 9 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30 | Adults & Pediatrics | 59,199 | | 22,230 | | 30 |
| | (General Routine Care) | , | | | | |
| 31 | Intensive Care Unit | 5,353 | | 1,690 | | 31 |
| 32 | Coronary Care Unit | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | 34 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 3,691 | | | | 35 |
| 40 | Subprovider - IPF | | | | | 40 |
| 41 | Subprovider - IRF | 2,806 | | 1,545 | | 41 |
| 42 | Subprovider I | | | | | 42 |
| 43 | Nursery | 4,262 | | | | 43 |
| 44 | Skilled Nursing Facility | | | | | 44 |
| 45 | Nursing Facility | | | | | 45 |
| 200 | Total (lines 30-199) | 75,311 | | 25,465 | | 200 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

COMPONENT CCN: 15-0012

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

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

| | | Non Physician Anesth- etist Cost | Nursing School Post- Stepdown Adjustments | Nursing School | Allied Health Post- Stepdown Adjustments | Allied Health | All Other Medical Education Cost | Total Cost (sum of col. 1 through col. 4) | Total Outpatient Cost (sum of col. 2, 3, and 4) | |
|-------|---------------------------------|--|---|-------------------|--|------------------|---|---|---|-------|
| (A) | Cost Center Description | 1 | 2A | 2 | 3A | 3 | 4 | 5 | 6 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 50 | Operating Room | | | | | | | | | 50 |
| 51 | Recovery Room | | | | | | | | | 51 |
| 52 | Delivery Room & Labor Room | | | | | | | | | 52 |
| 54 | Radiology-Diagnostic | | | | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | | | | 55 |
| 57 | CT Scan | | | | | | | | | 57 |
| 58 | MRI | | | | | | | | | 58 |
| 59 | Cardiac Catheterization | | | | | | | | | 59 |
| 60 | Laboratory | | | | | | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | | | | | | | | | 65 |
| 66 | Physical Therapy | | | | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | | | 68 |
| 69 | Electrocardiology | | | | | | | | | 69 |
| 71 | Medical Supplies Charged to Pat | | | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | | | | | 72 |
| 73 | Drugs Charged to Patients | | | | | 344,301 | | 344,301 | 344,301 | 73 |
| 74 | Renal Dialysis | | | | | | | | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 90 | Clinic | | | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | | | | | | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | | | | | | | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | | | | | | | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | | | | | | | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | | | | | | | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | | | | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | | | | | | 90.10 |
| 91 | Emergency | | | | | 173,000 | | 173,000 | 173,000 | 91 |
| 92 | Observation Beds (Non-Distinct | | | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 200 | Total (sum of lines 50-199) | | | | | 517,301 | | 517,301 | 517,301 | 200 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

COMPONENT CCN: 15-0012

WORKSHEET D

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

IER PASS THROUGH COSTS
PART IV

 Check
 [] Title V
 [XX] Hospital
 [] SUB (Other)
 [] ICF/IID
 [XX] PPS

 Applicable
 [XX] Title XVIII, Part A
 [] IPF
 [] SNF
 [] TEFRA

 Boxes:
 [] Title XIX
 [] IRF
 [] NF
 [] Other

| | | Total Charges (from Wkst. C, Part I, col. 8) | Ratio of Cost to Charges (col. 5÷ col. 7) | Outpatient Ratio of Cost to Charges (col. 6÷ col. 7) | Inpatient Program Charges | Inpatient Program Pass- Through Costs (col. 8 x col. 10) | Outpatient Program Charges | Outpatient Program Pass- Through Costs (col. 9 x col. 12) | |
|-----------|---------------------------------|---|---|--|---------------------------------|--|----------------------------------|---|------------|
| (A) | Cost Center Description | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| 70 | ANCILLARY SERVICE COST CENTERS | 225 005 405 | | | 11 221 000 | | 22.050.052 | | T O |
| 50 | Operating Room | 237,085,405 | | | 41,331,889 | | 23,050,972 | | 50 |
| 51 | Recovery Room | 21,019,694 | | | 3,407,933 | | 2,370,466 | | 51 |
| 52 | Delivery Room & Labor Room | 16,520,410 | | | 38,971 | | 2,144 | | 52 |
| 54 | Radiology-Diagnostic | 65,376,017 | | | 5,906,729 | | 10,398,557 | | 54 |
| 55 | Radiology-Therapeutic | 1,106,282 | | | 340,330 | | 32,118 | | 55 |
| 57 | CT Scan | 81,309,758 | | | 10,185,397 | | 13,342,139 | | 57 |
| 58 | MRI | 6,585,826 | | | 2,613,962 | | 575,223 | | 58 |
| 59 | Cardiac Catheterization | 64,933,575 | | | 9,814,562 | | 12,826,404 | | 59 |
| 60 | Laboratory | 122,916,084 | | | 29,966,487 | | 8,862,328 | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 19,542,373 | | | 5,418,139 | | 1,407,120 | | 65 |
| 66 | Physical Therapy | 16,145,157 | | | 1,980,029 | | 143,619 | | 66 |
| 67 | Occupational Therapy | 5,818,195 | | | 1,413,607 | | 80,046 | | 67 |
| 68 | Speech Pathology | 3,331,722 | | | 734,224 | | 17,136 | | 68 |
| 69 | Electrocardiology | 26,641,164 | | | 4,391,117 | | 4,638,529 | | 69 |
| 71 | Medical Supplies Charged to Pat | | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 86,436,232 | | | 23,899,213 | | 6,696,903 | | 72 |
| 73 | Drugs Charged to Patients | 99,950,061 | 0.003445 | 0.003445 | 20,298,215 | 69,927 | 12,602,637 | 43,416 | |
| 74 | Renal Dialysis | 1,852,636 | | | 670,766 | | 133,039 | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 1,169,251 | | | 16,008 | | 755,711 | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 90 | Clinic | | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 596,242 | | | | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 3,316,865 | | | | | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 5,349,636 | | | 34,255 | | 2,126,392 | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 5,328,685 | | | 104,084 | | 1,499,811 | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 352,245 | | | | | 1,187 | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 1,578,368 | | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | | | | | 90.10 |
| 91 | Emergency | 73,091,073 | 0.002367 | 0.002367 | 7,577,898 | 17,937 | 9,476,860 | 22,432 | 91 |
| 92 | Observation Beds (Non-Distinct | 7,462,511 | | | 1,404,926 | | 1,290,299 | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 200 | Total (sum of lines 50-199) | 974,815,467 | | | 171,548,741 | 87,864 | 112,329,640 | 65,848 | 200 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0012 WORKSHEET D
PART V

 Check
 [] Title V - O/P
 [XX] Hospital
 [] SUB (Other)
 [] Swing Bed SNF

 Applicable
 [XX] Title XVIII, Part B
 [] IPF
 [] SNF
 [] Swing Bed NF

 Boxes:
 [] Title XIX - O/P
 [] IRF
 [] NF
 [] ICF/IID

| | | | | Program Charges | | | Program Cost | | |
|-------|--|----------|-------------|-----------------|----------|------------|--------------|----------|-------|
| | | | 1 | | Cost | T | | Cost | |
| | | C | | Cost | Reim- | | Cost | | |
| | | Cost to | DDG D : | Reim- | | | Reim- | Reim- | |
| | | Charge | PPS Reim- | bursed | bursed | PPS | bursed | bursed | |
| | | Ratio | bursed | Subject | Not | Services | Subject | Not | |
| | | (from | Services | to Ded. | Subject | (see | to Ded. | Subject | |
| | | Wkst C, | (see | & Coins. | to Ded. | inst.) | & Coins. | to Ded. | |
| | | Part I, | inst.) | (see | & Coins. | 11131.) | (see | & Coins. | |
| | | col. 9) | | inst.) | (see | | inst.) | (see | |
| | | | | mst.) | inst.) | | mst.) | inst.) | |
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 50 | Operating Room | 0.207180 | 23,050,972 | | 1,127 | 4,775,700 | | 233 | 50 |
| 51 | Recovery Room | 0.145820 | 2,370,466 | | | 345,661 | | | 51 |
| 52 | Delivery Room & Labor Room | 0.268053 | 2,144 | | | 575 | | | 52 |
| 54 | Radiology-Diagnostic | 0.175447 | 10,398,557 | | | 1,824,396 | | | 54 |
| 55 | Radiology-Therapeutic | 0.719891 | 32,118 | | | 23,121 | | | 55 |
| 57 | CT Scan | 0.033289 | 13,342,139 | | 10 | 444,146 | | | 57 |
| 58 | MRI | 0.085084 | 575,223 | | 20 | 48,942 | | 2 | 58 |
| 59 | Cardiac Catheterization | 0.236346 | 12,826,404 | | 27 | 3,031,469 | | 6 | 59 |
| 60 | Laboratory | 0.124893 | 8,862,328 | | | 1,106,843 | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | 01121070 | 0,002,020 | | | 2,200,010 | | | 62.30 |
| 65 | Respiratory Therapy | 0.271409 | 1,407,120 | | | 381,905 | | | 65 |
| 66 | Physical Therapy | 0.322143 | 143,619 | | | 46,266 | | | 66 |
| 67 | Occupational Therapy | 0.219915 | 80,046 | | | 17,603 | | | 67 |
| 68 | Speech Pathology | 0.203790 | 17,136 | | | 3,492 | | | 68 |
| 69 | Electrocardiology | 0.096403 | 4,638,529 | | | 447.168 | | | 69 |
| 71 | Medical Supplies Charged to Pat | 0.070403 | 4,030,327 | | | 447,100 | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 0.375358 | 6,696,903 | | | 2,513,736 | | | 72 |
| 73 | Drugs Charged to Patients | 0.304706 | 12,602,637 | | 80,070 | 3.840.099 | | 24,398 | 73 |
| 74 | Renal Dialysis | 0.903241 | 133,039 | | 78 | 120,166 | | 70 | 74 |
| 76.97 | CARDIAC REHABILITATION | 0.903241 | 133,039 | | /6 | 120,100 | | /0 | 76.97 |
| | | 0.076500 | 755 711 | | | 57,070 | | | |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 0.076589 | 755,711 | | | 57,879 | | | 76.98 |
| 76.99 | LITHOTRIPSY OUTPUT THENER GENERAL GEN | | | | | | | | 76.99 |
| -00 | OUTPATIENT SERVICE COST CENTERS | | | | | | | | 00 |
| 90 | Clinic MODIL E MEDICAL LINET | 0.224012 | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 0.224813 | | | | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 0.568839 | 2.126.222 | | 2.101 | 700.127 | | 600 | 90.03 |
| 90.04 | WOUND HEALING CENTER | 0.366883 | 2,126,392 | | 2,181 | 780,137 | | 800 | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 0.271051 | 1,499,811 | | | 406,525 | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 1.718060 | 1,187 | | | 2,039 | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 0.556394 | | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | | | | | 90.10 |
| 91 | Emergency | 0.212778 | 9,476,860 | | | 2,016,467 | | | 91 |
| 92 | Observation Beds (Non-Distinct | 0.920138 | 1,290,299 | | | 1,187,253 | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 200 | Subtotal (see instructions) | | 112,329,640 | | 83,513 | 23,421,588 | | 25,509 | 200 |
| 201 | Less PBP Clinic Lab. Services-Program Only Charges | | | | | | | | 201 |
| 202 | Net Charges (line 200 - line 201) | | 112,329,640 | | 83,513 | 23,421,588 | | 25,509 | 202 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T012

WORKSHEET D PART II

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

| | | Capital | Total | D. C C | | | |
|------------|---------------------------------|------------|--|-----------|-----------|-----------|-------|
| | | Related | Charges | Ratio of | | Capital | |
| | | Cost | (from | Cost to | Inpatient | Costs | |
| | | (from | Wkst. C, | Charges | Program | (col. 3 | |
| | | Wkst. B, | Part I, | (col. 1 ÷ | Charges | x col. 4) | |
| | | Part II | (col. 8) | col. 2) | | , | |
| | | (col. 26) | ` ′ | _ | | | |
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | |
| 7 0 | ANCILLARY SERVICE COST CENTERS | E 004 E00 | 225 005 405 | 0.022005 | 2.510 | 400 | # O |
| 50 | Operating Room | 7,801,539 | 237,085,405 | 0.032906 | 3,718 | 122 | 50 |
| 51 | Recovery Room | 469,791 | 21,019,694 | 0.022350 | 2 | | 51 |
| 52 | Delivery Room & Labor Room | 121,954 | 16,520,410 | 0.007382 | 12 | | 52 |
| 54 | Radiology-Diagnostic | 1,960,951 | 65,376,017 | 0.029995 | 22,843 | 685 | 54 |
| 55 | Radiology-Therapeutic | 17,355 | 1,106,282 | 0.015688 | | | 55 |
| 57 | CT Scan | 298,111 | 81,309,758 | 0.003666 | 27,153 | 100 | 57 |
| 58 | MRI | 11,155 | 6,585,826 | 0.001694 | 25,212 | 43 | |
| 59 | Cardiac Catheterization | 2,124,686 | 64,933,575 | 0.032721 | 3,927 | 128 | 59 |
| 60 | Laboratory | 524,295 | 122,916,084 | 0.004265 | 257,191 | 1,097 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | 62.30 |
| 65 | Respiratory Therapy | 570,089 | 19,542,373 | 0.029172 | 3,664 | 107 | 65 |
| 66 | Physical Therapy | 530,658 | 16,145,157 | 0.032868 | 872,313 | 28,671 | 66 |
| 67 | Occupational Therapy | 34,380 | 5,818,195 | 0.005909 | 773,424 | 4,570 | 67 |
| 68 | Speech Pathology | 17,978 | 3,331,722 | 0.005396 | 565,495 | 3,051 | 68 |
| 69 | Electrocardiology | 398,536 | 26,641,164 | 0.014959 | 176 | 3 | 69 |
| 71 | Medical Supplies Charged to Pat | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 544,953 | 86,436,232 | 0.006305 | | | 72 |
| 73 | Drugs Charged to Patients | 1,374,215 | 99,950,061 | 0.013749 | 164,959 | 2,268 | 73 |
| 74 | Renal Dialysis | 166,003 | 1,852,636 | 0.089604 | 6,370 | 571 | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 3,047 | 1,169,251 | 0.002606 | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90 | Clinic | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 2,315 | 596,242 | 0.003883 | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 62,710 | 3,316,865 | 0.018906 | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 48,582 | 5,349,636 | 0.009081 | 1.080 | 10 | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 227,290 | 5,328,685 | 0.042654 | 12 | 1 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 16,251 | 352,245 | 0.046136 | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 23,749 | ,210 | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 13,195 | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 23,338 | 1,578,368 | 0.014786 | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | 32,090 | 1,070,000 | 0.01.700 | | | 90.10 |
| 91 | Emergency | 2,969,101 | 73,091,073 | 0.040622 | 3,022 | 123 | 91 |
| 92 | Observation Beds (Non-Distinct | 2,,0,,101 | 7,462,511 | 0.0.0022 | 5,022 | 123 | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | 7,102,011 | | | | |
| 200 | Total (sum of lines 50-199) | 20,388,317 | 974,815,467 | | 2,730,573 | 41,550 | 200 |
| | 1 | 20,000,017 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | 2,,00,010 | 11,000 | |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T012 WORKSHEET D
PART IV

 Check
 [] Title V
 [] Hospital
 [] SUB (Other)
 [] ICF/IID
 [XX] PPS

 Applicable
 [XX] Title XVIII, Part A
 [] IPF
 [] SNF
 [] TEFRA

 Boxes:
 [] Title XIX
 [XX] IRF
 [] NF
 [] Other

| | | Non Physician | Nursing School | Nursing | Allied Health | A III: a J | All Other Medical | Total Cost (sum of | Total Outpatient Cost | |
|----------|---------------------------------|------------------|-------------------------|---------|-------------------------|------------------|----------------------|--------------------------|-----------------------------|----------|
| | | Anesth- | Post- | School | Post- | Allied Health | Education | col. 1 | (sum of | |
| | | etist Cost | Stepdown Adjustments | | Stepdown Adjustments | | Cost | through | col. 2, | |
| | | | , | | , | | | col. 4) | 3, and 4) | |
| (A) | Cost Center Description | 1 | 2A | 2 | 3A | 3 | 4 | 5 | 6 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 50 | Operating Room | | | | | | | | | 50 |
| 51 | Recovery Room | | | | | | | | | 51 |
| 52 | Delivery Room & Labor Room | | | | | | | | | 52 |
| 54 | Radiology-Diagnostic | | | | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | | | | 55 |
| 57 58 | CT Scan MRI | | | | | | | | | 57 58 |
| 58 | MRI Cardiac Catheterization | | | | | | | | | 58 |
| 60 | Laboratory | | | | | | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | | | | | | | | | 65 |
| 66 | Physical Therapy | | | | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | | | 68 |
| 69 | Electrocardiology | | | | | | | | | 69 |
| 71 | Medical Supplies Charged to Pat | | | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | | | | | 72 |
| 73 | Drugs Charged to Patients | | | | | 344,301 | | 344,301 | 344,301 | 73 |
| 74 | Renal Dialysis | | | | | 511,501 | | 311,501 | 511,501 | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 90 | Clinic | | | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | | | | | | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | | | | | | | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | | | | | | | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | | | | | | | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | | | | | | | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | | | | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | | | | | | 90.10 |
| 91 | Emergency | | | | | 173,000 | | 173,000 | 173,000 | 91 |
| 92 | Observation Beds (Non-Distinct | | | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 200 | Total (sum of lines 50-199) | | | | | 517,301 | | 517,301 | 517,301 | 200 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T012 WORKSHEET D
PART IV

 Check
 [] Title V
 [] Hospital
 [] SUB (Other)
 [] ICF/IID
 [XX] PPS

 Applicable
 [XX] Title XVIII, Part A
 [] IPF
 [] SNF
 [] TEFRA

 Boxes:
 [] Title XIX
 [XX] IRF
 [] NF
 [] Other

| | | Total Charges (from Wkst. C, Part I, col. 8) | Ratio of Cost to Charges (col. 5÷ col. 7) | Outpatient Ratio of Cost to Charges (col. 6÷ col. 7) | Inpatient Program Charges | Inpatient Program Pass- Through Costs (col. 8 x col. 10) | Outpatient Program Charges | Outpatient Program Pass- Through Costs (col. 9 x col. 12) | |
|-------|---------------------------------|---|---|--|---------------------------------|--|----------------------------------|---|-------|
| (A) | Cost Center Description | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 50 | Operating Room | 237,085,405 | | | 3,718 | | | | 50 |
| 51 | Recovery Room | 21,019,694 | | | 2 | | | | 51 |
| 52 | Delivery Room & Labor Room | 16,520,410 | | | 12 | | | | 52 |
| 54 | Radiology-Diagnostic | 65,376,017 | | | 22,843 | | | | 54 |
| 55 | Radiology-Therapeutic | 1,106,282 | | | | | | | 55 |
| 57 | CT Scan | 81,309,758 | | | 27,153 | | | | 57 |
| 58 | MRI | 6,585,826 | | | 25,212 | | | | 58 |
| 59 | Cardiac Catheterization | 64,933,575 | | | 3,927 | | | | 59 |
| 60 | Laboratory | 122,916,084 | | | 257,191 | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 19,542,373 | | | 3,664 | | | | 65 |
| 66 | Physical Therapy | 16,145,157 | | | 872,313 | | | | 66 |
| 67 | Occupational Therapy | 5,818,195 | | | 773,424 | | | | 67 |
| 68 | Speech Pathology | 3,331,722 | | | 565,495 | | | | 68 |
| 69 | Electrocardiology | 26,641,164 | | | 176 | | | | 69 |
| 71 | Medical Supplies Charged to Pat | | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 86,436,232 | | | | | | | 72 |
| 73 | Drugs Charged to Patients | 99,950,061 | 0.003445 | 0.003445 | 164,959 | 568 | | | 73 |
| 74 | Renal Dialysis | 1,852,636 | | | 6,370 | | | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 1,169,251 | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 90 | Clinic | | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 596,242 | | | | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 3,316,865 | | | | | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 5,349,636 | | | 1,080 | | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 5,328,685 | | | 12 | | 146 | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 352,245 | | | | | 6 | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 1,578,368 | | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | | | | | 90.10 |
| 91 | Emergency | 73,091,073 | 0.002367 | 0.002367 | 3,022 | 7 | | | 91 |
| 92 | Observation Beds (Non-Distinct | 7,462,511 | | | , | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 200 | Total (sum of lines 50-199) | 974,815,467 | | | 2,730,573 | 575 | 152 | | 200 |

⁽A) Worksheet A line numbers

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T012 WORKSHEET D PART V

 Check
 [] Title V - O/P
 [] Hospital
 [] SUB (Other)
 [] Swing Bed SNF

 Applicable
 [XX] Title XVIII, Part B
 [] IPF
 [] SNF
 [] Swing Bed NF

 Boxes:
 [] Title XIX - O/P
 [XX] IRF
 [] NF
 [] ICF/IID

| | | | | Program Charges | | | Program Cost | | |
|-------|--|---------------|-----------|-----------------|--------------|----------|--------------|----------|-------|
| | | | | Cont | Cost | | _ | Cost | |
| | | Cost to | | Cost | Reim- | | Cost | Reim- | |
| | | Charge | PPS Reim- | Reim- | bursed | | Reim- | bursed | |
| | | Ratio | bursed | bursed | Not | PPS | bursed | Not | |
| | | (from | Services | Subject | Subject | Services | Subject | Subject | |
| | | Wkst C, | (see | to Ded. | to Ded. | (see | to Ded. | to Ded. | |
| | | Part I, | inst.) | & Coins. | & Coins. | inst.) | & Coins. | & Coins. | |
| | | col. 9) | mst.) | (see | (see | | (see | (see | |
| | | COI. 9) | | inst.) | inst.) | | inst.) | inst.) | |
| (4) | Cont Control Description | 1 | 2 | 3 | 111St.) 4 | 5 | 6 | 7 | |
| (A) | Cost Center Description ANCILLARY SERVICE COST CENTERS | 1 | | 3 | 4 | 3 | 0 | / | |
| 50 | Operating Room | 0.207180 | | | | | | | 50 |
| 51 | Recovery Room | 0.207180 | | | | | | | 51 |
| | | | | | | | | | |
| 52 | Delivery Room & Labor Room | 0.268053 | | | | | | | 52 |
| 54 | Radiology-Diagnostic | 0.175447 | | | | | | | 54 |
| 55 | Radiology-Therapeutic | 0.719891 | | | | | | | 55 |
| 57 | CT Scan | 0.033289 | | | | | | | 57 |
| 58 | MRI | 0.085084 | | | | | | | 58 |
| 59 | Cardiac Catheterization | 0.236346 | | | | | | | 59 |
| 60 | Laboratory | 0.124893 | | | | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 0.271409 | | | | | | | 65 |
| 66 | Physical Therapy | 0.322143 | | | | | | | 66 |
| 67 | Occupational Therapy | 0.219915 | | | | | | | 67 |
| 68 | Speech Pathology | 0.203790 | | | | | | | 68 |
| 69 | Electrocardiology | 0.096403 | | | | | | | 69 |
| 71 | Medical Supplies Charged to Pat | | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 0.375358 | | | | | | | 72 |
| 73 | Drugs Charged to Patients | 0.304706 | | | | | | | 73 |
| 74 | Renal Dialysis | 0.903241 | | | | | | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 0.076589 | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 90 | Clinic | | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 0.224813 | | | | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 0.568839 | | | | | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 0.366883 | | | | | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 0.271051 | 146 | | | 40 | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 1.718060 | 6 | | | 10 | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 0.556394 | | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | | | | | 90.10 |
| 91 | Emergency | 0.212778 | | | | | | | 91 |
| 92 | Observation Beds (Non-Distinct | 0.920138 | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | 555 2 5 1 5 0 | | | | | | | |
| 200 | Subtotal (see instructions) | | 152 | | | 50 | | | 200 |
| 201 | Less PBP Clinic Lab. Services-Program Only Charges | | 132 | | | 30 | | | 201 |
| 202 | Net Charges (line 200 - line 201) | | 152 | | | 50 | | | 202 |
| | | | 102 | | | | | 1 | |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | 1 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

