

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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 checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	Date: 11/25/2015 Time: 15:32
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 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

ECR Encryption: 11/25/2015 15:32
0LMP7GZhjQIPKgxUVj6ECCZm8TM0
utsFq087YC9rIFLIXInbty0GoAd2bG
8v1M11VU3a0ZFgwz

(Signed) *Janice L. Dura*
Officer or Administrator of Provider(s)
Title CEO
Date 11/30/15

PI Encryption: 11/25/2015 15:32
4VOi3Uj4ehj9ED7p:A0hMeJ0shQ6g0
RW46o0NRycRWLL6ngWeKuIv:1j0wmt
hQDb0azRin0yOBFu

PART III - SETTLEMENT SUMMARY

		TITLE XVIII			TITLE XIX	
		TITLE V	PART A	PART B		
		1	2	3	4	5
1	HOSPITAL		1,088,339	-78,484	33,809	13,374,957
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF		-81,164			203
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		1,007,175	-78,484	33,809	13,375,160

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. JOSEPH'S REG MED CENTER S. BEND	15-0012	43780	1	07 / 01 / 1996	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF	ST JOSEPH REG MED CTR - REHAB	15-T012	43780	5	06 / 01 / 1983	N	P	P	5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2014	To: 06 / 30 / 2015		20
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21	Type of control (see instructions)	1			21
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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.	3,798	650	76	142	6,715	377	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.	213						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 is 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
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)(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)(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
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
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

Teaching Hospitals		1	2	3	
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
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	Y			60
		Y/N	IME	Direct GME	
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 and enter in column 4 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 and enter in column 4 direct 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 64-67. (see instructions)	N		63
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**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 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 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)	Y	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 a 'subclause (II) LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

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**WORKSHEET S-2
PART I**

		V	XIX	
Title V and XIX Services		1	2	
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

Rural Providers

		1	2		
105	Does this hospital qualify as a critical access hospital (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	
		Physical	Occupational	Speech	Respiratory
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.				
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

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
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	71,605	947,066		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

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, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable 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

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**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 on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

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				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		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 transitional factor. (see instructions)	0.25				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 / 2014	06 / 30 / 2015			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. (see instructions)		N			171

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ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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	
Provider Organization and Operation				
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
Financial Data and Reports				
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
Approved Educational Activities			
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
Bad Debts		
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

Bed Complement		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
PS&R Report Data					
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	09/30/2015	Y	09/30/2015
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	

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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 relieved 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: CRAIG	Last name: NIETCH	Title: DIRECTOR OF REIMBURSEMENT
42	Employer: SAINT JOSEPH REGIONAL MEDICAL CENTER		
43	Phone number: 574-335-4653	E-mail Address: NIETCHC@SJRMC.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	228	83,220			21,334	3,065	50,603	1
2	HMO and other (see instructions)						9,939	6,715		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider							76		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)		228	83,220			21,334	3,065	50,603	7
8	Intensive Care Unit	31	28	10,220			1,781	396	4,909	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				758	1,010	12
13	Nursery	43						447	5,885	13
14	Total (see instructions)		268	97,820			23,115	4,666	62,407	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41	40	14,600			2,888	137	4,538	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								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		308							27
28	Observation Bed Days							919	5,523	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)		4	1,460			3	377	690	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								1	32.01
33	LTCH non-covered days									33

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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)					5,144	1,000	14,271	1
2	HMO and other (see instructions)					1,963	1,197		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)	32.00	1,420.00	34.00		5,144	1,000	14,271	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF					216	15	328	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)	32.00	1,420.00	34.00					27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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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	
SALARIES							
1	Total salaries (see instructions)	200	79,750,919		79,750,919	2,981,400.00	26.75
2	Non-physician anesthetist Part A						
3	Non-physician anesthetest Part B						
4	Physician-Part A - Administrative		532,566		532,566	3,327.00	160.07
4.01	Physician-Part A - Teaching		1,791,432		1,791,432	13,889.00	128.98
5	Physician-Part B		396,378		396,378	3,384.00	117.13
6	Non-physician-Part B						
7	Interns & residents (in an approved program)	21	1,642,478	284,310	1,926,788	69,301.00	27.80
7.01	Contracted interns & residents (in an approved program)						
8	Home office personnel						
9	SNF	44					
10	Excluded area salaries (see instructions)		6,249,034	-250,690	5,998,344	96,950.00	61.87
OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		260,012		260,012	5,423.00	47.95
12	Contract management and administrative services		127,296		127,296	2,080.00	61.20
13	Contract labor: Physician-Part A - Administrative		352,482		352,482	2,282.00	154.46
14	Home office salaries & wage-related costs		26,622,597		26,622,597	492,251.00	54.08
15	Home office: Physician Part A - Administrative						
16	Home office & Contract Physicians Part A - Teaching						
WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		14,561,219		14,561,219		
18	Wage-related costs (other)(see instructions)		6,715		6,715		
19	Excluded areas		1,559,569		1,559,569		
20	Non-physician anesthetist Part A						
21	Non-physician anesthetist Part B						
22	Physician Part A - Administrative		138,467		138,467		
22.01	Physician Part A - Teaching		465,772		465,772		
23	Physician Part B		103,058		103,058		
24	Wage-related costs (RHC/FQHC)						
25	Interns & residents (in an approved program)		427,044		427,044		
OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		117,452		117,452	21,807.00	5.39
27	Administrative & General		2,580,591	250,690	2,831,281	125,882.00	22.49
28	Administrative & General under contract (see instructions)		262,616		262,616	768.00	341.95
29	Maintenance & Repairs						
30	Operation of Plant		1,678,203		1,678,203	66,931.00	25.07
31	Laundry & Linen Service		108,678		108,678	8,449.00	12.86
32	Housekeeping		1,490,247		1,490,247	109,893.00	13.56
33	Housekeeping under contract (see instructions)		234,814		234,814	6,677.00	35.17
34	Dietary		1,933,493	-657,387	1,276,106	87,490.00	14.59
35	Dietary under contract (see instructions)		162,000		162,000	4,680.00	34.62
36	Cafeteria			657,387	657,387	45,071.00	14.59
37	Maintenance of Personnel						
38	Nursing Administration		2,201,351		2,201,351	72,483.00	30.37
39	Central Services and Supply		372,249		372,249	21,657.00	17.19
40	Pharmacy		3,167,578		3,167,578	76,549.00	41.38
41	Medical Records & Medical Records Library		1,580,089		1,580,089	73,387.00	21.53
42	Social Service		1,796,878		1,796,878	55,872.00	32.16
43	Other General Service		640,600		640,600	38,167.00	16.78

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		76,580,061	-284,310	76,295,751	2,906,951.00	26.25
2	Excluded area salaries (see instructions)		6,249,034	-250,690	5,998,344	96,950.00	61.87
3	Subtotal salaries (line 1 minus line 2)		70,331,027	-33,620	70,297,407	2,810,001.00	25.02
4	Subtotal other wages & related costs (see instructions)		27,362,387		27,362,387	502,036.00	54.50
5	Subtotal wage-related costs (see instructions)		14,706,401		14,706,401		20.92%
6	Total (sum of lines 3 through 5)		112,399,815	-33,620	112,366,195	3,312,037.00	33.93
7	Total overhead cost (see instructions)		18,326,839	250,690	18,577,529	815,763.00	22.77

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HOSPITAL WAGE RELATED COSTS

**WORKSHEET S-3
PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	579,705	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)	9,487,896	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	10,315,716	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	609,108	10
11	Life Insurance (If employee is owner or beneficiary)	189,984	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	86,837	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	420,513	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	-133,899	16
	TAXES		
17	FICA-Employers Portion Only	5,148,728	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	38,437	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	26,743,025	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	6,715	25
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ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	Supporting Exhibit for Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	Wage Index Fiscal Year Ending Date	06/30/2018	1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)	07/01/2014	06/30/2015
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month	1/01/2015	3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)	7/01/2013	4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)	7/01/2016	5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	Effective Date of Pension Plan		6
7	First Day of the Provider Cost Reporting Period Containing the Pension Plan Effective Date		7
8	Starting Date of the Adjusted Averaging Period (date on Line 7, adjusted to first of month)		8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	Beginning Date of Averaging Period from Line 4 or Line 8, as Applicable	7/01/2013	9
10	Ending Date of Averaging Period from Line 5	7/01/2016	10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	DEPOSIT DATE(S)	CONTRIBUTION(S)
11.01		06/30/2013	8,512,133
11.02		06/30/2014	8,512,133
11.03		06/30/2015	11,439,439
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)	36	12
13	Total Contributions Made During Averaging Period	28,463,705	13
14	Average Monthly Contribution (Line 13 divided by Line 12)	790,658	14
15	Number of MOnths in Provider Cost Reporting Period on Line 2	12	15
16	Average Pension Contributions (Line 14 times Line 15)	9,487,896	16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	Annual Prefunding Installment (see instructions)		17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)		18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	9,487,896	19

