

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**

**WORKSHEET S  
PARTS I, II & III**

**PART I - COST REPORT STATUS**

Provider use only		1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	Date: 09/25/2018 Time: 10:47
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**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.

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

(Signed) \_\_\_\_\_  
Chief Financial Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**PART III - SETTLEMENT SUMMARY**

		TITLE XVIII			HIT	TITLE XIX	
		TITLE V	PART A	PART B			
		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 respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 5215 HOLY CROSS PARKWAY	P.O. Box:		1
2	City: MISHAWAKA	State: IN	ZIP Code: 46545 County: SAINT JOSEPH	2

Hospital and Hospital-Based Component Identification:

Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
0	1	2	3	4	5	6	7	8	
3	Hospital	ST. JOSEPHS REG MED CENTER S. BEND	15-0012	43780	1	07 / 01 / 1996	N	P	P
4	Subprovider - IPF								
5	Subprovider - IRF	ST JOSEPH REG MED CTR - REHAB	15-T012	43780	5	06 / 01 / 1983	N	P	P
6	Subprovider - (OTHER)								
7	Swing Beds - SNF								
8	Swing Beds - NF								
9	Hospital-Based SNF								
10	Hospital-Based NF								
11	Hospital-Based OLTC								
12	Hospital-Based HHA								
13	Separately Certified ASC								
14	Hospital-Based Hospice								
15	Hospital-Based Health Clinic - RHC								
16	Hospital-Based Health Clinic - FQHC								
17	Hospital-Based (CMHC)								
18	Renal Dialysis								
19	Other								

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2017	To: 06 / 30 / 2018	20
21	Type of control (see instructions)	1		21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
	1	2	3	4	5	6		
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,162	1,402	43	250	12,495	413	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.					358		25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1					26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1					27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:			36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N					37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:			38

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

		1	2	3	
<b>Teaching Hospitals</b>					
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are 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 # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	Y			60
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23	1	60.01
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.02	1	60.02
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	

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

**ACA Provisions Affecting the Health Resources and Services Administration (HRSA)**

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

**Teaching Hospitals that Claim Residents in Nonprovider Settings**

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N			63
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))		
	1	2	3	4	5		
65							65

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))		
	1	2	3	4	5		
67							67

**Inpatient Psychiatric Facility PPS**

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 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)				71

**Inpatient Rehabilitation Facility PPS**

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	Y			75
76	If line 75 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)	N	N		76

**Long Term Care Hospital PPS**

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	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		81

**TEFRA Providers**

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	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.	N		87

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**WORKSHEET S-2  
PART I**

Title V and XIX Services		V	XIX	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98
98.01	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' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06

**Rural Providers**

		1	2	
105	Does this hospital qualify as a CAH?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Physical	Occupational Speech	Respiratory 109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this 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 prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.	1	2	111

**Miscellaneous Cost Reporting Information**

115	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.	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118
118.01	List amounts of malpractice premiums and paid losses:	Premiums	Paid Losses	Self Insurance 118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y		121
122	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 no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N		122

**Transplant Center Information**

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

All Providers

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

If this facility is part of a chain organization, enter 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.

141	Name: ST JOSEPH REG MED CTR	Contractor's Name: WISCONSIN PROVIDER SERVICES CO Contractor's Number: 08102			141
142	Street: 5215 HOLY CROSS PARKWAY	P.O. Box:			142
143	City: MISHAWAKA	State: IN	ZIP Code: 46545		143
144	Are provider based physicians' costs included in Worksheet A?	Y			144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N			147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N			148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N			149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII		Title V	Title XIX	
		Part A	Part B	3	4	
		1	2			
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 more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N				165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)					166
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	9.99			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07 / 01 / 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. 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 column 2. (see instructions)	N	0		171

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

**General Instruction: Enter Y for all YES responses. Enter N for all NO responses.  
Enter all dates in the mm/dd/yyyy format.**

**COMPLETED BY ALL HOSPITALS**

		Y/N	Date	
<b>Provider Organization and Operation</b>				
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1
		Y/N	Date	V/I
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N		2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3

		Y/N	Type	Date
<b>Financial Data and Reports</b>				
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N		5

		Y/N	Y/N
<b>Approved Educational Activities</b>			
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N	
7	Are costs claimed for allied health programs? If yes, see instructions.	Y	
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N	
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	Y	
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N	
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N	

		Y/N
<b>Bad Debts</b>		
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N

<b>Bed Complement</b>		Y
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	15

		Part A		Part B	
		Y/N	Date	Y/N	Date
<b>PS&amp;R Report Data</b>					
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
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

**General Instruction: Enter Y for all YES responses. Enter N for all NO responses.  
Enter all dates in the mm/dd/yyyy format.**

**COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)**

Capital Related 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 instructions.	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	27

Interest Expense		
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	31

Purchased Services		
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	33

Provider-Based Physicians		
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	35

Home Office Costs		Y/N	Date	
		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

Cost Report Preparer Contact Information			
41	First name: TRACY	Last name: WORKMAN	Title: FINANCE - REIMBURSEMENT
42	Employer: SAINT JOSEPH REGIONAL MEDICAL CENTER		
43	Phone number: (574) 335-4656	E-mail Address: WORKMANT@SJPMC.COM	



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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		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	30
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 days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET S-3  
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					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

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL WAGE INDEX INFORMATION**

**WORKSHEET S-3  
PARTS II-III**

**Part II - Wage Data**

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

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

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**HOSPITAL WAGE RELATED COSTS**

**WORKSHEET S-3  
PART IV**

**Part IV - Wage Related Cost**

**Part A - Core List**

		Amount Reported	
	<b>RETIREMENT COST</b>		
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
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
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
	<b>HEALTH AND INSURANCE COST</b>		
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
	<b>TAXES</b>		
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
	<b>OTHER</b>		
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 B - Other Than Core Related Cost**

25	OTHER WAGE RELATED COSTS (SPECIFY)	6,646	25
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**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET S-3  
PART V**

**Part V - Contract Labor and Benefit Cost**

**Hospital and Hospital-Based Component Identification:**

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

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## HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

### Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.259470	1
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### 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
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.			8

### State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP			9
10	Stand-alone SCHIP charges			10
11	Stand-alone SCHIP cost (line 1 times line 10)			11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.			12

### Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)			13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)			14
15	State or local indigent care program cost (line 1 times line 14)			15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.			16

### Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng 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 patients	Insured patients	TOTAL (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	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,027,817	1,574,784	4,602,601	21
22	Payments received from patients for amounts previously written off as charity care	37,894	62,182	100,076	22
23	Cost of charity care (line 21 minus line 22)	2,989,923	1,512,602	4,502,525	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24
25	If line 24 is yes, 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)		29,900,000	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		555,558	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		854,705	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		29,045,295	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		7,835,530	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		12,338,055	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		12,338,055	31

**KPMG LLP Compu-Max 2552-10**

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**RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES**

**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	Cap Rel Costs-Bldg & Fixt				37,310,850	37,310,850	3,662,857	40,973,707	1
2	00200	Cap Rel Costs-Mvble Equip				-6,950,371	-6,950,371		-6,950,371	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	137,458	3,902,872	4,040,330		4,040,330	680,376	4,720,706	4
5.01	00540	NONPATIENT TELEPHONES	233,758	56,734	290,492		290,492		290,492	5.01
5.04	00570	ADMITTING	1,088,081	331,811	1,419,892		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	10,262,419	7
8	00800	Laundry & Linen Service		1,090,627	1,090,627	-28,586	1,062,041		1,062,041	8
9	00900	Housekeeping	1,513,034	1,481,787	2,994,821	-996	2,993,825		2,993,825	9
10	01000	Dietary	2,081,310	3,216,331	5,297,641	-2,293,041	3,004,600	-147,965	2,856,635	10
11	01100	Cafeteria				2,094,506	2,094,506	-2,023,812	70,694	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	3,511,013	13
14	01400	Central Services & Supply	507,521	381,796	889,317	-8,813	880,504	1,624	882,128	14
15	01500	Pharmacy	3,729,554	17,813,178	21,542,732	-17,374,837	4,167,895	-44,456	4,123,439	15
16	01600	Medical Records & Library	1,968,850	940,312	2,909,162	-22,107	2,887,055	-183	2,886,872	16
17	01700	Social Service	2,034,316	589,516	2,623,832		2,623,832		2,623,832	17
18	01850	STERILE SUPPLY	816,574	1,847,201	2,663,775	-137,917	2,525,858		2,525,858	18
19	01900	Nonphysician Anesthetists								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	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	3,190,548	22
23	02300	PARAMED ED PRGM-(SPECIFY)	77,334	58,881	136,215	-618	135,597	-10,030	125,567	23
23.02	02302	PHARMACY RESIDENCY PROGRAM	386,369	94,755	481,124	-229,964	251,160		251,160	23.02
		<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	03000	Adults & Pediatrics	19,073,232	7,061,552	26,134,784	-2,531,949	23,602,835	-28,555	23,574,280	30
31	03100	Intensive Care Unit	3,726,812	1,264,082	4,990,894	-145,136	4,845,758	-48,636	4,797,122	31
35	02060	NEONATAL INTENSIVE CARE UNIT	2,084,532	852,924	2,937,456	-83,052	2,854,404		2,854,404	35
41	04100	Subprovider - IRF	1,479,528	2,221,475	3,701,003	-1,581,073	2,119,930	-118,338	2,001,592	41
43	04300	Nursery					2,747,908		2,747,908	43
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	Operating Room	10,069,621	39,207,110	49,276,731	-22,872,743	26,403,988	-2,216,365	24,187,623	50
51	05100	Recovery Room	1,275,886	312,321	1,588,207	-4,795	1,583,412		1,583,412	51
52	05200	Delivery Room & Labor Room	2,645,895	812,375	3,458,270	-363,797	3,094,473		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	54
55	05500	Radiology-Therapeutic	221,816	481,304	703,120	-20,700	682,420	-89,727	592,693	55
57	05700	CT Scan	752,849	748,202	1,501,051	-293,128	1,207,923		1,207,923	57
58	05800	MRI		398,747	398,747		398,747		398,747	58
59	05900	Cardiac Catheterization	2,593,909	11,775,934	14,369,843	-5,563,165	8,806,678	-18,270	8,788,408	59
60	06000	Laboratory		11,436,117	11,436,117	-453,893	10,982,224		10,982,224	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	1,837,414	1,600,673	3,438,087	-229,226	3,208,861	-4,000	3,204,861	65
66	06600	Physical Therapy	2,550,643	998,256	3,548,899	-391,196	3,157,703	-8,686	3,149,017	66
67	06700	Occupational Therapy	732,447	254,587	987,034	-98,058	888,976		888,976	67
68	06800	Speech Pathology	403,130	84,914	488,044	-17,221	470,823		470,823	68
69	06900	Electrocardiology	975,602	556,739	1,532,341	-255,063	1,277,278	1,332	1,278,610	69
71	07100	Medical Supplies Charged to Patients		-579,503	-579,503		579,503			71
72	07200	Impl. Dev. Charged to Patients				24,980,388	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		17,763,532	73
74	07400	Renal Dialysis		1,112,568	1,112,568	563	1,113,131		1,113,131	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				55,800	55,800		55,800	76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	09000	Clinic								90
90.02	09001	MOBILE MEDICAL UNIT	79,473	172,656	252,129	-135,402	116,727		116,727	90.02
90.03	09002	FAMILY MEDICINE CENTER	701,905	886,591	1,588,496	-284,270	1,304,226	-9,960	1,294,266	90.03
90.04	09003	WOUND HEALING CENTER	504,278	1,295,209	1,799,487	-375,796	1,423,691		1,423,691	90.04
90.05	09004	OUTPATIENT TREATMENT & INFUSION	624,346	137,232	761,578		761,578		761,578	90.05
90.06	09005	PEDIATRIC SPECIALTY CLINIC	302,611	380,961	683,572	-101,877	581,695	-148,004	433,691	90.06
90.07	09006	SPORTS MED FELLOWSHIP CLINIC	626,819	287,616	914,435	-155,802	758,633	-4,792	753,841	90.07
90.08	09007	PODIATRY RESIDENCY CLINIC	74,948	247,612	322,560	-44,464	278,096	-875	277,221	90.08
90.09	09008	FACULTY PRACTICE CLINIC	403,814	307,249	711,063	-90,787	620,276	-35	620,241	90.09
90.10	09009	OUR LADY OF ROSARY CLINIC	600,807	495,714	1,096,521	-211,662	884,859	-3,035	881,824	90.10
91	09100	Emergency	4,973,689	2,636,057	7,609,746	-40,346	7,569,400	-161,275	7,408,125	91
92	09200	Observation Beds (Non-Distinct Part)								92
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
		<b>SPECIAL PURPOSE COST CENTERS</b>								
118		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	118
		<b>NONREIMBURSABLE COST CENTERS</b>								