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

| | | Capital Related Cost (from Wkst. B, Part II, (col. 26) | Swing Bed Adjust- ment | Reduced Capital Related Cost (col. 1 minus col. 2) | Total Patient Days | Per Diem (col. 3 ÷ col. 4) | Inpatient Program Days | Inpatient Program Capital Cost (col. 5 x col. 6) | |
|-----|---|--|---------------------------------|--|--------------------------|-------------------------------------|------------------------------|---|-----|
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | |
| 30 | Adults & Pediatrics General Routine Care) | 16,410,723 | | 16,410,723 | 59,199 | 277.21 | 1,940 | 537,787 | 30 |
| 31 | Intensive Care Unit | 2,065,024 | | 2,065,024 | 5,353 | 385.77 | 631 | 243,421 | 31 |
| 32 | Coronary Care Unit | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | 34 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 750,620 | | 750,620 | 3,691 | 203.36 | 2,425 | 493,148 | 35 |
| 40 | Subprovider - IPF | | | | | | | | 40 |
| 41 | Subprovider - IRF | 149,741 | | 149,741 | 2,806 | 53.36 | 358 | 19,103 | 41 |
| 42 | Subprovider I | | | | | | | | 42 |
| 43 | Nursery | 93,985 | | 93,985 | 4,262 | 22.05 | 2,343 | 51,663 | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | 45 |
| 200 | Total (lines 30-199) | 19,470,093 | | 19,470,093 | 75,311 | | 7,697 | 1,345,122 | 200 |

⁽A) Worksheet A line numbers

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0012 WORKSHEET D
PART II

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

| | | Capital Related Cost (from Wkst. B, Part II (col. 26) | Total Charges (from Wkst. C, Part I, (col. 8) | Ratio of Cost to Charges (col. 1 ÷ col. 2) | Inpatient Program Charges | Capital Costs (col. 3 x col. 4) | |
|-------|---------------------------------|---|--|--|---------------------------------|--|-------|
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50 | Operating Room | 7,801,539 | 237,085,405 | 0.032906 | 13,888,778 | 457,024 | |
| 51 | Recovery Room | 469,791 | 21,019,694 | 0.022350 | 785,721 | 17,561 | 51 |
| 52 | Delivery Room & Labor Room | 121,954 | 16,520,410 | 0.007382 | | | 52 |
| 54 | Radiology-Diagnostic | 1,960,951 | 65,376,017 | 0.029995 | 2,217,662 | 66,519 | 54 |
| 55 | Radiology-Therapeutic | 17,355 | 1,106,282 | 0.015688 | 264,292 | 4,146 | |
| 57 | CT Scan | 298,111 | 81,309,758 | 0.003666 | 3,125,044 | 11,456 | |
| 58 | MRI | 11,155 | 6,585,826 | 0.001694 | 830,080 | 1,406 | |
| 59 | Cardiac Catheterization | 2,124,686 | 64,933,575 | 0.032721 | 3,305,458 | 108,158 | |
| 60 | Laboratory | 524,295 | 122,916,084 | 0.004265 | 11,293,330 | 48,166 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | 62.30 |
| 65 | Respiratory Therapy | 570,089 | 19,542,373 | 0.029172 | 2,519,203 | 73,490 | 65 |
| 66 | Physical Therapy | 530,658 | 16,145,157 | 0.032868 | 639,968 | 21,034 | |
| 67 | Occupational Therapy | 34,380 | 5,818,195 | 0.005909 | 447,086 | 2,642 | |
| 68 | Speech Pathology | 17,978 | 3,331,722 | 0.005396 | 284,297 | 1,534 | |
| 69 | Electrocardiology | 398,536 | 26,641,164 | 0.014959 | 1,253,857 | 18,756 | 69 |
| 71 | Medical Supplies Charged to Pat | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 544,953 | 86,436,232 | 0.006305 | | | 72 |
| 73 | Drugs Charged to Patients | 1,374,215 | 99,950,061 | 0.013749 | 455,968 | 6,269 | 73 |
| 74 | Renal Dialysis | 166,003 | 1,852,636 | 0.089604 | 145,533 | 13,040 | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 3,047 | 1,169,251 | 0.002606 | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90 | Clinic | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 2,315 | 596,242 | 0.003883 | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 62,710 | 3,316,865 | 0.018906 | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 48,582 | 5,349,636 | 0.009081 | 2,211 | 20 | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 227,290 | 5,328,685 | 0.042654 | 1,974 | 84 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 16,251 | 352,245 | 0.046136 | 298 | 14 | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 23,749 | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 13,195 | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 23,338 | 1,578,368 | 0.014786 | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | 32,090 | | | | | 90.10 |
| 91 | Emergency | 2,969,101 | 73,091,073 | 0.040622 | 2,643,646 | 107,390 | 91 |
| 92 | Observation Beds (Non-Distinct | 1,695,993 | 7,462,511 | 0.227268 | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 200 | Total (sum of lines 50-199) | 22,084,310 | 974,815,467 | | 44,104,406 | 958,709 | 200 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

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

| | | Nursing School Post- Stepdown Adjustments | Nursing School | Allied Health Post- Stepdown Adjustments | Allied Health Cost | All Other Medical Education Cost | Swing-Bed Adjust- ment Amount (see instruct- ions) | Total Costs (sum of cols. 1 through 3 minus col 4.) | |
|-----|---|---|-------------------|--|--------------------------|---|--|---|-----|
| (A) | Cost Center Description | 1A | 1 | 2A | 2 | 3 | 4 | 5 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | |
| 30 | Adults & Pediatrics General Routine Care) | | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | | 31 |
| 32 | Coronary Care Unit | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | 34 |
| 35 | NEONATAL INTENSIVE CARE UNIT | | | | | | | | 35 |
| 40 | Subprovider - IPF | | | | | | | | 40 |
| 41 | Subprovider - IRF | | | | | | | | 41 |
| 42 | Subprovider I | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | 45 |
| 200 | TOTAL (lines 30-199) | | | | | | | | 200 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

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

| | | Total Patient Days | Per Diem (col. 5÷ col. 6) | Inpatient Program Days | Inpatient Program Pass- Through Cost (col. 7 x col. 8) | |
|-----|--|--------------------------|---------------------------------|------------------------------|--|-----|
| (A) | Cost Center Description | 6 | 7 | 8 | 9 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30 | Adults & Pediatrics | 59,199 | | 1,940 | | 30 |
| 30 | (General Routine Care) | 39,199 | | 1,940 | | 30 |
| 31 | Intensive Care Unit | 5,353 | | 631 | | 31 |
| 32 | Coronary Care Unit | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | 34 |
| 35 | NEONATAL INTENSIVE CARE UNIT | 3,691 | | 2,425 | | 35 |
| 40 | Subprovider - IPF | | | | | 40 |
| 41 | Subprovider - IRF | 2,806 | | 358 | | 41 |
| 42 | Subprovider I | | | | | 42 |
| 43 | Nursery | 4,262 | | 2,343 | | 43 |
| 44 | Skilled Nursing Facility | | | | | 44 |
| 45 | Nursing Facility | | | | | 45 |
| 200 | Total (lines 30-199) | 75,311 | | 7,697 | | 200 |

⁽A) Worksheet A line numbers

| - - | In Lieu of Form | Period: | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0012 WORKSHEET D
PART IV

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

| | | Non Physician Anesth- etist Cost | Nursing School Post- Stepdown Adjustments | Nursing School | Allied Health Post- Stepdown Adjustments | Allied Health | All Other Medical Education Cost | Total Cost (sum of col. 1 through col. 4) | Total Outpatient Cost (sum of col. 2, 3, and 4) | |
|------------|---------------------------------|--|---|-------------------|--|------------------|---|---|---|-------|
| (A) | Cost Center Description | 1 | 2A | 2 | 3A | 3 | 4 | 5 | 6 | |
| 7 0 | ANCILLARY SERVICE COST CENTERS | | | | | | | | | - |
| 50 | Operating Room | | | | | | | | | 50 |
| 51 | Recovery Room | | | | | | | | | 51 |
| 52 | Delivery Room & Labor Room | | | | | | | | | 52 |
| 54 | Radiology-Diagnostic | | | | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | | | | 55 |
| 57 | CT Scan | | | | | | | | | 57 |
| 58 | MRI | | | | | | | | | 58 |
| 59 | Cardiac Catheterization | | | | | | | | | 59 |
| 60 | Laboratory | | | | | | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | | | | | | | | | 65 |
| 66 | Physical Therapy | | | | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | | | 68 |
| 69 | Electrocardiology | | | | | | | | | 69 |
| 71 | Medical Supplies Charged to Pat | | | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | | | | | 72 |
| 73 | Drugs Charged to Patients | | | | | 344,301 | | 344,301 | 344,301 | 73 |
| 74 | Renal Dialysis | | | | | | | | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 90 | Clinic | | | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | | | | | | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | | | | | | | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | | | | | | | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | | | | | | | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | | | | | | | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | | | | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | | | | | | 90.10 |
| 91 | Emergency | | | | | 173,000 | | 173,000 | 173,000 | 91 |
| 92 | Observation Beds (Non-Distinct | | | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 200 | Total (sum of lines 50-199) | | | | | 517,301 | | 517,301 | 517,301 | 200 |

⁽A) Worksheet A line numbers

Applicable Boxes:

| | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0012

WORKSHEET D PART IV

| | | Total Charges (from Wkst. C, Part I, col. 8) | Ratio of Cost to Charges (col. 5÷ col. 7) | Outpatient Ratio of Cost to Charges (col. 6÷ col. 7) | Inpatient Program Charges | Inpatient Program Pass- Through Costs (col. 8 x col. 10) | Outpatient Program Charges | Outpatient Program Pass- Through Costs (col. 9 x col. 12) | |
|------------|---------------------------------|---|---|--|---------------------------------|--|----------------------------------|---|-------|
| (A) | Cost Center Description | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| # 0 | ANCILLARY SERVICE COST CENTERS | 225 005 405 | | | 4.2.000 550 | | | | #O |
| 50 | Operating Room | 237,085,405 | | | 13,888,778 | | | | 50 |
| 51 | Recovery Room | 21,019,694 | | | 785,721 | | | | 51 |
| 52 | Delivery Room & Labor Room | 16,520,410 | | | 2.245.442 | | | | 52 |
| 54 | Radiology-Diagnostic | 65,376,017 | | | 2,217,662 | | | | 54 |
| 55 | Radiology-Therapeutic | 1,106,282 | | | 264,292 | | | | 55 |
| 57 | CT Scan | 81,309,758 | | | 3,125,044 | | | | 57 |
| 58 | MRI | 6,585,826 | | | 830,080 | | | | 58 |
| 59 | Cardiac Catheterization | 64,933,575 | | | 3,305,458 | | | | 59 |
| 60 | Laboratory | 122,916,084 | | | 11,293,330 | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 19,542,373 | | | 2,519,203 | | | | 65 |
| 66 | Physical Therapy | 16,145,157 | | | 639,968 | | | | 66 |
| 67 | Occupational Therapy | 5,818,195 | | | 447,086 | | | | 67 |
| 68 | Speech Pathology | 3,331,722 | | | 284,297 | | | | 68 |
| 69 | Electrocardiology | 26,641,164 | | | 1,253,857 | | | | 69 |
| 71 | Medical Supplies Charged to Pat | | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 86,436,232 | | | | | | | 72 |
| 73 | Drugs Charged to Patients | 99,950,061 | 0.003445 | 0.003445 | 455,968 | 1,571 | | | 73 |
| 74 | Renal Dialysis | 1,852,636 | | | 145,533 | | | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 1,169,251 | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 90 | Clinic | | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 596,242 | | | | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 3,316,865 | | | | | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 5,349,636 | | | 2,211 | | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 5,328,685 | | | 1,974 | | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 352,245 | | | 298 | | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | , , , , | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 1,578,368 | | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | -,, | | | | | | | 90.10 |
| 91 | Emergency | 73,091,073 | 0.002367 | 0.002367 | 2,643,646 | 6,258 | | | 91 |
| 92 | Observation Beds (Non-Distinct | 7.462.511 | | | _,, | 5,200 | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | 7,102,311 | | | | | | | 1 |
| 200 | Total (sum of lines 50-199) | 974.815.467 | | | 44,104,406 | 7,829 | | | 200 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0012 WORKSHEET D PART V

 Check
 [] Title V - O/P
 [XX] Hospital
 [] SUB (Other)
 [] Swing Bed SNF

 Applicable
 [] Title XVIII, Part B
 [] IPF
 [] SNF
 [] Swing Bed NF

 Boxes:
 [XX] Title XIX - O/P
 [] IRF
 [] NF
 [] ICF/IID

| | | | | Program Charges | , | | Program Cost | | |
|-------|--|----------|-----------|-----------------|--|----------|--------------|----------|-------|
| | | | | | Cost | | | Cost | _ |
| | | Contro | | Cost | | | Cost | | |
| | | Cost to | ppg p | Reim- | Reim- | | Reim- | Reim- | |
| | | Charge | PPS Reim- | bursed | bursed | PPS | bursed | bursed | |
| | | Ratio | bursed | Subject | Not | Services | Subject | Not | |
| | | (from | Services | to Ded. | Subject | | 3 | Subject | |
| | | Wkst C, | (see | | to Ded. | (see | to Ded. | to Ded. | |
| | | Part I, | inst.) | & Coins. | & Coins. | inst.) | & Coins. | & Coins. | |
| | | col. 9) | 111001) | (see | (see | | (see | (see | |
| | | coi.)) | | inst.) | inst.) | | inst.) | inst.) | |
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 50 | Operating Room | 0.207180 | | | | | | | 50 |
| 51 | Recovery Room | 0.145820 | | | | | | | 51 |
| 52 | Delivery Room & Labor Room | 0.268053 | | | | | | | 52 |
| | | | | | | | | | 54 |
| 54 | Radiology-Diagnostic | 0.175447 | | | - | | | | |
| 55 | Radiology-Therapeutic | 0.719891 | | | | | | | 55 |
| 57 | CT Scan | 0.033289 | | | | | | | 57 |
| 58 | MRI | 0.085084 | | | | | | | 58 |
| 59 | Cardiac Catheterization | 0.236346 | | | | | | | 59 |
| 60 | Laboratory | 0.124893 | | | | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 0.271409 | | | | | | | 65 |
| 66 | Physical Therapy | 0.322143 | | | | | | | 66 |
| 67 | Occupational Therapy | 0.219915 | | | | | | | 67 |
| 68 | Speech Pathology | 0.203790 | | | | | | | 68 |
| 69 | Electrocardiology | 0.096403 | | | | | | | 69 |
| 71 | Medical Supplies Charged to Pat | 0.070.05 | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 0.375358 | | | | | | | 72 |
| 73 | Drugs Charged to Patients | 0.304706 | | | | | | | 73 |
| 74 | Renal Dialysis | 0.903241 | | | | | | | 74 |
| 76.97 | CARDIAC REHABILITATION | 0.903241 | | | | | | | 76.97 |
| | | 0.076590 | | | | | | | |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 0.076589 | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | - |
| 90 | Clinic | | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 0.224813 | | | | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 0.568839 | | | | | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 0.366883 | | | | | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 0.271051 | | | | | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 1.718060 | | | | | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 0.556394 | | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | 0.000074 | | | | | | | 90.10 |
| 91 | Emergency | 0.212778 | | | | | | | 91 |
| 92 | Observation Beds (Non-Distinct | 0.920138 | | | | | | | 92 |
| 74 | OTHER REIMBURSABLE COST CENTERS | 0.920136 | | | | | | | 74 |
| 200 | Subtotal (see instructions) | | | | | | | | 200 |
| | | | | | - | | | - | |
| 201 | Less PBP Clinic Lab. Services-Program Only Charges | | | | | | | | 201 |
| 202 | Net Charges (line 200 - line 201) | | | | | | l | | 202 |

⁽A) Worksheet A line numbers

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T012

WORKSHEET D PART II

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

| | | Capital | Total | | | | |
|-------|--|-----------------|-------------|-----------|-----------|-----------|-------|
| | | Related | Charges | Ratio of | | Capital | |
| | | Cost | (from | Cost to | Inpatient | Costs | |
| | | (from | Wkst. C, | Charges | Program | (col. 3 | |
| | | Wkst. B, | Part I, | (col. 1 ÷ | Charges | x col. 4) | |
| | | Part II | | col. 2) | | X COL 4) | |
| | | (col. 26) | (col. 8) | | | | |
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50 | Operating Room | 7,801,539 | 237,085,405 | 0.032906 | | | 50 |
| 51 | Recovery Room | 469,791 | 21,019,694 | 0.022350 | | | 51 |
| 52 | Delivery Room & Labor Room | 121,954 | 16,520,410 | 0.007382 | | | 52 |
| 54 | Radiology-Diagnostic | 1,960,951 | 65,376,017 | 0.029995 | | | 54 |
| 55 | Radiology-Therapeutic | 17,355 | 1,106,282 | 0.015688 | | | 55 |
| 57 | CT Scan | 298,111 | 81,309,758 | 0.003666 | | | 57 |
| 58 | MRI | 11,155 | 6,585,826 | 0.001694 | | | 58 |
| 59 | Cardiac Catheterization | 2,124,686 | 64,933,575 | 0.032721 | | | 59 |
| 60 | Laboratory | 524,295 | 122,916,084 | 0.004265 | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | , in the second | | | | | 62.30 |
| 65 | Respiratory Therapy | 570,089 | 19,542,373 | 0.029172 | | | 65 |
| 66 | Physical Therapy | 530,658 | 16,145,157 | 0.032868 | | | 66 |
| 67 | Occupational Therapy | 34,380 | 5,818,195 | 0.005909 | | | 67 |
| 68 | Speech Pathology | 17,978 | 3,331,722 | 0.005396 | | | 68 |
| 69 | Electrocardiology | 398,536 | 26,641,164 | 0.014959 | | | 69 |
| 71 | Medical Supplies Charged to Pat | 0.0,000 | | 0.02.0,00 | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 544,953 | 86,436,232 | 0.006305 | | | 72 |
| 73 | Drugs Charged to Patients | 1,374,215 | 99,950,061 | 0.013749 | | | 73 |
| 74 | Renal Dialysis | 166,003 | 1,852,636 | 0.089604 | | | 74 |
| 76.97 | CARDIAC REHABILITATION | 100,003 | 1,002,000 | 0.00,001 | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 3.047 | 1,169,251 | 0.002606 | | | 76.98 |
| 76.99 | LITHOTRIPSY | 3,047 | 1,107,251 | 0.002000 | | | 76.99 |
| 10.77 | OUTPATIENT SERVICE COST CENTERS | | | | | | 70.77 |
| 90 | Clinic | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 2,315 | 596,242 | 0.003883 | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 62,710 | 3,316,865 | 0.018906 | | | 90.03 |
| 90.03 | WOUND HEALING CENTER | 48,582 | 5,349,636 | 0.009081 | | | 90.03 |
| 90.04 | OUTPATIENT TREATMENT & INFUSION | 227,290 | 5,328,685 | 0.042654 | | | 90.04 |
| 90.05 | PEDIATRIC SPECIALTY CLINIC | 16,251 | 352,245 | 0.042034 | | | 90.05 |
| 90.00 | SPORTS MED FELLOWSHIP CLINIC | 23,749 | 332,243 | 0.040130 | | | 90.00 |
| 90.07 | PODIATRY RESIDENCY CLINIC | 13,195 | | | | | 90.07 |
| 90.08 | FACULTY PRACTICE CLINIC | 23,338 | 1,578,368 | 0.014786 | | | 90.08 |
| 90.09 | OUR LADY OF ROSARY CLINIC | 32,090 | 1,570,308 | 0.014/80 | | | 90.09 |
| 90.10 | | 2,969,101 | 73,091,073 | 0.040622 | | | 90.10 |
| 91 | Emergency Observation Beds (Non-Distinct | 2,969,101 | | 0.040622 | | | 91 |
| 92 | | | 7,462,511 | | | | 92 |
| 200 | OTHER REIMBURSABLE COST CENTERS | 20 200 217 | 074.015.467 | | | | 200 |
| 200 | Total (sum of lines 50-199) | 20,388,317 | 974,815,467 | | | | 200 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T012 WORKSHEET D
PART IV

 Check
 [] Title V
 [] Hospital
 [] SUB (Other)
 [] ICF/IID
 [XX] PPS

 Applicable
 [] Title XVIII, Part A
 [] IPF
 [] SNF
 [] TEFRA

 Boxes:
 [XX] Title XIX
 [XX] IRF
 [] NF
 [] Other

| | | Non Physician Anesth- etist Cost | Nursing School Post- Stepdown Adjustments | Nursing School | Allied Health Post- Stepdown Adjustments | Allied Health | All Other Medical Education Cost | Total Cost (sum of col. 1 through col. 4) | Total Outpatient Cost (sum of col. 2, 3, and 4) | |
|-------|---------------------------------|--|---|-------------------|--|------------------|---|---|---|-------|
| (A) | Cost Center Description | 1 | 2A | 2 | 3A | 3 | 4 | 5 | 6 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 50 | Operating Room | | | | | | | | | 50 |
| 51 | Recovery Room | | | | | | | | | 51 |
| 52 | Delivery Room & Labor Room | | | | | | | | | 52 |
| 54 | Radiology-Diagnostic | | | | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | | | | 55 |
| 57 | CT Scan | | | | | | | | | 57 |
| 58 | MRI | | | | | | | | | 58 |
| 59 | Cardiac Catheterization | | | | | | | | | 59 |
| 60 | Laboratory | | | | | | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | | | | | | | | | 65 |
| 66 | Physical Therapy | | | | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | | | 68 |
| 69 | Electrocardiology | | | | | | | | | 69 |
| 71 | Medical Supplies Charged to Pat | | | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | | | | | 72 |
| 73 | Drugs Charged to Patients | | | | | 344,301 | | 344,301 | 344,301 | 73 |
| 74 | Renal Dialysis | | | | | | | | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 90 | Clinic | | | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | | | | | | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | | | | | | | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | | | | | | | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | | | | | | | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | | | | | | | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | | | | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | | | | | | 90.10 |
| 91 | Emergency | | | | | 173,000 | | 173,000 | 173,000 | 91 |
| 92 | Observation Beds (Non-Distinct | | | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 200 | Total (sum of lines 50-199) | | | | | 517,301 | | 517,301 | 517,301 | 200 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T012 WORKSHEET D
PART IV

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

| | | Total Charges (from Wkst. C, Part I, col. 8) | Ratio of Cost to Charges (col. 5÷ col. 7) | Outpatient Ratio of Cost to Charges (col. 6÷ col. 7) | Inpatient Program Charges | Inpatient Program Pass- Through Costs (col. 8 x col. 10) | Outpatient Program Charges | Outpatient Program Pass- Through Costs (col. 9 x col. 12) | |
|-------|---------------------------------|---|---|--|---------------------------------|--|----------------------------------|---|-------|
| (A) | Cost Center Description | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | - |
| 50 | Operating Room | 237,085,405 | | | | | | | 50 |
| 51 | Recovery Room | 21,019,694 | | | | | | | 51 |
| 52 | Delivery Room & Labor Room | 16,520,410 | | | | | | | 52 |
| 54 | Radiology-Diagnostic | 65,376,017 | | | | | | | 54 |
| 55 | Radiology-Therapeutic | 1,106,282 | | | | | | | 55 |
| 57 | CT Scan | 81,309,758 | | | | | | | 57 |
| 58 | MRI | 6,585,826 | | | | | | | 58 |
| 59 | Cardiac Catheterization | 64,933,575 | | | | | | | 59 |
| 60 | Laboratory | 122,916,084 | | | | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 19,542,373 | | | | | | | 65 |
| 66 | Physical Therapy | 16,145,157 | | | | | | | 66 |
| 67 | Occupational Therapy | 5,818,195 | | | | | | | 67 |
| 68 | Speech Pathology | 3,331,722 | | | | | | | 68 |
| 69 | Electrocardiology | 26,641,164 | | | | | | | 69 |
| 71 | Medical Supplies Charged to Pat | | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 86,436,232 | | | | | | | 72 |
| 73 | Drugs Charged to Patients | 99,950,061 | 0.003445 | 0.003445 | | | | | 73 |
| 74 | Renal Dialysis | 1,852,636 | | | | | | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 1,169,251 | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 90 | Clinic | | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 596,242 | | | | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 3,316,865 | | | | | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 5,349,636 | | | | | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 5,328,685 | | | | | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 352,245 | | | | | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 1,578,368 | | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | 2,2 : 3,5 00 | | | | | | | 90.10 |
| 91 | Emergency | 73,091,073 | 0.002367 | 0.002367 | | | | | 91 |
| 92 | Observation Beds (Non-Distinct | 7,462,511 | 0.002307 | 0.002507 | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | 7,102,511 | | | | | | | 1 |
| 200 | Total (sum of lines 50-199) | 974.815.467 | | | | | | | 200 |
| | | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | | , =00 |