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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 RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list			11
12	Number of patients transplanted during the cost reporting period			12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider			13
14	Epoetin amount from Worksheet A for home dialysis program			14
15	Number of EPO units furnished relating to the renal dialysis department			15
16	Number of EPO units furnished relating to the home dialysis department			16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider			17
18	ARANESP amount from Worksheet A for home dialysis program			18
19	Number of ARANESP units furnished relating to the renal dialysis department			19
20	Number of ARANESP units furnished relating to the home dialysis department			20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))

21	MCP	INITIAL METHOD	
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	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

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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)		0.285334	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		25,577,050	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 or supplemental payments from Medicaid?		Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid			5
6	Medicaid charges		115,751,076	6
7	Medicaid cost (line 1 times line 6)		33,027,718	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.		7,450,668	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

Uncompensated care (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)		7,450,668	19
		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)
		1	2	3
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	10,429,092	2,634,733	13,063,825
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,975,775	751,779	3,727,554
22	Partial payment by patients approved for charity care	60,457		60,457
23	Cost of charity care (line 21 minus line 22)	2,915,318	751,779	3,667,097

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, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)			25
26	Total bad debt expense for the entire hospital complex (see instructions)		21,984,494	26
27	Medicare bad debts for the entire hospital complex (see instructions)		854,820	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		21,129,674	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		6,029,014	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		9,696,111	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		17,146,779	31

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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	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				19,041,991	19,041,991	3,747,007	22,788,998	1
2	00200	Cap Rel Costs-Mvble Equip				12,825,468	12,825,468		12,825,468	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	117,452	2,643,101	2,760,553		2,760,553	-43,556	2,716,997	4
5.01	00540	NONPATIENT TELEPHONES	228,894	54,586	283,480		283,480	-19,993	263,487	5.01
5.04	00570	ADMITTING	1,139,641	455,628	1,595,269		1,595,269		1,595,269	5.04
5.06	00590	OTHER ADMINISTRATIVE & GENERAL	1,212,056	76,673,399	77,885,455	-18,855,465	59,029,990	-4,248,530	54,781,460	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,678,203	7,134,544	8,812,747	-945,873	7,866,874	-96,399	7,770,475	7
8	00800	Laundry & Linen Service	108,678	1,009,734	1,118,412	-21,084	1,097,328		1,097,328	8
9	00900	Housekeeping	1,490,247	1,391,898	2,882,145	-11,136	2,871,009		2,871,009	9
10	01000	Dietary	1,933,493	3,147,368	5,080,861	-2,108,000	2,972,861	-280,287	2,692,574	10
11	01100	Cafeteria				1,916,334	1,916,334	-1,738,774	177,560	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	2,201,351	856,710	3,058,061	-97,549	2,960,512	245	2,960,757	13
14	01400	Central Services & Supply	372,249	573,979	946,228	-7,332	938,896	440	939,336	14
15	01500	Pharmacy	3,167,578	12,649,059	15,816,637	-11,996,889	3,819,748	-7,889	3,811,859	15
16	01600	Medical Records & Library	1,580,089	2,112,438	3,692,527	-20,700	3,671,827	-548	3,671,279	16
17	01700	Social Service	1,796,878	636,341	2,433,219		2,433,219	562	2,433,781	17
18	01850	STERILE SUPPLY	640,600	1,603,932	2,244,532	-117,219	2,127,313		2,127,313	18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	1,642,478	648,014	2,290,492	141,315	2,431,807	-83,719	2,348,088	21
22	02200	I&R Services-Other Prgm Costs Apprvd	1,764,880	677,204	2,442,084	75,045	2,517,129	-95,787	2,421,342	22
23	02300	PARAMED ED PRGM-(SPECIFY)	72,489	124,917	197,406		197,406	-54,369	143,037	23
23.01	02301	CLINICAL PASTORAL EDUCATION	224,004	53,268	277,272	42,848	320,120	-44,462	275,658	23.01
23.02	02302	PHARMACY RESIDENCY PROGRAM	381,817	184,210	566,027	-376,506	189,521		189,521	23.02
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	19,268,654	8,005,263	27,273,917	-4,301,802	22,972,115	-100,277	22,871,838	30
31	03100	Intensive Care Unit	3,503,959	1,637,833	5,141,792	-198,329	4,943,463	-18,474	4,924,989	31
35	02060	NEONATAL INTENSIVE CARE UNIT	1,888,408	990,546	2,878,954	-55,587	2,823,367		2,823,367	35
41	04100	Subprovider - IRF	1,818,520	2,670,290	4,488,810	-1,768,668	2,720,142	-61,951	2,658,191	41
43	04300	Nursery				3,156,107	3,156,107		3,156,107	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	7,342,539	31,685,841	39,028,380	-18,287,041	20,741,339	-1,977,055	18,764,284	50
51	05100	Recovery Room	954,100	364,556	1,318,656	-4,795	1,313,861		1,313,861	51
52	05200	Delivery Room & Labor Room				939,618	939,618		939,618	52
54	05400	Radiology-Diagnostic	3,084,793	3,168,543	6,253,336	-1,391,121	4,862,215	-94,614	4,767,601	54
55	05500	Radiology-Therapeutic	52,576	165,398	217,974	-20,700	197,274	-7,946	189,328	55
57	05700	CT Scan	604,137	833,387	1,437,524	-393,053	1,044,471	-1,238	1,043,233	57
58	05800	MRI		395,297	395,297		395,297		395,297	58
59	05900	Cardiac Catheterization	2,290,507	9,775,118	12,065,625	-5,617,700	6,447,925		6,447,925	59
60	06000	Laboratory		14,021,647	14,021,647	-523,996	13,497,651	-2,052	13,495,599	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	1,613,373	1,578,995	3,192,368	-253,427	2,938,941	1,373	2,940,314	65
66	06600	Physical Therapy	2,224,807	957,045	3,181,852	-269,768	2,912,084	-91,317	2,820,767	66
67	06700	Occupational Therapy	657,125	369,168	1,026,293	-158,145	868,148	5,590	873,738	67
68	06800	Speech Pathology	326,944	100,743	427,687	-12,899	414,788	3,503	418,291	68
69	06900	Electrocardiology	814,358	801,064	1,615,422	-402,437	1,212,985	-1,870	1,211,115	69
71	07100	Medical Supplies Charged to Patients		-435,477	-435,477	435,477				71
72	07200	Impl. Dev. Charged to Patients					19,410,247		19,410,247	72
73	07300	Drugs Charged to Patients	294,277	417,558	711,835	11,446,126	12,157,961		12,157,961	73
74	07400	Renal Dialysis		909,455	909,455		909,455		909,455	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				176,954	176,954		176,954	76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90.02	09001	MOBILE MEDICAL UNIT	78,550	69,065	147,615	-29,150	118,465		118,465	90.02
90.03	09002	FAMILY MEDICINE CENTER	583,201	931,450	1,514,651	-290,179	1,224,472	-60,101	1,164,371	90.03
90.04	09003	WOUND HEALING CENTER	455,201	1,123,819	1,579,020	-304,180	1,274,840	-1,948	1,272,892	90.04
90.05	09004	OUTPATIENT TREATMENT & INFUSION	489,712	151,085	640,797		640,797		640,797	90.05
90.06	09005	PEDIATRIC SPECIALTY CLINIC	233,370	438,568	671,938	-92,599	579,339	-190,880	388,459	90.06
90.07	09006	SPORTS MED FELLOWSHIP CLINIC	421,683	241,483	663,166	-129,571	533,595	-12,508	521,087	90.07
90.08	09007	PODIATRY RESIDENCY CLINIC	339,707	217,895	557,602	-337,377	220,225	-850	219,375	90.08
90.09	09008	FACULTY PRACTICE CLINIC	372,168	199,402	571,570	-38,104	533,466	-52	533,414	90.09
90.10	09009	OUR LADY OF ROSARY CLINIC	314,665	370,395	685,060	-149,390	535,670	-70	535,600	90.10
91	09100	Emergency	4,218,304	2,079,562	6,297,866	-19,759	6,278,107	-240,107	6,038,000	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense								113