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**RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES**

**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices								192
192.01	19201	MATERNAL FETAL MEDICINE/LABORIST	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



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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
1	NEGATIVE BALANCES	1					
		A	Medical Supplies Charged to P	71		579,503	1
500	Total reclassifications					579,503	500
	Code Letter - A						
1	IMPLANTABLE DEVICES	B	Impl. Dev. Charged to Patient	72		24,980,388	1
2	IMPLANTABLE DEVICES	B					2
3	IMPLANTABLE DEVICES	B					3
4	IMPLANTABLE DEVICES	B					4
500	Total reclassifications					24,980,388	500
	Code Letter - B						
1	DRUGS	C	Drugs Charged to Patients	73		17,035,084	1
500	Total reclassifications					17,035,084	500
	Code Letter - C						
1	CAFETERIA/DIETARY	D	Cafeteria	11	790,898	1,383,022	1
500	Total reclassifications				790,898	1,383,022	500
	Code Letter - D						
1	INTEREST EXPENSE	E	Cap Rel Costs-Bldg & Fixt	1		11,525,713	1
2	INTEREST EXPENSE	E					2
500	Total reclassifications					11,525,713	500
	Code Letter - E						
1	DEPRECIATION	F	Cap Rel Costs-Bldg & Fixt	1		25,496,132	1
2	DEPRECIATION	F	Renal Dialysis	74		563	2
3	DEPRECIATION	F					3
4	DEPRECIATION	F					4
5	DEPRECIATION	F					5
6	DEPRECIATION	F					6
7	DEPRECIATION	F					7
8	DEPRECIATION	F					8
9	DEPRECIATION	F					9
10	DEPRECIATION	F					10
11	DEPRECIATION	F					11
12	DEPRECIATION	F					12
13	DEPRECIATION	F					13
14	DEPRECIATION	F					14
15	DEPRECIATION	F					15
16	DEPRECIATION	F					16
17	DEPRECIATION	F					17
18	DEPRECIATION	F					18
19	DEPRECIATION	F					19
20	DEPRECIATION	F					20
21	DEPRECIATION	F					21
22	DEPRECIATION	F					22
23	DEPRECIATION	F					23
24	DEPRECIATION	F					24
25	DEPRECIATION	F					25
26	DEPRECIATION	F					26
27	DEPRECIATION	F					27
28	DEPRECIATION	F					28
29	DEPRECIATION	F					29
30	DEPRECIATION	F					30
31	DEPRECIATION	F					31
32	DEPRECIATION	F					32
33	DEPRECIATION	F					33
34	DEPRECIATION	F					34
35	DEPRECIATION	F					35
36	DEPRECIATION	F					36
37	DEPRECIATION	F					37
38	DEPRECIATION	F					38
39	DEPRECIATION	F					39
40	DEPRECIATION	F					40
41	DEPRECIATION	F					41
500	Total reclassifications					25,496,695	500
	Code Letter - F						
1	OB/NURSERY/LABOR ROOM	G	Nursery	43	1,227,254	1,158,239	1
500	Total reclassifications				1,227,254	1,158,239	500
	Code Letter - G						
1	HYPERBARIC OXYGEN	H	HYPERBARIC OXYGEN THERAPY	76.98	54,762	1,038	1
500	Total reclassifications				54,762	1,038	500
	Code Letter - H						

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
1	SBMF CAPITAL	1		3			
		AB	2 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.

**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET A-6**

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

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref. 10	
		1	6	7	8	9		
1	SBMF CAPITAL	AB	Laboratory	60		289,005	9	1
500	Total reclassifications					289,005		500
	Code letter - AB							
1	2ND YR PHARMACY RESIDENTS	AC	Pharmacy	15	55,803	8,761		1
2	2ND YR PHARMACY RESIDENTS	AC	PHARMACY RESIDENCY PROGRAM	23.02	199,898	30,066		2
3	2ND YR PHARMACY RESIDENTS	AC	AMBULATORY PHARMACY SERVICES	194.04	10,147	1,518		3
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		1
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		1
500	Total reclassifications				63,532	19,249		500
	Code letter - AE							
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							
	<b>GRAND TOTAL (Decreases)</b>				<b>2,852,107</b>	<b>82,648,299</b>		

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

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**RECONCILIATION OF CAPITAL COST CENTERS**

**WORKSHEET A-7  
PARTS I, II & III**

**PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		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**

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

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

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

**PART III - RECONCILIATION OF CAPITAL COST CENTERS**

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

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		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.)

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.
				COST CENTER	LINE#	
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)	B	-313,072	OTHER ADMINISTRATIVE & GENERAL	5.06	3
4	Trade, quantity, and time discounts (chapter 8)					4
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)	A				7
8	Television and radio service (chapter 21)	A				8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-2,658,836			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	17,654,081			12
13	Laundry and linen service					13
14	Cafeteria - employees and guests	B	-1,863,140	Cafeteria	11	14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients	B	-44,456	Pharmacy	15	17
18	Sale of medical records and abstracts					18
19	Nursing and allied health education (tuition, fees, books, etc.)					19
20	Vending machines	B	-160,672	Cafeteria	11	20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation					32
33	DONATIONS	A				33
33.01	OTHER REVENUE	B	-628,290	OTHER ADMINISTRATIVE & GENERAL	5.06	33.01
33.02	OTHER REVENUE	B	-637,468	Operation of Plant	7	33.02
33.03	OTHER REVENUE	B	-147,965	Dietary	10	33.03
33.04	OTHER REVENUE	B	-611	Nursing Administration	13	33.04
33.06	OTHER REVENUE	B	-183	Medical Records & Library	16	33.06
33.08	OTHER REVENUE	B	-2,700	I&R Services-Salary & Fringes Apprvd	21	33.08
33.09	OTHER REVENUE	B	-8,209	I&R Services-Other Prgm Costs Apprvd	22	33.09
33.10	OTHER REVENUE	B	-10,030	PARAMED ED PRGM-(SPECIFY)	23	33.10
33.11	OTHER REVENUE	B	-3,862	Adults & Pediatrics	30	33.11
33.14	OTHER REVENUE	B	-7,322	Subprovider - IRF	41	33.14
33.15	OTHER REVENUE	B	-25	Operating Room	50	33.15
33.16	OTHER REVENUE	B	-4,915	Radiology-Diagnostic	54	33.16
33.17	OTHER REVENUE	B	-89,727	Radiology-Therapeutic	55	33.17
33.19	OTHER REVENUE	B	-4,000	Respiratory Therapy	65	33.19
33.20	OTHER REVENUE	B	-8,686	Physical Therapy	66	33.20
33.21	OTHER REVENUE	B	1,668	Electrocardiology	69	33.21
33.23	OTHER REVENUE	B	-9,960	FAMILY MEDICINE CENTER	90.03	33.23
33.25	OTHER REVENUE	B	-4,792	SPORTS MED FELLOWSHIP CLINIC	90.07	33.25
33.26	OTHER REVENUE	B	-875	PODIATRY RESIDENCY CLINIC	90.08	33.26
33.27	OTHER REVENUE	B	-35	FACULTY PRACTICE CLINIC	90.09	33.27
33.28	OTHER REVENUE	B	-3,035	OUR LADY OF ROSARY CLINIC	90.10	33.28
33.29	OTHER REVENUE	B	-6,078	Emergency	91	33.29
34	MEDICAID PROVIDER BED TAX	A	-17,479,932	OTHER ADMINISTRATIVE & GENERAL	5.06	34
35	PURCHASE DISCOUNTS	A				35
35.01	DONATIONS	A	-656,788	OTHER ADMINISTRATIVE & GENERAL	5.06	35.01
36	PROPERTY TAX	A	-111,016	Subprovider - IRF	41	36
37	DISCOUNTS	A	6,760	OTHER ADMINISTRATIVE & GENERAL	5.06	37
37.01	DISCOUNTS	A	1,624	Central Services & Supply	14	37.01
38	INTERNATIONAL MEDICINE	A	-955	OTHER ADMINISTRATIVE & GENERAL	5.06	38
39	OTHER REVENUE	B				39
40	OTHER REVENUE	B				40
41	OTHER REVENUE	B				41