⁽A) Worksheet A line numbers

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T012 WORKSHEET D PART V

 Check
 [] Title V - O/P
 [] Hospital
 [] SUB (Other)
 [] Swing Bed SNF

 Applicable
 [] Title XVIII, Part B
 [] IPF
 [] SNF
 [] Swing Bed NF

 Boxes:
 [XX] Title XIX - O/P
 [XX] IRF
 [] NF
 [] ICF/IID

| | | | | P. G. | | I | | | |
|----------|--|-------------------------------------|---------------------------------|------------------------------------|---|-----------------|------------------------------------|-------------------------------|----------|
| | | | | Program Charges | | | Program Cost | | + |
| | | Cost to Charge Ratio (from | PPS Reim- bursed Services | Cost Reim- bursed Subject | Cost Reim- bursed Not Subject | PPS Services | Cost Reim- bursed Subject | Cost Reim- bursed Not Subject | |
| | | Wkst C, Part I, col. 9) | (see inst.) | to Ded. & Coins. (see | to Ded. & Coins. (see | (see inst.) | to Ded. & Coins. (see | to Ded. & Coins. (see | |
| | | | | inst.) | inst.) | | inst.) | inst.) | |
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | ANCILLARY SERVICE COST CENTERS | 0.005400 | | | | | | | |
| 50 | Operating Room | 0.207180 | | | | | | | 50 |
| 51 | Recovery Room | 0.145820 | | | | | | | 51 |
| 52 | Delivery Room & Labor Room | 0.268053 | | | | | | | 52 |
| 54 | Radiology-Diagnostic | 0.175447 | | | | | | | 54 |
| 55 | Radiology-Therapeutic | 0.719891 | | | | | | | 55 |
| 57 | CT Scan | 0.033289 | | | | | | | 57 |
| 58 59 | MRI Cardiac Catheterization | 0.085084 | | | | | | | 58 59 |
| 60 | Laboratory | 0.236346 0.124893 | | | | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | 0.124893 | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 0.271409 | | | | | | | 65 |
| 66 | Physical Therapy | 0.322143 | | | | | | | 66 |
| 67 | Occupational Therapy | 0.322143 | | | | | | | 67 |
| 68 | Speech Pathology | 0.203790 | | | | | | | 68 |
| 69 | Electrocardiology | 0.096403 | | | | | | | 69 |
| 71 | Medical Supplies Charged to Pat | 0.090403 | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 0.375358 | | | | | | | 72 |
| 73 | Drugs Charged to Patients | 0.304706 | | | | | | | 73 |
| 74 | Renal Dialysis | 0.903241 | | | | | | | 74 |
| 76.97 | CARDIAC REHABILITATION | 0.903241 | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 0.076589 | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | 0.070207 | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 90 | Clinic | | | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 0.224813 | | | | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 0.568839 | | | | | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 0.366883 | | | | | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 0.271051 | | | | | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 1.718060 | | | | | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 0.556394 | | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | | | | | 90.10 |
| 91 | Emergency | 0.212778 | | | | | | | 91 |
| 92 | Observation Beds (Non-Distinct | 0.920138 | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 200 | Subtotal (see instructions) | | | | | | | | 200 |
| 201 | Less PBP Clinic Lab. Services-Program Only Charges | | | ļ | | | | | 201 |
| 202 | Net Charges (line 200 - line 201) | | | | | | | | 202 |

⁽A) Worksheet A line numbers

| - | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

WORKSHEET D-1 PART I COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-0012

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

| PA | RT I - ALL PROVIDER COMPONENTS | | |
|----|---|------------|----|
| | INPATIENT DAYS | | |
| 1 | Inpatient days (including private room days and swing-bed days, excluding newborn) | 59,199 | 1 |
| 2 | Inpatient days (including private room days, excluding swing-bed and newborn days) | 59,199 | 2 |
| | Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line. | | 3 |
| 4 | Semi-private room days (excluding swing-bed private room days) | 53,081 | 4 |
| 5 | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period | | 5 |
| 6 | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 6 |
| 7 | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period | | 7 |
| 8 | Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 8 |
| 9 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) | 22,230 | 9 |
| 10 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) | | 10 |
| 11 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 11 |
| 12 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period | | 12 |
| 13 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 13 |
| 14 | Medically necessary private room days applicable to the program (excluding swing-bed days) | | 14 |
| 15 | Total nursery days (title V or XIX only) | | 15 |
| 16 | Nursery days (title V or XIX only) | | 16 |
| | SWING-BED ADJUSTMENT | | |
| 17 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period | | 17 |
| 18 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period | | 18 |
| 19 | Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period | | 19 |
| 20 | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period | | 20 |
| 21 | Total general inpatient routine service cost (see instructions) | 66,441,749 | 21 |
| 22 | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) | | 22 |
| 23 | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) | | 23 |
| 24 | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) | | 24 |
| 25 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) | | 25 |
| 26 | Total swing-bed cost (see instructions) | | 26 |
| 27 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 66,441,749 | 27 |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | |
| 28 | General inpatient routine service charges (excluding swing-bed and observation bed charges) | | 28 |
| 29 | Private room charges (excluding swing-bed charges) | | 29 |
| 30 | Semi-private room charges (excluding swing-bed charges) | | 30 |
| 31 | General inpatient routine service cost/charge ratio (line 27 ÷ line 28) | | 31 |
| 32 | Average private room per diem charge (line 29 ÷ line 3) | | 32 |
| 33 | Average semi-private room per diem charge (line 30 ÷ line 4) | | 33 |
| 34 | Average per diem private room charge differential (line 32 minus line 33) (see instructions) | | 34 |
| 35 | Average per diem private room cost differential (line 34 x line 31) | | 35 |
| 36 | Private room cost differential adjustment (line 3 x line 35) | | 36 |
| 37 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) | 66,441,749 | 37 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-0012 WORKSHEET D-1 PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

| | PROGRAM INPATIENT OPERATING COST BEFORE PASS-T | THROUGH COS | T ADJUSTME | NTS | | 1 | |
|----|--|----------------------|--------------------|-------------------|------------------|------------------------|-----|
| 38 | Adjusted general inpatient routine service cost per diem (see instructions) | | | | | 1,122.35 | |
| 39 | Program general inpatient routine service cost (line 9 x line 38) | | | | | 24,949,841 | 39 |
| 40 | Medically necessary private room cost applicable to the Program (line 14 x line 35) | | | | | | 40 |
| 41 | Total Program general inpatient routine service cost (line 39 + line 40) | | | | | | 41 |
| | | Total | Total | Average | | Program | |
| | | Inpatient | Inpatient | Per Diem | Program | Cost | |
| | | Cost | Days | (col. 1 ÷ | Days | (col. 3 x | |
| | | | | col. 2) | | col. 4) | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 42 | Nursery (Titles V and XIX only) | | | | | | 42 |
| | Intensive Care Type Inpatient Hospital Units | | | | | | |
| 43 | Intensive Care Unit | 10,646,535 | 5,353 | 1,988.89 | 1,690 | 3,361,224 | |
| 44 | Coronary Care Unit | | | | | | 44 |
| 45 | Burn Intensive Care Unit | | | | | | 45 |
| 46 | Surgical Intensive Care Unit | 7 404 540 | 2 (04 | 4 40 4 55 | | | 46 |
| 47 | NEONATAL INTENSIVE CARE UNIT | 5,191,649 | 3,691 | 1,406.57 | | | 47 |
| 10 | D 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | | | | 1 | 1.0 |
| 48 | Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) | | | | | 38,707,353 | |
| 49 | Total program inpatient costs (sum of lines 41 through 48)(see instructions) | ED TOPO | | | | 67,018,418 | 49 |
| 50 | PASS THROUGH COST ADJUSTM | | | | | 6.014.220 | 50 |
| 50 | Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I a | | | | | 6,814,329 3,620,539 | |
| 52 | Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I Total Program excludable cost (sum of lines 50 and 51) | I and IV) | | | | 10,434,868 | |
| 53 | Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medi | | to (line 10 minus | line 52) | | 56,583,550 | |
| 33 | TARGET AMOUNT AND LIMIT COMI | | ts (line 49 minus | iiie 32) | | 30,383,330 | 33 |
| 54 | Program discharges | | | | | | 54 |
| 55 | Target amount per discharge | | | | | | 55 |
| 56 | Target amount (line 54 x line 55) | | | | | | 56 |
| 57 | Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) | | | | | | 57 |
| 58 | Bonus payment (see instructions) | | | | | | 58 |
| 59 | Lesser of line 53 - line 54 or line 55 from the cost reporting period ending 1996, updated and comp | pounded by the ma | arket basket. | | | | 59 |
| 60 | Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket. | • | | | | | 60 |
| 61 | If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by | which operating co | osts (line 53) are | less than expecte | d costs (line 54 | | 61 |
| 61 | x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions) | | | | | | 61 |
| 62 | Relief payment (see instructions) | | | | | | 62 |
| 63 | Allowable Inpatient cost plus incentive payment (see instructions) | | | | | | 63 |
| | PROGRAM INPATIENT ROUTINE SWIN | | | | | | |
| 64 | Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period | | | <i>i</i>) | | | 64 |
| 65 | Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (Se | | tle XVIII only) | | | | 65 |
| 66 | Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions | | | | | | 66 |
| 67 | Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting per | | | | | | 67 |
| 68 | Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period | d (line 13 x line 20 | 0) | | | | 68 |
| 69 | Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) | | | | | | 69 |

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0012

WORKSHEET D-1
PARTS III & IV

 Check
 [] Title V - I/P
 [XX] Hospital
 [] SUB (Other)
 [] ICF/IID
 [XX] PPS

 Applicable
 [XX] Title XVIII, Part A
 [] IPF
 [] SNF
 [] TEFRA

 Boxes:
 [] Title XIX - I/P
 [] IRF
 [] NF
 [] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

| 87 | Total observation bed days (see instructions) | | | | 6,118 | 87 | |
|----|---|------------|-----------------------------------|---------------|--|---|----|
| 88 | Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) | | | | | 1,122.35 | 88 |
| 89 | Observation bed cost (line 87 x line 88) (see instructions) | | | | | 6,866,537 | 89 |
| | | Cost | Routine Cost (from line 21) | col. 1÷col. 2 | Total Observation Bed Cost (from line 89) | Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions) | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 90 | Capital-related cost | 16,410,723 | 66,441,749 | 0.246994 | 6,866,537 | 1,695,993 | 90 |
| 91 | Nursing School | | | | | | 91 |
| 92 | Allied Health | | | | | | 92 |
| 93 | Other Medical Education | | | | | | 93 |

| - | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-T012

WORKSHEET D-1 PART I

| Check Applicable Boxes: | [] Title V - I/P [XX] Title XVIII, Part A [] Title XIX - I/P | [] Hospital [] IPF [XX] IRF | [] SUB (Other) [] SNF [] NF | [] ICF/IID | [XX] PPS [] TEFRA [] Other | |
|-------------------------------|--|-------------------------------------|--------------------------------|-------------|------------------------------|--|
| PART I - ALL P | PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS | | | | | |

ROVIDER COMPONENTS

| | INFATIENT DATS | | |
|----|---|-----------|----|
| 1 | Inpatient days (including private room days and swing-bed days, excluding newborn) | 2,806 | 1 |
| 2 | Inpatient days (including private room days, excluding swing-bed and newborn days) | 2,806 | 2 |
| 3 | Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line. | | 3 |
| 4 | Semi-private room days (excluding swing-bed private room days) | 2,806 | 4 |
| 5 | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period | | 5 |
| 6 | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 6 |
| 7 | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period | | 7 |
| 8 | Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 8 |
| 9 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) | 1,545 | 9 |
| 10 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) | | 10 |
| 11 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 11 |
| 12 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period | | 12 |
| 13 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 13 |
| 14 | Medically necessary private room days applicable to the program (excluding swing-bed days) | | 14 |
| 15 | Total nursery days (title V or XIX only) | | 15 |
| 16 | Nursery days (title V or XIX only) | | 16 |
| | SWING-BED ADJUSTMENT | | |
| 17 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period | | 17 |
| 18 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period | | 18 |
| 19 | Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period | | 19 |
| 20 | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period | | 20 |
| 21 | Total general inpatient routine service cost (see instructions) | 3,180,935 | 21 |
| 22 | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) | | 22 |
| 23 | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) | | 23 |
| 24 | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) | | 24 |
| 25 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) | | 25 |
| 26 | Total swing-bed cost (see instructions) | | 26 |
| 27 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 3,180,935 | 27 |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | |
| 28 | General inpatient routine service charges (excluding swing-bed and observation bed charges) | | 28 |
| 20 | Private room charges (excluding swing-bed charges) | | 20 |

| 26 | Total swing-bed cost (see instructions) | | 26 |
|----|---|-----------|----|
| 27 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 3,180,935 | 27 |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | |
| 28 | General inpatient routine service charges (excluding swing-bed and observation bed charges) | | 28 |
| 29 | Private room charges (excluding swing-bed charges) | | 29 |
| 30 | Semi-private room charges (excluding swing-bed charges) | | 30 |
| 31 | General inpatient routine service cost/charge ratio (line 27 ÷ line 28) | | 31 |
| 32 | Average private room per diem charge (line 29 ÷ line 3) | | 32 |
| 33 | Average semi-private room per diem charge (line 30 ÷ line 4) | | 33 |
| 34 | Average per diem private room charge differential (line 32 minus line 33) (see instructions) | | 34 |
| 35 | Average per diem private room cost differential (line 34 x line 31) | | 35 |
| 36 | Private room cost differential adjustment (line 3 x line 35) | | 36 |
| 37 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) | 3,180,935 | 37 |
| | | | |

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-T012 WORKSHEET D-1 PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

| | PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS | 1 | |
|----|---|-----------|----|
| 38 | Adjusted general inpatient routine service cost per diem (see instructions) | 1,133.62 | 38 |
| 39 | Program general inpatient routine service cost (line 9 x line 38) | 1,751,443 | 39 |
| 40 | Medically necessary private room cost applicable to the Program (line 14 x line 35) | | 40 |
| 41 | Total Program general inpatient routine service cost (line 39 + line 40) | 1,751,443 | 41 |
| 48 | Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) | 665,303 | 48 |
| 49 | Total program inpatient costs (sum of lines 41 through 48)(see instructions) | 2,416,746 | 49 |
| | PASS THROUGH COST ADJUSTMENTS | | |
| 50 | Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III) | 82,441 | 50 |
| 51 | Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV) | 42,125 | 51 |
| 52 | Total Program excludable cost (sum of lines 50 and 51) | 124,566 | 52 |
| 53 | Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52) | 2,292,180 | 53 |
| | TARGET AMOUNT AND LIMIT COMPUTATION | | |
| 54 | Program discharges | | 54 |
| 55 | Target amount per discharge | | 55 |
| 56 | Target amount (line 54 x line 55) | | 56 |
| 57 | Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) | | 57 |
| 58 | Bonus payment (see instructions) | | 58 |
| 59 | Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket. | | 59 |
| 60 | Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket. | | 60 |
| 61 | If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 | | 61 |
| 01 | x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions) | | 01 |
| 62 | Relief payment (see instructions) | | 62 |
| 63 | Allowable Inpatient cost plus incentive payment (see instructions) | | 63 |
| | PROGRAM INPATIENT ROUTINE SWING BED COST | | |
| 64 | Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) | | 64 |
| 65 | Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) | | 65 |
| 66 | Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions) | | 66 |
| 67 | Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) | | 67 |
| 68 | Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) | | 68 |
| 69 | Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) | | 69 |

| • | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

WORKSHEET D-1 PART I COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-0012

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

| PA | RT I - ALL PROVIDER COMPONENTS | | |
|----|---|------------|----|
| | INPATIENT DAYS | | |
| 1 | Inpatient days (including private room days and swing-bed days, excluding newborn) | 59,199 | 1 |
| 2 | Inpatient days (including private room days, excluding swing-bed and newborn days) | 59,199 | 2 |
| | Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line. | | 3 |
| 4 | Semi-private room days (excluding swing-bed private room days) | 53,081 | 4 |
| 5 | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period | | 5 |
| 6 | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 6 |
| 7 | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period | | 7 |
| 8 | Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 8 |
| 9 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) | 1,940 | 9 |
| 10 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) | | 10 |
| 11 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 11 |
| 12 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period | | 12 |
| 13 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 13 |
| 14 | Medically necessary private room days applicable to the program (excluding swing-bed days) | | 14 |
| 15 | Total nursery days (title V or XIX only) | 4,262 | 15 |
| 16 | Nursery days (title V or XIX only) | 2,343 | 16 |
| | SWING-BED ADJUSTMENT | | |
| 17 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period | | 17 |
| 18 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period | | 18 |
| 19 | Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period | | 19 |
| 20 | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period | | 20 |
| 21 | Total general inpatient routine service cost (see instructions) | 66,441,749 | 21 |
| 22 | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) | | 22 |
| 23 | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) | | 23 |
| 24 | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) | | 24 |
| 25 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) | | 25 |
| 26 | Total swing-bed cost (see instructions) | | 26 |
| 27 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 66,441,749 | 27 |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | |
| 28 | General inpatient routine service charges (excluding swing-bed and observation bed charges) | | 28 |
| 29 | Private room charges (excluding swing-bed charges) | | 29 |
| 30 | Semi-private room charges (excluding swing-bed charges) | | 30 |
| 31 | General inpatient routine service cost/charge ratio (line 27 ÷ line 28) | | 31 |
| 32 | Average private room per diem charge (line 29 ÷ line 3) | | 32 |
| 33 | Average semi-private room per diem charge (line 30 ÷ line 4) | | 33 |
| 34 | Average per diem private room charge differential (line 32 minus line 33) (see instructions) | | 34 |
| 35 | Average per diem private room cost differential (line 34 x line 31) | | 35 |
| 36 | Private room cost differential adjustment (line 3 x line 35) | | 36 |
| 37 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) | 66,441,749 | 37 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-0012 WORKSHEET D-1 PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

| | PROGRAM INPATIENT OPERATING COST BEFORE PASS- | THROUGH COS | ST ADJUSTME | NTS | | 1 | |
|----|--|--|--------------------|-------------------|------------------|------------|----|
| 38 | Adjusted general inpatient routine service cost per diem (see instructions) | | | | | 1,122.35 | 38 |
| 39 | Program general inpatient routine service cost (line 9 x line 38) | | | | | 2,177,359 | 39 |
| 40 | Medically necessary private room cost applicable to the Program (line 14 x line 35) | | | | | | 40 |
| 41 | Total Program general inpatient routine service cost (line 39 + line 40) | | | | | 2,177,359 | 41 |
| | | Total | Total | Average | | Program | |
| | | Inpatient | Inpatient | Per Diem | Program | Cost | |
| | | Cost | Days | (col. 1 ÷ | Days | (col. 3 x | |
| | | Cost | • | col. 2) | | col. 4) | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 42 | Nursery (Titles V and XIX only) | 3,780,922 | 4,262 | 887.12 | 2,343 | 2,078,522 | 42 |
| | Intensive Care Type Inpatient Hospital Units | | | | | | |
| 43 | Intensive Care Unit | 10,646,535 | 5,353 | 1,988.89 | 631 | 1,254,990 | |
| 44 | Coronary Care Unit | | | | | | 44 |
| 45 | Burn Intensive Care Unit | | | | | | 45 |
| 46 | Surgical Intensive Care Unit | | | | | | 46 |
| 47 | NEONATAL INTENSIVE CARE UNIT | 5,191,649 | 3,691 | 1,406.57 | 2,425 | 3,410,932 | 47 |
| | 1 | | | | | 1 | |
| 48 | Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) | | | | | 7,950,148 | |
| 49 | Total program inpatient costs (sum of lines 41 through 48)(see instructions) | | | | | 16,871,951 | 49 |
| | PASS THROUGH COST ADJUST | | | | | | |
| 50 | Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I | | | | | 1,326,019 | |
| 51 | | eass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV) | | | 966,538 | | |
| 52 | Total Program excludable cost (sum of lines 50 and 51) | | | | | 2,292,557 | |
| 53 | Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and med TARGET AMOUNT AND LIMIT COM | | sts (line 49 minus | line 52) | | 14,579,394 | 53 |
| 54 | Program discharges | ICIATION | | | | | 54 |
| 55 | Target amount per discharge | | | | | | 55 |
| 56 | Target amount (line 54 x line 55) | | | | | | 56 |
| 57 | Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) | | | | | | 57 |
| 58 | Bonus payment (see instructions) | | | | | | 58 |
| 59 | Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and com | mounded by the m | arket basket | | | | 59 |
| 60 | Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket. | , | | | | | 60 |
| | If line $53 \div 54$ is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by | which operating c | osts (line 53) are | less than expecte | d costs (line 54 | | |
| 61 | x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions) | | | | | | 61 |
| 62 | Relief payment (see instructions) | | | | | | 62 |
| 63 | Allowable Inpatient cost plus incentive payment (see instructions) | | | | | | 63 |
| | PROGRAM INPATIENT ROUTINE SWI | NG BED COST | | | , | | |
| 64 | Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period | d (See instructions) | (title XVIII only | 7) | | | 64 |
| 65 | Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (S | ee instructions) (ti | tle XVIII only) | | | | 65 |
| 66 | Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instruction | s) | | | | | 66 |
| 67 | Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting p | eriod (line 12 x line | e 19) | | | | 67 |
| 68 | Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period | d (line 13 x line 20 | 0) | | | | 68 |
| 69 | Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) | | | | | | 69 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0012

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

| 87 | Total observation bed days (see instructions) | | | | | 6,118 | 87 |
|----|---|------|-----------------------------------|---------------|--|---|----|
| 88 | Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) | | | | | | 88 |
| 89 | Observation bed cost (line 87 x line 88) (see instructions) | | | | | | 89 |
| | | Cost | Routine Cost (from line 21) | col. 1÷col. 2 | Total Observation Bed Cost (from line 89) | Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions) | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 90 | Capital-related cost | | | | | | 90 |
| 91 | Nursing School | | | | | | 91 |
| 92 | Allied Health | | | | | | 92 |
| 93 | Other Medical Education | | | | | | 93 |