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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	
118		SUBTOTALS (sum of lines 1-117)	75,998,715	196,865,324	272,864,039		272,864,039	-5,818,903	267,045,136	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices								192
192.01	19201	MATERNAL FETAL MEDICINE/LABORIST		1,369,886	1,369,886		1,369,886		1,369,886	192.01
192.02	19202	NEONATOLOGISTS	1,249,089	375,319	1,624,408		1,624,408		1,624,408	192.02
192.03	19203	HOSPITALISTS/INTENSIVISTS	244,270	4,438,301	4,682,571		4,682,571		4,682,571	192.03
194	07950	SPORTS MED-ATHLETIC TRAINERS	200,516	40,799	241,315		241,315		241,315	194
194.01	07951	OUTREACH SERVICES	1,901,037	1,093,359	2,994,396		2,994,396		2,994,396	194.01
194.02	07952	KINDRED/OUR LADY OF PEACE	157,109	22,666	179,775		179,775		179,775	194.02
194.03	07953	ADVANCED SPECIALTIES	183	136,480	136,663		136,663		136,663	194.03
200		TOTAL (sum of lines 118-199)	79,750,919	204,342,134	284,093,053		284,093,053	-5,818,903	278,274,150	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS NEGATIVE COST CTR EXP TOTAL	A	Medical Supplies Charged to P	71		435,477	1
500	Total reclassifications					435,477	500
	Code Letter - A						
1	DEPRECIATION RECLASS	B	Cap Rel Costs-Bldg & Fixt	1		32,725	1
2			Cap Rel Costs-Bldg & Fixt	1		4,249,298	2
3			Cap Rel Costs-Mvble Equip	2		3,887,126	3
4			Cap Rel Costs-Bldg & Fixt	1		300,289	4
5			Cap Rel Costs-Mvble Equip	2		2,030	5
6			Cap Rel Costs-Mvble Equip	2		643,554	6
7			Cap Rel Costs-Mvble Equip	2		21,084	7
8			Cap Rel Costs-Mvble Equip	2		11,136	8
9			Cap Rel Costs-Bldg & Fixt	1		16,933	9
10			Cap Rel Costs-Mvble Equip	2		174,733	10
11			Cap Rel Costs-Bldg & Fixt	1		490	11
12			Cap Rel Costs-Mvble Equip	2		97,059	12
13			Cap Rel Costs-Mvble Equip	2		7,332	13
14			Cap Rel Costs-Mvble Equip	2		547,083	14
15			Cap Rel Costs-Bldg & Fixt	1		20,700	15
16			Cap Rel Costs-Bldg & Fixt	1		7,548	16
17			Cap Rel Costs-Mvble Equip	2		109,671	17
18			Cap Rel Costs-Bldg & Fixt	1		148,158	18
19			Cap Rel Costs-Mvble Equip	2		213	19
20			Cap Rel Costs-Mvble Equip	2		50,600	20
21			Cap Rel Costs-Bldg & Fixt	1		1,726	21
22			Cap Rel Costs-Mvble Equip	2		153,751	22
23			Cap Rel Costs-Mvble Equip	2		2,405	23
24			Cap Rel Costs-Bldg & Fixt	1		39,788	24
25			Cap Rel Costs-Mvble Equip	2		156,136	25
26			Cap Rel Costs-Mvble Equip	2		55,587	26
27			Subprovider - IRF	41		6,198	27
28			Cap Rel Costs-Mvble Equip	2		544	28
29			Cap Rel Costs-Bldg & Fixt	1		926,664	29
30			Cap Rel Costs-Bldg & Fixt	1		1,632	30
31			Cap Rel Costs-Mvble Equip	2		68,257	31
32			Cap Rel Costs-Mvble Equip	2		150,446	32
33			Cap Rel Costs-Mvble Equip	2		75,627	33
34			Cap Rel Costs-Bldg & Fixt	1		1,133	34
35			Cap Rel Costs-Mvble Equip	2		2,637,736	35
36			Cap Rel Costs-Mvble Equip	2		4,795	36
37			Cap Rel Costs-Bldg & Fixt	1		105,846	37
38			Cap Rel Costs-Bldg & Fixt	1		126,606	38
39			Cap Rel Costs-Mvble Equip	2		1,158,669	39
40			Cap Rel Costs-Bldg & Fixt	1		20,700	40
41			Cap Rel Costs-Mvble Equip	2		393,053	41
42			Cap Rel Costs-Mvble Equip	2		3,906	42
43			Cap Rel Costs-Bldg & Fixt	1		27,485	43
44			Cap Rel Costs-Mvble Equip	2		1,749,972	44
45			Cap Rel Costs-Bldg & Fixt	1		135,112	45
46			Cap Rel Costs-Mvble Equip	2		20,061	46
47			Cap Rel Costs-Bldg & Fixt	1		151,260	47
48			Cap Rel Costs-Mvble Equip	2		6,101	48
49			Cap Rel Costs-Bldg & Fixt	1		1,964	49
50			Cap Rel Costs-Mvble Equip	2		94,102	50
51			Cap Rel Costs-Bldg & Fixt	1		260,960	51
52			Cap Rel Costs-Mvble Equip	2		8,808	52
53			Cap Rel Costs-Mvble Equip	2		5,865	53
54			Cap Rel Costs-Bldg & Fixt	1		157,860	54
55			Cap Rel Costs-Mvble Equip	2		285	55
56			Cap Rel Costs-Bldg & Fixt	1		8,659	56
57			Cap Rel Costs-Mvble Equip	2		4,240	57
58			Cap Rel Costs-Bldg & Fixt	1		141,804	58
59			Cap Rel Costs-Mvble Equip	2		500	59
60			Cap Rel Costs-Bldg & Fixt	1		467	60
61			Cap Rel Costs-Mvble Equip	2		259,666	61
62			Cap Rel Costs-Mvble Equip	2		3,680	62
63			Cap Rel Costs-Mvble Equip	2		29,150	63
64			Cap Rel Costs-Bldg & Fixt	1		237,265	64
65			Cap Rel Costs-Bldg & Fixt	1		8,062	65
66			Cap Rel Costs-Mvble Equip	2		44,852	66
67			Cap Rel Costs-Bldg & Fixt	1		114,394	67
68			Cap Rel Costs-Mvble Equip	2		12,832	68
69			Cap Rel Costs-Bldg & Fixt	1		88,668	69
70			Cap Rel Costs-Bldg & Fixt	1		269	70
71			Cap Rel Costs-Mvble Equip	2		3,662	71
72			Cap Rel Costs-Bldg & Fixt	1		56,450	72

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
73			Cap Rel Costs-Mvble Equip	2		5,147	73
74			Cap Rel Costs-Bldg & Fixt	1		40,620	74
75			Cap Rel Costs-Bldg & Fixt	1		38,104	75
76			Cap Rel Costs-Bldg & Fixt	1		3,772	76
77			Cap Rel Costs-Mvble Equip	2		145,618	77
78			Cap Rel Costs-Mvble Equip	2		18,394	78
500	Total reclassifications					20,305,077	500
	Code Letter - B						
1	RECLASS CHAPLAIN COST TO CPE PROGRA	C	CLINICAL PASTORAL EDUCATION	23.01	36,190	6,658	1
500	Total reclassifications				36,190	6,658	500
	Code Letter - C						
1	RECLASS CAFETERIA FROM DIETARY	D	Cafeteria	11	657,387	1,258,947	1
500	Total reclassifications				657,387	1,258,947	500
	Code Letter - D						
1	RECLASS DRUGS	E	Drugs Charged to Patients	73		11,449,806	1
500	Total reclassifications					11,449,806	500
	Code Letter - E						
1	RECLASS INTEREST EXPENSE	F	Interest Expense	113		10,584,497	1
2			Interest Expense	113		627,323	2
3			Cap Rel Costs-Bldg & Fixt	1		10,584,497	3
4			Cap Rel Costs-Bldg & Fixt	1		627,323	4
500	Total reclassifications					22,423,640	500
	Code Letter - F						
1	RECLASS HYPERBARIC FROM WOUND CARE	G	HYPERBARIC OXYGEN THERAPY	76.98	35,882	141,072	1
500	Total reclassifications				35,882	141,072	500
	Code Letter - G						
1	OBSTETRIC RECLASS TO L&D AND NURSER	H	Delivery Room & Labor Room	52	575,826	363,792	1
2			Nursery	43	1,934,157	1,221,950	2
500	Total reclassifications				2,509,983	1,585,742	500
	Code Letter - H						
1	SBMF CAPITAL RECLASS	I	Cap Rel Costs-Bldg & Fixt	1		362,958	1
500	Total reclassifications					362,958	500
	Code Letter - I						
1	RECLASS IMPLANTS	J	Impl. Dev. Charged to Patient	72		15,572,545	1
2			Impl. Dev. Charged to Patient	72		3,836,337	2
3			Impl. Dev. Charged to Patient	72		1,365	3
500	Total reclassifications					19,410,247	500
	Code Letter - J						
1	RECLS 2ND YR PHARM RES TO A & G	K	OTHER ADMINISTRATIVE & GENERA	5.06	286,880	89,626	1
500	Total reclassifications				286,880	89,626	500
	Code Letter - K						
1	RESIDENT OT OTHER MEDICAL EDUCATION	M	I&R Services-Other Prgm Costs	22	2,880	220,536	1
500	Total reclassifications				2,880	220,536	500
	Code Letter - M						
1	RECLASS PODIATRY-SPS MED TO MED ED	N	I&R Services-Salary & Fringes	21	53,523	14,451	1
2			I&R Services-Salary & Fringes	21	233,667	63,090	2
500	Total reclassifications				287,190	77,541	500
	Code Letter - N						
	GRAND TOTAL (Increases)				3,816,392	77,767,327	