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref. 5
				COST CENTER 3	LINE# 4		
42	OTHER REVENUE	B					42
43	OTHER REVENUE	B					43
44	OTHER REVENUE	B					44
45	OTHER REVENUE	B					45
46	OTHER REVENUE	B					46
47	OTHER REVENUE	B					47
48	OTHER REVENUE	B					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
- (2) Basis for adjustment (see instructions)
  - A. Costs - if cost, including applicable overhead, can be determined
  - B. Amount Received - if cost cannot be determined
- (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5.06	OTHER ADMINISTRATIVE & GENERAL	HO NON CAPITAL COSTS	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	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet 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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		Type of Business	
				Name	Percentage of Ownership		
	1	2	3	4	5	6	
6	G			CHE TRINTIY HEALTH		HO OF PARENT COMPANY	6
7	G			SJRCM - INC		PARENT COMPANY	7
8	G	SJRCM- 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:



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**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

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**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

**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET B  
PART I**

	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	
		0	1	2	4	5.01	5.04	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	40,973,707	40,973,707					1
2	Cap Rel Costs-Mvble Equip	-6,950,371		-6,950,371				2
4	Employee Benefits Department	4,720,706	26,647		4,747,353			4
5.01	NONPATIENT TELEPHONES	290,492	41,151		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		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	Dietary	2,856,635	722,507		69,821	2,938		10
11	Cafeteria	70,694	981,895		35,968	2,571		11
12	Maintenance of Personnel							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	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd	2,478,399	75,894		95,652			21
22	I&R Services-Other Prgm Costs Apprvd	3,190,548			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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
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	2,001,592			75,201	10,529	7,504	41
43	Nursery	2,747,908			76,478		7,720	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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	54
55	Radiology-Therapeutic	592,693			11,274		1,575	55
57	CT Scan	1,207,923	143,861		38,266		115,785	57
58	MRI	398,747				1,592	9,378	58
59	Cardiac Catheterization	8,788,408	1,236,813		131,843	9,549	92,465	59
60	Laboratory	10,982,224	165,954			4,775	175,033	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							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			20,490	490	4,744	68
69	Electrocardiology	1,278,610	226,838		49,588	3,918	37,937	69
71	Medical Supplies Charged to Patients							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	73
74	Renal Dialysis	1,113,131	95,542			122	2,638	74
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
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT	116,727			4,039		849	90.02
90.03	FAMILY MEDICINE CENTER	1,294,266			35,676	6,856	4,723	90.03
90.04	WOUND HEALING CENTER	1,423,691			22,848	1,836	7,618	90.04
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		90.08
90.09	FACULTY PRACTICE CLINIC	620,241			20,525		2,248	90.09
90.10	OUR LADY OF ROSARY CLINIC	881,824			30,538			90.10
91	Emergency	7,408,125	1,782,657		252,803	17,262	104,082	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	303,458,171	40,796,622		4,495,318	300,431	1,628,928	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen		158,786			612		190
192	Physicians' Private Offices		9,782			32,687		192

**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET B  
PART I**

	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	
		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

**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL (cols.0-4)		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	
		4A	5.06	7	8	9	10	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	69,072,023	69,072,023					5.06
6	Maintenance & Repairs							6
7	Operation of Plant	20,932,838	5,692,246	26,625,084				7
8	Laundry & Linen Service	1,062,653	288,966		1,351,619			8
9	Housekeeping	3,581,972	974,042	541,584		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	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd	2,649,945	720,597	80,726		15,777		21
22	I&R Services-Other Prgm Costs Apprvd	3,328,849	905,211					22
23	PARAMED ED PRGM-(SPECIFY)	130,233	35,414					23
23.02	PHARMACY RESIDENCY PROGRAM	261,005	70,975					23.02
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
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
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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		19,411			52
54	Radiology-Diagnostic	7,117,574	1,935,475	1,210,447	76,817	236,562		54
55	Radiology-Therapeutic	605,542	164,664		1,300			55
57	CT Scan	1,506,937	409,780	153,021	95,539	29,906		57
58	MRI	409,717	111,414		7,738			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							71
72	Impl. Dev. Charged to Patients	25,103,473	6,826,362		101,563			72
73	Drugs Charged to Patients	17,963,670	4,884,843	41,978	117,441	8,204		73
74	Renal Dialysis	1,211,433	329,424	101,626	2,177	19,861		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	60,493	16,450		1,374			76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
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					90.08
90.09	FACULTY PRACTICE CLINIC	643,014	174,854		1,855			90.09
90.10	OUR LADY OF ROSARY CLINIC	912,362	248,098					90.10
91	Emergency	9,564,929	2,600,982	1,896,173	85,882	370,576		91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
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
	<b>NONREIMBURSABLE COST CENTERS</b>							
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

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL (cols.0-4)		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	
		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

**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11	13	14	15	16	17	
<b>GENERAL SERVICE COST CENTERS</b>								
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.04	ADMITTING							5.04
5.06	OTHER ADMINISTRATIVE & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria	2,636,372						11
12	Maintenance of Personnel							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			4,255,344		16
17	Social Service	52,795	106,449		5,343		3,766,226	17
18	STERILE SUPPLY	44,340	89,401		1			18
19	Nonphysician Anesthetists							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
<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	Adults & Pediatrics	644,184	1,298,864	138,650	561	475,574	3,347,756	30
31	Intensive Care Unit	113,627	229,104	26,833	85	92,038	376,623	31
35	NEONATAL INTENSIVE CARE UNIT	59,910	120,796	13,615	2	46,699	41,847	35
41	Subprovider - IRF	50,137	101,091	5,686		19,504		41
43	Nursery	48,271	97,327	5,850	800	20,066		43
<b>ANCILLARY SERVICE COST CENTERS</b>								
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		61,142		52
54	Radiology-Diagnostic	113,012	227,864	70,541	235,343	241,957		54
55	Radiology-Therapeutic	6,501	13,107	1,194		4,094		55
57	CT Scan	21,127	42,597	87,733	59,187	300,927		57
58	MRI			7,106		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	Physical Therapy	65,686	132,441	17,421	826	59,753		66
67	Occupational Therapy	18,162	36,619	6,278	72	21,533		67
68	Speech Pathology	9,136	18,420	3,595		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	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,867	3,764	1,262	15	4,327		76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
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	17,701	35,690	5,750		19,721		90.05
90.06	PEDIATRIC SPECIALTY CLINIC	9,377	18,908	380	322	1,304		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	9,509	19,173		4,770			90.07
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)							92
<b>OTHER REIMBURSABLE COST CENTERS</b>								
<b>SPECIAL PURPOSE COST CENTERS</b>								
118	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
<b>NONREIMBURSABLE COST CENTERS</b>								
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		192.02

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		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



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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION		SUBTOTAL	
		18	21	22	23	23.02	24	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.04	ADMITTING							5.04
5.06	OTHER ADMINISTRATIVE & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
18	STERILE SUPPLY	5,052,903						18
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd		3,646,227					21
22	I&R Services-Other Prgm Costs Apprvd			4,332,494				22
23	PARAMED ED PRGM-(SPECIFY)				173,000			23
23.02	PHARMACY RESIDENCY PROGRAM					344,301		23.02
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
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	35
41	Subprovider - IRF	13,021					3,180,935	41
43	Nursery		231,099	274,595			4,286,616	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	4,590,056	112,982	134,246			49,366,644	50
51	Recovery Room						3,065,095	51
52	Delivery Room & Labor Room		25,678	30,511			4,484,541	52
54	Radiology-Diagnostic	4,454	25,678	30,511			11,526,235	54
55	Radiology-Therapeutic						796,402	55
57	CT Scan						2,706,754	57
58	MRI						560,349	58
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							71
72	Impl. Dev. Charged to Patients						32,444,563	72
73	Drugs Charged to Patients					344,301	30,455,379	73
74	Renal Dialysis		15,407	18,306			1,707,090	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY						89,552	76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic		662,483	787,171			1,449,654	90
90.02	MOBILE MEDICAL UNIT						134,043	90.02
90.03	FAMILY MEDICINE CENTER	26,155					1,886,763	90.03
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	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	1,277					1,031,068	90.07
90.08	PODIATRY RESIDENCY CLINIC						391,521	90.08
90.09	FACULTY PRACTICE CLINIC	823					878,195	90.09
90.10	OUR LADY OF ROSARY CLINIC						1,223,960	90.10
91	Emergency	4,454	220,828	262,390	173,000		16,035,419	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	4,780,376	3,646,227	4,332,494	173,000	344,301	304,820,496	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen						404,649	190
192	Physicians' Private Offices						66,456	192
192.01	MATERNAL FETAL MEDICINE/LABORIST						2,087,012	192.01
192.02	NEONATOLOGISTS						2,303,240	192.02