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-T012 WORKSHEET D-1 PART I

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

PART I - ALL PROVIDER COMPONENTS

| 1 Inpatient days (including private room days, actsoluting swing-bed and newborn) 2,806 1 2 Inpatient days (including private room days, actsoluting swing-bed and newborn days). If you have only private room days, do not complete this line. 2,806 3 3 Semi-private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line. 2,806 4 5 Total swing-bed SNF type inpatient days (including private room days) althrough December 31 of the cost reporting period 5 6 Total swing-bed SNF type inpatient days (including private room days) althrough December 31 of the cost reporting period 7 8 Total swing-bed SNF type inpatient days (including private room days) althrough December 31 of the cost reporting period 7 8 Total swing-bed SNF type inpatient days (including private room days) althrough December 31 of the cost reporting period 8 9 Total inpatient days including private room days) althrough December 31 of the cost reporting period (see instructions) 8 10 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 8 11 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 8 12 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 12 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11 12 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12 13 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13 14 Medically necessary p | PA | RT I - ALL PROVIDER COMPONENTS | | |
|--|----|--|-----------|----|
| 2 Inpatient days (including private room days, excluding swing-bed and newborn days, do not complete this line. 3 3 3 4 5 7 5 5 5 5 5 5 5 5 | | INPATIENT DAYS | | |
| 3 Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line. 2,806 4 | 1 | | | 1 |
| 4 Semi-private room davs (excluding swing-bed private room days) through December 31 of the cost reporting period 5 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 6 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) 7 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8 Total insulated days including private room days applicable to the Program (excluding swing-bed and newbown days) 10 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 11 On this line) 12 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 11 on this line) 12 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (fir calendar year, enter 0 on this line) 12 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (fir calendar year, enter 0 on this line) 13 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (fir calendar year, enter 0 on this line) 14 Medicard necessary private room days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (fir calendar year, enter 1 on this line) 15 Total nursery days (title V or XIX only) 16 None of the private room days applicable to the program (excluding swing-bed days) 17 Medicard rate for swing-bed SNF services applicable to the program (| | | 2,806 | _ |
| 5 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) applicable to the Program (excluding swing-bed and newborn days) after December 31 of the cost reporting period (see instructions) (including private room days) after December 31 of the cost reporting period (see instructions) (including private room days) after December 31 of the cost reporting period (see instructions) (including private room days) after December 31 of the cost reporting period (see instructions) (including private | | | | _ |
| 6 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (7 a Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (7 a Total inpatient days including private room days) after December 31 of the cost reporting period (8 calendar year, enter 0 on this line) 8 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 1 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 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (1 calendar year, enter 0 on this line) 11 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (1 calendar year, enter 0 on this line) 12 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (1 calendar year, enter 0 on this line) 12 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (1 calendar year, enter 0 on this line) 13 Swing-bed NF type inpatient days applicable to the program (excluding swing-bed days) 14 Swing-bed NF type inpatient days applicable to the program (excluding swing-bed days) 14 Swing-bed NF type inpatient days applicable to the program (excluding swing-bed days) 15 Swing-bed NF type inpatient days applicable to the program (excluding swing-bed days) 15 Swing-bed NF type inpatient days applicable to the program (excluding swing-bed days) 15 Swing-bed Swing-be | | | 2,806 | |
| 7 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8 Total swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 10 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 11 Swing-bed SNF type inpatient days applicable to the RVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12 Swing-bed NF 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) 13 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14 Medically necessary private room days applicable to the program (excluding swing-bed days) 15 Total nursery days (title V or XIX only) 16 Nursery days (title V or XIX only) 17 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18 Medical rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19 Medical rate for swing-bed NF services applicable to exervices through December 31 of the cost reporting period 19 Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19 Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20 Total general inpatient routine service cost (see instructions) 21 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line | | | | _ |
| 8 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 358 8 9 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 11 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) 12 Swing-bed NF type inpatient days applicable to title X VIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13 Swing-bed NF type inpatient days applicable to the program (excluding swing-bed days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14 Medicail necessary private room days applicable to the program (excluding swing-bed days) 15 Total nursery days (title V or XIX only) 16 Nursery days (title V or XIX only) 17 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 10 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 11 Total general inpatient routine service cost (see instructions) 12 Swing-bed cost applicable to SNF type services shrough December 31 of the cost reporting period 13 Swing-bed cost applicable to SNF type services shrough Decem | | | | |
| 9 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 11 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, emer 0 on this line) 12 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, emer 0 on this line) 13 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14 Medically necessary private room days applicable to the program (excluding swing-bed days) 15 Total universery days (title V or XIX only) 16 Nursery days (title V or XIX only) 17 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18 Medicard rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19 Medicard rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 19 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17) 20 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting pe | | | | _ |
| 10 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (fic alendar year, enter 0 on this line) 11 12 Swing-bed SNF type inpatient days applicable to title X VIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period 12 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14 Medically necessary private room days applicable to the program (excluding swing-bed days) 14 15 Total nursery days (title V or XIX only) 15 Nursery days (title V or XIX only) 15 Nursery days (title V or XIX only) 15 Nursery days (title V or XIX only) 16 Nursery days (title V or XIX only) 16 Nursery days (title V or XIX only) 17 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18 Medicaid rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17) 22 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18) 23 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period | | | | _ |
| Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12 | | | 358 | _ |
| 11 on this line) 12 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 3 on this line) 14 Medically necessary private room days applicable to the program (excluding swing-bed days) 15 Total nursery days (title V or XIX only) (including private room days) after December 31 of the cost reporting period (if calendar year, enter 14 Medically necessary private room days applicable to the program (excluding swing-bed days) 15 Mursery days (title V or XIX only) 15 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19 Medicarid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20 Medicarid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20 Medicarid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20 Medicarid rate for swing-bed NF type services through December 31 of the cost reporting period 30 Medicarid rate for swing-bed NF type services after December 31 of the cost reporting period (line 5 x line 17) 20 Medicarid rate for swing-bed NF type services after December 31 of the cost reporting period (line 5 x line 18) 21 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18) 22 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18) 22 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 19) 24 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period | 10 | | | 10 |
| Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14 Medically necessary private room days applicable to the program (excluding swing-bed days) 15 Total nursery days (title V or XIX only) 15 Nursery days (title V or XIX only) 16 Nursery days (title V or XIX only) 16 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19 Medicare for swing-bed NF services applicable to services after December 31 of the cost reporting period 19 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19 Medicare rate for swing-bed SNF services after December 31 of the cost reporting period 19 Medicare rate for swing-bed SNF services after December 31 of the cost reporting period 19 Medicare rate for swing-bed SNF services after December 31 of the cost reporting period 19 Medicare rate for swing-bed SNF services after December 31 of the cost reporting period 19 Medicare rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period 19 Medicare rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period 19 Medicare rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period 10 Medicare rate for swing-b | 11 | | | 11 |
| 1 Medically necessary private room days applicable to the program (excluding swing-bed days) 14 14 15 16 Nursery days (title V or XIX only) 15 16 Nursery days (title V or XIX only) 17 18 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 17 18 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18 18 18 18 18 18 19 19 | 12 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period | | 12 |
| 15 Total nursery days (title V or XIX only) 15 16 Nursery days (title V or XIX only) 16 16 Nursery days (title V or XIX only) 16 16 16 16 16 16 16 1 | 13 | | | 13 |
| Nursery days (title V or XIX only) SWING-BED ADJUSTMENT | 14 | Medically necessary private room days applicable to the program (excluding swing-bed days) | | 14 |
| SWING-BED ADJUSTMENT 17 | 15 | Total nursery days (title V or XIX only) | | 15 |
| 17 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18 | 16 | Nursery days (title V or XIX only) | | 16 |
| Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19 | | SWING-BED ADJUSTMENT | | |
| 19 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20 21 Total general inpatient routine service cost (see instructions) 3,180,935 21 22 23 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 22 23 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 23 24 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 24 25 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25 26 Total swing-bed cost (see instructions) 26 26 Total swing-bed cost (see instructions) 26 27 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3,180,935 27 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29 Private room charges (excluding swing-bed and observation bed charges) 29 30 Semi-private room charges (excluding swing-bed charges) 30 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31 32 Average private room per diem charge (line 30 ÷ line 4) 33 Average per diem private room per diem charge (line 30 ÷ line 4) 34 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35 Average per diem private room cost differential (line 32 x line 31) 35 Average per diem private room cost differential (line 32 x line 35) 36 Private room cost differential (line 33 x line 35) 36 Average per diem private room cost differential (line 33 x line 35) 36 Average per diem private room cost differential (line 34 x line 31) 36 Average per diem private r | 17 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period | | 17 |
| Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 3,180,935 21 | 18 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period | | 18 |
| 21 Total general inpatient routine service cost (see instructions) 22 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 25 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26 Total swing-bed cost (see instructions) 27 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29 Private room charges (excluding swing-bed charges) 30 Semi-private room charges (excluding swing-bed charges) 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32 Average private room per diem charge (line 30 ÷ line 4) 33 Average semi-private room per diem charge (line 30 ÷ line 4) 34 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 36 Private room cost differential adjustment (line 3 x line 31) 37 Private room cost differential adjustment (line 3 x line 35) | 19 | Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period | | 19 |
| 22 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26 Total swing-bed cost (see instructions) 27 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29 Private room charges (excluding swing-bed charges) 29 Private room charges (excluding swing-bed charges) 30 Semi-private room charges (excluding swing-bed charges) 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32 Average private room per diem charge (line 30 ÷ line 4) 33 Average semi-private room per diem charge (line 30 ÷ line 4) 34 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35 Average per diem private room cost differential (line 34 x line 31) 36 Private room cost differential adjustment (line 3 x line 35) | 20 | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period | | 20 |
| Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 23 | 21 | Total general inpatient routine service cost (see instructions) | 3,180,935 | 21 |
| 24 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26 Total swing-bed cost (see instructions) 27 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29 Private room charges (excluding swing-bed charges) 29 Private room charges (excluding swing-bed charges) 30 Semi-private room charges (excluding swing-bed charges) 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32 Average private room per diem charge (line 29 ÷ line 3) 33 Average semi-private room per diem charge (line 30 ÷ line 4) 34 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 36 Private room cost differential adjustment (line 3 x line 31) 37 Average per diem private room cost differential (line 3 x line 31) 38 Private room cost differential adjustment (line 3 x line 35) | 22 | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) | | 22 |
| 25 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26 Total swing-bed cost (see instructions) 27 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29 Private room charges (excluding swing-bed charges) 30 Semi-private room charges (excluding swing-bed charges) 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32 Average private room per diem charge (line 30 ÷ line 4) 33 Average semi-private room per diem charge (line 30 ÷ line 4) 34 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35 Average per diem private room cost differential (line 34 x line 31) 36 Private room cost differential adjustment (line 3 x line 35) | 23 | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) | | 23 |
| 25 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26 Total swing-bed cost (see instructions) 27 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29 Private room charges (excluding swing-bed charges) 30 Semi-private room charges (excluding swing-bed charges) 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32 Average private room per diem charge (line 30 ÷ line 4) 33 Average semi-private room per diem charge (line 30 ÷ line 4) 34 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35 Average per diem private room cost differential (line 34 x line 31) 36 Private room cost differential adjustment (line 3 x line 35) | 24 | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) | | 24 |
| 26 Total swing-bed cost (see instructions) 26 27 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3,180,935 27 | 25 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) | | 25 |
| PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28 29 Private room charges (excluding swing-bed charges) 29 30 Semi-private room charges (excluding swing-bed charges) 30 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31 32 Average private room per diem charge (line 29 ÷ line 3) 32 33 Average semi-private room per diem charge (line 30 ÷ line 4) 33 34 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34 35 Average per diem private room cost differential (line 34 x line 31) 35 36 Private room cost differential adjustment (line 3 x line 35) 36 | 26 | Total swing-bed cost (see instructions) | | 26 |
| PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28 29 Private room charges (excluding swing-bed charges) 29 30 Semi-private room charges (excluding swing-bed charges) 30 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31 32 Average private room per diem charge (line 29 ÷ line 3) 32 33 Average semi-private room per diem charge (line 30 ÷ line 4) 33 34 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34 35 Average per diem private room cost differential (line 34 x line 31) 35 36 Private room cost differential adjustment (line 3 x line 35) 36 | 27 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 3,180,935 | 27 |
| 29 Private room charges (excluding swing-bed charges) 29 30 Semi-private room charges (excluding swing-bed charges) 30 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31 32 Average private room per diem charge (line 29 ÷ line 3) 32 33 Average semi-private room per diem charge (line 30 ÷ line 4) 32 34 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34 35 Average per diem private room cost differential (line 34 x line 31) 35 36 Private room cost differential adjustment (line 3 x line 35) 36 | | | .,, | |
| 30 Semi-private room charges (excluding swing-bed charges) 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32 Average private room per diem charge (line 29 ÷ line 3) 33 Average semi-private room per diem charge (line 30 ÷ line 4) 34 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35 Average per diem private room cost differential (line 34 x line 31) 36 Private room cost differential adjustment (line 3 x line 35) 37 Average per diem private room cost differential (line 3 x line 31) 38 Average per diem private room cost differential adjustment (line 3 x line 35) | 28 | General inpatient routine service charges (excluding swing-bed and observation bed charges) | | 28 |
| 30 Semi-private room charges (excluding swing-bed charges) 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32 Average private room per diem charge (line 29 ÷ line 3) 33 Average semi-private room per diem charge (line 30 ÷ line 4) 34 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35 Average per diem private room cost differential (line 34 x line 31) 36 Private room cost differential adjustment (line 3 x line 35) 37 Average per diem private room cost differential (line 3 x line 31) 38 Average per diem private room cost differential adjustment (line 3 x line 35) | 29 | | | 29 |
| 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32 Average private room per diem charge (line 29 ÷ line 3) 33 Average semi-private room per diem charge (line 30 ÷ line 4) 34 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35 Average per diem private room cost differential (line 34 x line 31) 36 Private room cost differential adjustment (line 3 x line 35) 37 Average per diem private room cost differential (line 34 x line 31) 38 Average per diem private room cost differential (line 3 x line 35) | | | | 30 |
| 32 Average private room per diem charge (line 29 ÷ line 3) 33 Average semi-private room per diem charge (line 30 ÷ line 4) 34 Average semi-private room charge differential (line 32 minus line 33) (see instructions) 35 Average per diem private room cost differential (line 34 x line 31) 36 Private room cost differential adjustment (line 3 x line 35) 36 Private room cost differential adjustment (line 3 x line 35) 37 Average per diem private room cost differential adjustment (line 3 x line 31) 38 Average per diem private room cost differential adjustment (line 3 x line 35) 39 Average per diem private room cost differential adjustment (line 3 x line 31) 30 Average per diem private room per diem charge (line 29 ÷ line 4) 31 Average per diem private room per diem charge (line 20 ÷ line 4) 31 Average per diem private room per diem charge (line 20 ÷ line 4) 31 Average per diem private room per diem charge (line 32 minus line 33) (see instructions) 32 Average per diem private room cost differential (line 34 x line 31) 35 Average per diem private room cost differential (line 34 x line 31) 36 Private room cost differential adjustment (line 3 x line 35) | | | | 31 |
| 33 Average semi-private room per diem charge (line 30 ÷ line 4) 34 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35 Average per diem private room cost differential (line 34 x line 31) 36 Private room cost differential adjustment (line 3 x line 35) 37 Average per diem private room cost differential (line 34 x line 31) 38 Average per diem private room cost differential (line 33 x line 35) | | | | 32 |
| 34Average per diem private room charge differential (line 32 minus line 33) (see instructions)3435Average per diem private room cost differential (line 34 x line 31)3536Private room cost differential adjustment (line 3 x line 35)36 | 33 | | | 33 |
| 35 Average per diem private room cost differential (line 34 x line 31) 36 Private room cost differential adjustment (line 3 x line 35) 36 36 Average per diem private room cost differential adjustment (line 3 x line 35) | | | | 34 |
| 36 Private room cost differential adjustment (line 3 x line 35) 36 | | | | 35 |
| | | | | 36 |
| 37 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) 3 180 935 37 | | General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) | 3,180,935 | |

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-T012 WORKSHEET D-1 PART II

 Check
 [] Title V - I/P
 [] Hospital
 [] SUB (Other)
 [XX] PPS

 Applicable
 [] Title XVIII, Part A
 [] IPF
 [] TEFRA

 Boxes:
 [XX] Title XIX - I/P
 [XX] IRF
 [] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

| | PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS | 1 | |
|-----------|---|----------|------------|
| 38 | Adjusted general inpatient routine service cost per diem (see instructions) | 1,133.62 | 38 |
| 39 | Program general inpatient routine service cost (line 9 x line 38) | 405,836 | 39 |
| 40 | Medically necessary private room cost applicable to the Program (line 14 x line 35) | | 40 |
| 41 | Total Program general inpatient routine service cost (line 39 + line 40) | 405,836 | 41 |
| 48 | Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) | | 48 |
| 49 | Total program inpatient costs (sum of lines 41 through 48)(see instructions) | 405,836 | 49 |
| | PASS THROUGH COST ADJUSTMENTS | | |
| 50 | Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III) | 19,103 | 50 |
| 51 | Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV) | | 51 |
| 52 | Total Program excludable cost (sum of lines 50 and 51) | 19,103 | 52 |
| 53 | Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52) | 386,733 | 53 |
| | TARGET AMOUNT AND LIMIT COMPUTATION | | |
| 54 | Program discharges | | 54 |
| 55 | Target amount per discharge | | 55 |
| 56 | Target amount (line 54 x line 55) | | 56 |
| 57 | Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) | | 57 |
| 58 | Bonus payment (see instructions) | | 58 |
| 59 | Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket. | | 59 |
| 60 | Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket. | | 60 |
| C1 | If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 | | <i>c</i> 1 |
| 61 | x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions) | | 61 |
| 62 | Relief payment (see instructions) | | 62 |
| 63 | Allowable Inpatient cost plus incentive payment (see instructions) | | 63 |
| | PROGRAM INPATIENT ROUTINE SWING BED COST | | • |
| 64 | Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) | | 64 |
| 65 | Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) | | 65 |
| 66 | Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions) | | 66 |
| 67 | Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) | | 67 |
| 68 | Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) | | 68 |
| 69 | Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) | | 69 |

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

COMPONENT CCN: 15-0012

WORKSHEET D-3

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

 Check
 [] Title V
 [XX] Hospital
 [] SUB (Other)
 [] Swing Bed SNF
 [XX] PPS

 Applicable
 [XX] Title XVIII, Part A
 [] IPF
 [] SNF
 [] Swing Bed NF
 [] TEFRA

 Boxes:
 [] Title XIX
 [] IRF
 [] NF
 [] ICF/IID
 [] Other

| | | Ratio of Cost To Charges | Inpatient Program Charges | Inpatient Program Costs (col. 1 x col. 2) | |
|----------------|--|--------------------------------|---------------------------------|---|-------|
| (A) | COST CENTER DESCRIPTION | 1 | 2 | 3 | |
| (A) | INPATIENT ROUTINE SERVICE COST CENTERS | 1 | <u> </u> | <u>, , , , , , , , , , , , , , , , , , , </u> | |
| 30 | Adults & Pediatrics | | 51,390,545 | | 30 |
| 31 | Intensive Care Unit | | 7,709,944 | | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | | 7,702,244 | | 35 |
| 41 | Subprovider - IRF | | | | 41 |
| 71 | ANCILLARY SERVICE COST CENTERS | | | | 71 |
| 50 | Operating Room | 0.207436 | 41,331,889 | 8,573,722 | 50 |
| 51 | Recovery Room | 0.145820 | 3,407,933 | 496,945 | |
| 52 | Delivery Room & Labor Room | 0.268053 | 38,971 | 10,446 | |
| 54 | Radiology-Diagnostic | 0.175674 | 5,906,729 | 1,037,659 | |
| 55 | Radiology-Diagnostic Radiology-Therapeutic | 0.719891 | 340,330 | 245,001 | |
| 57 | CT Scan | 0.033289 | 10,185,397 | 339,062 | |
| 58 | MRI | 0.085084 | 2.613.962 | 222,406 | |
| 59 | Cardiac Catheterization | 0.236628 | 9.814.562 | 2.322.400 | |
| 60 | Laboratory | 0.124893 | 29,966,487 | 3.742.604 | |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | 0.124893 | 29,900,467 | 3,742,004 | 62.30 |
| 65 | Respiratory Therapy | 0.271409 | 5,418,139 | 1,470,532 | |
| 66 | Physical Therapy | 0.322143 | 1,980,029 | 637,852 | |
| 67 | Occupational Therapy | 0.322143 | 1,413,607 | 310,873 | |
| 68 | Speech Pathology | 0.219913 | 734.224 | 149,628 | |
| 69 | Electrocardiology | 0.203790 | 4,391,117 | 423,374 | |
| 71 | Medical Supplies Charged to Patients | 0.090416 | 4,391,117 | 423,374 | 71 |
| 72 | Impl. Dev. Charged to Patients | 0.375358 | 23,899,213 | 8.970.761 | 72 |
| 73 | Drugs Charged to Patients Drugs Charged to Patients | 0.375358 | | | |
| 74 | Renal Dialysis | 0.304706 | 20,298,215 | 6,184,988 | |
| 76.97 | CARDIAC REHABILITATION | 0.903241 | 670,766 | 605,863 | 76.97 |
| | | 0.076500 | 16,000 | 1.226 | |
| 76.98 76.99 | HYPERBARIC OXYGEN THERAPY LITHOTRIPSY | 0.076589 | 16,008 | 1,226 | 76.98 |
| /6.99 | OUTPATIENT SERVICE COST CENTERS | | | | 76.99 |
| 00 | | | | | 00 |
| 90.02 | Clinic MOBILE MEDICAL UNIT | 0.224813 | | | 90.02 |
| 90.02 | | 0.224813 | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER WOUND HEALING CENTER | 0.366883 | 34.255 | 12.568 | 90.03 |
| | | | | | |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 0.271051 | 104,084 | 28,212 | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 1.718060 | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | 0.555204 | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 0.556394 | | | |
| 90.10 | OUR LADY OF ROSARY CLINIC | 0.214002 | 7 577 000 | 1 (20 505 | 90.10 |
| 91 | Emergency | 0.214902 | 7,577,898 | 1,628,505 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 0.920138 | 1,404,926 | 1,292,726 | 92 |
| 200 | OTHER REIMBURSABLE COST CENTERS | | 171 540 511 | 20 707 252 | 2000 |
| 200 | Total (sum of lines 50-94, and 96-98) | | 171,548,741 | 38,707,353 | |
| 201 | Less PBP Clinic Laboratory Services-Program only charges (line 61) | | 171 540 711 | | 201 |
| 202 | Net Charges (line 200 minus line 201) | | 171,548,741 | | 202 |

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

COMPONENT CCN: 15-T012

WORKSHEET D-3

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

 Check
 [] Title V
 [] Hospital
 [] SUB (Other)
 [] Swing Bed SNF
 [XX] PPS

 Applicable
 [XX] Title XVIII, Part A
 [] IPF
 [] SNF
 [] Swing Bed NF
 [] TEFRA

 Boxes:
 [] Title XIX
 [XX] IRF
 [] NF
 [] ICF/IID
 [] Other

| | | Ratio of Cost To Charges | Inpatient Program Charges | Inpatient Program Costs (col. 1 x col. 2) | |
|-------|--|--------------------------------|---------------------------------|---|-------|
| (A) | COST CENTER DESCRIPTION | 1 | 2 | 3 | |
| (21) | INPATIENT ROUTINE SERVICE COST CENTERS | 1 | | <u> </u> | |
| 30 | Adults & Pediatrics | | | | 30 |
| 31 | Intensive Care Unit | | | | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | | | | 35 |
| 41 | Subprovider - IRF | | 2,892,994 | | 41 |
| | ANCILLARY SERVICE COST CENTERS | | 2,022,224 | | |
| 50 | Operating Room | 0.207436 | 3,718 | 771 | 50 |
| 51 | Recovery Room | 0.145820 | 2 | ,,, | 51 |
| 52 | Delivery Room & Labor Room | 0.268053 | 12 | 3 | |
| 54 | Radiology-Diagnostic | 0.175674 | 22,843 | 4,013 | |
| 55 | Radiology-Therapeutic | 0.719891 | 22,043 | 4,013 | 55 |
| 57 | CT Scan | 0.033289 | 27.153 | 904 | |
| 58 | MRI | 0.085084 | 25.212 | 2,145 | |
| 59 | Cardiac Catheterization | 0.236628 | 3,927 | 929 | |
| 60 | Laboratory | 0.124893 | 257,191 | 32.121 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | 0.124893 | 237,191 | 32,121 | 62.30 |
| 65 | Respiratory Therapy | 0.271409 | 3,664 | 994 | |
| 66 | Physical Therapy | 0.322143 | 872,313 | 281,010 | |
| 67 | Occupational Therapy | 0.219915 | 773,424 | 170,088 | |
| 68 | Speech Pathology | 0.203790 | 565,495 | 115,242 | |
| 69 | Electrocardiology | 0.203790 | 176 | 17 | |
| 71 | Medical Supplies Charged to Patients | 0.090410 | 170 | 17 | 71 |
| 72 | Impl. Dev. Charged to Patients | 0.375358 | | | 72 |
| 73 | Drugs Charged to Patients | 0.304706 | 164,959 | 50,264 | 73 |
| 74 | Renal Dialysis | 0.903241 | 6,370 | 5.754 | |
| 76.97 | CARDIAC REHABILITATION | 0.903241 | 0,370 | 3,734 | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 0.076589 | | | 76.98 |
| 76.99 | LITHOTRIPSY | 0.070389 | | | 76.99 |
| 70.55 | OUTPATIENT SERVICE COST CENTERS | | | | 70.99 |
| 90 | Clinic | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 0.224813 | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 0.568839 | | | 90.03 |
| 90.03 | WOUND HEALING CENTER | 0.366883 | 1.080 | 396 | , |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 0.271051 | 12 | 390 | |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 1.718060 | 12 | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | 1.718000 | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 0.556394 | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | 3.330374 | | | 90.10 |
| 91 | Emergency | 0.214902 | 3,022 | 649 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 0.920138 | 3,022 | 042 | 92 |
| 12 | OTHER REIMBURSABLE COST CENTERS | 3.920138 | | | 12 |
| 200 | Total (sum of lines 50-94, and 96-98) | | 2,730,573 | 665,303 | 200 |
| 201 | Less PBP Clinic Laboratory Services-Program only charges (line 61) | | 2,730,373 | 005,505 | 201 |
| 202 | Net Charges (line 200 minus line 201) | | 2,730,573 | | 202 |