(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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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	RECLASS NEGATIVE COST CTR EXP TOTAL	A	OTHER ADMINISTRATIVE & GENERA	5.06		435,477	1	
500	Total reclassifications					435,477	500	
	Code letter - A							
1	DEPRECIATION RECLASS	B	OTHER ADMINISTRATIVE & GENERA	5.06		32,725	10	
2			OTHER ADMINISTRATIVE & GENERA	5.06		4,249,298	9	
3			OTHER ADMINISTRATIVE & GENERA	5.06		3,887,126	9	
4			Operation of Plant	7		300,289	9	
5			Operation of Plant	7		2,030	9	
6			Operation of Plant	7		643,554	9	
7			Laundry & Linen Service	8		21,084	9	
8			Housekeeping	9		11,136	9	
9			Dietary	10		16,933	9	
10			Dietary	10		174,733	9	
11			Nursing Administration	13		490	9	
12			Nursing Administration	13		97,059	9	
13			Central Services & Supply	14		7,332	9	
14			Pharmacy	15		547,083	9	
15			Medical Records & Library	16		20,700	10	
16			STERILE SUPPLY	18		7,548	9	
17			STERILE SUPPLY	18		109,671	9	
18			I&R Services-Other Prgm Costs	22		148,158	10	
19			I&R Services-Other Prgm Costs	22		213	9	
20			Adults & Pediatrics	30		50,600	10	
21			Adults & Pediatrics	30		1,726	9	
22			Adults & Pediatrics	30		153,751	9	
23			Intensive Care Unit	31		2,405	10	
24			Intensive Care Unit	31		39,788	9	
25			Intensive Care Unit	31		156,136	9	
26			NEONATAL INTENSIVE CARE UNIT	35		55,587	9	
27			Cap Rel Costs-Bldg & Fixt	1		6,198	10	
28			Subprovider - IRF	41		544	10	
29			Subprovider - IRF	41		926,664	14	
30			Subprovider - IRF	41		1,632	9	
31			Subprovider - IRF	41		68,257	9	
32			Subprovider - IRF	41		150,446	9	
33			Operating Room	50		75,627	10	
34			Operating Room	50		1,133	9	
35			Operating Room	50		2,637,736	9	
36			Recovery Room	51		4,795	9	
37			Radiology-Diagnostic	54		105,846	10	
38			Radiology-Diagnostic	54		126,606	9	
39			Radiology-Diagnostic	54		1,158,669	9	
40			Radiology-Therapeutic	55		20,700	10	
41			CT Scan	57		393,053	9	
42			Cardiac Catheterization	59		3,906	10	
43			Cardiac Catheterization	59		27,485	9	
44			Cardiac Catheterization	59		1,749,972	9	
45			Laboratory	60		135,112	10	
46			Laboratory	60		20,061	9	
47			Respiratory Therapy	65		151,260	10	
48			Respiratory Therapy	65		6,101	10	
49			Respiratory Therapy	65		1,964	9	
50			Respiratory Therapy	65		94,102	9	
51			Physical Therapy	66		260,960	10	
52			Physical Therapy	66		8,808	10	
53			Laboratory	60		5,865	9	
54			Occupational Therapy	67		157,860	10	
55			Occupational Therapy	67		285	9	
56			Speech Pathology	68		8,659	10	
57			Speech Pathology	68		4,240	9	
58			Electrocardiology	69		141,804	10	
59			Electrocardiology	69		500	10	
60			Electrocardiology	69		467	9	
61			Electrocardiology	69		259,666	9	
62			Drugs Charged to Patients	73		3,680	9	
63			MOBILE MEDICAL UNIT	90.02		29,150	9	
64			FAMILY MEDICINE CENTER	90.03		237,265	10	
65			FAMILY MEDICINE CENTER	90.03		8,062	9	
66			FAMILY MEDICINE CENTER	90.03		44,852	9	
67			WOUND HEALING CENTER	90.04		114,394	10	
68			WOUND HEALING CENTER	90.04		12,832	9	
69			PEDIATRIC SPECIALTY CLINIC	90.06		88,668	10	
70			PEDIATRIC SPECIALTY CLINIC	90.06		269	9	
71			PEDIATRIC SPECIALTY CLINIC	90.06		3,662	9	

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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	
72			SPORTS MED FELLOWSHIP CLINIC	90.07		56,450	10	72
73			SPORTS MED FELLOWSHIP CLINIC	90.07		5,147	9	73
74			PODIATRY RESIDENCY CLINIC	90.08		40,620	10	74
75			FACULTY PRACTICE CLINIC	90.09		38,104	10	75
76			OUR LADY OF ROSARY CLINIC	90.10		3,772	9	76
77			OUR LADY OF ROSARY CLINIC	90.10		145,618	9	77
78			Emergency	91		18,394	9	78
500	Total reclassifications					20,305,077		500
	Code letter - B							
1	RECLASS CHAPLAIN COST TO CPE PROGRA	C	OTHER ADMINISTRATIVE & GENERA	5.06	36,190	6,658		1
500	Total reclassifications				36,190	6,658		500
	Code letter - C							
1	RECLASS CAFETERIA FROM DIETARY	D	Dietary	10	657,387	1,258,947		1
500	Total reclassifications				657,387	1,258,947		500
	Code letter - D							
1	RECLASS DRUGS	E	Pharmacy	15		11,449,806		1
500	Total reclassifications					11,449,806		500
	Code letter - E							
1	RECLASS INTEREST EXPENSE	F	OTHER ADMINISTRATIVE & GENERA	5.06		10,584,497	11	1
2			Subprovider - IRF	41		627,323	11	2
3			Interest Expense	113		10,584,497	11	3
4			Interest Expense	113		627,323	11	4
500	Total reclassifications					22,423,640		500
	Code letter - F							
1	RECLASS HYPERBARIC FROM WOUND CARE	G	WOUND HEALING CENTER	90.04	35,882	141,072		1
500	Total reclassifications				35,882	141,072		500
	Code letter - G							
1	OBSTETRIC RECLASS TO L&D AND NURSER	H	Adults & Pediatrics	30	575,826	363,792		1
2			Adults & Pediatrics	30	1,934,157	1,221,950		2
500	Total reclassifications				2,509,983	1,585,742		500
	Code letter - H							
1	SBMF CAPITAL RECLASS	I	Laboratory	60		362,958	9	1
500	Total reclassifications					362,958		500
	Code letter - I							
1	RECLASS IMPLANTS	J	Operating Room	50		15,572,545		1
2			Cardiac Catheterization	59		3,836,337		2
3			Emergency	91		1,365		3
500	Total reclassifications					19,410,247		500
	Code letter - J							
1	RECLS 2ND YR PHARM RES TO A & G	K	PHARMACY RESIDENCY PROGRAM	23.02	286,880	89,626		1
500	Total reclassifications				286,880	89,626		500
	Code letter - K							
1	RESIDENT OT OTHER MEDICAL EDUCATION	M	I&R Services-Salary & Fringes	21	2,880	220,536		1
500	Total reclassifications				2,880	220,536		500
	Code letter - M							
1	RECLASS PODIATRY-SPS MED TO MED ED	N	SPORTS MED FELLOWSHIP CLINIC	90.07	53,523	14,451		1
2			PODIATRY RESIDENCY CLINIC	90.08	233,667	63,090		2
500	Total reclassifications				287,190	77,541		500
	Code letter - N							
	GRAND TOTAL (Decreases)				3,816,392	77,767,327		