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION		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

**KPMG LLP Compu-Max 2552-10**

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	NONPATIENT TELEPHONES						5.01
5.04	ADMITTING						5.04
5.06	OTHER ADMINISTRATIVE & GENERAL						5.06
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
18	STERILE SUPPLY						18
19	Nonphysician Anesthetists						19
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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
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
	<b>ANCILLARY SERVICE COST CENTERS</b>						
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						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		678,970				68
69	Electrocardiology	-191,040	2,568,295				69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients		32,444,563				72
73	Drugs Charged to Patients		30,455,379				73
74	Renal Dialysis	-33,713	1,673,377				74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY		89,552				76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	-1,449,654					90
90.02	MOBILE MEDICAL UNIT		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
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)	-7,978,721	296,841,775				118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop & Canteen		404,649				190
192	Physicians' Private Offices		66,456				192
192.01	MATERNAL FETAL MEDICINE/LABORIST		2,087,012				192.01
192.02	NEONATOLOGISTS		2,303,240				192.02

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & 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

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NON- PATIENT TELEPHONES	
		0	1	2	2A	4	5.01	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		26,647		26,647	26,647		4
5.01	NONPATIENT TELEPHONES		41,151		41,151	67	41,218	5.01
5.04	ADMITTING		157,353		157,353	310	573	5.04
5.06	OTHER ADMINISTRATIVE & GENERAL		5,158,490		5,158,490	449	5,303	5.06
6	Maintenance & Repairs							6
7	Operation of Plant		10,558,910		10,558,910	567	1,249	7
8	Laundry & Linen Service						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					145	44	14
15	Pharmacy		560,770		560,770	1,047	837	15
16	Medical Records & Library		82,218		82,218	561	646	16
17	Social Service		50,005		50,005	580	529	17
18	STERILE SUPPLY		649,481		649,481	233	162	18
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd		75,894		75,894	536		21
22	I&R Services-Other Prgm Costs Apprvd					751	514	22
23	PARAMED ED PRGM-(SPECIFY)					22	88	23
23.02	PHARMACY RESIDENCY PROGRAM					53	44	23.02
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
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
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room		4,028,687		4,028,687	2,870	3,672	50
51	Recovery Room		266,977		266,977	364	544	51
52	Delivery Room & Labor Room					675		52
54	Radiology-Diagnostic		1,137,983		1,137,983	1,045	2,071	54
55	Radiology-Therapeutic					63		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	Occupational Therapy					209	132	67
68	Speech Pathology					115	59	68
69	Electrocardiology		226,838		226,838	278	470	69
71	Medical Supplies Charged to Patients							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	76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT					23		90.02
90.03	FAMILY MEDICINE CENTER					200	823	90.03
90.04	WOUND HEALING CENTER					128	220	90.04
90.05	OUTPATIENT TREATMENT & INFUSION		130,537		130,537	178	176	90.05
90.06	PEDIATRIC SPECIALTY CLINIC					86	250	90.06
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)		40,796,622		40,796,622	25,233	36,048	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen		158,786		158,786		73	190
192	Physicians' Private Offices		9,782		9,782		3,922	192
192.01	MATERNAL FETAL MEDICINE/LABORIST		8,517		8,517	25		192.01
192.02	NEONATOLOGISTS					418	44	192.02

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NON- PATIENT TELEPHONES	
		0	1	2	2A	4	5.01	
192.03	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

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	ADMITTING		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.04	5.06	7	8	9	10	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	158,236						5.04
5.06	OTHER ADMINISTRATIVE & GENERAL		5,164,242					5.06
6	Maintenance & Repairs							6
7	Operation of Plant		425,586	10,986,312				7
8	Laundry & Linen Service		21,605		21,678			8
9	Housekeeping		72,825	223,474		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	STERILE SUPPLY		65,429	285,061		21,351		18
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd		53,876	33,310		2,495		21
22	I&R Services-Other Prgm Costs Apprvd		67,679					22
23	PARAMED ED PRGM-(SPECIFY)		2,648					23
23.02	PHARMACY RESIDENCY PROGRAM		5,306					23.02
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
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
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	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		314			52
54	Radiology-Diagnostic	9,022	144,707	499,467	1,242	37,410		54
55	Radiology-Therapeutic	153	12,311		21			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							62.30
65	Respiratory Therapy	2,697	73,876	132,907	371	9,955		65
66	Physical Therapy	2,228	72,842	120,435	307	9,021		66
67	Occupational Therapy	803	19,022		111			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							76.97
76.98	HYPERBARIC OXYGEN THERAPY	161	1,230		22			76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
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		5,753					90.08
90.09	FACULTY PRACTICE CLINIC	218	13,073		30			90.09
90.10	OUR LADY OF ROSARY CLINIC		18,549					90.10
91	Emergency	10,087	194,465	782,418	1,389	58,604		91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	157,422	4,894,392	10,908,589	21,566	800,320	1,032,040	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen		3,241	69,692		5,220		190
192	Physicians' Private Offices		863	4,293		322		192
192.01	MATERNAL FETAL MEDICINE/LABORIST	17	33,148	3,738	2	280		192.01
192.02	NEONATOLOGISTS	222	35,930		31			192.02

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	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



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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11	13	14	15	16	17	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.04	ADMITTING							5.04
5.06	OTHER ADMINISTRATIVE & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria	1,467,827						11
12	Maintenance of Personnel							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		982,484			15
16	Medical Records & Library	44,335	11,256			240,314		16
17	Social Service	29,394	7,462		733		168,849	17
18	STERILE SUPPLY	24,687	6,267					18
19	Nonphysician Anesthetists							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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
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
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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	Radiology-Therapeutic	3,619	919	38		231		55
57	CT Scan	11,762	2,986	2,765	8,122	16,994		57
58	MRI			224		1,376		58
59	Cardiac Catheterization	38,613	9,803	2,208	14,376	13,571		59
60	Laboratory			4,179		25,689		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							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
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
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		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	1,344		655			90.07
90.08	PODIATRY RESIDENCY CLINIC	5,588	1,419		179			90.08
90.09	FACULTY PRACTICE CLINIC	4,842	1,229	54	3,276	330		90.09
90.10	OUR LADY OF ROSARY CLINIC	9,121	2,316		1,933			90.10
91	Emergency	93,550	23,750	2,485	3	15,276		91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	1,390,259	341,260	38,339	978,990	239,082	168,849	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.01	MATERNAL FETAL MEDICINE/LABORIST	306	78	4		26		192.01
192.02	NEONATOLOGISTS	8,461	2,148	55		336		192.02

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11	13	14	15	16	17	
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

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

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	I&R SALARY & FRINGES 21	I&R PROGRAM COSTS 22	PARAMED EDUCATION 23	23.02	SUBTOTAL 24	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.04	ADMITTING							5.04
5.06	OTHER ADMINISTRATIVE & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
18	STERILE SUPPLY	1,052,671						18
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd		207,582					21
22	I&R Services-Other Prgm Costs Apprvd			91,726				22
23	PARAMED ED PRGM-(SPECIFY)				4,460			23
23.02	PHARMACY RESIDENCY PROGRAM					8,254		23.02
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	17,263					16,410,723	30
31	Intensive Care Unit	160					2,065,024	31
35	NEONATAL INTENSIVE CARE UNIT	898					750,620	35
41	Subprovider - IRF	2,713					149,741	41
43	Nursery						93,985	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	956,246					7,801,539	50
51	Recovery Room						469,791	51
52	Delivery Room & Labor Room						121,954	52
54	Radiology-Diagnostic	928					1,960,951	54
55	Radiology-Therapeutic						17,355	55
57	CT Scan						298,111	57
58	MRI						11,155	58
59	Cardiac Catheterization	5,142					2,124,686	59
60	Laboratory						524,295	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,956					570,089	65
66	Physical Therapy						530,658	66
67	Occupational Therapy						34,380	67
68	Speech Pathology						17,978	68
69	Electrocardiology						398,536	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients						544,953	72
73	Drugs Charged to Patients						1,374,215	73
74	Renal Dialysis						166,003	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY						3,047	76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT						2,315	90.02
90.03	FAMILY MEDICINE CENTER	5,449					62,710	90.03
90.04	WOUND HEALING CENTER	3,776					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	266					23,749	90.07
90.08	PODIATRY RESIDENCY CLINIC						13,195	90.08
90.09	FACULTY PRACTICE CLINIC	171					23,338	90.09
90.10	OUR LADY OF ROSARY CLINIC						32,090	90.10
91	Emergency	928					2,969,101	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	995,896					39,858,410	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen						237,012	190
192	Physicians' Private Offices						19,182	192
192.01	MATERNAL FETAL MEDICINE/LABORIST						46,141	192.01
192.02	NEONATOLOGISTS						47,645	192.02

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION		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

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	NONPATIENT TELEPHONES						5.01
5.04	ADMITTING						5.04
5.06	OTHER ADMINISTRATIVE & GENERAL						5.06
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
18	STERILE SUPPLY						18
19	Nonphysician Anesthetists						19
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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
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
	<b>ANCILLARY SERVICE COST CENTERS</b>						
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						62.30
65	Respiratory Therapy		570,089				65
66	Physical Therapy		530,658				66
67	Occupational Therapy		34,380				67
68	Speech Pathology		17,978				68
69	Electrocardiology		398,536				69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients		544,953				72
73	Drugs Charged to Patients		1,374,215				73
74	Renal Dialysis		166,003				74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY		3,047				76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)		39,858,410				118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop & Canteen		237,012				190
192	Physicians' Private Offices		19,182				192
192.01	MATERNAL FETAL MEDICINE/LABORIST		46,141				192.01
192.02	NEONATOLOGISTS		47,645				192.02

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	I&R COST & 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