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

COMPONENT CCN: 15-0012

WORKSHEET D-3

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

 Check
 [] Title V
 [XX] Hospital
 [] SUB (Other)
 [] Swing Bed SNF
 [XX] PPS

 Applicable
 [] Title XVIII, Part A
 [] IPF
 [] SNF
 [] Swing Bed NF
 [] TEFRA

 Boxes:
 [XX] Title XIX
 [] IRF
 [] NF
 [] ICF/IID
 [] Other

| (A) | | Cost To Charges | Program Charges | Program Costs (col. 1 x col. 2) | |
|----------------|--|----------------------|--------------------|---------------------------------|-------|
| | COST CENTER DESCRIPTION | 1 | 2 | 3 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 30 | Adults & Pediatrics | | 20,401,271 | | 30 |
| | Intensive Care Unit | | 3,750,381 | | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | | 7,953,832 | | 35 |
| 41 | Subprovider - IRF | | | | 41 |
| | Nursery | | | | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | |
| 50 | Operating Room | 0.207436 | 13,888,778 | 2,881,033 | |
| | Recovery Room | 0.145820 | 785,721 | 114,574 | |
| 52 | Delivery Room & Labor Room | 0.268053 | | | 52 |
| 54 | Radiology-Diagnostic | 0.175674 | 2,217,662 | 389,586 | _ |
| | Radiology-Therapeutic | 0.719891 | 264,292 | 190,261 | |
| 57 | CT Scan | 0.033289 | 3,125,044 | 104,030 | |
| 58 | MRI | 0.085084 | 830,080 | 70,627 | |
| 59 | Cardiac Catheterization | 0.236628 | 3,305,458 | 782,164 | |
| | Laboratory | 0.124893 | 11,293,330 | 1,410,458 | |
| | BLOOD CLOTTING FOR HEMOPHILIACS | | | | 62.30 |
| 65 | Respiratory Therapy | 0.271409 | 2,519,203 | 683,734 | |
| 66 | Physical Therapy | 0.322143 | 639,968 | 206,161 | |
| 67 | Occupational Therapy | 0.219915 | 447,086 | 98,321 | |
| 68 | Speech Pathology | 0.203790 | 284,297 | 57,937 | |
| | Electrocardiology | 0.096416 | 1,253,857 | 120,892 | |
| | Medical Supplies Charged to Patients | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 0.375358 | | | 72 |
| | Drugs Charged to Patients | 0.304706 | 455,968 | 138,936 | |
| 74 | Renal Dialysis | 0.903241 | 145,533 | 131,451 | |
| | CARDIAC REHABILITATION | | | | 76.97 |
| | HYPERBARIC OXYGEN THERAPY | 0.076589 | | | 76.98 |
| | LITHOTRIPSY | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | - 00 |
| | Clinic | 0.201010 | | | 90 |
| | MOBILE MEDICAL UNIT | 0.224813 | | | 90.02 |
| | FAMILY MEDICINE CENTER | 0.568839 | 2.211 | 011 | 90.03 |
| 90.04 | WOUND HEALING CENTER | 0.366883 | 2,211 | 811 | |
| 90.05 | OUTPATIENT TREATMENT & INFUSION PEDIATRIC SPECIALTY CLINIC | 0.271051 1.718060 | 1,974 298 | 535 512 | 90.05 |
| | | 1./18060 | 298 | 512 | |
| 90.07 90.08 | SPORTS MED FELLOWSHIP CLINIC PODIATRY RESIDENCY CLINIC | | | | 90.07 |
| | FACULTY PRACTICE CLINIC | 0.556204 | | | 90.08 |
| | OUR LADY OF ROSARY CLINIC | 0.556394 | - | | 90.09 |
| 90.10 | Emergency | 0.214902 | 2.643.646 | 568.125 | |
| 92 | Observation Beds (Non-Distinct Part) | 0.214902 | 2,043,040 | 308,123 | 92 |
| | OTHER REIMBURSABLE COST CENTERS | 0.920138 | | | 92 |
| | Total (sum of lines 50-94, and 96-98) | | 44,104,406 | 7.950.148 | 200 |
| | Less PBP Clinic Laboratory Services-Program only charges (line 61) | | 44,104,406 | 7,930,148 | 200 |
| | Net Charges (line 200 minus line 201) | | 44,104,406 | | 201 |

| - | In Lieu of Form | Period: | Run Date: 09/25/2018 | ı |
|------------------------------------|-----------------|------------------|-------------------------------|---|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | ı |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | ı |

COMPONENT CCN: 15-T012

WORKSHEET D-3

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

 Check
 [] Title V
 [] Hospital
 [] SUB (Other)
 [] Swing Bed SNF
 [XX] PPS

 Applicable
 [] Title XVIII, Part A
 [] IPF
 [] SNF
 [] Swing Bed NF
 [] TEFRA

 Boxes:
 [XX] Title XIX
 [XX] IRF
 [] NF
 [] ICF/IID
 [] Other

| | | | | Inpatient | |
|-------|--|----------|-----------|-----------|-------|
| | | Ratio of | Inpatient | Program | |
| | | Cost To | Program | Costs | |
| | | Charges | Charges | (col. 1 x | |
| | | | | col. 2) | |
| (A) | COST CENTER DESCRIPTION | 1 | 2 | 3 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 30 | Adults & Pediatrics | | | | 30 |
| 31 | Intensive Care Unit | | | | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | | | | 35 |
| 41 | Subprovider - IRF | | 680,525 | | 41 |
| | ANCILLARY SERVICE COST CENTERS | | | | |
| 50 | Operating Room | 0.207436 | | | 50 |
| 51 | Recovery Room | 0.145820 | | | 51 |
| 52 | Delivery Room & Labor Room | 0.268053 | | | 52 |
| 54 | Radiology-Diagnostic | 0.175674 | | | 54 |
| 55 | Radiology-Therapeutic | 0.719891 | | | 55 |
| 57 | CT Scan | 0.033289 | | | 57 |
| 58 | MRI | 0.085084 | | | 58 |
| 59 | Cardiac Catheterization | 0.236628 | | | 59 |
| 60 | Laboratory | 0.124893 | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | 62.30 |
| 65 | Respiratory Therapy | 0.271409 | | | 65 |
| 66 | Physical Therapy | 0.322143 | | | 66 |
| 67 | Occupational Therapy | 0.219915 | | | 67 |
| 68 | Speech Pathology | 0.203790 | | | 68 |
| 69 | Electrocardiology | 0.096416 | | | 69 |
| 71 | Medical Supplies Charged to Patients | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 0.375358 | | | 72 |
| 73 | Drugs Charged to Patients | 0.304706 | | | 73 |
| 74 | Renal Dialysis | 0.903241 | | | 74 |
| 76.97 | CARDIAC REHABILITATION | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | 0.076589 | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | |
| 90 | Clinic | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | 0.224813 | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER | 0.568839 | | | 90.03 |
| 90.04 | WOUND HEALING CENTER | 0.366883 | | | 90.04 |
| 90.05 | OUTPATIENT TREATMENT & INFUSION | 0.271051 | | | 90.05 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | 1.718060 | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | 0.556394 | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | 90.10 |
| 91 | Emergency | 0.214902 | | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 0.920138 | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | |
| 200 | Total (sum of lines 50-94, and 96-98) | | | | 200 |
| 201 | Less PBP Clinic Laboratory Services-Program only charges (line 61) | | | | 201 |
| 202 | Net Charges (line 200 minus line 201) | | | | 202 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

| Description of the form of the process of the control of the process of the pro | | | 1 | 1.01 | 1.02 | |
|--|-------|--|------------|--------|---------------|-------|
| 1.02 DRC amounts other than confirst propriests for decharges counting on a rifer Order's 1 (see 1.05) | 1 | | | | | 1 |
| BAGE for folional specific operating payment for Model 4 BPCT for discharges occurring on or after October 1 (see Inching the payments for discharges (see instructions) Outlier reconciliation amount Outlier reconciliation | | | 45,234,538 | | | |
| Superscience 1.00 DROE to federal specific operating payment for Model # BPC for discharges occurring on or after October 1 (see 1.04) DROE to federal specific operating payment for Model # BPC for discharges occurring on or after October 1 (see 1.04) Drofter payment for discharges (see instructions) 2.01 Drofter payment for discharges (see instructions) 2.00 Drofter payment for discharges (see instructi | 1.02 | | | | | 1.02 |
| International In | 1.03 | | | | | 1.03 |
| 2.0 Online governments for discharges (see instructions) 2.01 Online government for discharges for Model & DPCI (see instructions) 2.02 Online government for discharges for Model & DPCI (see instructions) 2.03 Online government for discharges for Model & DPCI (see instructions) 2.04 Online government for discharges for Model & DPCI (see instructions) 2.05 Online government for discharges for Model & DPCI (see instructions) 2.06 Online government for discharges for Model & DPCI (see instructions) 2.07 Online government for discharges for Model & DPCI (see instructions) 2.08 Online government for the Model & DPCI (see instructions) 2.08 Online government for the Model & DPCI (see instructions) 2.09 Online government for the Model & DPCI (see instructions) 2.00 Online government | 1.04 | | | | | 1.04 |
| 2.00 Conflier reconstitution amount 2.01 Conflier reconstitution amount 2.02 Conflier reconstitution amount 3.02 Conflier reconstitution amount 3.03 Advanced are simulated provisions. 3.04 Advanced are simulated provisions. 4.05 Conflier reconstitution and accordance provided and accordance of the conflience of the c | 2. | | 1 630 069 | | _ | 2. |
| 2020. Online procurent for discharges for Model APPC (see instructions) 1 Managed one similared prymate of days in the cost reporting period for instructions) 2 House days carefully discharge for Model APPC (see instructions) 2 House days carefully discharge for Model APPC (see instructions) 2 House of the days are with a second control of the control of a legislate and control of the control of all public and control of all public and control of the control of a legislate and control of all public and control of the control of a legislate and control of all public and control of a legislate and control of the control of a model on to the cap for new programs 6 7 PER count to adjustable and control of the Cop as specified under 2 CER \$412.0850((3)***(1)**(1)**(1)**(1)** ACA Section 422 reduction amount to the MR cap as specified under 2 CER \$412.0850((3)**(1)**(1)**(1)**(1)** in control of a legislate and control of the cap for new programs and control of the cap for a legislate and control of the cap for new programs in a control of the cap for a legislate and control of the cap for a | | | 1,030,007 | | | |
| Bed Johns available divided by number of these in the cost apporting period (see instructions) 229,89 | 2.02 | | | | | 2.02 |
| International Content of Processing Content of Processing Processing Content of Processing Processing Content of Processing Proces | | | | | | |
| FET count for allopaths and osteopathic programs which ment the criteria for an add-on to the cup for new programs 6 FET count for allopaths and osteopathic programs which ment the criteria for an add-on to the cup for new programs 6 FET count for allopaths and osteopathic programs which ment the criteria for an add-on to the cup for new programs 7 The AGA Section 422 reduction amount to the MEI cap as specified under 42 CFR 4412 (050ff(1019/SBE)1) 8 AGA Section 5503 reduction amount to the MEI cap as specified under 42 CFR 4412 (050ff(1019/SBE)1) 8 Adjustment (increase or decrease) to the FET count for allopathic and osteopaths programs for affitiated programs in accordance with 42 CFR 4152,005,01437(1019/SBE)2. He do set of the count of the count of the count for allopathic and osteopaths programs for affitiated programs in accordance with 42 CFR 4152,005,01437(1019/SBE)4000 (August 1.) 8 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of the AGA. If the cost report strategies by 1, 2011, see interactions. 9 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of the AGA. If the cost report strategies by 1, 2011, see interactions. 10 TET count for allopaths and osteopathic programs in the current year from your records. 11 TET count for allopaths and osteopathic programs in the current year from your records. 12 TET count for allopaths and osteopathic programs in the current year from your records. 13 Total allowable FTE count for the prior year 14 Total allowable FTE count for the prior year count year from your records. 15 Total allowable FTE count for the prior year 16 Total allowable FTE count for the prior year count year from your records. 17 Total allowable FTE count for the prior year count year from your records. 18 Total allowable FTE count for the prior year county year from your records. 19 Total Adjustment for readers is allocated by a county year fro | 4 | | 239.89 | | | 4 |
| Services of all postulies and oscoopathic programs which meet the criteria for an add-on to the cap for new programs and accordance with 2 CFR 413 (Not.) ACA Section 550 related manuton to the Mice cap as specified under 2 CFR 412 (195(M) (iv) BH) 1 ACA Section 550 related manuton to the Mice cap as specified under 2 CFR 412 (195(M) (iv) BH) 2. ACA Section 550 related manuton to the Mice cap as specified under 2 CFR 412 (195(M) (iv) BH) 2. ACA Section 550 related manuton to the Mice cap as specified under 2 CFR 412 (195(M) (iv) BH) 2. ACA Section 550 related manuton to the Mice cap as specified under 2 CFR 412 (195(M) (iv) BH) 2. ACA Section 550 related manuton to the Mice cap as specified under 2 CFR 412 (195(M) (iv) BH) 2. ACA Section 650 (iv) and 650 (| | | | | | |
| On In accordance with 42 CFR 413.79(c) 7 7 7 7 7 7 7 7 7 | 5 | 12/31/1996 (see instructions) | 17.61 | | | 5 |
| MAM Section 122 calculation amount to the ME cap as specified under 42 CFR 8412 (050 (CHV)RB(32). If the cost report straidles Int) 1, 2011 then see instructions. Adoption (increase or decrease) to the PTE can for allequalities and outcopatible programs for affiliated programs in 2003. Adoption (increase) or decrease) to the PTE can for allequalities and outcopatible programs for affiliated programs in 2003. Report and of increase of the hospital was warded FTE cap also under section 5500 of the ACA. If the cost report straidles Int) 1, 2011, see instructions. 8 | 6 | | | | | 6 |
| AcA Section 5503 reduction amount to the ME cap as specified under 42 CFR \$412.05(f(t)/kiy/B)21. If the cost report standards both 12, DIM 16 these reinstructions and section 5500 of the Adjustment (increase or decrease) to the PTE count for allopathic and ostopathic programs for affiliated programs in a confined with 2 CFR \$412.05(f(t)/kiy/B)21. July 18, and 07 PE 50000 (Angust 1, and 18) and 18 per 18 p | 7 | | 1.02 | | | 7 |
| Adjustment (increase or decrease) to the FTE count for allopathic and coteopathic programs for affiliated programs in a carcinates with a 2CPR 84175(b), 6418 795(25)(b) of 24 PS 2030 (b) 12, 1998, and of PR 80000 (AD) | 7.01 | ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost | | | | 7.01 |
| 2007 . | | | | | | |
| Roll StrateBisch 1/2 211, see instructions Roll strateBisch 1/2 211, see instructions Roll 201, see 1/2 201, see 1/2 201, see 1/2 201, see | 8 | accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, | | | | 8 |
| Strake Sur A 2011 see instructions Sur S | 8.01 | The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report | | | | 8.01 |
| Society Soci | | | | | | |
| Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) 22.46 | 8.02 | | 5.87 | | | 8.02 |
| FIE count for allopathic and osteopathic programs in the current year from your records | 9 | | 22.46 | | | 9 |
| 12 Current year allowable FTE (see instructions) | 10 | | 25.72 | | | 10 |
| Total allowable FTE count for the profit year Total allowable FTE count for the profilmate year if that year ended on or after September 30, 1997, otherwise enter zero. Total allowable FTE count for the prolifimate year if that year ended on or after September 30, 1997, otherwise enter zero. Total Adjustment for residents in initial years of the program Adjustment for residents in initial years of the program Adjustment for residents in initial years of the program or hospital closure Total Adjustment for residents sin initial years of the program or hospital closure Total Adjustment for residents sin initial years of the program or hospital closure Total Adjustment for residents sin initial years of the program or hospital closure Total Adjustment for residents sin initial years of the program or hospital closure Total Adjustment for residents sin initial years of the program or hospital closure Total Adjustment for residents sin initial years of the program or hospital closure Total Miles years resident to bed ratio (see instructions) | 11 | | 4.88 | | | 11 |
| 1 1 1 1 1 2 2 1 1 1 | | | | | | |
| 14 27.40 14 15 15 15 15 15 16 16 16 | 13 | Total allowable FTE count for the prior year | 27.46 | | | 13 |
| 16 Adjustment for residents in initial years of the program 16 Adjustment for residents displaced by program or hospital closure 17 Adjustment for residents displaced by program or hospital closure 17 18 Adjusted rolling average FTE count 18 18 19 Curret wear resident to bed ratio (fine IR divided by line 4) 0.114302 19 19 10 114302 19 10 114302 19 10 114302 19 10 114302 19 10 114302 19 10 114302 19 10 114302 19 10 114302 19 10 114302 19 10 114302 19 10 114302 10 114302 19 10 114302 114302 | | zero | | | | |
| 17 | | | 27.42 | | | |
| 18 | | | | | | |
| 19 | | | 27.42 | | | |
| Prior year resident to bed ratio (see instructions) | | | | | | |
| 21 | | | | | | |
| 220.1 IME payment adjustment (See instructions) 2,735,106 22. 220.1 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 1,062,179 22.01 23 | | | | | | |
| Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23 3 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C) 2 3 24 1ME FTE resident count over cap (see instructions) 3.26 24 24 25 1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 25 26 Resident to bed ratio (divide line 25 by line 4) 26 27 1ME payments adjustment factor (see instructions) 27 28 1ME add-on adjustment amount (see instructions) 28 28 1ME add-on adjustment amount (see instructions) 28 28 29 27 27 28 29 29 29 20 20 20 20 20 | | | | | | |
| Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C) 3.26 24 4 14 15 15 16 16 16 16 16 16 | 22.01 | | | | | 22.01 |
| 24 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 25 26 Resident to bed ratio (divide line 25 by line 4) 26 27 IME payments adjustment factor (see instructions) 28 IME add-on adjustment amount (see instructions) 28 28 29 20 20 20 20 20 20 20 | | | | | | |
| 25 | | | | | | |
| 26 | | | 3.26 | | | |
| ME payments adjustment factor (see instructions) 27 | | | | | | |
| 28 IME add-on adjustment amount (see instructions) 28 28 28 28 10 IME add-on adjustment amount - Managed Care (see instructions) 28 28 28 29 Total IME payment (sum of lines 22 and 28) 2,735,106 29 29 10 Total IME payment (sum of lines 22 and 28) 2,735,106 29 29 10 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 1,062,179 29 20 10 20 10 20 20 10 20 2 | | | | | | |
| 28.01 IME add-on adjustment amount - Managed Care (see instructions) 28.01 | | | | | | |
| 29 | | | | | _ | |
| 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 1,062,179 29.01 | | | 2.735.106 | | | |
| Disproportionate Share Adjustment 30 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 0.0426 31 Percentage of Medicaid patient days to total patient days (see instructions) 0.2318 31 32 Sum of lines 30 and 31 0.2744 32 33 Allowable disproportionate share percentage (see instructions) 0.1185 33 34 Disproportionate share adjustment (see instructions) 1,340,073 34 Disproportionate share adjustment (see instructions) Prior to On or after | | | | | | |
| 30 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 0.0426 31 Percentage of Medicaid patient days to total patient days (see instructions) 0.2318 31 32 Sum of lines 30 and 31 0.2744 32 33 Allowable disproportionate share percentage (see instructions) 0.1185 33 34 Disproportionate share adjustment (see instructions) 1,340,073 34 Prior to Ono rafter Uncompensated Care Adjustment October 1 (1.00) (1.01) October 1 (2.00) 35 Total uncompensated care amount (see instructions) 0.000000000 0.000340888 35.01 35.01 Foctor 3 (see instructions) 1,849,006 2,306,685 35.02 35.02 Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) 1,849,006 2,306,685 35.02 35.03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 466,051 1,725,274 35.03 36 Total uncompensated care (sum of columns 1 and 2 on line 35.03) 2,191,325 36 Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46) 40 40 Total ESRD Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41.01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 42 43 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 43 44 Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days) 44 45 Average weekly cost for dialysis treatments (see instructions) 45 | | | -,,-/> | | | |
| 32 Sum of lines 30 and 31 0.2744 32 33 34 35 34 35 34 35 34 35 34 35 35 | 30 | | 0.0426 | | | 30 |
| 33 Allowable disproportionate share percentage (see instructions) 1,340,073 34 | | | | | | |
| 34 Disproportionate share adjustment (see instructions) 1,340,073 Prior to On or after | | | | | | |
| Note Compensated Care Adjustment Cotober 1 (1.00) Cotober 1 (1.00) Cotober 1 (2.00) | | | | | | |
| Uncompensated Care Adjustment | 34 | Disproportionate share adjustment (see instructions) | | | On or after | 34 |
| 35 | | Uncompensated Care Adjustment | | (1.01) | | |
| 35.02 Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) 1,849,006 2,306,685 35.02 35.03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 466,051 1,725,274 35.03 36 Total uncompensated care (sum of columns 1 and 2 on line 35.03) 2,191,325 36 Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46) 40 Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 40 41 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41.01 42 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 42 43 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 43 44 Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days) 44 45 Average weekly cost for dialysis treatments (see instructions) 45 | | Total uncompensated care amount (see instructions) | | | 6,766,695,164 | 35 |
| 35.03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 466,051 1,725,274 35.03 36 Total uncompensated care (sum of columns 1 and 2 on line 35.03) 2,191,325 36 Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46) 40 Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41 41.01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41.01 42 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 42 43 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 43 44 Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days) 44 45 Average weekly cost for dialysis treatments (see instructions) 45 | | | | | | |
| Total uncompensated care (sum of columns 1 and 2 on line 35.03) Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46) Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 40 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 42 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 44 Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days) 45 Average weekly cost for dialysis treatments (see instructions) | | | | | | |
| Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46) 40 Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41 At 1.01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 42 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 44 Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days) 45 Average weekly cost for dialysis treatments (see instructions) 45 Average weekly cost for dialysis treatments (see instructions) | | | | | 1,725,274 | |
| 40Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)4041Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)4141.01Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)41.0142Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)4243Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)4344Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)4445Average weekly cost for dialysis treatments (see instructions)45 | 36 | | 2,191,325 | | | 36 |
| 41Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)4141.01Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)41.0142Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)4243Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)4344Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)4445Average weekly cost for dialysis treatments (see instructions)45 | 40 | | | | | 40 |
| 41.01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41.01 42 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 42 43 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 43 44 Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days) 44 45 Average weekly cost for dialysis treatments (see instructions) 45 | | | | | | |
| 42Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)4243Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)4344Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)4445Average weekly cost for dialysis treatments (see instructions)45 | | | | | | |
| 43Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)4344Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)4445Average weekly cost for dialysis treatments (see instructions)45 | | | | | | |
| 44 Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days) 44 45 Average weekly cost for dialysis treatments (see instructions) 45 | | | | | | |
| | | | | | | |
| 46 Total additional payment (line 45 times line 44 times line 41.01) 46 | | | | | | |
| | 46 | Total additional payment (line 45 times line 44 times line 41.01) | | | | 46 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

| | 1 | 1.01 | 1.02 | |
|---|---------------------|------------------|------|-------|
| 47 Subtotal (see instructions) | 53,131,111 | 1.01 | 1.02 | 47 |
| Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions) | 33,131,111 | | | 48 |
| 49 Total payment for inpatient operating costs (see instructions) | 54,193,290 | | | 49 |
| 50 Payment for inpatient program capital (from Wkst. L. Pt. 1 and Pt. II, as applicable) | 4.442.057 | | | 50 |
| 51 Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions) | 4,442,037 | | | 51 |
| 52 Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions) | 1,546,160 | | | 52 |
| 53 Nursing and allied health managed care payment | 175.663 | | | 53 |
| 54 Special add-on payments for new technologies | 173,003 | | | 54 |
| 55 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) | | | | 55 |
| 56 Cost of physicians' services in a teaching hospital (see instructions) | | | | 56 |
| Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35). | | | | 57 |
| Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200) | 87,864 | | | 58 |
| 59 Total (sum of amounts on lines 49 through 58) | 60,445,034 | | | 59 |
| 60 Primary payer payments | 32.669 | | | 60 |
| 61 Total amount payable for program beneficiaries (line 59 minus line 60) | 60,412,365 | | | 61 |
| 62 Deductibles billed to program beneficiaries Deductibles billed to program beneficiaries | 4,953,624 | | | 62 |
| 63 Coinsurance billed to program beneficiaries | 4,933,624 53,814 | | | 63 |
| 64 Allowable bad debts (see instructions) | 363,054 | | | 64 |
| | | | | 65 |
| Adjusted reimbursable bad debts (see instructions) | 235,985 | | | |
| Allowable bad debts for dual eligible beneficiaries (see instructions) | 78,378 | | | 66 |
| Subtotal (line 61 plus line 65 minus lines 62 and 63) | 55,640,912 | | | 67 |
| Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions) | | | | 68 |
| Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions) | | | | 69 |
| 70 Other adjustments (specify) (see instructions) | 220.045 | | | 70 |
| 70.93 HVBP payment adjustment amount (see instructions) | -228,867 | | | 70.93 |
| 70.94 HRR adjustment amount (see instructions) | -31,875 | | | 70.94 |
| 71 Amount due provider (see instructions) | 55,380,170 | | | 71 |
| 71.01 Sequestration adjustment (see instructions) | 1,107,603 | | | 71.01 |
| 71.02 Demonstration payment adjustment amount after sequestration | | | | 71.02 |
| 72 Interim payments | 54,403,279 | | | 72 |
| 73 Tentative settlement (for contractor use only) | | | | 73 |
| 74 Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73) | -130,712 | | | 74 |
| Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2 | 1,662,502 | | | 75 |
| TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) | | | | |
| 90 Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions) | | | | 90 |
| Capital outlier from Wkst. L, Pt. I, line 2 | | | | 91 |
| Operating outlier reconciliation adjustment amount (see instructions) | | | | 92 |
| 93 Capital outlier reconciliation adjustment amount (see instructions) | | | | 93 |
| The rate used to calculate the time value of money (see instructions) | | | | 94 |
| Time value of money for operating expenses (see instructions) | | | | 95 |
| Time value of money for capital related expenses (see instructions) | | | | 96 |
| HSP Bonus Payment Amount | Prior to 10/1 | On or After 10/1 | | |
| 100 HSP bonus amount (see instructions) | | | | 100 |
| HVBP Adjustment for HSP Bonus Payment | Prior to 10/1 | On or After 10/1 | | |
| 101 HVBP adjustment factor (see instructions) | 0.0000000000 | 0.0000000000 | | 101 |
| HVBP adjustment amount for HSP bonus payment (see instructions) | | | | 102 |
| HRR Adjustment for HSP Bonus Payment | Prior to 10/1 | On or After 10/1 | | |
| HRR adjustment factor (see instructions) | 0.0000 | 0.0000 | | 103 |
| 104 HRR adjustment amount for HSP bonus payment (see instructions) | | | | 104 |

| | In Lieu of Form | Period: | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0012