(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	1,553,389					1,553,389		1
2	Land Improvements								2
3	Buildings and Fixtures	225,816,800	817,941		817,941	1,018,401	225,616,340	1,655,503	3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	189,466,041	7,359,360		7,359,360	5,200,218	191,625,183	21,846,026	6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	416,836,230	8,177,301		8,177,301	6,218,619	418,794,912	23,501,529	8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	416,836,230	8,177,301		8,177,301	6,218,619	418,794,912	23,501,529	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 line 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				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi				0.000000					1
2	Cap Rel Costs-Mvble 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	8,897,427	1,753,087	11,211,820			926,664	22,788,998	1	
2	Cap Rel Costs-Mvble Equip	12,676,977	148,491					12,825,468	2	
3	Total (sum of lines 1-2)	21,574,404	1,901,578	11,211,820			926,664	35,614,466	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	-1,488,520	Cap Rel Costs-Bldg & Fixt	1	9	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	-16,543	NONPATIENT TELEPHONES	5.01		7
8	Television and radio service (chapter 21)	A	-35,497	Operation of Plant	7		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-2,510,231				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	13,224,130				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-1,729,276	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						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-9,498	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	-1,023,167	OTHER ADMINISTRATIVE & GENERAL	5.06		33
34	MEDICAID PROVIDER BED TAX	A	-11,169,837	OTHER ADMINISTRATIVE & GENERAL	5.06		34
35	PURCHASE DISCOUNTS	A	11,250	OTHER ADMINISTRATIVE & GENERAL	5.06		35
35.01	PURCHASE DISCOUNTS	A	440	Central Services & Supply	14		35.01
36	INTERNATIONAL MEDICINE	A	-5,840	OTHER ADMINISTRATIVE & GENERAL	5.06		36
37	OTHER REVENUE	B	707	Employee Benefits Department	4		37
38	OTHER REVENUE	B	-3,450	NONPATIENT TELEPHONES	5.01		38
39	OTHER REVENUE	B	-49,031	OTHER ADMINISTRATIVE & GENERAL	5.06		39
40	OTHER REVENUE	B	-44,771	OTHER ADMINISTRATIVE & GENERAL	5.06		40
41	OTHER REVENUE	B	-60,902	Operation of Plant	7		41
42	OTHER REVENUE	B	-280,287	Dietary	10		42
43	OTHER REVENUE	B	245	Nursing Administration	13		43
44	OTHER REVENUE	B	-7,889	Pharmacy	15		44
45	OTHER REVENUE	B	-548	Medical Records & Library	16		45
46	OTHER REVENUE	B	562	Social Service	17		46
47	OTHER REVENUE	B	-83,719	I&R Services-Salary & Fringes Apprvd	21		47
47.10	OTHER REVENUE	B	-95,787	I&R Services-Other Prgm Costs Apprvd	22		47.10
47.20	OTHER REVENUE	B	-7,448	PARAMED ED PRGM-(SPECIFY)	23		47.20
47.30	OTHER REVENUE	B	-44,462	CLINICAL PASTORAL EDUCATION	23.01		47.30
47.40	OTHER REVENUE	B	-51,277	Adults & Pediatrics	30		47.40
47.50	OTHER REVENUE	B	-11,984	Subprovider - IRF	41		47.50
47.60	OTHER REVENUE	B	-9,158	Radiology-Diagnostic	54		47.60
47.70	OTHER REVENUE	B	-7,946	Radiology-Therapeutic	55		47.70
47.80	OTHER REVENUE	B	-2,052	Laboratory	60		47.80
47.90	OTHER REVENUE	B	1,373	Respiratory Therapy	65		47.90
48	OTHER REVENUE	B	-91,317	Physical Therapy	66		48
48.01	OTHER REVENUE	B	5,590	Occupational Therapy	67		48.01
48.02	OTHER REVENUE	B	3,503	Speech Pathology	68		48.02
48.03	OTHER REVENUE	B	-1,870	Electrocardiology	69		48.03
48.04	OTHER REVENUE	B	-60,101	FAMILY MEDICINE CENTER	90.03		48.04
48.05	OTHER REVENUE	B	-4,783	PEDIATRIC SPECIALTY CLINIC	90.06		48.05
48.06	OTHER REVENUE	B	-12,508	SPORTS MED FELLOWSHIP CLINIC	90.07		48.06
48.07	OTHER REVENUE	B	-850	PODIATRY RESIDENCY CLINIC	90.08		48.07

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
48.08	OTHER REVENUE	B	-52	FACULTY PRACTICE CLINIC	90.09		48.08
48.09	OTHER REVENUE	B	-70	OUR LADY OF ROSARY CLINIC	90.10		48.09
48.10	OTHER REVENUE	B	-146,032	Emergency	91		48.10
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-5,818,903				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	44,460,320	43,369,641	1,090,679		1
2	4	Employee Benefits Department	WORKER'S COMP	253,255	465,365	-212,110		2
3	5.06	OTHER ADMINISTRATIVE & GENERAL	INSURANCE	1,277,401	1,944,167	-666,766		3
3.01	5.06	OTHER ADMINISTRATIVE & GENERAL	PENSION	8,321,258	712,305	7,608,953		3.01
3.02	4	Employee Benefits Department	RETIREE HEALTH COSTS	33,948	-133,899	167,847		3.02
3.03	1	Cap Rel Costs-Bldg & Fixt	HO CAPITAL COSTS	5,235,527		5,235,527	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			59,581,709	46,357,579	13,224,130		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			
				Name	Percentage of Ownership		Type of Business
	1	2	3	4	5	6	
6	G			CHE TRINTIY HEALTH		HO OF PARENT COMPANY	6
7	G			SJRM - INC		PARENT COMPANY	7
8	G	SJRM - 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: FINANCIAL

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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	23	PARAMED ED PRGM-(SPE A	79,650		79,650	136,700	498	32,729	1,636	1
2	30	Adults & Pediatrics B	49,000	49,000		136,700				2
3	31	Intensive Care Unit C	45,288		45,288	136,700	408	26,814	1,341	3
4	50	Operating Room D	30,319		30,319	136,700	141	9,267	463	4
5	50	Operating Room E	30,240		30,240	136,700	200	13,144	657	5
6	54	Radiology-Diagnostic F	39,000		39,000	136,700	200	13,144	657	6
7	90.04	WOUND HEALING CENTER G	3,525		3,525	136,700	24	1,577	79	7
8	90.06	PEDIATRIC SPECIALTY H	10,080		10,080	136,700	96	6,309	315	8
9	91	Emergency I	194,031		194,031	171,400	1,213	99,956	4,998	9
10	57	CT Scan J	1,238	1,238		136,700				10
11	54	Radiology-Diagnostic K	59,600	59,600		136,700				11
12	90.06	PEDIATRIC SPECIALTY L	182,326	182,326		136,700				12
13	50	Operating Room M	1,938,907	1,938,907		136,700				13
14	41	Subprovider - IRF N	79,147		79,147	136,700	444	29,180	1,459	14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,742,351	2,231,071	511,280		3,224	232,120	11,605	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	23	PARAMED ED PRGM-(SPE A					32,729	46,921	46,921	1
2	30	Adults & Pediatrics B							49,000	2
3	31	Intensive Care Unit C					26,814	18,474	18,474	3
4	50	Operating Room D					9,267	21,052	21,052	4
5	50	Operating Room E					13,144	17,096	17,096	5
6	54	Radiology-Diagnostic F					13,144	25,856	25,856	6
7	90.04	WOUND HEALING CENTER G					1,577	1,948	1,948	7
8	90.06	PEDIATRIC SPECIALTY H					6,309	3,771	3,771	8
9	91	Emergency I					99,956	94,075	94,075	9
10	57	CT Scan J							1,238	10
11	54	Radiology-Diagnostic K							59,600	11
12	90.06	PEDIATRIC SPECIALTY L							182,326	12
13	50	Operating Room M							1,938,907	13
14	41	Subprovider - IRF N					29,180	49,967	49,967	14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					232,120	279,160	2,510,231	200