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON-PATIENT TELEPHONES PHONE EXTENSIONS	ADMITTING GROSS REVENUE	RECONCILIATION	
		1	2	4	5.01	5.04	5A.06	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	485,895						1
2	Cap Rel Costs-Mvble Equip		485,895					2
4	Employee Benefits Department	316	316	93,400,048				4
5.01	NONPATIENT TELEPHONES	488	488	233,758	2,806			5.01
5.04	ADMITTING	1,866	1,866	1,088,081	39	1,149,926,299		5.04
5.06	OTHER ADMINISTRATIVE & GENERAL	61,173	61,173	1,576,087	361		-69,072,023	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	125,215	125,215	1,989,129	85			7
8	Laundry & Linen Service				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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
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			1,504,646		5,421,672		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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			2,368,503		16,520,410		52
54	Radiology-Diagnostic	13,495	13,495	3,665,312	141	65,376,018		54
55	Radiology-Therapeutic			221,816		1,106,282		55
57	CT Scan	1,706	1,706	752,849	9	81,309,758		57
58	MRI				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							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							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT			79,473		596,242	-121,615	90.02
90.03	FAMILY MEDICINE CENTER			701,905	56	3,316,865		90.03
90.04	WOUND HEALING CENTER			449,516	15	5,349,636		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	1,548	1,548	624,346	12	5,328,685		90.05
90.06	PEDIATRIC SPECIALTY CLINIC			302,611	17	352,245		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC			563,287	7			90.07
90.08	PODIATRY RESIDENCY CLINIC			74,948	16			90.08
90.09	FACULTY PRACTICE CLINIC			403,814		1,578,368		90.09
90.10	OUR LADY OF ROSARY CLINIC			600,807				90.10
91	Emergency	21,140	21,140	4,973,689	141	73,091,073		91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	483,795	483,795	88,441,448	2,454	1,144,029,706	-69,193,638	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	1,883	1,883		5			190
192	Physicians' Private Offices	116	116		267			192
192.01	MATERNAL FETAL MEDICINE/LABORIST	101	101	88,558		126,079		192.01

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON- PATIENT TELEPHONES PHONE EXTE NSIONS	ADMITTING GROSS REVE NUE	RECON- CILLIATION	
		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		194.01
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



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

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE GROSS REVE NUE	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTES	
		5.06	7	8	9	10	11	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	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		1,149,926,299				8
9	Housekeeping	3,581,972	6,038		290,799			9
10	Dietary	3,651,901	8,568		8,568	227,604		10
11	Cafeteria	1,091,128	11,644		11,644		120,047	11
12	Maintenance of Personnel							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	Social Service	2,781,644	593		593		2,404	17
18	STERILE SUPPLY	3,218,191	7,702		7,702		2,019	18
19	Nonphysician Anesthetists							19
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					1,486	22
23	PARAMED ED PRGM-(SPECIFY)	130,233					111	23
23.02	PHARMACY RESIDENCY PROGRAM	261,005					186	23.02
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	34,327,352	113,795	128,498,757	113,795	181,550	29,333	30
31	Intensive Care Unit	6,234,010	14,308	24,868,507	14,308	10,890	5,174	31
35	NEONATAL INTENSIVE CARE UNIT	3,407,756	5,062	12,617,860	5,062	509	2,728	35
41	Subprovider - IRF	2,094,826		5,269,952		13,125	2,283	41
43	Nursery	2,832,106		5,421,672			2,198	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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	13,495	65,376,018	13,495		5,146	54
55	Radiology-Therapeutic	605,542		1,106,282			296	55
57	CT Scan	1,506,937	1,706	81,309,758	1,706		962	57
58	MRI	409,717		6,585,826				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	Occupational Therapy	935,592		5,818,195			827	67
68	Speech Pathology	496,547		3,331,722			416	68
69	Electrocardiology	1,596,891	2,690	26,641,164	2,690		1,354	69
71	Medical Supplies Charged to Patients							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	73
74	Renal Dialysis	1,211,433	1,133	1,852,636	1,133			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	60,493		1,169,251			85	76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
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	SPORTS MED FELLOWSHIP CLINIC	783,329					433	90.07
90.08	PODIATRY RESIDENCY CLINIC	282,989					457	90.08
90.09	FACULTY PRACTICE CLINIC	643,014		1,578,368			396	90.09
90.10	OUR LADY OF ROSARY CLINIC	912,362					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
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	240,734,294	294,737	1,144,029,706	288,699	206,346	113,703	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	159,398	1,883		1,883			190
192	Physicians' Private Offices	42,469	116		116			192
192.01	MATERNAL FETAL MEDICINE/LABORIST	1,630,418	101	126,079	101		25	192.01

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE GROSS REVENUE	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTES	
		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

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	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	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.04	ADMITTING							5.04
5.06	OTHER ADMINISTRATIVE & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	116,280						13
14	Central Services & Supply	1,297	1,149,926,299					14
15	Pharmacy	3,659		18,515,486				15
16	Medical Records & Library	3,626			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	186						23.02
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
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
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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		16,520,410			52
54	Radiology-Diagnostic	5,146	65,376,018	608,606	65,376,018		157	54
55	Radiology-Therapeutic	296	1,106,282		1,106,282			55
57	CT Scan	962	81,309,758	153,060	81,309,758			57
58	MRI		6,585,826		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		3,331,722			68
69	Electrocardiology	1,354	26,641,164	1,004	26,641,164			69
71	Medical Supplies Charged to Patients							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		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
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT	134	596,242		596,242			90.02
90.03	FAMILY MEDICINE CENTER	1,470	3,316,865	96,106	3,316,865		922	90.03
90.04	WOUND HEALING CENTER	701	5,349,636	37,110	5,349,636		639	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	806	5,328,685		5,328,685			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		36,422				90.10
91	Emergency	7,651	73,091,073	49	73,091,073		157	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	109,936	1,144,029,706	18,449,647	1,144,029,706	90	168,516	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
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

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	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	
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

**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET B-1**

COST CENTER DESCRIPTIONS	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME	PATIENT DAYS
	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	NONPATIENT TELEPHONES			5.01
5.04	ADMITTING			5.04
5.06	OTHER ADMINISTRATIVE & GENERAL			5.06
6	Maintenance & Repairs			6
7	Operation of Plant			7
8	Laundry & Linen Service			8
9	Housekeeping			9
10	Dietary			10
11	Cafeteria			11
12	Maintenance of Personnel			12
13	Nursing Administration			13
14	Central Services & Supply			14
15	Pharmacy			15
16	Medical Records & Library			16
17	Social Service			17
18	STERILE SUPPLY			18
19	Nonphysician Anesthetists			19
21	I&R Services-Salary & Fringes Apprvd	710		21
22	I&R Services-Other Prgm Costs Apprvd		710	22
23	PARAMED ED PRGM-(SPECIFY)		100	23
23.02	PHARMACY RESIDENCY PROGRAM			100
	23.02			23.02
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>			
30	Adults & Pediatrics	394	394	30
31	Intensive Care Unit	37	37	31
35	NEONATAL INTENSIVE CARE UNIT	10	10	35
41	Subprovider - IRF			41
43	Nursery	45	45	43
	<b>ANCILLARY SERVICE COST CENTERS</b>			
50	Operating Room	22	22	50
51	Recovery Room			51
52	Delivery Room & Labor Room	5	5	52
54	Radiology-Diagnostic	5	5	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	17	17	69
71	Medical Supplies Charged to Patients			71
72	Impl. Dev. Charged to Patients			72
73	Drugs Charged to Patients			100
74	Renal Dialysis	3	3	74
76.97	CARDIAC REHABILITATION			76.97
76.98	HYPERBARIC OXYGEN THERAPY			76.98
76.99	LITHOTRIPSY			76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>			
90	Clinic	129	129	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	43	43	100
92	Observation Beds (Non-Distinct Part)			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>			
	<b>SPECIAL PURPOSE COST CENTERS</b>			
118	SUBTOTALS (sum of lines 1-117)	710	710	100
	<b>NONREIMBURSABLE COST CENTERS</b>			
190	Gift, Flower, Coffee Shop & Canteen			190

**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION  ASSIGNED TIME	PATIENT DA 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

**KPMG LLP Compu-Max 2552-10**

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

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		CODE	LINE NO.	AMOUNT
	1	2	3	4

**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET C  
PART I**

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
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
	<b>ANCILLARY SERVICE COST CENTERS</b>						
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
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
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



**KPMG LLP Compu-Max 2552-10**

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

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
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
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							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	10,042,134	16,599,030	26,641,164	0.096403	0.096403	0.096416	69
71	Medical Supplies Charged to Patients							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	0.304706	0.304706	73
74	Renal Dialysis	1,477,962	374,674	1,852,636	0.903241	0.903241	0.903241	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	16,008	1,153,243	1,169,251	0.076589	0.076589	0.076589	76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
90.04	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							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							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
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

**WORKSHEET C  
PART I**

	COST CENTER DESCRIPTIONS	COSTS				
		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
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics					30
31	Intensive Care Unit					31
35	NEONATAL INTENSIVE CARE UNIT					35
41	Subprovider - IRF					41
43	Nursery					43
	<b>ANCILLARY SERVICE COST CENTERS</b>					
50	Operating Room					50
51	Recovery Room					51
52	Delivery Room & Labor Room					52
54	Radiology-Diagnostic					54
55	Radiology-Therapeutic					55
57	CT Scan					57
58	MRI					58
59	Cardiac Catheterization					59
60	Laboratory					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy					65
66	Physical Therapy					66
67	Occupational Therapy					67
68	Speech Pathology					68
69	Electrocardiology					69
71	Medical Supplies Charged to Patients					71
72	Impl. Dev. Charged to Patients					72
73	Drugs Charged to Patients					73
74	Renal Dialysis					74
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>					
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					91
92	Observation Beds (Non-Distinct Part)					92
	<b>OTHER REIMBURSABLE COST CENTERS</b>					
200	Subtotal (sum of lines 30 thru 199)					200
201	Less Observation Beds					201
202	Total (line 200 minus line 201)					202