WORKSHEET E PART B

Check applicable box: [XX] Hospital [] IFF [] IRF [] SUB (Other) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

| | | 1 | 1.01 | 1.02 | |
|-------------|---|------------|------|------|-------------|
| 1 | Medical and other services (see instructions) | 25,509 | | | 1 |
| 2 | Medical and other services reimbursed under OPPS (see instructions) | 23,355,740 | | | 2 |
| 3 | OPPS payments | 21,733,729 | | | 3 |
| 4 | Outlier payment (see instructions) | 103,003 | | | 4 |
| 4.01 | Outlier reconciliation amount (see instructions) | | | | 4.01 |
| 5 | Enter the hospital specific payment to cost ratio (see instructions) | | | | 5 |
| 6 | Line 2 times line 5 | | | | 6 |
| 7 | Sum of lines 3, 4, and 4.01, divided by line 6 | | | | 7 |
| 8 | Transitional corridor payment (see instructions) | | | | 8 |
| 9 | Ancillary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200 | 65,848 | | | 9 |
| 10 | Organ acquisition | | | | 10 |
| 11 | Total cost (sum of lines 1 and 10) (see instructions) | 25,509 | | | 11 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | |
| | REASONABLE CHARGES | | | | |
| 12 | Ancillary service charges | 83,513 | | | 12 |
| 13 | Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69) | 35,535 | | | 13 |
| 14 | Total reasonable charges (sum of lines 12 and 13) | 83,513 | | | 14 |
| | CUSTOMARY CHARGES | 33,232 | | | |
| 15 | Aggregate amount actually collected from patients liable for payment for services on a charge basis | | | | 15 |
| | Amounts that would have been realized from patients liable for payment for services on a charge basis had such | | | | |
| 16 | payment been made in accordance with 42 CFR §413.13(e) | | | | 16 |
| 17 | Ratio of line 15 to line 16 (not to exceed 1.000000) | 1.000000 | | | 17 |
| 18 | Total customary charges (see instructions) | 83,513 | | | 18 |
| 19 | Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions) | 58,004 | | | 19 |
| 20 | Excess of customary charges over ressolution cost (complete only if line 11 exceeds line 18 (see instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions) | 38,004 | | | 20 |
| 21 | Lesser of cost or charges (see instructions) | 25,509 | | | 21 |
| 22 | Interns and residents (see instructions) | 23,309 | | | 22 |
| 23 | Cost of physicians' services in a teaching hospital (see instructions) | | | | 23 |
| 24 | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) | 21,902,580 | | | 24 |
| 24 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | 21,902,380 | | | 24 |
| 25 | Deductibles and coinsurance (see instructions) | | | | 25 |
| 26 | Deductibles and coinsurance (see instructions) Deductibles and coinsurance relating to amount on line 24 (see instructions) | 3,967,688 | | | 26 |
| 27 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) | 17,960,401 | | | 27 |
| 28 | Direct graduate medical education payments (from Wkst. E-4, line 50) | 522,152 | | | 28 |
| 29 | ESRD direct medical education payments (from Wkst. E-4, line 36) | 322,132 | | | 29 |
| 30 | Subtotal (sum of lines 27 through 29) | 18,482,553 | | | 30 |
| 31 | Primary payer payments | 9,301 | | | 31 |
| 32 | Subtotal (line 30 minus line 31) | 18,473,252 | | | 32 |
| 32 | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | 18,473,232 | | | 32 |
| 33 | Composite rate ESRD (from Wkst. I-5, line 11) | | | | 33 |
| 34 | Allowable bad debts (see instructions) | 491,651 | | | 34 |
| | Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) | 319,573 | | | 35 |
| 35 | Adjusted reimoursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) | | | | 36 |
| 36 | Subtotal (see instructions) | 279,273 | | | 37 |
| 37 | | 18,792,825 | | | 38 |
| 38 39 | MSP-LCC reconciliation amount from PS&R | | | | 39 |
| | Other adjustments (specify) (see instructions) | | | | |
| 39.50 40 | Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) | 19 702 925 | | | 39.50 40 |
| | | 18,792,825 | | | _ |
| 40.01 | Sequestration adjustment (see instructions) | 375,857 | | | 40.01 |
| 40.02 | Demonstration payment adjustment amount after sequestration | 10.000.75 | | | 40.02 |
| 41 | Interim payments 1 | 18,606,767 | | | 41 |
| 42 | Tentative settlement (for contractors use only) | 100 505 | | | 42 |
| 43 | Balance due provider/program (see instructions) | -189,799 | | | 43 |
| 44 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | | | 44 |

TO BE COMPLETED BY CONTRACTOR

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

| | In Lieu of Form | Period: | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T012

WORKSHEET E PART B

Check applicable box: [] Hospital [] IPF [XX] IRF [] SUB (Other) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

| | | 1 | 1.01 | 1.02 | |
|-------|--|----------|------|------|-------|
| 1 | Medical and other services (see instructions) | | | | 1 |
| 2 | Medical and other services reimbursed under OPPS (see instructions) | 50 | | | 2 |
| 3 | OPPS payments | 303 | | | 3 |
| 4 | Outlier payment (see instructions) | | | | 4 |
| 4.01 | Outlier reconciliation amount (see instructions) | | | | 4.01 |
| 5 | Enter the hospital specific payment to cost ratio (see instructions) | | | | 5 |
| 6 | Line 2 times line 5 | | | | 6 |
| 7 | Sum of lines 3, 4, and 4.01, divided by line 6 | | | | 7 |
| 8 | Transitional corridor payment (see instructions) | | | | 8 |
| 9 | Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 | | | | 9 |
| 10 | Organ acquisition | | | | 10 |
| 11 | Total cost (sum of lines 1 and 10) (see instructions) | | | | 11 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | |
| | REASONABLE CHARGES | | | | |
| 12 | Ancillary service charges | | | | 12 |
| 13 | Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69) | | | | 13 |
| 14 | Total reasonable charges (sum of lines 12 and 13) | | | | 14 |
| | CUSTOMARY CHARGES | | | | |
| 15 | Aggregate amount actually collected from patients liable for payment for services on a charge basis | | | | 15 |
| 16 | Amounts that would have been realized from patients liable for payment for services on a charge basis had such | | | | 16 |
| 10 | payment been made in accordance with 42 CFR §413.13(e) | | | | 10 |
| 17 | Ratio of line 15 to line 16 (not to exceed 1.000000) | 1.000000 | | | 17 |
| 18 | Total customary charges (see instructions) | | | | 18 |
| 19 | Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions) | | | | 19 |
| 20 | Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions) | | | | 20 |
| 21 | Lesser of cost or charges (see instructions) | | | | 21 |
| 22 | Interns and residents (see instructions) | | | | 22 |
| 23 | Cost of physicians' services in a teaching hospital (see instructions) | | | | 23 |
| 24 | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) | 303 | | | 24 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | |
| 25 | Deductibles and coinsurance (see instructions) | | | | 25 |
| 26 | Deductibles and coinsurance relating to amount on line 24 (see instructions) | | | | 26 |
| 27 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) | 303 | | | 27 |
| 28 | Direct graduate medical education payments (from Wkst. E-4, line 50) | | | | 28 |
| 29 | ESRD direct medical education costs (from Wkst. E-4, line 36) | | | | 29 |
| 30 | Subtotal (sum of lines 27 through 29) | 303 | | | 30 |
| 31 | Primary payer payments | | | | 31 |
| 32 | Subtotal (line 30 minus line 31) | 303 | | | 32 |
| | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | | | |
| 33 | Composite rate ESRD (from Wkst. I-5, line 11) | | | | 33 |
| 34 | Allowable bad debts (see instructions) | | | | 34 |
| 35 | Adjusted reimbursable bad debts (see instructions) | | | | 35 |
| 36 | Allowable bad debts for dual eligible beneficiaries (see instructions) | | | | 36 |
| 37 | Subtotal (see instructions) | 303 | | | 37 |
| 38 | MSP-LCC reconciliation amount from PS&R | | | | 38 |
| 39 | Other adjustments (specify) (see instructions) | | | | 39 |
| 39.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | | | 39.50 |
| 40 | Subtotal (see instructions) | 303 | | | 40 |
| 40.01 | Sequestration adjustment (see instructions) | 6 | | | 40.01 |
| 40.02 | Demonstration payment adjustment amount after sequestration | | | | 40.02 |
| 41 | Interim payments | 822 | | | 41 |
| 42 | Tentative settlement (for contractors use only) | | | | 42 |
| 43 | Balance due provider/program (see instructions) | -525 | | | 43 |
| 44 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | | | 44 |

TO BE COMPLETED BY CONTRACTOR

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

Run Date: 09/25/2018 In Lieu of Form Period: ST. JOSEPHS REG MED CENTER S. BEND CMS-2552-10 From: 07/01/2017 Run Time: 10:47 Provider CCN: 15-0012 To: 06/30/2018 Version: 2018.04 (08/29/2018)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-0012 WORKSHEET E-1

PART I

[XX] Hospital [] SUB (Other)] IPF] IRF Applicable] SNF] Swing Bed SNF Boxes:

| | | | | | NPATIENT PART B | | `B | |
|--------|--|------------------------|-------|-------------------|-----------------|--------------------|------------|------|
| | | | | mm/dd/yyyy | AMOUNT | mm/dd/yyyy | AMOUNT | |
| | DESCRIPTION | | | 1 | 2 | 3 | 4 | |
| 1 | Total interim payments paid to provider | | | | 54,324,279 | | 18,606,767 | 1 |
| 2 | Interim payments payable on individual bills, eitehr submitted or to be sub | omitted to the interme | diary | | | | | 2 |
| | for services rendered in the cost reporting period. If none, write 'NONE' or | r enter a zero | | | | | | |
| 3 | List separately each retroactive lump sum adjustment | | .01 | 01/23/2018 | 79,000 | | | 3.01 |
| | amount based on subsequent revision of the interim | | .02 | | | | | 3.02 |
| | rate for the cost reporting period. Also show date of | Program | .03 | | | | | 3.03 |
| | each payment. If none, write 'NONE' or enter a zero. (1) | to | .04 | | | | | 3.04 |
| | | Provider | .05 | | | | | 3.05 |
| | | | .06 | | | | | 3.06 |
| | | | .08 | | | | | 3.08 |
| | | | .09 | | | | | 3.09 |
| | | | .10 | | | | | 3.10 |
| | | | .50 | | | | | 3.50 |
| | | | .51 | | | | | 3.51 |
| | | Provider | .52 | | | | | 3.52 |
| | | to | .53 | | | | | 3.53 |
| | | Program | .54 | | | | | 3.54 |
| | | | .55 | | | | | 3.55 |
| | | | .56 | | | | | 3.56 |
| | | | .57 | | | | | 3.57 |
| | | | .58 | | | | | 3.58 |
| | | | .59 | | | | | 3.59 |
| | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | | .99 | | 79,000 | | | 3.99 |
| 4 | Total interim payments (sum of lines 1, 2, and 3.99) | | | | 54,403,279 | | 18,606,767 | 4 |
| | (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) | | | | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | | | | | |
| 5 | | | .01 | | | | | 5.01 |
| | after desk review. Also show date of each payment. | | .02 | | | | | 5.02 |
| | If none, write 'NONE' or enter a zero. (1) | Program | .03 | | | | | 5.03 |
| | | to | .04 | | | | | 5.04 |
| | | Provider | .05 | | | | | 5.05 |
| | | | .06 | | | | | 5.06 |
| | | | .07 | | | | | 5.07 |
| | | | .09 | | | | | 5.09 |
| | | | .10 | | | | | 5.10 |
| | | | .50 | | | | | 5.50 |
| | | | .51 | | | | | 5.51 |
| | | Provider | .52 | | | | | 5.52 |
| | | to | .53 | | | | | 5.53 |
| | | Program | .54 | | | | | 5.54 |
| | | | .55 | | _ | | | 5.55 |
| | | | .56 | | | | | 5.56 |
| | | | .57 | | | | · | 5.57 |
| | | | .58 | | | | | 5.58 |
| | | | .59 | | | | | 5.59 |
| L_ | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | .99 | | | | | 5.99 |
| 6 | | | .01 | | 100 = : = | | 400 = | 6.01 |
| _ | based on the cost report (1) | | .02 | | -130,712 | | -189,799 | 6.02 |
| 7 8 | Total Medicare program liability (see instructions) Name of Contractor | | 1 | Contractor Number | 54,272,567 | NPR Date (Month/Da | 18,416,968 | 8 |
| 8 | Name of Contractor | | | Contractor Number | | MEK Date (Month/Da | y/ 1 ear) | 8 |

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

In Lieu of Form Period: Run Date: 09/25/2018
ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012

In Lieu of Form CMS-2552-10

CMS-2552-10

Period: Run Date: 09/25/2018
Run Time: 10:47
Version: 2018.04 (08/29/2018)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-T012 WORKSHEET E-1 PART I

 Check
 [] Hospital
 [] SUB (Other)

 Applicable
 [] IPF
 [] SNF

 Boxes:
 [XX] IRF
 [] Swing Bed SNF

| | | | | | INPATIENT PART B | | `B | |
|----------|---|---------------|--------|---|------------------|--------------------|--------|--------------|
| | | | | mm/dd/yyyy | AMOUNT | mm/dd/yyyy | AMOUNT | |
| | DESCRIPTION | | | 1 | 2 | 3 | 4 | |
| 1 | Total interim payments paid to provider | | | | 2,253,232 | | 822 | 1 |
| 2 | Interim payments payable on individual bills, eitehr submitted or to be submi | | ediary | | | | | 2 |
| | for services rendered in the cost reporting period. If none, write 'NONE' or en | iter a zero | _ | | | | | |
| 3 | List separately each retroactive lump sum adjustment | | .01 | | | | | 3.01 |
| | amount based on subsequent revision of the interim | _ | .02 | | | | | 3.02 |
| | rate for the cost reporting period. Also show date of | Program | .03 | | | | | 3.03 |
| | each payment. If none, write 'NONE' or enter a zero. (1) | to | .04 | | | | | 3.04 |
| | | Provider | .05 | | | | | 3.05 |
| | | | .06 | | | | | 3.06 |
| | | | .07 | | | | | 3.08 |
| - | | | .09 | | | | | 3.09 |
| | | | .10 | | | | | 3.10 |
| | | | .50 | | | | | 3.50 |
| | | | .51 | | | | | 3.51 |
| | | Provider | .52 | | | | | 3.52 |
| | | to | .53 | | | | | 3.53 |
| | | Program | .54 | | | | | 3.54 |
| | | riogram | .55 | | | | | 3.55 |
| | | | .56 | | | | | 3.56 |
| | | | .57 | | | | | 3.57 |
| | | | .58 | | | | | 3.58 |
| | | | .59 | | | | | 3.59 |
| | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | | .99 | | | | | 3.99 |
| 4 | Total interim payments (sum of lines 1, 2, and 3.99) | | | | 2 252 222 | | 022 | |
| 4 | (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) | | | | 2,253,232 | | 822 | 4 |
| | | | | | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | | | | | |
| 5 | | | .01 | | | | | 5.01 |
| | after desk review. Also show date of each payment. | | .02 | | | | | 5.02 |
| | If none, write 'NONE' or enter a zero. (1) | Program | .03 | | | | | 5.03 |
| | | to | .04 | | | | | 5.04 |
| | | Provider | .05 | | | | | 5.05 |
| | | | .06 | | | | | 5.06 |
| | | | .07 | | | | | 5.07 |
| | | | .08 | | | | | 5.08 |
| | | | .09 | | | | | 5.09 |
| \vdash | | | .10 | | | | | 5.10 |
| - | | | .50 | | | | | 5.50 |
| - | | D 1 | .51 | | | | | 5.51 |
| \vdash | | Provider | .52 | | | | | 5.52 |
| | | to Program | .53 | | | | | 5.53 5.54 |
| - | | Fiograffi | .55 | | | | | 5.55 |
| - | | | .56 | | | | | 5.56 |
| \vdash | | | .57 | | | | | 5.57 |
| \vdash | | | .58 | | | | | 5.58 |
| | | | .59 | | | | | 5.59 |
| | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | .99 | | | | | 5.99 |
| 6 | Determined net settlement amount (balance due) | | .01 | | 33,132 | | | 6.01 |
| | based on the cost report (1) | | .02 | | 33,132 | | -525 | 6.02 |
| 7 | Total Medicare program liability (see instructions) | | 1.02 | | 2,286,364 | | 297 | 7 |
| 8 | Name of Contractor | | | Contractor Number | -,,,,,,,, | NPR Date (Month/Da | | 8 |
| | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | (| ,, | |

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

| In Lieu of Form | Period : | Run Date: 09/25/2018 | ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | Version: 2018.04 (08/29/2018)

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T012

WORKSHEET E-3 PART III

Check [] Hospital
Applicable [XX] Subprovider IRF

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

| | | 1 | 1.01 | |
|-------|---|-----------|------|-------|
| 1 | Net Federal PPS payment (see instructions) | 2,153,829 | | 1 |
| 2 | Medicare SSI ratio (IRF PPS only) (see instructions) | 0.043200 | | 2 |
| 3 | Inpatient Rehabilitation LIP payments (see instructions) | 109,415 | | 3 |
| 4 | Outlier payments | 81,474 | | 4 |
| 5 | Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions) | | | 5 |
| 5.01 | Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) | | | 5.01 |
| 6 | New teaching program adjustment (see instructions) | | | 6 |
| 7 | Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions) | | | 7 |
| 8 | Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions) | | | 8 |
| 9 | Intern and resident count for IRF PPS medical education adjustment (see instructions) | | | 9 |
| 10 | Average daily census (see instructions) | 7.687671 | | 10 |
| 11 | Teaching Adjustment Factor (see instructions) | | | 11 |
| 12 | Teaching Adjustment (see instructions) | | | 12 |
| 13 | Total PPS Payment (see instructions) | 2,344,718 | | 13 |
| 14 | Nursing and allied health managed care payments (see instructions) | , , | | 14 |
| 15 | Organ acquisition DO NOT USE THIS LINE | | | 15 |
| 16 | Cost of physicians' services in a teaching hospital (see instructions) | | | 16 |
| 17 | Subtotal (see instructions) | 2,344,718 | | 17 |
| 18 | Primary payer payments | , , | | 18 |
| 19 | Subtotal (line 17 less line 18) | 2,344,718 | | 19 |
| 20 | Deductibles | 6,652 | | 20 |
| 21 | Subtotal (line 19 minus line 20) | 2,338,066 | | 21 |
| 22 | Coinsurance | 5,617 | | 22 |
| 23 | Subtotal (line 21 minus line 22) | 2,332,449 | | 23 |
| 24 | Allowable bad debts (exclude bad debts for professional services) (see instructions) | , , | | 24 |
| 25 | Adjusted reimbursable bad debts (see instructions) | | | 25 |
| 26 | Allowable bad debts for dual eligible beneficiaries (see instructions) | | | 26 |
| 27 | Subtotal (sum of lines 23 and 25) | 2,332,449 | | 27 |
| 28 | Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only) | , , | | 28 |
| 29 | Other pass through costs (see instructions) | 575 | | 29 |
| 30 | Outlier payments reconciliation | | | 30 |
| 31 | Other adjustments (specify) (see instructions) | | | 31 |
| 31.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | | 31.50 |
| 32 | Total amount payable to the provider (see instructions) | 2,333,024 | | 32 |
| 32.01 | Sequestration adjustment (see instructions) | 46,660 | | 32.01 |
| 32.02 | Demonstration payment adjustment amount after sequestration | , | | 32.02 |
| 33 | Interim payments | 2,253,232 | | 33 |
| 34 | Tentative settlement (for contractor use only) | , , | | 34 |
| 35 | Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34) | 33,132 | | 35 |
| 36 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | , | | 36 |

TO BE COMPLETED BY CONTRACTOR

| 10 11 | COMILETED DI CONTRACTOR | | |
|-------|--|--------|----|
| 50 | Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions) | 81,474 | 50 |
| 51 | Outlier reconciliation adjustment amount (see instructions) | | 51 |
| 52 | The rate used to calculate the Time Value of Money (see instructions) | | 52 |
| 53 | Time Value of Money (see instructions) | | 53 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

CALCULATION OF REIMBURSEMENT SETTLEMENT COMPONENT CCN: 15-0012 WORKSHEET E-3 PART VII

| Check | [] Title V | [XX] Hospital | [] NF | [XX] PPS |
|------------|----------------|-----------------|-------------|-----------|
| Applicable | [XX] Title XIX | [] SUB (Other) | [] ICF/IID | [] TEFRA |
| Boxes: | | [] SNF | | [] Other |