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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	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	22,788,998	22,788,998					1
2	Cap Rel Costs-Mvble Equip	12,825,468		12,825,468				2
4	Employee Benefits Department	2,716,997	14,925	8,400	2,740,322			4
5.01	NONPATIENT TELEPHONES	263,487	23,049	12,972	7,877	307,385		5.01
5.04	ADMITTING	1,595,269	88,135	49,601	39,217	4,272	1,776,494	5.04
5.06	OTHER ADMINISTRATIVE & GENERAL	54,781,460	2,836,226	1,596,206	50,336	38,889		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	7,770,475	6,032,830	3,395,230	57,750	9,311		7
8	Laundry & Linen Service	1,097,328			3,740	548		8
9	Housekeeping	2,871,009	285,186	160,500	51,282	1,862		9
10	Dietary	2,692,574	404,683	227,752	43,913	2,629		10
11	Cafeteria	177,560	549,968	309,518	22,622	2,300		11
12	Maintenance of Personnel							12
13	Nursing Administration	2,960,757	89,788	50,532	75,753	3,067		13
14	Central Services & Supply	939,336			12,810	329		14
15	Pharmacy	3,811,859	240,269	135,221	109,003	6,244		15
16	Medical Records & Library	3,671,279	46,051	25,917	54,374	4,820		16
17	Social Service	2,433,781	28,008	15,763	61,834	3,944		17
18	STERILE SUPPLY	2,127,313	363,780	204,732	22,044	1,205		18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	2,348,088			66,305			21
22	I&R Services-Other Prgm Costs Apprvd	2,421,342	42,509	23,924	60,832	3,834		22
23	PARAMED ED PRGM-(SPECIFY)	143,037	15,161	8,533	2,494	657		23
23.01	CLINICAL PASTORAL EDUCATION	275,658			8,954	657		23.01
23.02	PHARMACY RESIDENCY PROGRAM	189,521			3,267	329		23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	22,871,838	5,374,750	3,024,867	576,677	60,031	213,484	30
31	Intensive Care Unit	4,924,989	675,794	380,331	120,578	4,930	38,402	31
35	NEONATAL INTENSIVE CARE UNIT	2,823,367	239,088	134,557	64,984	2,300	19,273	35
41	Subprovider - IRF	2,658,191			62,579	9,421	13,223	41
43	Nursery	3,156,107			66,558		8,242	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	18,764,284	2,256,502	1,269,942	252,671	27,386	357,375	50
51	Recovery Room	1,313,861	149,536	84,158	32,832	4,053	33,567	51
52	Delivery Room & Labor Room	939,618			19,815		15,606	52
54	Radiology-Diagnostic	4,767,601	630,451	354,813	106,154	15,446	103,684	54
55	Radiology-Therapeutic	189,328			1,809		1,483	55
57	CT Scan	1,043,233	80,578	45,348	20,790	986	110,181	57
58	MRI	395,297				1,424	8,427	58
59	Cardiac Catheterization	6,447,925	692,750	389,874	78,821	8,545	108,061	59
60	Laboratory	13,495,599	92,952	52,313		4,272	190,912	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,940,314	169,610	95,455	55,519	4,272	30,575	65
66	Physical Therapy	2,820,767	153,692	86,497	76,560	6,025	26,947	66
67	Occupational Therapy	873,738			22,613	986	10,859	67
68	Speech Pathology	418,291			11,251	438	5,450	68
69	Electrocardiology	1,211,115	127,054	71,505	28,024	3,505	41,202	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	19,410,247					131,537	72
73	Drugs Charged to Patients	12,157,961	22,105	12,440	10,127	657	165,533	73
74	Renal Dialysis	909,455	53,514	30,117		110	3,876	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	176,954			1,235	219	2,982	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	118,465			2,703		812	90.02
90.03	FAMILY MEDICINE CENTER	1,164,371			20,069	6,135	5,221	90.03
90.04	WOUND HEALING CENTER	1,272,892			14,430	1,643	4,729	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	640,797	73,115	41,149	16,852	1,315	5,978	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	388,459			8,031	1,862	509	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	521,087			12,669	767	1	90.07
90.08	PODIATRY RESIDENCY CLINIC	219,375			3,649	1,753		90.08
90.09	FACULTY PRACTICE CLINIC	533,414			12,807		1,343	90.09
90.10	OUR LADY OF ROSARY CLINIC	535,600			10,828		19	90.10
91	Emergency	6,038,000	837,752	471,480	145,160	15,446	117,001	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	267,045,136	22,689,811	12,769,647	2,611,202	268,824	1,776,494	118
	NONREIMBURSABLE COST CENTERS							

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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	
190	Gift, Flower, Coffee Shop & Canteen		88,938	50,053		548		190
192	Physicians' Private Offices		5,479	3,083		29,249		192
192.01	MATERNAL FETAL MEDICINE/LABORIST	1,369,886	4,770	2,685				192.01
192.02	NEONATOLOGISTS	1,624,408			42,984	329		192.02
192.03	HOSPITALISTS/INTENSIVISTS	4,682,571			8,406	1,315		192.03
194	SPORTS MED-ATHLETIC TRAINERS	241,315			6,900			194
194.01	OUTREACH SERVICES	2,994,396			65,418	5,039		194.01
194.02	KINDRED/OUR LADY OF PEACE	179,775			5,406	2,081		194.02
194.03	ADVANCED SPECIALTIES	136,663			6			194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	278,274,150	22,788,998	12,825,468	2,740,322	307,385	1,776,494	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL (cols.0-4) 4A	OTHER ADMIN & GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY + LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
	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	59,303,117	59,303,117					5.06
6	Maintenance & Repairs							6
7	Operation of Plant	17,265,596	4,675,972	21,941,568				7
8	Laundry & Linen Service	1,101,616	298,346		1,399,962			8
9	Housekeeping	3,369,839	912,640	453,640		4,736,119		9
10	Dietary	3,371,551	913,104	643,721		141,881	5,070,257	10
11	Cafeteria	1,061,968	287,609	874,823		192,818		11
12	Maintenance of Personnel							12
13	Nursing Administration	3,179,897	861,199	142,824		31,480		13
14	Central Services & Supply	952,475	257,955					14
15	Pharmacy	4,302,596	1,165,255	382,190		84,238		15
16	Medical Records & Library	3,802,441	1,029,800	73,253		16,145		16
17	Social Service	2,543,330	688,800	44,553		9,820		17
18	STERILE SUPPLY	2,719,074	736,396	578,657		127,541		18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	2,414,393	653,880					21
22	I&R Services-Other Prgm Costs Apprvd	2,552,441	691,267	67,618		14,904		22
23	PARAMED ED PRGM-(SPECIFY)	169,882	46,008	24,117		5,316		23
23.01	CLINICAL PASTORAL EDUCATION	285,269	77,258					23.01
23.02	PHARMACY RESIDENCY PROGRAM	193,117	52,301					23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	32,121,647	8,699,444	8,549,505	168,307	1,884,382	3,893,410	30
31	Intensive Care Unit	6,145,024	1,664,232	1,074,971	30,276	236,933	217,620	31
35	NEONATAL INTENSIVE CARE UNIT	3,283,569	889,276	380,312	15,194	83,824	12,685	35
41	Subprovider - IRF	2,743,414	742,988		10,425		343,361	41
43	Nursery	3,230,907	875,014		6,498			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	22,928,160	6,209,542	3,589,373	281,151	791,128		50
51	Recovery Room	1,618,007	438,198	237,864	26,464	52,427		51
52	Delivery Room & Labor Room	975,039	264,066		12,303			52
54	Radiology-Diagnostic	5,978,149	1,619,038	1,002,846	81,743	221,036		54
55	Radiology-Therapeutic	192,620	52,167		1,169			55
57	CT Scan	1,301,116	352,376	128,173	86,865	28,250		57
58	MRI	405,148	109,725		6,644			58
59	Cardiac Catheterization	7,725,976	2,092,395	1,101,943	85,194	242,877		59
60	Laboratory	13,836,048	3,747,162	147,857	150,512	32,589		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,295,745	892,573	269,795	24,105	59,465		65
66	Physical Therapy	3,170,488	858,651	244,476	21,245	53,884		66
67	Occupational Therapy	908,196	245,963		8,561			67
68	Speech Pathology	435,430	117,926		4,297			68
69	Electrocardiology	1,482,405	401,474	202,102	32,483	44,545		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	19,541,784	5,292,423		103,702			72
73	Drugs Charged to Patients	12,368,823	3,349,799	35,161	130,504	7,750		73
74	Renal Dialysis	997,072	270,033	85,123	3,055	18,762		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	181,390	49,125		2,351			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	121,980	33,035		640			90.02
90.03	FAMILY MEDICINE CENTER	1,195,796	323,853		4,116			90.03
90.04	WOUND HEALING CENTER	1,293,694	350,366		3,728			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	779,206	211,029	116,302	4,713	25,634	1,718	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	398,861	108,022		401			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	534,524	144,763					90.07
90.08	PODIATRY RESIDENCY CLINIC	224,777	60,875					90.08
90.09	FACULTY PRACTICE CLINIC	547,564	148,295		1,059			90.09
90.10	OUR LADY OF ROSARY CLINIC	546,447	147,992		15			90.10
91	Emergency	7,624,839	2,065,005	1,332,595	92,242	293,715		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	266,722,447	56,174,615	21,783,794	1,399,962	4,701,344	4,468,794	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	139,539	37,791	141,471		31,181		190
192	Physicians' Private Offices	37,811	10,240	8,715		1,921		192

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL (cols.0-4)	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	
		4A	5.06	7	8	9	10	
192.01	MATERNAL FETAL MEDICINE/LABORIST	1,377,341	373,020	7,588		1,673		192.01
192.02	NEONATOLOGISTS	1,667,721	451,662					192.02
192.03	HOSPITALISTS/INTENSIVISTS	4,692,292	1,270,795					192.03
194	SPORTS MED-ATHLETIC TRAINERS	248,215	67,223					194
194.01	OUTREACH SERVICES	3,064,853	830,042					194.01
194.02	KINDRED/OUR LADY OF PEACE	187,262	50,715				601,463	194.02
194.03	ADVANCED SPECIALTIES	136,669	37,014					194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	278,274,150	59,303,117	21,941,568	1,399,962	4,736,119	5,070,257	202