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
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
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							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
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		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	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
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
	<b>ANCILLARY SERVICE COST CENTERS</b>						
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
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
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
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							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	10,042,134	16,599,030	26,641,164	0.096403	0.096403	0.096416	69
71	Medical Supplies Charged to Patients							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	0.304706	0.304706	73
74	Renal Dialysis	1,477,962	374,674	1,852,636	0.903241	0.903241	0.903241	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	16,008	1,153,243	1,169,251	0.076589	0.076589	0.076589	76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
90.04	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							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							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
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**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, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	<b>ANCILLARY SERVICE COST CENTERS</b>					
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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>					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	<b>CARDIAC REHABILITATION</b>					76.97
76.98	HYPERBARIC OXYGEN THERAPY	89,552	3,047	86,505		76.98
76.99	LITHOTRIPSY					76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>					
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>					
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY**

**WORKSHEET C  
PART II**

Title V

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)	
		5	6	7	8	
	<b>ANCILLARY SERVICE COST CENTERS</b>					
50	Operating Room		49,119,416	237,085,405	0.207180	50
51	Recovery Room		3,065,095	21,019,694	0.145820	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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>					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	<b>CARDIAC REHABILITATION</b>					76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>		89,552	1,169,251	0.076589	76.98
76.99	<b>LITHOTRIPSY</b>					76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>					
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			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
	<b>OTHER REIMBURSABLE COST CENTERS</b>					
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D  
PART I**

Check            [ ] Title V                                [XX] PPS  
Applicable    [XX] Title XVIII, Part A            [ ] TEFRA  
Boxes:         [ ] 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	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
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



**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 15-0012**

**WORKSHEET D  
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>						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	72
73	Drugs Charged to Patients	1,374,215	99,950,061	0.013749	20,298,215	279,080	73
74	Renal Dialysis	166,003	1,852,636	0.089604	670,766	60,103	74
76.97	<b>CARDIAC REHABILITATION</b>						76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>	3,047	1,169,251	0.002606	16,008	42	76.98
76.99	<b>LITHOTRIPSY</b>						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D  
PART III**

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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	59,199		22,230		30
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-0012**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	<b>ANCILLARY SERVICE COST CENTERS</b>									
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
	<b>OUTPATIENT SERVICE COST CENTERS</b>									
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>									
200	Total (sum of lines 50-199)					517,301		517,301	517,301	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-0012**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	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)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								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	73
74	Renal Dialysis	1,852,636			670,766		133,039		74
76.97	<b>CARDIAC REHABILITATION</b>								76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>	1,169,251			16,008		755,711		76.98
76.99	<b>LITHOTRIPSY</b>								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0012

WORKSHEET D  
PART V

Check [ ] Title V - O/P [XX] Hospital [ ] SUB (Other) [ ] Swing Bed SNF  
 Applicable [XX] Title XVIII, Part B [ ] IPF [ ] SNF [ ] Swing Bed NF  
 Boxes: [ ] Title XIX - O/P [ ] IRF [ ] NF [ ] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
1	2	3	4	5	6	7		
<b>ANCILLARY SERVICE COST CENTERS</b>								
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							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							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							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.076589	755,711			57,879		76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
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	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
<b>OTHER REIMBURSABLE COST CENTERS</b>								
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 15-T012**

**WORKSHEET D  
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
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	58
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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>						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	<b>CARDIAC REHABILITATION</b>						76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>	3,047	1,169,251	0.002606			76.98
76.99	<b>LITHOTRIPSY</b>						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
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					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	3,022	123	91
92	Observation Beds (Non-Distinct		7,462,511				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	20,388,317	974,815,467		2,730,573	41,550	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-T012**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	<b>ANCILLARY SERVICE COST CENTERS</b>									
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
	<b>OUTPATIENT SERVICE COST CENTERS</b>									
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>									
200	Total (sum of lines 50-199)					517,301		517,301	517,301	200

(A) Worksheet A line numbers



**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-T012**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	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)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								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	<b>CARDIAC REHABILITATION</b>								76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>	1,169,251							76.98
76.99	<b>LITHOTRIPSY</b>								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	974,815,467			2,730,573	575	152		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS**

**COMPONENT CCN: 15-T012**

**WORKSHEET D  
PART V**

Check  Title V - O/P  Hospital  SUB (Other)  Swing Bed SNF  
 Applicable  Title XVIII, Part B  IPF  SNF  Swing Bed NF  
 Boxes:  Title XIX - O/P  IRF  NF  ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
1	2	3	4	5	6	7			
<b>ANCILLARY SERVICE COST CENTERS</b>									
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	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	
<b>OUTPATIENT SERVICE COST CENTERS</b>									
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	
<b>OTHER REIMBURSABLE COST CENTERS</b>									
200	Subtotal (see instructions)		152			50		200	
201	Less PBP Clinic Lab. Services-Program Only Charges							201	
202	Net Charges (line 200 - line 201)		152			50		202	

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D  
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed 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)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 15-0012**

**WORKSHEET D  
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	7,801,539	237,085,405	0.032906	13,888,778	457,024	50
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	55
57	CT Scan	298,111	81,309,758	0.003666	3,125,044	11,456	57
58	MRI	11,155	6,585,826	0.001694	830,080	1,406	58
59	Cardiac Catheterization	2,124,686	64,933,575	0.032721	3,305,458	108,158	59
60	Laboratory	524,295	122,916,084	0.004265	11,293,330	48,166	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>						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	66
67	Occupational Therapy	34,380	5,818,195	0.005909	447,086	2,642	67
68	Speech Pathology	17,978	3,331,722	0.005396	284,297	1,534	68
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	<b>CARDIAC REHABILITATION</b>						76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>	3,047	1,169,251	0.002606			76.98
76.99	<b>LITHOTRIPSY</b>						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	22,084,310	974,815,467		44,104,406	958,709	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D  
PART III**

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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	59,199		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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-0012**

**WORKSHEET D  
PART IV**

Check  Title V  Hospital  SUB (Other)  ICF/IID  PPS  
 Applicable  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	
	<b>ANCILLARY SERVICE COST CENTERS</b>									
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
	<b>OUTPATIENT SERVICE COST CENTERS</b>									
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>									
200	Total (sum of lines 50-199)					517,301		517,301	517,301	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-0012**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	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)	
		7	8	9	10	11	12	13	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
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							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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								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	<b>CARDIAC REHABILITATION</b>								76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>	1,169,251							76.98
76.99	<b>LITHOTRIPSY</b>								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic								90
90.02	<b>MOBILE MEDICAL UNIT</b>	596,242							90.02
90.03	<b>FAMILY MEDICINE CENTER</b>	3,316,865							90.03
90.04	<b>WOUND HEALING CENTER</b>	5,349,636			2,211				90.04
90.05	<b>OUTPATIENT TREATMENT &amp; INFUSION</b>	5,328,685			1,974				90.05
90.06	<b>PEDIATRIC SPECIALTY CLINIC</b>	352,245			298				90.06
90.07	<b>SPORTS MED FELLOWSHIP CLINIC</b>								90.07
90.08	<b>PODIATRY RESIDENCY CLINIC</b>								90.08
90.09	<b>FACULTY PRACTICE CLINIC</b>	1,578,368							90.09
90.10	<b>OUR LADY OF ROSARY CLINIC</b>								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							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	974,815,467			44,104,406	7,829			200

(A) Worksheet A line numbers



**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS**

**COMPONENT CCN: 15-0012**

**WORKSHEET D  
PART V**

Check  Title V - O/P       Hospital       SUB (Other)       Swing Bed SNF  
 Applicable  Title XVIII, Part B       IPF       SNF       Swing Bed NF  
 Boxes:  Title XIX - O/P       IRF       NF       ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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	MRI	0.085084						58
59	Cardiac Catheterization	0.236346						59
60	Laboratory	0.124893						60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							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	<b>CARDIAC REHABILITATION</b>							76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>	0.076589						76.98
76.99	<b>LITHOTRIPSY</b>							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic							90
90.02	<b>MOBILE MEDICAL UNIT</b>	0.224813						90.02
90.03	<b>FAMILY MEDICINE CENTER</b>	0.568839						90.03
90.04	<b>WOUND HEALING CENTER</b>	0.366883						90.04
90.05	<b>OUTPATIENT TREATMENT &amp; INFUSION</b>	0.271051						90.05
90.06	<b>PEDIATRIC SPECIALTY CLINIC</b>	1.718060						90.06
90.07	<b>SPORTS MED FELLOWSHIP CLINIC</b>							90.07
90.08	<b>PODIATRY RESIDENCY CLINIC</b>							90.08
90.09	<b>FACULTY PRACTICE CLINIC</b>	0.556394						90.09
90.10	<b>OUR LADY OF ROSARY CLINIC</b>							90.10
91	Emergency	0.212778						91
92	Observation Beds (Non-Distinct)	0.920138						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 15-T012**

**WORKSHEET D  
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>						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						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	<b>CARDIAC REHABILITATION</b>						76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>	3,047	1,169,251	0.002606			76.98
76.99	<b>LITHOTRIPSY</b>						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
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			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	227,290	5,328,685	0.042654			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			91
92	Observation Beds (Non-Distinct		7,462,511				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	20,388,317	974,815,467				200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-T012**

**WORKSHEET D  
PART IV**

Check  Title V  Hospital  SUB (Other)  ICF/IID  PPS  
 Applicable  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	
	<b>ANCILLARY SERVICE COST CENTERS</b>									
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
	<b>OUTPATIENT SERVICE COST CENTERS</b>									
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>									
200	Total (sum of lines 50-199)					517,301		517,301	517,301	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-T012**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	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)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
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	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								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	<b>CARDIAC REHABILITATION</b>								76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>	1,169,251							76.98
76.99	<b>LITHOTRIPSY</b>								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
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								90.10
91	Emergency	73,091,073	0.002367	0.002367					91
92	Observation Beds (Non-Distinct	7,462,511							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	974,815,467							200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS**