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

| | | | OUTDAT | |
|----|---|------------|-----------------|----|
| | | INPATIENT | OUTPAT- IENT | |
| | | TITLE V | TITLE V | |
| | | OR | OR | |
| | | TITLE XIX | TITLE XIX | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | IIILE AIA | |
| 1 | Undition thospital/SNF/NF services | | | 1 |
| 2 | Impatient indeption 3(1) 7(1) set vices Medical and other services | | | 2 |
| 3 | Wretten and other services Organ acquisition (certified transplant centers only) | | | 3 |
| 4 | Subtotal (sum of lines 1, 2 and 3) | | | 4 |
| 5 | Survivar (sum of lines 1, 2 and 3) Inpatient primary payer payments | | | 5 |
| 6 | Outpatient primary payer payments | | | 6 |
| 7 | Subtotal (lime 4 less sum of lines 5 and 6) | | | 7 |
| / | Subtotal (tine 4 ress sum of mes 3 and 0) COMPUTATION OF LESSER OF COST OR CHARGES | | | / |
| | COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES | | | |
| 8 | ROUTINE SERVICE CHARGES ROUTINE SERVICE CHARGES | | | 8 |
| 9 | Ancillary service charges | 44,104,406 | | 9 |
| 10 | Organ acquisition charges, net of revenue | 44,104,400 | | 10 |
| 11 | | | | 11 |
| 12 | Incentive from target amount computation Total reasonable charges (sum of lines 8-11) | 44 104 406 | | 12 |
| 12 | CUSTOMARY CHARGES | 44,104,406 | | 12 |
| 12 | | | | 12 |
| 13 | Amount actually collected from patients liable for payment for services on a cahrge basis | | | 13 |
| 14 | Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in | | | 14 |
| | accordance with 42 CFR §413.13(e) | 4.000000 | 4 000000 | |
| 15 | Ratio of line 13 to line 14 (not to exceed 1.000000) | 1.000000 | 1.000000 | |
| 16 | Total customary charges (see instructions) | 44,104,406 | | 16 |
| 17 | Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions) | 44,104,406 | | 17 |
| 18 | Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) | | | 18 |
| 19 | Interns and residents (see instructions) | | | 19 |
| 20 | Cost of physicians' services in a teaching hospital (see instructions) | | | 20 |
| 21 | Cost of covered services (lesser of line 4 or line 16) | | | 21 |
| | PROSPECTIVE PAYMENT AMOUNT | | | |
| 22 | Other than outlier payments | | | 22 |
| 23 | Outlier payments | | | 23 |
| 24 | Program capital payments | | | 24 |
| 25 | Capital exception payments (see instructions) | | | 25 |
| 26 | Routine and ancillary service other pass through costs | 7,829 | | 26 |
| 27 | Subtotal (sum of lines 22 through 26) | 7,829 | | 27 |
| 28 | Customary charges (Titles V or XIX PPS covered services only) | | | 28 |
| 29 | Titles V or XIX (sum of lines 21 and 27) | 7,829 | | 29 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | |
| 30 | Excess of reasonable cost (from line 18) | | | 30 |
| 31 | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) | 7,829 | | 31 |
| 32 | Deductibles | | | 32 |
| 33 | Coinsurance | | | 33 |
| 34 | Allowable bad debts (see instructions) | | | 34 |
| 35 | Utilization review | | | 35 |
| 36 | Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33) | 7,829 | | 36 |
| 37 | OTHER ADJUSTMENTS (SPECIFY) (see instructions) | | | 37 |
| 38 | Subtotal (line 36 ± line 37) | 7,829 | | 38 |
| 39 | Direct graduate medical education payments (from Wkst. E-4) | | | 39 |
| 40 | Total amount payable to the provider (sum of lines 38 and 39) | 7,829 | | 40 |
| 41 | Interim payments | | | 41 |
| 42 | Balance due provider/program (line 40 minus line 41) | 7,829 | | 42 |
| 43 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | | 43 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

CALCULATION OF REIMBURSEMENT SETTLEMENT COMPONENT CCN: 15-T012

WORKSHEET E-3 PART VII

| Check | [] Title V | [] Hospital | [] NF | [XX |] PPS |
|------------|----------------|----------------------|-------------|-----|---------|
| Applicable | [XX] Title XIX | [XX] Subprovider IRF | [] ICF/IID | [|] TEFRA |
| Boxes: | | [] SNF | | [|] Other |

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

| | | INPATIENT | OUTPAT- | |
|----|---|-----------|-----------|----|
| | | TITLE V | IENT | |
| | | OR | TITLE V | |
| | | | OR | |
| | | TITLE XIX | TITLE XIX | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | |
| 1 | Inpatient hospital/SNF/NF services | | | 1 |
| 2 | Medical and other services | | | 2 |
| 3 | Organ acquisition (certified transplant centers only) | | | 3 |
| 4 | Subtotal (sum of lines 1, 2 and 3) | | | 4 |
| 5 | Inpatient primary payer payments | | | 5 |
| 6 | Outpatient primary payer payments | | | 6 |
| 7 | Subtotal (line 4 less sum of lines 5 and 6) | | | 7 |
| -/ | Subtotal (Init's 1 less suin to 1 lines 3 and 0) COMPUTATION OF LESSER OF COST OR CHARGES | | | / |
| | COMPUTATION OF LESSER OF COST ON CHARGES REASONABLE CHARGES | | | |
| 0 | | | | |
| 8 | Routine service charges | | | 8 |
| 9 | Ancillary service charges | | | 9 |
| 10 | Organ acquisition charges, net of revenue | | | 10 |
| 11 | Incentive from target amount computation | | | 11 |
| 12 | Total reasonable charges (sum of lines 8-11) | | | 12 |
| | CUSTOMARY CHARGES | | | |
| 13 | Amount actually collected from patients liable for payment for services on a cahrge basis | | | 13 |
| 14 | Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in | | | 14 |
| | accordance with 42 CFR §413.13(e) | | | |
| 15 | Ratio of line 13 to line 14 (not to exceed 1.000000) | 1.000000 | 1.000000 | 15 |
| 16 | Total customary charges (see instructions) | | | 16 |
| 17 | Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions) | | | 17 |
| 18 | Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) | | | 18 |
| 19 | Interns and residents (see instructions) | | | 19 |
| 20 | Cost of physicians' services in a teaching hospital (see instructions) | | | 20 |
| 21 | Cost of covered services (lesser of line 4 or line 16) | | | 21 |
| | PROSPECTIVE PAYMENT AMOUNT | | | |
| 22 | Other than outlier payments | | | 22 |
| 23 | Outlier payments | | | 23 |
| 24 | Program capital payments | | | 24 |
| 25 | Capital exception payments (see instructions) | | | 25 |
| 26 | Routine acception payments (see instructions) Routine and ancillary service other pass through costs | | | 26 |
| 27 | Rottine and antimary service other pass unough costs Subtotal (sum of lines 22 through 26) | | | 27 |
| 28 | Customary charges (Titles V or XIX PPS covered services only) | | | 28 |
| 29 | Titles V or XIX (sum of lines 21 and 27) | | | 29 |
| 29 | | | | 29 |
| 20 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | 20 |
| 30 | Excess of reasonable cost (from line 18) | | | 30 |
| 31 | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) | | | 31 |
| 32 | Deductibles | | | 32 |
| 33 | Coinsurance | | | 33 |
| 34 | Allowable bad debts (see instructions) | | | 34 |
| 35 | Utilization review | | | 35 |
| 36 | Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33) | | | 36 |
| 37 | OTHER ADJUSTMENTS (SPECIFY) (see instructions) | | | 37 |
| 38 | Subtotal (line 36 ± line 37) | | | 38 |
| 39 | Direct graduate medical education payments (from Wkst. E-4) | | | 39 |
| 40 | Total amount payable to the provider (sum of lines 38 and 39) | | | 40 |
| 41 | Interim payments | | | 41 |
| 42 | Balance due provider/program (line 40 minus line 41) | | | 42 |
| 43 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | | 43 |
| | | | | |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

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

WORKSHEET E-4

Check [] Title V
Applicable [XX] Title XVIII
Box: [] Title XIX

| | COMPUTATION OF TOTAL DIRECT GME AMOUNT | | | | |
|--|--|------------------------|--|---|--|
| 1 | Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before I | December 31 1996 | | 22.87 | 1 |
| 2 | Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions) | | 22.07 | 2 | |
| 3 | Amount of reduction to Direct GME cap under §422 of MMA | | 2.14 | 3 | |
| 3.01 | Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost | reporting periods stra | ddling 7/1/2011) | 2.17 | 3.01 |
| | Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation a | | | | |
| 4 | \$413.79(f)) | greement (42 Cr K ş4 | 13.75(b) and | | 4 |
| 4.01 | ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011) | | | | 4.01 |
| 4.02 | ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/20 | 011) | | 7.00 | 4.02 |
| 5 | FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable su | | | 27.73 | 5 |
| 6 | Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instruction). | | | 26.70 | 6 |
| 7 | Enter the lesser of line 5 or line 6 | uctions) | | 26.70 | 7 |
| | Enter the lesser of time 5 of time 6 | Primary Care | Other | Total | <u> </u> |
| | | 1 | 2 | 3 | |
| 8 | Weighted FTE count for physicians in an allopathic and osteopathic program for the current year | 26.20 | 0.50 | 26.70 | 8 |
| | If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by | 20.20 | 0.50 | 20.70 | |
| 9 | the amount on line 6 | 26.20 | 0.50 | 26.70 | 9 |
| 10 | Weighted dental and podiatric resident FTE count for the current year | | 5.00 | | 10 |
| 10.01 | Unweighted dental and podiatric resident FTE count for the current year | | 3.00 | | 10.01 |
| 11 | Total weighted FTE count | 26.20 | 5.50 | | 11 |
| 12 | | | 5.00 | | 12 |
| | Total weighted resident FTE count for the prior cost reporting year (see instructions) | 26.25 | | | |
| 13 | Total weighted resident FTE count for the penultimate cost reporting year (see instructions) | 26.74 | 5.49 | | 13 |
| 14 | Rolling average FTE count (sum of lines 11 through 13 divided by 3) | 26.40 | 5.33 | | 14 |
| 15 | Adjustment for residents in initial years of new programs | 0.00 | 0.00 | | 15 |
| 15.01 | Unweighted adjustment for residents in initial years of new programs | | | | 15.01 |
| 16 | Adjustment for residents displaced by program or hospital closure | 0.00 | 0.00 | | 16 |
| 16.01 | Unweighted adjustment for residents displaced by program or hospital closure | | | | 16.01 |
| 17 | Adjusted rolling average FTE count | 26.40 | 5.33 | | 17 |
| 18 | Per resident amount | 129,720.68 | 123,217.74 | | 18 |
| 19 | Approved amount for resident costs | 3,424,626 | 656,751 | 4,081,377 | 19 |
| 20 | Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4) | | | | 20 |
| 21 | Direct GME FTE unweighted resident count over cap (see instructions) | | | | 21 |
| 22 | Allowable additional direct GME FTE resident count (see instructions) | | | | 22 |
| 23 | Enter the locality adjustment national average per resident amount (see instructions) | | | | 23 |
| 24 | Multiply line 22 times line 23 | | | | 24 |
| 25 | Total direct GME amount (sum of lines 19 and 24) | | | 4,081,377 | 25 |
| | COMPUTATION OF PROGRAM PATIENT LOAD | Inpatient Part A | Managed Care | | |
| 26 | Inpatient days (see instructions) | 25,465 | 9,085 | | 26 |
| 27 | Total inpatient days (see instructions) | 65,644 | 65,644 | | 27 |
| 28 | Ratio of inpatient days to total inpatient days | 0.387926 | 0.138398 | | 28 |
| 29 | Program direct GME amount | 1,583,272 | 564,854 | | 29 |
| 30 | Reduction for direct GME payments for Medicare Advantage | | 79,814 | | 30 |
| 31 | Net Program direct GME amount | | | 2,068,312 | 31 |
| | DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING | SCHOOL AND PA | RAMEDICAL | _,, | - |
| | EDUCATION COSTS) | | THE PROPERTY OF THE PARTY OF TH | | |
| 32 | Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) | | | | 32 |
| 33 | Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) | | | 1,852,636 | 33 |
| 34 | Ratio of direct medical education costs to total charges (line 32 ÷ line 33) | | | 1,002,000 | 34 |
| 35 | Medicare outpatient ESRD charges (see instructions) | | | | 35 |
| 36 | Medicare outpatient ESRD direct medical education costs (line 34 x line 35) | | | | 36 |
| 50 | Areas output ent botto uncer medical education costs (time 57 x time 55) | | | | 50 |
| | APPORTIONMENT OF MEDICARE REASONABLE COST OF CME | | 1 | | ı |
| | APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost | | | | |
| 37 | Part A Reasonable Cost | | | 60 135 161 | 37 |
| 37 | Part A Reasonable Cost Reasonable cost (see instructions) | | | 69,435,164 | 37 |
| 38 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) | | | 69,435,164 | 38 |
| 38 39 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) | | | | 38 39 |
| 38 39 40 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) | | | 32,669 | 38 39 40 |
| 38 39 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) | | | | 38 39 40 |
| 38 39 40 41 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost | | | 32,669 69,402,495 | 38 39 40 41 |
| 38 39 40 41 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) | | | 32,669 69,402,495 23,447,147 | 38 39 40 41 |
| 38 39 40 41 42 43 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) Primary payer payments (see instructions) | | | 32,669 69,402,495 23,447,147 9,301 | 38 39 40 41 42 43 |
| 38 39 40 41 42 43 44 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) | | | 32,669 69,402,495 23,447,147 9,301 23,437,846 | 38 39 40 41 42 43 44 |
| 38 39 40 41 42 43 44 45 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total reasonable cost (sum of lines 41 and 44) | | | 32,669 69,402,495 23,447,147 9,301 23,437,846 92,840,341 | 38 39 40 41 42 43 44 45 |
| 38 39 40 41 42 43 44 45 46 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) | | | 32,669 69,402,495 23,447,147 9,301 23,437,846 92,840,341 0.747547 | 38 39 40 41 42 43 44 45 46 |
| 38 39 40 41 42 43 44 45 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) Primary payer payments (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) | | | 32,669 69,402,495 23,447,147 9,301 23,437,846 92,840,341 | 38 39 40 41 42 43 44 45 |
| 38 39 40 41 42 43 44 45 46 47 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total Part B reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B | | | 32,669 69,402,495 23,447,147 9,301 23,437,846 92,840,341 0.747547 0.252453 | 38 39 40 41 42 43 44 45 46 47 |
| 38 39 40 41 42 43 44 45 46 47 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total Part B reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B Total program GME payment (line 31) | | | 32,669 69,402,495 23,447,147 9,301 23,437,846 92,840,341 0,747547 0,252453 | 38 39 40 41 42 43 44 45 46 47 |
| 38 39 40 41 42 43 44 45 46 47 | Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total Part B reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B | | | 32,669 69,402,495 23,447,147 9,301 23,437,846 92,840,341 0.747547 0.252453 | 38 39 40 41 42 43 44 45 46 47 48 49 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

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

WORKSHEET E-4

Check [] Title V
Applicable [] Title XVIII
Box: [XX] Title XIX

| 1 | COMPUTATION OF TOTAL DIRECT GME AMOUNT | | | | |
|--|---|-------------------------|--------------------|-------|--|
| | Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before D | ecember 31, 1996 | | | 1 |
| 2 | Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions) | , | | | 2 |
| 3 | Amount of reduction to Direct GME cap under §422 of MMA | | | | 3 |
| 3.01 | Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost | reporting periods strac | ddling 7/1/2011) | | 3.01 |
| 4 | Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation a §413.79(f)) | greement (42 CFR §4 | 13.75(b) and | | 4 |
| 1.01 | ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011) | | | | 4.01 |
| .02 | ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/20 | | | | 4.02 |
| 5 | FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable sul | | | | 5 |
| 6 | Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instr | uctions) | | | 6 |
| 7 | Enter the lesser of line 5 or line 6 | | | | 7 |
| | | Primary Care | Other | Total | |
| | With IRR | 1 | 2 | 3 | |
| 8 | Weighted FTE count for physicians in an allopathic and osteopathic program for the current year | 0.00 | 0.00 | 0.00 | 8 |
| 9 | If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6 | 0.00 | 0.00 | 0.00 | 9 |
| 10 | Weighted dental and podiatric resident FTE count for the current year | | 0.00 | | 10 |
| 10.01 | Unweighted dental and podiatric resident FTE count for the current year | | | | 10.01 |
| 11 | Total weighted FTE count | 0.00 | 0.00 | | 11 |
| 12 | Total weighted resident FTE count for the prior cost reporting year (see instructions) | 0.00 | 0.00 | | 12 |
| 13 | Total weighted resident FTE count for the penultimate cost reporting year (see instructions) | 0.00 | 0.00 | | 13 |
| 14 | Rolling average FTE count (sum of lines 11 through 13 divided by 3) | 0.00 | 0.00 | | 14 |
| 15 01 | Adjustment for residents in initial years of new programs | 0.00 | 0.00 | | 15 |
| 15.01 | Unweighted adjustment for residents in initial years of new programs | 0.5- | 2.05 | | 15.01 |
| 16 | Adjustment for residents displaced by program or hospital closure | 0.00 | 0.00 | | 16 |
| 16.01 | Unweighted adjustment for residents displaced by program or hospital closure | 0.00 | 0.00 | | 16.01 |
| 17 18 | Adjusted rolling average FTE count | 0.00 | 0.00 | | 17 |
| | Per resident amount | 0.00 | 0.00 | | 18 |
| 19 | Approved amount for resident costs | | | | 19 |
| 20 | Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instructions) | | | | 20 |
| 21 22 | Allowable additional direct GME FTE resident count (see instructions) | | | | 21 |
| | | | | | |
| 23 24 | Enter the locality adjustment national average per resident amount (see instructions) Multiply line 22 times line 23 | | | | 23 |
| 24 25 | Total direct GME amount (sum of lines 19 and 24) | | | | 25 |
| 23 | COMPUTATION OF PROGRAM PATIENT LOAD | Inpatient Part A | Managed Care | | 23 |
| 26 | Inpatient days (see instructions) | | | | |
| | | 5 767 | 8.013 | | 26 |
| 27 | | 5,767 | 8,013 65,644 | | 26 |
| | Total inpatient days (see instructions) | 65,644 | 65,644 | | 27 |
| 28 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days | | | | 27 28 |
| 28 29 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount | 65,644 | 65,644 | | 27 28 29 |
| 28 29 30 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage | 65,644 | 65,644 | | 27 28 29 30 |
| 28 29 30 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 |
| 28 29 30 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 |
| 28 29 30 31 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 |
| 28 29 30 31 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 |
| 28 29 30 31 32 33 34 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 |
| 28 29 30 31 32 33 34 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 |
| 28 29 30 31 32 33 34 35 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 |
| 28 29 30 31 32 33 34 35 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 |
| 28 29 30 31 32 33 34 35 36 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 36 |
| 28 29 30 31 32 33 34 35 36 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 36 |
| 28 29 30 31 32 33 34 35 36 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 36 37 38 |
| 228 229 330 331 332 333 334 335 336 337 338 339 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 36 37 38 39 |
| 228 229 330 331 333 344 35 366 37 38 38 39 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 36 37 38 |
| 228 229 330 331 32 33 34 35 36 37 38 39 40 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 36 37 38 39 |
| 28 29 30 31 32 33 34 35 36 37 38 39 40 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 36 37 38 39 40 |
| 28 29 30 31 32 33 34 35 36 37 38 39 40 41 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 |
| 228 229 30 31 32 33 34 35 36 37 38 39 40 41 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable Cost Reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) Primary payer payments (see instructions) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 |
| 28 29 30 31 32 33 33 34 335 36 37 38 39 40 41 42 43 44 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost Reasonable cost (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 |
| 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 44 45 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) Primary payer payments (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total reasonable cost (sum of lines 41 and 44) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 31 32 33 34 35 36 37 38 39 40 41 41 42 43 44 44 45 |
| 228 229 229 333 331 332 333 334 335 336 337 338 339 440 441 444 444 445 446 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Renal dialysis and home dialysis total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable Cost Reasonable Cost (see instructions) Primary payer payments (see instructions) Primary payer payments (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 44 45 46 |
| 228 229 229 333 331 332 333 334 335 336 337 338 339 440 441 444 444 445 446 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable cost (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total Part B reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 31 32 33 34 35 36 37 38 39 40 41 41 42 43 44 44 45 |
| 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) Total Part B reasonable cost (sum of lines 41 and 44) Ratio of Part B reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 |
| 28 29 30 30 31 33 33 34 34 35 36 37 38 38 39 40 40 41 41 41 44 44 44 44 44 | Total inpatient days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Ratio of direct medical education costs to total charges (line 32 ÷ line 33) Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT OF MEDICARE REASONABLE COST OF GME Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable cost (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total Part B reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) | 65,644 0.087853 | 65,644 0.122068 | | 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 44 45 46 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

BALANCE SHEET G WORKSHEET G

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

| | Assets | General Fund | Specific Purpose Fund | Endowment Fund | Plant Fund | |
|--|---|---|-----------------------------|-------------------|---------------|--|
| | (Omit Cents) | 1 | 2 | 3 | 4 | |
| 1 | | 837,383 | | | | 1 |
| 2 | | 36,431,530 | | | | 2 |
| 3 | | 30,431,330 | | | | 3 |
| 4 | Accounts receivable | 84,877,850 | | | | 4 |
| 5 | Other receivables | 15,554,838 | | | | 5 |
| 6 | | -15,742,848 | | | | 6 |
| 7 8 | | 7,324,698 | | | | 7 8 |
| 9 | | 497,292 | | | | 9 |
| 10 | | | | | | 10 |
| 11 | Total current assets (sum of lines 1-10) | 129,780,743 | | | | 11 |
| | FIXED ASSETS | | | | | |
| 12 | | 406,021 | | | | 12 |
| 13 | | | | | | 13 |
| 14 | | | | | | 14 15 |
| 16 | | | | | | 16 |
| 17 | | 309,510,210 | | | | 17 |
| 18 | Accumulated depreciation | 507,510,210 | | | | 18 |
| 19 | Fixed equipment | | | | | 19 |
| 20 | Accumulated depreciation | | | | | 20 |
| 21 | Audomobiles and trucks | | | | | 21 |
| 22 | | | | | | 22 |
| 23 24 | | 112,624,184 -157,467,699 | | | | 23 |
| 25 | | -157,467,699 | | | | 25 |
| 26 | | | | | | 26 |
| 27 | | | | | | 27 |
| 28 | Accumulated depreciation | | | | | 28 |
| 29 | Minor equipment-nondepreciable | | | | | 29 |
| 30 | Total fixed assets (sum of lines 12-29) | 265,072,716 | | | | 30 |
| | | | | | | |
| 31 | | | | | | 31 |
| 32 | | | | | | 32 |
| 34 | | 22,049,720 | | | | 34 |
| 35 | | 22,049,720 | | | | 35 |
| 36 | Total assets (sum of lines 11, 30 and 35) | 416,903,179 | | | | 36 |
| | | | | | | |
| | Current ASSETS Cash on hand and in banks | General | Specific | Endowment | Plant | |
| | | | Purpose | Fund | Fund | |
| | T 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Fund | F 1 | | | |
| | | | Fund | 2 | | _ |
| | (Omit Cents) | Fund 1 | Fund 2 | 3 | 4 | |
| 37 | (Omit Cents) CURRENT LIABILITIES | 1 | | 3 | | 37 |
| | (Omit Cents) CURRENT LIABILITIES Accounts payable | | | 3 | | 37 38 |
| 38 39 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable | 25,204,074 | | 3 | | 38 39 |
| 38 39 40 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) | 1 25,204,074 7,580,534 7,381,172 | | 3 | | 38 39 40 |
| 38 39 40 41 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income | 25,204,074 7,580,534 | | 3 | | 38 39 40 41 |
| 38 39 40 41 42 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments | 1 25,204,074 7,580,534 7,381,172 | | 3 | | 38 39 40 41 42 |
| 38 39 40 41 42 43 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds | 25,204,074 7,580,534 7,381,172 52,285 | | 3 | | 38 39 40 41 42 43 |
| 38 39 40 41 42 43 44 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities | 25,204,074 7,580,534 7,381,172 52,285 | | 3 | | 38 39 40 41 42 43 44 |
| 38 39 40 41 42 43 44 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities | 25,204,074 7,580,534 7,381,172 52,285 | | 3 | | 38 39 40 41 42 43 |
| 38 39 40 41 42 43 44 45 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES | 25,204,074 7,580,534 7,381,172 52,285 | | 3 | | 38 39 40 41 42 43 44 |
| 38 39 40 41 42 43 44 45 46 47 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES Mortgage payable Notes payable | 25,204,074 7,580,534 7,381,172 52,285 | | 3 | | 38 39 40 41 42 43 44 45 |
| 38 39 40 41 42 43 44 45 46 47 48 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans | 1 25,204,074 7,580,534 7,381,172 52,285 958,951 41,177,016 | | 3 | | 38 39 40 41 42 43 44 45 46 47 48 |
| 38 39 40 41 42 43 44 45 46 47 48 49 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities | 1 25,204,074 7,580,534 7,381,172 52,285 958,951 41,177,016 284,077,975 11,530,484 | | 3 | | 38 39 40 41 42 43 44 45 46 47 48 49 |
| 38 39 40 41 42 43 44 45 46 47 48 49 50 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities Total long term liabilities | 25,204,074 7,580,534 7,381,172 52,285 958,951 41,177,016 284,077,975 11,530,484 295,608,459 | | 3 | | 38 39 40 41 42 43 44 45 46 47 48 49 50 |
| 38 39 40 41 42 43 44 45 46 47 48 49 50 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities Total long term liabilities Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50) | 1 25,204,074 7,580,534 7,381,172 52,285 958,951 41,177,016 284,077,975 11,530,484 | | 3 | | 38 39 40 41 42 43 44 45 46 47 48 49 |
| 39 40 41 42 43 44 45 46 47 48 49 50 51 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS | 1 25,204,074 7,580,534 7,381,172 52,285 958,951 41,177,016 284,077,975 11,530,484 295,608,459 336,785,475 | | 3 | | 38 39 40 41 42 43 44 45 46 47 48 49 50 |
| 38 39 40 41 42 43 44 45 46 47 48 49 50 51 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS General fund balance | 25,204,074 7,580,534 7,381,172 52,285 958,951 41,177,016 284,077,975 11,530,484 295,608,459 | | 3 | | 38 39 40 41 42 43 44 45 46 47 48 49 50 51 |
| 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS General fund balance Specific purpose fund | 1 25,204,074 7,580,534 7,381,172 52,285 958,951 41,177,016 284,077,975 11,530,484 295,608,459 336,785,475 | | 3 | | 38 39 40 41 42 43 44 45 46 47 48 49 50 |
| 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 | (Omit Cents) CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS General fund balance Specific purpose fund | 1 25,204,074 7,580,534 7,381,172 52,285 958,951 41,177,016 284,077,975 11,530,484 295,608,459 336,785,475 | | 3 | | 38 39 40 41 42 43 44 45 46 47 48 49 50 51 |
| 38 39 40 41 42 43 44 45 46 47 48 49 50 51 51 52 55 56 | CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities Total long term liabilities Total long term liabilities Total liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance Governing body created - endowment fund balance | 1 25,204,074 7,580,534 7,381,172 52,285 958,951 41,177,016 284,077,975 11,530,484 295,608,459 336,785,475 | | 3 | | 38 39 40 41 41 42 43 44 45 46 47 48 49 50 51 |
| 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 | CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES Mortgage payable Notes payable Notes payable Unsecured loans Other long term liabilities Total long term liabilities Total long term liabilities Total long term liabilities Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance Plant fund balance - invested in plant | 1 25,204,074 7,580,534 7,381,172 52,285 958,951 41,177,016 284,077,975 11,530,484 295,608,459 336,785,475 | | 3 | | 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 |
| 38 39 40 41 42 43 44 45 46 47 48 49 55 51 52 53 54 55 | CURRENT LIABILITIES Accounts payable Salaries, wages and fees payable Payroll taxes payable Notes and loans payable (short term) Deferred income Accelerated payments Due to other funds Other current liabilities Total current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities Total long term liabilities Total long term liabilities Total liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance Governing body created - endowment fund balance | 1 25,204,074 7,580,534 7,381,172 52,285 958,951 41,177,016 284,077,975 11,530,484 295,608,459 336,785,475 | | 3 | | 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