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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	
	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	2,417,218						11
12	Maintenance of Personnel							12
13	Nursing Administration	74,870	4,290,270					13
14	Central Services & Supply	21,391		1,231,821				14
15	Pharmacy	79,148			6,013,427			15
16	Medical Records & Library	74,870				4,996,509		16
17	Social Service	57,757			14,033		3,358,293	17
18	STERILE SUPPLY	38,504			232			18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	70,591						21
22	I&R Services-Other Prgm Costs Apprvd	25,670						22
23	PARAMED ED PRGM-(SPECIFY)	2,139						23
23.01	CLINICAL PASTORAL EDUCATION	19,252						23.01
23.02	PHARMACY RESIDENCY PROGRAM	12,835						23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	695,217	1,740,746	148,037	685	600,559	2,677,424	30
31	Intensive Care Unit	119,791	299,944	26,630	150	108,031	292,741	31
35	NEONATAL INTENSIVE CARE UNIT	57,757	144,616	13,365	144	54,217	49,338	35
41	Subprovider - IRF		198,177	9,169		37,197		41
43	Nursery	70,591	176,753	5,715		23,186		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	267,391	669,518	247,756	63,459	1,004,338	13,157	50
51	Recovery Room	34,226	85,698	23,277	2	94,429		51
52	Delivery Room & Labor Room	21,391	53,561	10,822		43,901		52
54	Radiology-Diagnostic	113,374		71,898	267,396	291,678		54
55	Radiology-Therapeutic	4,278		1,028		4,172		55
57	CT Scan	19,252		76,403	65,092	309,953		57
58	MRI			5,843		23,706		58
59	Cardiac Catheterization	72,730	182,109	74,933	39,298	303,990		59
60	Laboratory			132,385		537,061		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	57,757		21,202	588	86,013		65
66	Physical Therapy	66,313		18,686	1,098	75,806		66
67	Occupational Therapy	21,391		7,530	55	30,547		67
68	Speech Pathology	8,557		3,779		15,332		68
69	Electrocardiology	27,809	69,630	28,571	95	115,907		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients			91,212		370,031		72
73	Drugs Charged to Patients	8,557		114,786	5,446,172	465,667		73
74	Renal Dialysis			2,687	317	10,902		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY			2,068		8,388		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT		10,712	563		2,284		90.02
90.03	FAMILY MEDICINE CENTER	29,948	74,986	3,621	25,171	14,688		90.03
90.04	WOUND HEALING CENTER	19,252	48,205	3,279	16,960	13,303		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	17,113	42,849	4,145	1	16,817		90.05
90.06	PEDIATRIC SPECIALTY CLINIC	8,557	21,425	353	383	1,432		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	6,417	16,068		2,877	2		90.07
90.08	PODIATRY RESIDENCY CLINIC	2,139	5,356		323			90.08
90.09	FACULTY PRACTICE CLINIC	10,696	26,781	932	20,963	3,779		90.09
90.10	OUR LADY OF ROSARY CLINIC		21,425	13	11,813	53		90.10
91	Emergency	160,435	401,711	81,133	24	329,140	325,633	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	2,397,966	4,290,270	1,231,821	5,977,331	4,996,509	3,358,293	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192

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COST ALLOCATION - GENERAL SERVICE COSTS

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PART I**

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11	13	14	15	16	17	
192.01	MATERNAL FETAL MEDICINE/LABORIST				258			192.01
192.02	NEONATOLOGISTS	14,974						192.02
192.03	HOSPITALISTS/INTENSIVISTS	4,278						192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES				35,838			194.01
194.02	KINDRED/OUR LADY OF PEACE							194.02
194.03	ADVANCED SPECIALTIES							194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,417,218	4,290,270	1,231,821	6,013,427	4,996,509	3,358,293	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	STERILE SUPPLY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	CLINICAL PASTORAL EDUCATION	PHARMACY RESIDENCY PROGRAM	
		18	21	22	23	23.01	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	4,200,404						18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		3,138,864					21
22	I&R Services-Other Prgm Costs Apprvd			3,351,900				22
23	PARAMED ED PRGM-(SPECIFY)				247,462			23
23.01	CLINICAL PASTORAL EDUCATION					381,779		23.01
23.02	PHARMACY RESIDENCY PROGRAM						258,253	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	79,569	1,854,216	1,980,063		246,586		30
31	Intensive Care Unit		166,297	177,584		92,525		31
35	NEONATAL INTENSIVE CARE UNIT	4,873	112,251	119,869				35
41	Subprovider - IRF					3,144		41
43	Nursery		120,566	128,748		9,432		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,740,651	124,723	133,188		4,042		50
51	Recovery Room							51
52	Delivery Room & Labor Room		24,945	26,638				52
54	Radiology-Diagnostic	13,289	20,787	22,198		1,347		54
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization	22,592						59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	6,423						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						258,253	73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT							90.02
90.03	FAMILY MEDICINE CENTER	27,852	515,522	550,511				90.03
90.04	WOUND HEALING CENTER	9,635						90.04
90.05	OUTPATIENT TREATMENT & INFUSION							90.05
90.06	PEDIATRIC SPECIALTY CLINIC							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	1,274						90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC	886						90.09
90.10	OUR LADY OF ROSARY CLINIC							90.10
91	Emergency	4,928	199,557	213,101	247,462	24,703		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	3,911,972	3,138,864	3,351,900	247,462	381,779	258,253	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	STERILE SUPPLY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	CLINICAL PASTORAL EDUCATION	PHARMACY RESIDENCY PROGRAM	
		18	21	22	23	23.01	23.02	
192.01	MATERNAL FETAL MEDICINE/LABORIST	5,759						192.01
192.02	NEONATOLOGISTS							192.02
192.03	HOSPITALISTS/INTENSIVISTS							192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES	191,808						194.01
194.02	KINDRED/OUR LADY OF PEACE	90,865						194.02
194.03	ADVANCED SPECIALTIES							194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,200,404	3,138,864	3,351,900	247,462	381,779	258,253	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		24	25	26			
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	NONPATIENT TELEPHONES						5.01
5.04	ADMITTING						5.04
5.06	OTHER ADMINISTRATIVE & GENERAL						5.06
6	Maintenance & Repairs						6
7	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
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMED ED PRGM-(SPECIFY)						23
23.01	CLINICAL PASTORAL EDUCATION						23.01
23.02	PHARMACY RESIDENCY PROGRAM						23.02
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	65,339,797	-3,834,279	61,505,518			30
31	Intensive Care Unit	10,652,749	-343,881	10,308,868			31
35	NEONATAL INTENSIVE CARE UNIT	5,221,290	-232,120	4,989,170			35
41	Subprovider - IRF	4,087,875		4,087,875			41
43	Nursery	4,647,410	-249,314	4,398,096			43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	40,067,577	-257,911	39,809,666			50
51	Recovery Room	2,610,592		2,610,592			51
52	Delivery Room & Labor Room	1,432,666	-51,583	1,381,083			52
54	Radiology-Diagnostic	9,704,779	-42,985	9,661,794			54
55	Radiology-Therapeutic	255,434		255,434			55
57	CT Scan	2,367,480		2,367,480			57
58	MRI	551,066		551,066			58
59	Cardiac Catheterization	11,944,037		11,944,037			59
60	Laboratory	18,583,614		18,583,614			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	4,713,666		4,713,666			65
66	Physical Therapy	4,510,647		4,510,647			66
67	Occupational Therapy	1,222,243		1,222,243			67
68	Speech Pathology	585,321		585,321			68
69	Electrocardiology	2,405,021		2,405,021			69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients	25,399,152		25,399,152			72
73	Drugs Charged to Patients	22,185,472		22,185,472			73
74	Renal Dialysis	1,387,951		1,387,951			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	243,322		243,322			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT	169,214		169,214			90.02
90.03	FAMILY MEDICINE CENTER	2,766,064	-1,066,033	1,700,031			90.03
90.04	WOUND HEALING CENTER	1,758,422		1,758,422			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	1,219,527		1,219,527			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	539,434		539,434			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	705,925		705,925			90.07
90.08	PODIATRY RESIDENCY CLINIC	293,470		293,470			90.08
90.09	FACULTY PRACTICE CLINIC	760,955		760,955			90.09
90.10	OUR LADY OF ROSARY CLINIC	727,758		727,758			90.10
91	Emergency	13,396,223	-412,658	12,983,565			91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	262,456,153	-6,490,764	255,965,389			118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	349,982		349,982			190
192	Physicians' Private Offices	58,687		58,687			192