**COMPONENT CCN: 15-T012**

**WORKSHEET D  
PART V**

Check  Title V - O/P  Hospital  SUB (Other)  Swing Bed SNF  
 Applicable  Title XVIII, Part B  IPF  SNF  Swing Bed NF  
 Boxes:  Title XIX - O/P  IRF  NF  ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
1	2	3	4	5	6	7		
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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	MRI	0.085084					58	
59	Cardiac Catheterization	0.236346					59	
60	Laboratory	0.124893					60	
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>						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	<b>CARDIAC REHABILITATION</b>						76.97	
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>	0.076589					76.98	
76.99	<b>LITHOTRIPSY</b>						76.99	
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic						90	
90.02	<b>MOBILE MEDICAL UNIT</b>	0.224813					90.02	
90.03	<b>FAMILY MEDICINE CENTER</b>	0.568839					90.03	
90.04	<b>WOUND HEALING CENTER</b>	0.366883					90.04	
90.05	<b>OUTPATIENT TREATMENT &amp; INFUSION</b>	0.271051					90.05	
90.06	<b>PEDIATRIC SPECIALTY CLINIC</b>	1.718060					90.06	
90.07	<b>SPORTS MED FELLOWSHIP CLINIC</b>						90.07	
90.08	<b>PODIATRY RESIDENCY CLINIC</b>						90.08	
90.09	<b>FACULTY PRACTICE CLINIC</b>	0.556394					90.09	
90.10	<b>OUR LADY OF ROSARY CLINIC</b>						90.10	
91	Emergency	0.212778					91	
92	Observation Beds (Non-Distinct)	0.920138					92	
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Subtotal (see instructions)						200	
201	Less PBP Clinic Lab. Services-Program Only Charges						201	
202	Net Charges (line 200 - line 201)						202	

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-0012

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	59,199	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	59,199	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)	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

**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-0012

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,122.35	38	
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)					24,949,841	41	
42	Nursery (Titles V and XIX only)						42	
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit	10,646,535	5,353	1,988.89	1,690	3,361,224	43	
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			47	

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					38,707,353	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					67,018,418	49	

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					6,814,329	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,620,539	51
52	Total Program excludable cost (sum of lines 50 and 51)					10,434,868	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					56,583,550	53

**TARGET AMOUNT AND LIMIT COMPUTATION**

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

**PROGRAM INPATIENT ROUTINE SWING BED COST**

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-0012

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					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



**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-T012

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

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
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

**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-T012

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

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 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

**PROGRAM INPATIENT ROUTINE SWING BED COST**

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-0012

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	59,199	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	59,199	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)	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

**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-0012

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,122.35	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	
42	Nursery (Titles V and XIX only)	3,780,922	4,262	887.12	2,343	2,078,522	42	
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit	10,646,535	5,353	1,988.89	631	1,254,990	43	
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	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					7,950,148	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					16,871,951	49	

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,326,019	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					966,538	51
52	Total Program excludable cost (sum of lines 50 and 51)					2,292,557	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					14,579,394	53

**TARGET AMOUNT AND LIMIT COMPUTATION**

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

**PROGRAM INPATIENT ROUTINE SWING BED COST**

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-0012

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					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

**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-T012

WORKSHEET D-1  
PART I

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

**INPATIENT DAYS**

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)	358	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
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

**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-T012

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

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
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

**PROGRAM INPATIENT ROUTINE SWING BED COST**

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-0012

WORKSHEET D-3

Check  Title V  Hospital  SUB (Other)  Swing Bed SNF  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  Swing Bed NF  TEFRA  
 Boxes:  Title XIX  IRF  NF  ICF/IID  Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		51,390,545		30
31	Intensive Care Unit		7,709,944		31
35	NEONATAL INTENSIVE CARE UNIT				35
41	Subprovider - IRF				41
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.207436	41,331,889	8,573,722	50
51	Recovery Room	0.145820	3,407,933	496,945	51
52	Delivery Room & Labor Room	0.268053	38,971	10,446	52
54	Radiology-Diagnostic	0.175674	5,906,729	1,037,659	54
55	Radiology-Therapeutic	0.719891	340,330	245,001	55
57	CT Scan	0.033289	10,185,397	339,062	57
58	MRI	0.085084	2,613,962	222,406	58
59	Cardiac Catheterization	0.236628	9,814,562	2,322,400	59
60	Laboratory	0.124893	29,966,487	3,742,604	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.271409	5,418,139	1,470,532	65
66	Physical Therapy	0.322143	1,980,029	637,852	66
67	Occupational Therapy	0.219915	1,413,607	310,873	67
68	Speech Pathology	0.203790	734,224	149,628	68
69	Electrocardiology	0.096416	4,391,117	423,374	69
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.375358	23,899,213	8,970,761	72
73	Drugs Charged to Patients	0.304706	20,298,215	6,184,988	73
74	Renal Dialysis	0.903241	670,766	605,863	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.076589	16,008	1,226	76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
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	34,255	12,568	90.04
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				90.08
90.09	FACULTY PRACTICE CLINIC	0.556394			90.09
90.10	OUR LADY OF ROSARY CLINIC				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
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		171,548,741	38,707,353	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		171,548,741		202

(A) Worksheet A line numbers



**KPMG LLP Compu-Max 2552-10**

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

**COMPONENT CCN: 15-T012**

**WORKSHEET D-3**

Check  Title V  Hospital  SUB (Other)  Swing Bed SNF  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  Swing Bed NF  TEFRA  
 Boxes:  Title XIX  IRF  NF  ICF/IID  Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
35	NEONATAL INTENSIVE CARE UNIT				35
41	Subprovider - IRF		2,892,994		41
	<b>ANCILLARY SERVICE COST CENTERS</b>				
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	52
54	Radiology-Diagnostic	0.175674	22,843	4,013	54
55	Radiology-Therapeutic	0.719891			55
57	CT Scan	0.033289	27,153	904	57
58	MRI	0.085084	25,212	2,145	58
59	Cardiac Catheterization	0.236628	3,927	929	59
60	Laboratory	0.124893	257,191	32,121	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.271409	3,664	994	65
66	Physical Therapy	0.322143	872,313	281,010	66
67	Occupational Therapy	0.219915	773,424	170,088	67
68	Speech Pathology	0.203790	565,495	115,242	68
69	Electrocardiology	0.096416	176	17	69
71	Medical Supplies Charged to Patients				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	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.076589			76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
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	1,080	396	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.271051	12	3	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	3,022	649	91
92	Observation Beds (Non-Distinct Part)	0.920138			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
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)				201
202	Net Charges (line 200 minus line 201)		2,730,573		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-0012

WORKSHEET D-3

Check  Title V  Hospital  SUB (Other)  Swing Bed SNF  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  Swing Bed NF  TEFRA  
 Boxes:  Title XIX  IRF  NF  ICF/IID  Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		20,401,271		30
31	Intensive Care Unit		3,750,381		31
35	NEONATAL INTENSIVE CARE UNIT		7,953,832		35
41	Subprovider - IRF				41
43	Nursery				43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.207436	13,888,778	2,881,033	50
51	Recovery Room	0.145820	785,721	114,574	51
52	Delivery Room & Labor Room	0.268053			52
54	Radiology-Diagnostic	0.175674	2,217,662	389,586	54
55	Radiology-Therapeutic	0.719891	264,292	190,261	55
57	CT Scan	0.033289	3,125,044	104,030	57
58	MRI	0.085084	830,080	70,627	58
59	Cardiac Catheterization	0.236628	3,305,458	782,164	59
60	Laboratory	0.124893	11,293,330	1,410,458	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.271409	2,519,203	683,734	65
66	Physical Therapy	0.322143	639,968	206,161	66
67	Occupational Therapy	0.219915	447,086	98,321	67
68	Speech Pathology	0.203790	284,297	57,937	68
69	Electrocardiology	0.096416	1,253,857	120,892	69
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.375358			72
73	Drugs Charged to Patients	0.304706	455,968	138,936	73
74	Renal Dialysis	0.903241	145,533	131,451	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.076589			76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
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	2,211	811	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.271051	1,974	535	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	1.718060	298	512	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	2,643,646	568,125	91
92	Observation Beds (Non-Distinct Part)	0.920138			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		44,104,406	7,950,148	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		44,104,406		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-T012

WORKSHEET D-3

Check  Title V  Hospital  SUB (Other)  Swing Bed SNF  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  Swing Bed NF  TEFRA  
 Boxes:  Title XIX  IRF  NF  ICF/IID  Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
35	NEONATAL INTENSIVE CARE UNIT				35
41	Subprovider - IRF		680,525		41
	<b>ANCILLARY SERVICE COST CENTERS</b>				
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
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
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

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET E  
PART A**

**PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	45,234,538			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)				1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	1,630,069			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	17,566,842			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	239.89			4
	<b>Indirect Medical Education Adjustment Calculation for Hospitals</b>				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)	17.61			5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	1.02			7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	5.87			8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)	22.46			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	25.72			10
11	FTE count for residents in dental and podiatric programs	4.88			11
12	Current year allowable FTE (see instructions)	27.34			12
13	Total allowable FTE count for the prior year	27.46			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	27.46			14
15	Sum of lines 12 through 14 divided by 3	27.42			15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count	27.42			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.114302			19
20	Prior year resident to bed ratio (see instructions)	0.114255			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.114255			21
22	IME payment adjustment (see instructions)	2,735,106			22
22.01	IME payment adjustment - Managed Care (see instructions)	1,062,179			22.01
	<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)	3.26			24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	2,735,106			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	1,062,179			29.01
	<b>Disproportionate Share Adjustment</b>				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0426			30
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
		<b>Prior to</b>		<b>On or after</b>	
		<b>October 1 (1.00)</b>	<b>(1.01)</b>	<b>October 1 (2.00)</b>	
35	Total uncompensated care amount (see instructions)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000340888	35.01
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
	<b>Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)</b>				
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
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 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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**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			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	54,193,290			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	4,442,057			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				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				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
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	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	4,953,624			62
63	Coinsurance billed to program beneficiaries	53,814			63
64	Allowable bad debts (see instructions)	363,054			64
65	Adjusted reimbursable bad debts (see instructions)	235,985			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	78,378			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	55,640,912			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				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
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	1,662,502			75
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
<b>HSP Bonus Payment Amount</b>		<b>Prior to 10/1</b>	<b>On or After 10/1</b>		
100	HSP bonus amount (see instructions)				100
<b>HVBP Adjustment for HSP Bonus Payment</b>		<b>Prior to 10/1</b>	<b>On or After 10/1</b>		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
<b>HRR Adjustment for HSP Bonus Payment</b>		<b>Prior to 10/1</b>	<b>On or After 10/1</b>		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