| | GENERA | L FUND | SPECIFIC PU | RPOSE FUND | |
|--|-------------|-------------|-------------|------------|----|
| | 1 | 2 | 3 | 4 | |
| 1 Fund balances at beginning of period | | 62,999,576 | | | 1 |
| 2 Net income (loss) (from Worksheet G-3, line 29) | | 43,313,519 | | | 2 |
| Total (sum of line 1 and line 2) | | 106,313,095 | | | 3 |
| 4 Additions (credit adjustments) (specify) | | | | | 4 |
| 5 TOTAL UNREST EQ TRANSFERS EXT | -26,367,841 | | | | 5 |
| 6 NA REL FROM REST FOR CAP ACQ | 172,441 | | | | 6 |
| 7 | | | | | 7 |
| 8 | | | | | 8 |
| 9 | | | | | 9 |
| Total additions (sum of lines 4-9) | | -26,195,400 | | | 10 |
| Subtotal (line 3 plus line 10) | | 80,117,695 | | | 11 |
| 12 Deductions (debit adjustments) (specify) | | | | | 12 |
| 3 | | | | | 13 |
| 4 | | | | | 14 |
| 15 | | | | | 15 |
| 16 | | | | | 16 |
| 17 | | | | | 17 |
| Total deductions (sum of lines 12-17) | | | | | 18 |
| 19 Fund balance at end of period per balance sheet (line 11 minus line 18) | | 80,117,695 | | | 19 |

| | | ENDOWN | MENT FUND | PLAN | T FUND | |
|----|---|--------|-----------|------|--------|----|
| | | 5 | 6 | 7 | 8 | |
| 1 | Fund balances at beginning of period | | | | | 1 |
| 2 | Net income (loss) (from Worksheet G-3, line 29) | | | | | 2 |
| 3 | Total (sum of line 1 and line 2) | | | | | 3 |
| 4 | Additions (credit adjustments) (specify) | | | | | 4 |
| 5 | TOTAL UNREST EQ TRANSFERS EXT | | | | | 5 |
| 6 | NA REL FROM REST FOR CAP ACQ | | | | | 6 |
| 7 | | | | | | 7 |
| 8 | | | | | | 8 |
| 9 | | | | | | 9 |
| 10 | Total additions (sum of lines 4-9) | | | | | 10 |
| 11 | Subtotal (line 3 plus line 10) | | | | | 11 |
| 12 | Deductions (debit adjustments) (specify) | | | | | 12 |
| 13 | | | | | | 13 |
| 14 | | | | | | 14 |
| 15 | | | | | | 15 |
| 16 | | | | | | 16 |
| 17 | | | | | | 17 |
| 18 | Total deductions (sum of lines 12-17) | | | | | 18 |
| 19 | Fund balance at end of period per balance sheet (line 11 minus line 18) | | | | | 19 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2 PARTS I & II

PART I - PATIENT REVENUES

| | | INPATIENT | OUTPATIENT | TOTAL | |
|-------|--|-------------|-------------|---------------|-------|
| | REVENUE CENTER | 1 | 2 | 3 | |
| | GENERAL INPATIENT ROUTINE CARE SERVICES | | | | |
| 1 | Hospital | 126,457,918 | | 126,457,918 | 1 |
| 2 | Subprovider IPF | | | | 2 |
| 3 | Subprovider IRF | 5,269,952 | | 5,269,952 | 3 |
| 5 | Swing Bed - SNF | | | | 5 |
| 6 | Swing Bed - NF | | | | 6 |
| 7 | Skilled nursing facility | | | | 7 |
| 8 | Nursing facility | | | | 8 |
| 9 | Other long term care | | | | 9 |
| 10 | Total general inpatient care services (sum of lines 1-9) | 131,727,870 | | 131,727,870 | 10 |
| | INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES | | | | |
| 11 | Intensive Care Unit | 24,868,507 | | 24,868,507 | 11 |
| 12 | Coronary Care Unit | | | | 12 |
| 13 | Burn Intensive Care Unit | | | | 13 |
| 14 | Surgical Intensive Care Unit | | | | 14 |
| 15 | NEONATAL INTENSIVE CARE UNIT | 12,617,860 | | 12,617,860 | 15 |
| 16 | Total intensive care type inpatient hospital services (sum of lines 11-15) | 37,486,367 | | 37,486,367 | 16 |
| 17 | Total inpatient routine care services (sum of lines 10 and 16) | 169,214,237 | | 169,214,237 | 17 |
| 18 | Ancillary services | 434,495,081 | 443,244,762 | 877,739,843 | 18 |
| 19 | Outpatient services | 21,232,648 | 75,842,977 | 97,075,625 | 19 |
| 20 | Rural Health Clinic (RHC) | | | | 20 |
| 21 | Federally Qualified Health Center (FQHC) | | | | 21 |
| 22 | Home health agency | | | | 22 |
| 23 | Ambulance | | | | 23 |
| 25 | ASC | | | | 25 |
| 26 | Hospice | | | | 26 |
| 27 | Other (specify) | | | | 27 |
| 27.01 | KIDNEY ACQUISITION | 93,904 | 3,289,816 | 3,383,720 | 27.01 |
| 27.02 | INTERN-RESIDENT SERVICE (NOT APPVD. | 1,605,297 | 1,585 | 1,606,882 | 27.02 |
| 27.03 | HOSPITALISTS/INTENSIVISTS | 836,412 | 69,579 | 905,991 | 27.03 |
| 27.99 | REVENUE ADJUSTMENTS | 7,773,853 | 16,582,544 | 24,356,397 | 27.99 |
| 28 | Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1) | 635,251,432 | 539,031,263 | 1,174,282,695 | 28 |

PART II - OPERATING EXPENSES

| | | 1 | 2 | |
|----|--|---|-------------|----|
| 29 | Operating expenses (per Worksheet A, column 3, line 200) | | 323,453,954 | 29 |
| 30 | Add (specify) | | | 30 |
| 31 | | | | 31 |
| 32 | | | | 32 |
| 33 | | | | 33 |
| 34 | | | | 34 |
| 35 | | | | 35 |
| 36 | Total additions (sum of lines 30-35) | | | 36 |
| 37 | Deduct (specify) | | | 37 |
| 38 | | | | 38 |
| 39 | | | | 39 |
| 40 | | | | 40 |
| 41 | | | | 41 |
| 42 | Total deductions (sum of lines 37-41) | | | 42 |
| 43 | Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3 line 4) | | 323 453 954 | 43 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

| | DESCRIPTION | | I |
|---|--|---------------|---|
| 1 | Total patient revenues (from Worksheet G-2, Part I, column 3, line 28) | 1,174,282,695 | 1 |
| 2 | Less contractual allowances and discounts on patients' accounts | 815,045,491 | 2 |
| 3 | Net patient revenues (line 1 minus line 2) | 359,237,204 | 3 |
| 4 | Less total operating expenses (from Worksheet G-2, Part II, line 43) | 323,453,954 | 4 |
| 5 | Net income from service to patients (line 3 minus line 4) | 35,783,250 | 5 |

OTHER INCOME

| 6 | Contributions, donations, bequests, etc. | | 6 |
|----|---|------------|----|
| 7 | Income from investments | | 7 |
| 8 | Revenues from telephone and other miscellaneous communication services | | 8 |
| 9 | Revenue from television and radio service | | 9 |
| 10 | Purchase discounts | | 10 |
| 11 | Rebates and refunds of expenses | | 11 |
| 12 | Parking lot receipts | | 12 |
| 13 | Revenue from laundry and linen service | | 13 |
| 14 | Revenue from meals sold to employees and guests | | 14 |
| 15 | Revenue from rental of living quarters | | 15 |
| 16 | Revenue from sale of medical and surgical supplies to otehr than patients | | 16 |
| 17 | Revenue from sale of drugs to other than patients | | 17 |
| 18 | Revenue from sale of medical records and abstracts | | 18 |
| 19 | Tuition (fees, sale of textbooks, uniforms, etc.) | | 19 |
| 20 | Revenue from gifts, flowers, coffee shops and canteen | | 20 |
| 21 | Rental of vending machines | | 21 |
| 22 | Rental of hosptial space | | 22 |
| 23 | Governmental appropriations | | 23 |
| 24 | Other (specify) | 7,530,269 | 24 |
| 25 | Total other income (sum of lines 6-24) | 7,530,269 | 25 |
| 26 | Total (line 5 plus line 25) | 43,313,519 | 26 |
| 29 | Net income (or loss) for the period (line 26 minus line 28) | 43,313,519 | 29 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|------------------------------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

CALCULATION OF CAPITAL PAYMENT COMPONENT CCN: 15-0012 WORKSHEET L

Check

[XX] Hospital [] SUB (Other) [XX] PPS [] Cost Method [] Title V
[XX] Title XVIII, Part A
[] Title XIX Applicable Boxes:

PART I - FULLY PROSPECTIVE METHOD

| LAN | 11-FULLI PROSPECTIVE METHOD | | |
|------|---|-----------|------|
| | CAPITAL FEDERAL AMOUNT | | |
| 1 | Capital DRG other than outlier | 3,657,239 | 1 |
| 1.01 | Model 4 BPCI Capital DRG other than outlier | | 1.01 |
| 2 | Capital DRG outlier payments | 409,951 | 2 |
| 2.01 | Model 4 BPCI Capital DRG outlier payments | | 2.01 |
| 3 | Total inpatient days divided by number of days in the cost reporting period (see instructions) | 174.65 | 3 |
| 4 | Number of interns & residents (see instructions) | 27.42 | 4 |
| 5 | Indirect medical education percentage (see instructions) | 4.53 | 5 |
| 6 | Indirect medical education adjustment (see instructions) | 165,673 | 6 |
| 7 | Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions) | 0.0426 | 7 |
| 8 | Percentage of Medicaid patient days to total days (see instructions) | 0.2318 | 8 |
| 9 | Sum of lines 7 and 8 | 0.2744 | 9 |
| 10 | Allowable disproportionate share percentage (see instructions) | 0.0572 | 10 |
| 11 | Disproportionate share adjustment (see instructions) | 209,194 | 11 |
| 12 | Total prospective capital payments (see instructions) | 4,442,057 | 12 |

PART II - PAYMENT UNDER REASONABLE COST

| 1 | Program inpatient routine capital cost (see instructions) | 1 |
|---|---|---|
| 2 | Program inpatient ancillary capital cost (see instructions) | 2 |
| 3 | Total inpatient program capital cost (line 1 plus line 2) | 3 |
| 4 | Capital cost payment factor (see instructions) | 4 |
| 5 | Total inpatient program capital cost (line 3 times line 4) | 5 |

PART III - COMPUTATION OF EXCEPTION PAYMENTS

| 1 | Program inpatient capital costs (see instructions) | 1 |
|----|--|----|
| 2 | Program inpatient capital costs for extraordinary circumstances (see instructions) | 2 |
| 3 | Net program inpatient capital costs (line 1 minus line 2) | 3 |
| 4 | Applicable exception percentage (see instructions) | 4 |
| 5 | Capital cost for comparison to payments (line 3 x line 4) | 5 |
| 6 | Percentage adjustment for extraordinary circumstances (see instructions) | 6 |
| 7 | Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) | 7 |
| 8 | Capital minimum payment level (line 5 plus line 7) | 8 |
| 9 | Current year capital payments (from Part I, line 12 as applicable) | 9 |
| 10 | Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) | 10 |
| 11 | Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) | 11 |
| 12 | Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) | 12 |
| 13 | Current year exception payment (if line 12 is positive, enter the amount on this line) | 13 |
| 14 | Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) | 14 |
| 15 | Current year allowable operating and capital payment (see instructions) | 15 |
| 16 | Current year operating and capital costs (see instructions) | 16 |
| 17 | Current year exception offset amount (see instructions) | 17 |

| • | | In Lieu of Form | Period : | Run Date: 09/25/2018 |
|-----------------------|----------------|-----------------|------------------|-------------------------------|
| ST. JOSEPHS REG MED | CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 |
| Provider CCN: 15-0012 | | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) |

CALCULATION OF CAPITAL PAYMENT COMPONENT CCN: 15-0012 WORKSHEET L

[] Title V [XX] Hospital
[] Title XVIII, Part A [] SUB (Other)
[XX] Title XIX Check

[XX] PPS [] Cost Method Applicable Boxes:

PART I - FULLY PROSPECTIVE METHOD

| PAK | 11-FULLY PROSPECTIVE METHOD | |
|------|---|------|
| | CAPITAL FEDERAL AMOUNT | |
| 1 | Capital DRG other than outlier | 1 |
| 1.01 | Model 4 BPCI Capital DRG other than outlier | 1.01 |
| 2 | Capital DRG outlier payments | 2 |
| 2.01 | Model 4 BPCI Capital DRG outlier payments | 2.01 |
| 3 | Total inpatient days divided by number of days in the cost reporting period (see instructions) | 3 |
| 4 | Number of interns & residents (see instructions) | 4 |
| 5 | Indirect medical education percentage (see instructions) | 5 |
| 6 | Indirect medical education adjustment (see instructions) | 6 |
| 7 | Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions) | 7 |
| 8 | Percentage of Medicaid patient days to total days (see instructions) | 8 |
| 9 | Sum of lines 7 and 8 | 9 |
| 10 | Allowable disproportionate share percentage (see instructions) | 10 |
| 11 | Disproportionate share adjustment (see instructions) | 11 |
| 12 | Total prospective capital payments (see instructions) | 12 |

PART II - PAYMENT UNDER REASONABLE COST

| 1 | Program inpatient routine capital cost (see instructions) | 1 |
|---|---|---|
| 2 | Program inpatient ancillary capital cost (see instructions) | 2 |
| 3 | Total inpatient program capital cost (line 1 plus line 2) | 3 |
| 4 | Capital cost payment factor (see instructions) | 4 |
| 5 | Total inpatient program capital cost (line 3 times line 4) | 5 |

PART III - COMPUTATION OF EXCEPTION PAYMENTS

| 1 | Program inpatient capital costs (see instructions) | 1 |
|----|--|----|
| 2 | Program inpatient capital costs for extraordinary circumstances (see instructions) | 2 |
| 3 | Net program inpatient capital costs (line 1 minus line 2) | 3 |
| 4 | Applicable exception percentage (see instructions) | 4 |
| 5 | Capital cost for comparison to payments (line 3 x line 4) | 5 |
| 6 | Percentage adjustment for extraordinary circumstances (see instructions) | 6 |
| 7 | Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) | 7 |
| 8 | Capital minimum payment level (line 5 plus line 7) | 8 |
| 9 | Current year capital payments (from Part I, line 12 as applicable) | 9 |
| 10 | Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) | 10 |
| 11 | Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) | 11 |
| 12 | Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) | 12 |
| 13 | Current year exception payment (if line 12 is positive, enter the amount on this line) | 13 |
| 14 | Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) | 14 |
| 15 | Current year allowable operating and capital payment (see instructions) | 15 |
| 16 | Current year operating and capital costs (see instructions) | 16 |
| 17 | Current year exception offset amount (see instructions) | 17 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1 PART I

| | | EXTRAORDI- | | | I&R COST & | | |
|------------------|--|----------------|------------------|----------------|-----------------|-------------|------------------|
| | COST CENTER DESCRIPTIONS | NARY CAP- | SUBTOTAL | GLIDTOT I | POST STEP- | TOTAL | |
| | | REL COSTS 0 | (cols.0-4) 2A | SUBTOTAL 24 | DOWN ADJS 25 | TOTAL 26 | \vdash |
| | GENERAL SERVICE COST CENTERS | U | ZA | 24 | 23 | 20 | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | 1 |
| 2 | Cap Rel Costs-Myble Equip | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | 4 |
| 5.01 | NONPATIENT TELEPHONES | | | | | | 5.01 |
| 5.04 | ADMITTING | | | | | | 5.04 |
| 5.06 | OTHER ADMINISTRATIVE & GENERAL Maintenance & Repairs | | | | | | 5.06 |
| 7 | Operation of Plant | | | | | | 7 |
| 8 | Laundry & Linen Service | | | | | | 8 |
| 9 | Housekeeping | | | | | | 9 |
| 10 | Dietary | | | | | | 10 |
| 11 | Cafeteria | | | | | | 11 |
| 12 | Maintenance of Personnel | | | | | | 12 |
| 13 | Nursing Administration | | | | | | 13 |
| 15 | Central Services & Supply Pharmacy | | | | | | 15 |
| 16 | Medical Records & Library | | | | | | 16 |
| 17 | Social Service | | | | | | 17 |
| 18 | STERILE SUPPLY | | | | | | 18 |
| 19 | Nonphysician Anesthetists | | | | | | 19 |
| 21 | I&R Services-Salary & Fringes Apprvd | | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd PARAMED ED PRGM-(SPECIFY) | | | | | | 22 |
| 23.02 | PHARMACY RESIDENCY PROGRAM | | | | | | 23.02 |
| 23.02 | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | 23.02 |
| 30 | Adults & Pediatrics | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | 31 |
| 35 | NEONATAL INTENSIVE CARE UNIT | | | | | | 35 |
| 41 | Subprovider - IRF | | | | | | 41 |
| 43 | Nursery | | | | | | 43 |
| 50 | ANCILLARY SERVICE COST CENTERS Operating Room | | | | | | 50 |
| 50 | Recovery Room | | | | | | 51 |
| 52 | Delivery Room & Labor Room | | | | | | 52 |
| 54 | Radiology-Diagnostic | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | 55 |
| 57 | CT Scan | | | | | | 57 |
| 58 | MRI | | | | | | 58 |
| 59 | Cardiac Catheterization | | | | | | 59 |
| 60 62.30 | Laboratory BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | 60 62.30 |
| 65 | Respiratory Therapy | | | | | | 65 |
| 66 | Physical Therapy | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | 67 |
| 68 | Speech Pathology | | | | | | 68 |
| 69 | Electrocardiology | | | | | | 69 |
| 71 | Medical Supplies Charged to Patients | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients Drugs Charged to Patients | | | | | | 72 |
| 74 | Renal Dialysis | | | | | | 74 |
| | CARDIAC REHABILITATION | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90 | Clinic | | | | | | 90 |
| 90.02 | MOBILE MEDICAL UNIT | | | | | | 90.02 |
| 90.03 | FAMILY MEDICINE CENTER WOUND HEALING CENTER | | | | | | 90.03 |
| 90.04 | OUTPATIENT TREATMENT & INFUSION | | | | | | 90.04 |
| 90.06 | PEDIATRIC SPECIALTY CLINIC | | | | | | 90.06 |
| 90.07 | SPORTS MED FELLOWSHIP CLINIC | | | | | | 90.07 |
| 90.08 | PODIATRY RESIDENCY CLINIC | | | | | | 90.08 |
| 90.09 | FACULTY PRACTICE CLINIC | | | | | | 90.09 |
| 90.10 | OUR LADY OF ROSARY CLINIC | | | | | | 90.10 |
| 91 | Emergency Observation Beds (Non-Distinct Part) | | | | | | 91 |
| 92 | OTHER REIMBURSABLE COST CENTERS | | | | | | 94 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | | | | | | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | |
| 190 | Gift, Flower, Coffee Shop & Canteen | | | | | | 190 |
| 192 | Physicians' Private Offices | | | | | | 192 |
| 192.01 192.02 | MATERNAL FETAL MEDICINE/LABORIST NEONATOLOGISTS | | | | | | 192.01 192.02 |
| 172.02 | TALOTATIOLOGISTS | 1 | | 1 | | | 174.04 |

| | In Lieu of Form | Period : | Run Date: 09/25/2018 | |
|------------------------------------|-----------------|------------------|-------------------------------|--|
| ST. JOSEPHS REG MED CENTER S. BEND | CMS-2552-10 | From: 07/01/2017 | Run Time: 10:47 | |
| Provider CCN: 15-0012 | | To: 06/30/2018 | Version: 2018.04 (08/29/2018) | |

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1 PART I

| | | EXTRAORDI- | | | I&R COST & | | I |
|--------|------------------------------|------------|------------|----------|------------|-------|--------|
| | GOGE GENEED DEGGDINEIONG | | GLIDWOTLL | | | | |
| | COST CENTER DESCRIPTIONS | NARY CAP- | SUBTOTAL | | POST STEP- | | |
| | | REL COSTS | (cols.0-4) | SUBTOTAL | DOWN ADJS | TOTAL | |
| | | 0 | 2A | 24 | 25 | 26 | |
| 192.03 | HOSPITALISTS/INTENSIVISTS | | | | | | 192.03 |
| 194 | SPORTS MED-ATHLETIC TRAINERS | | | | | | 194 |
| 194.01 | OUTREACH SERVICES | | | | | | 194.01 |
| 194.02 | KINDRED/OUR LADY OF PEACE | | | | | | 194.02 |
| 194.03 | ADVANCED SPECIALTIES | | | | | | 194.03 |
| 194.04 | AMBULATORY PHARMACY SERVICES | | | | | | 194.04 |
| 200 | Cross Foot Adjustments | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | | | | | | 202 |