**KPMG LLP Compu-Max 2552-10**

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

**COMPONENT CCN: 15-0012**

**WORKSHEET E  
PART B**

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

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	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
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
12	Ancillary service charges	83,513			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)	83,513			14
	<b>CUSTOMARY CHARGES</b>				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	83,513			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	58,004			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)	25,509			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)	21,902,580			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	Deductibles and coinsurance (see instructions)				25
26	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 costs (from Wkst. E-4, line 36)				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
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	491,651			34
35	Adjusted reimbursable bad debts (see instructions)	319,573			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	279,273			36
37	Subtotal (see instructions)	18,792,825			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)	18,792,825			40
40.01	Sequestration adjustment (see instructions)	375,857			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	18,606,767			41
42	Tentative settlement (for contractors use only)				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 (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

**KPMG LLP Compu-Max 2552-10**

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

**COMPONENT CCN: 15-T012**

**WORKSHEET E  
PART B**

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

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPSS (see instructions)	50			2
3	OPSS 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
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
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
	<b>CUSTOMARY CHARGES</b>				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (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
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
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**

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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**

**COMPONENT CCN: 15-0012**

**WORKSHEET E-1  
PART I**

Check  Hospital  SUB (Other)  
 Applicable  IPF  SNF  
 Boxes:  IRF  Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		54,324,279		18,606,767
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01	01/23/2018		
		.02			
	Program	.03			
	to	.04			
	Provider	.05			
		.06			
		.07			
		.08			
		.09			
		.10			
		.50			
		.51			
	Provider	.52			
	to	.53			
	Program	.54			
		.55			
		.56			
		.57			
		.58			
		.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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		54,403,279		18,606,767
<b>TO BE COMPLETED BY CONTRACTOR</b>					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01			6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		54,272,567		18,416,968
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)

(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.



**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-T012

WORKSHEET E-1  
PART I

Check  Hospital  SUB (Other)  
Applicable  IPF  SNF  
Boxes:  IRF  Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		2,253,232		822
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,253,232		822
	<b>TO BE COMPLETED BY CONTRACTOR</b>				
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	33,132		6.01
		.02			-525
7	Total Medicare program liability (see instructions)		2,286,364		297
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)
					8

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

**KPMG LLP Compu-Max 2552-10**

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

**COMPONENT CCN: 15-T012**

**WORKSHEET E-3  
PART III**

Check [ ] Hospital  
Applicable [XX] Subprovider IRF  
Box:

**PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS**

		1	1.01	
1	Net Federal PPS payment (see instructions)	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 excluding 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**

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

**KPMG LLP Compu-Max 2552-10**

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

COMPONENT CCN: 15-0012

WORKSHEET E-3  
PART VII

Check  Title V  Hospital  NF  PPS  
 Applicable  Title XIX  SUB (Other)  ICF/IID  TEFRA  
 Boxes:  SNF  Other

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
<b>REASONABLE CHARGES</b>			
8			8
9	44,104,406		9
10			10
11			11
12	44,104,406		12
<b>CUSTOMARY CHARGES</b>			
13			13
14			14
15	1.000000	1.000000	15
16	44,104,406		16
17	44,104,406		17
18			18
19			19
20			20
21			21
<b>PROSPECTIVE PAYMENT AMOUNT</b>			
22			22
23			23
24			24
25			25
26	7,829		26
27	7,829		27
28			28
29	7,829		29
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30			30
31	7,829		31
32			32
33			33
34			34
35			35
36	7,829		36
37			37
38	7,829		38
39			39
40	7,829		40
41			41
42	7,829		42
43			43

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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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 TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
<b>REASONABLE CHARGES</b>			
8			8
9			9
10			10
11			11
12			12
<b>CUSTOMARY CHARGES</b>			
13			13
14			14
15	1.000000	1.000000	15
16			16
17			17
18			18
19			19
20			20
21			21
<b>PROSPECTIVE PAYMENT AMOUNT</b>			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**

**WORKSHEET E-4**

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			22.87	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				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 straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §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 7/1/2011)			7.00	4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			27.73	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			26.70	6
7	Enter the lesser of line 5 or line 6			26.70	7
		Primary Care 1	Other 2	Total 3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	26.20	0.50	26.70	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	26.20	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				10.01
11	Total weighted FTE count	26.20	5.50		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	26.25	5.00		12
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					
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 PARAMEDICAL EDUCATION COSTS)					
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)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME					
Part A Reasonable Cost					
37	Reasonable cost (see instructions)			69,435,164	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)			32,669	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			69,402,495	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			23,447,147	42
43	Primary payer payments (see instructions)			9,301	43
44	Total Part B reasonable cost (line 42 minus line 43)			23,437,846	44
45	Total reasonable cost (sum of lines 41 and 44)			92,840,341	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.747547	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.252453	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)			2,068,312	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			1,546,160	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			522,152	50

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**

**WORKSHEET E-4**

Check  Title V  
 Applicable  Title XVIII  
 Box:  Title XIX

<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
		Primary Care 1	Other 2	Total 3	
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996				1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (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 straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §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 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	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	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	0.00	0.00		17
18	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)				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)				25
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>					
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	5,767	8,013		26
27	Total inpatient days (see instructions)	65,644	65,644		27
28	Ratio of inpatient days to total inpatient days	0.087853	0.122068		28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				31
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>					
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)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
<b>APPORTIONMENT OF MEDICARE REASONABLE COST OF GME</b>					
<b>Part A Reasonable Cost</b>					
37	Reasonable cost (see instructions)				37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				41
<b>Part B Reasonable Cost</b>					
42	Reasonable cost (see instructions)				42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)				44
45	Total reasonable cost (sum of lines 41 and 44)				45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				47
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>					
48	Total program GME payment (line 31)				48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)				50

**KPMG LLP Compu-Max 2552-10**

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**BALANCE SHEET**

**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
<b>Assets</b> (Omit Cents)		1	2	3	4	
<b>CURRENT ASSETS</b>						
1	Cash on hand and in banks	837,383				1
2	Temporary investments	36,431,530				2
3	Notes receivable					3
4	Accounts receivable	84,877,850				4
5	Other receivables	15,554,838				5
6	Allowances for uncollectible notes and accounts receivable	-15,742,848				6
7	Inventory	7,324,698				7
8	Prepaid expenses	497,292				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	129,780,743				11
<b>FIXED ASSETS</b>						
12	Land	406,021				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation					16
17	Leasehold improvements	309,510,210				17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	112,624,184				23
24	Accumulated depreciation	-157,467,699				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	265,072,716				30
<b>OTHER ASSETS</b>						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	22,049,720				34
35	Total other assets (sum of lines 31-34)	22,049,720				35
36	Total assets (sum of lines 11, 30 and 35)	416,903,179				36
<b>Liabilities and Fund Balances</b> (Omit Cents)						
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	Accounts payable	25,204,074				37
38	Salaries, wages and fees payable	7,580,534				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	7,381,172				40
41	Deferred income	52,285				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	958,951				44
45	Total current liabilities (sum of lines 37 thru 44)	41,177,016				45
<b>LONG TERM LIABILITIES</b>						
46	Mortgage payable					46
47	Notes payable	284,077,975				47
48	Unsecured loans					48
49	Other long term liabilities	11,530,484				49
50	Total long term liabilities (sum of lines 46 thru 49)	295,608,459				50
51	Total liabilities (sum of lines 45 and 50)	336,785,475				51
<b>CAPITAL ACCOUNTS</b>						
52	General fund balance	80,117,704				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	80,117,704				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	416,903,179				60

**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET G-1**

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

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



**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET G-2  
PARTS I & II**

**PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
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
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**STATEMENT OF REVENUES AND EXPENSES****WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	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 hospitial 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

**KPMG LLP Compu-Max 2552-10**

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

**COMPONENT CCN: 15-0012**

**WORKSHEET L**

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

**PART I - FULLY 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

**KPMG LLP Compu-Max 2552-10**

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

**COMPONENT CCN: 15-0012**

**WORKSHEET L**

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

**PART I - FULLY PROSPECTIVE METHOD**

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier		1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments		2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)		3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (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

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES**

**WORKSHEET L-1  
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	NONPATIENT TELEPHONES						5.01
5.04	ADMITTING						5.04
5.06	OTHER ADMINISTRATIVE & GENERAL						5.06
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
18	STERILE SUPPLY						18
19	Nonphysician Anesthetists						19
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
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
35	NEONATAL INTENSIVE CARE UNIT						35
41	Subprovider - IRF						41
43	Nursery						43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room						50
51	Recovery Room						51
52	Delivery Room & Labor Room						52
54	Radiology-Diagnostic						54
55	Radiology-Therapeutic						55
57	CT Scan						57
58	MRI						58
59	Cardiac Catheterization						59
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology						69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
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						91
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)						118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
192.01	MATERNAL FETAL MEDICINE/LABORIST						192.01
192.02	NEONATOLOGISTS						192.02

**KPMG LLP Compu-Max 2552-10**

ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 09/25/2018 Run Time: 10:47 Version: 2018.04 (08/29/2018)
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**ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES**

**WORKSHEET L-1  
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26		
192.03	HOSPITALISTS/INTENSIVISTS	0						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