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		24	25	26			
192.01	MATERNAL FETAL MEDICINE/LABORIST	1,765,639		1,765,639			192.01
192.02	NEONATOLOGISTS	2,134,357		2,134,357			192.02
192.03	HOSPITALISTS/INTENSIVISTS	5,967,365		5,967,365			192.03
194	SPORTS MED-ATHLETIC TRAINERS	315,438		315,438			194
194.01	OUTREACH SERVICES	4,122,541		4,122,541			194.01
194.02	KINDRED/OUR LADY OF PEACE	930,305		930,305			194.02
194.03	ADVANCED SPECIALTIES	173,683		173,683			194.03
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	278,274,150	-6,490,764	271,783,386			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	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		14,925	8,400	23,325	23,325		4
5.01	NONPATIENT TELEPHONES		23,049	12,972	36,021	67	36,088	5.01
5.04	ADMITTING		88,135	49,601	137,736	334	502	5.04
5.06	OTHER ADMINISTRATIVE & GENERAL		2,836,226	1,596,206	4,432,432	429	4,566	5.06
6	Maintenance & Repairs							6
7	Operation of Plant		6,032,830	3,395,230	9,428,060	492	1,093	7
8	Laundry & Linen Service					32	64	8
9	Housekeeping		285,186	160,500	445,686	437	219	9
10	Dietary		404,683	227,752	632,435	374	309	10
11	Cafeteria		549,968	309,518	859,486	193	270	11
12	Maintenance of Personnel							12
13	Nursing Administration		89,788	50,532	140,320	645	360	13
14	Central Services & Supply					109	39	14
15	Pharmacy		240,269	135,221	375,490	928	733	15
16	Medical Records & Library		46,051	25,917	71,968	463	566	16
17	Social Service		28,008	15,763	43,771	526	463	17
18	STERILE SUPPLY		363,780	204,732	568,512	188	141	18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					565		21
22	I&R Services-Other Prgm Costs Apprvd		42,509	23,924	66,433	518	450	22
23	PARAMED ED PRGM-(SPECIFY)		15,161	8,533	23,694	21	77	23
23.01	CLINICAL PASTORAL EDUCATION					76	77	23.01
23.02	PHARMACY RESIDENCY PROGRAM					28	39	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		5,374,750	3,024,867	8,399,617	4,899	7,047	30
31	Intensive Care Unit		675,794	380,331	1,056,125	1,027	579	31
35	NEONATAL INTENSIVE CARE UNIT		239,088	134,557	373,645	553	270	35
41	Subprovider - IRF					533	1,106	41
43	Nursery					567		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		2,256,502	1,269,942	3,526,444	2,151	3,215	50
51	Recovery Room		149,536	84,158	233,694	280	476	51
52	Delivery Room & Labor Room					169		52
54	Radiology-Diagnostic		630,451	354,813	985,264	904	1,813	54
55	Radiology-Therapeutic					15		55
57	CT Scan		80,578	45,348	125,926	177	116	57
58	MRI						167	58
59	Cardiac Catheterization		692,750	389,874	1,082,624	671	1,003	59
60	Laboratory		92,952	52,313	145,265		502	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		169,610	95,455	265,065	473	502	65
66	Physical Therapy		153,692	86,497	240,189	652	707	66
67	Occupational Therapy					193	116	67
68	Speech Pathology					96	51	68
69	Electrocardiology		127,054	71,505	198,559	239	412	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		22,105	12,440	34,545	86	77	73
74	Renal Dialysis		53,514	30,117	83,631		13	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY					11	26	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT					23		90.02
90.03	FAMILY MEDICINE CENTER					171	720	90.03
90.04	WOUND HEALING CENTER					123	193	90.04
90.05	OUTPATIENT TREATMENT & INFUSION		73,115	41,149	114,264	143	154	90.05
90.06	PEDIATRIC SPECIALTY CLINIC					68	219	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC					108	90	90.07
90.08	PODIATRY RESIDENCY CLINIC					31	206	90.08
90.09	FACULTY PRACTICE CLINIC					109		90.09
90.10	OUR LADY OF ROSARY CLINIC					92		90.10
91	Emergency		837,752	471,480	1,309,232	1,236	1,813	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		22,689,811	12,769,647	35,459,458	22,225	31,561	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		88,938	50,053	138,991		64	190
192	Physicians' Private Offices		5,479	3,083	8,562		3,434	192

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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	
192.01	MATERNAL FETAL MEDICINE/LABORIST		4,770	2,685	7,455			192.01
192.02	NEONATOLOGISTS					366	39	192.02
192.03	HOSPITALISTS/INTENSIVISTS					72	154	192.03
194	SPORTS MED-ATHLETIC TRAINERS					59		194
194.01	OUTREACH SERVICES					557	592	194.01
194.02	KINDRED/OUR LADY OF PEACE					46	244	194.02
194.03	ADVANCED SPECIALTIES							194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		22,788,998	12,825,468	35,614,466	23,325	36,088	202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	ADMITTING	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.04	5.06	7	8	9	10	
	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	138,572						5.04
5.06	OTHER ADMINISTRATIVE & GENERAL		4,437,427					5.06
6	Maintenance & Repairs							6
7	Operation of Plant		349,887	9,779,532				7
8	Laundry & Linen Service		22,324		22,420			8
9	Housekeeping		68,290	202,191		716,823		9
10	Dietary		68,324	286,911		21,474	1,009,827	10
11	Cafeteria		21,521	389,915		29,184		11
12	Maintenance of Personnel							12
13	Nursing Administration		64,441	63,658		4,765		13
14	Central Services & Supply		19,302					14
15	Pharmacy		87,192	170,345		12,750		15
16	Medical Records & Library		77,056	32,649		2,444		16
17	Social Service		51,541	19,857		1,486		17
18	STERILE SUPPLY		55,102	257,912		19,304		18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		48,928					21
22	I&R Services-Other Prgm Costs Apprvd		51,725	30,138		2,256		22
23	PARAMED ED PRGM-(SPECIFY)		3,443	10,749		805		23
23.01	CLINICAL PASTORAL EDUCATION		5,781					23.01
23.02	PHARMACY RESIDENCY PROGRAM		3,914					23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	16,604	650,924	3,810,585	2,696	285,204	775,439	30
31	Intensive Care Unit	2,987	124,529	479,123	485	35,860	43,343	31
35	NEONATAL INTENSIVE CARE UNIT	1,499	66,542	169,508	243	12,687	2,526	35
41	Subprovider - IRF	1,028	55,595		167		68,386	41
43	Nursery	641	65,474		104			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	28,196	464,639	1,599,812	4,503	119,739		50
51	Recovery Room	2,611	32,789	106,018	424	7,935		51
52	Delivery Room & Labor Room	1,214	19,759		197			52
54	Radiology-Diagnostic	8,064	121,147	446,976	1,309	33,454		54
55	Radiology-Therapeutic	115	3,903		19			55
57	CT Scan	8,570	26,367	57,128	1,391	4,276		57
58	MRI	655	8,210		106			58
59	Cardiac Catheterization	8,405	156,567	491,145	1,364	36,760		59
60	Laboratory	14,849	280,388	65,901	2,411	4,932		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,378	66,788	120,250	386	9,000		65
66	Physical Therapy	2,096	64,250	108,965	340	8,156		66
67	Occupational Therapy	845	18,405		137			67
68	Speech Pathology	424	8,824		69			68
69	Electrocardiology	3,205	30,041	90,078	520	6,742		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	10,231	396,014		1,661			72
73	Drugs Charged to Patients	12,875	250,654	15,672	2,090	1,173		73
74	Renal Dialysis	301	20,206	37,940	49	2,840		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	232	3,676		38			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	63	2,472		10			90.02
90.03	FAMILY MEDICINE CENTER	406	24,233		66			90.03
90.04	WOUND HEALING CENTER	368	26,217		60			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	465	15,791	51,837	75	3,880	342	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	40	8,083		6			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC		10,832					90.07
90.08	PODIATRY RESIDENCY CLINIC		4,555					90.08
90.09	FACULTY PRACTICE CLINIC	104	11,096		17			90.09
90.10	OUR LADY OF ROSARY CLINIC	1	11,074					90.10
91	Emergency	9,100	154,517	593,948	1,477	44,454		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	138,572	4,203,332	9,709,211	22,420	711,560	890,036	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,828	63,055		4,719		190
192	Physicians' Private Offices		766	3,884		291		192

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	ADMITTING	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	
		5.04	5.06	7	8	9	10	
192.01	MATERNAL FETAL MEDICINE/LABORIST		27,912	3,382		253		192.01
192.02	NEONATOLOGISTS		33,796					192.02
192.03	HOSPITALISTS/INTENSIVISTS		95,089					192.03
194	SPORTS MED-ATHLETIC TRAINERS		5,030					194
194.01	OUTREACH SERVICES		62,109					194.01
194.02	KINDRED/OUR LADY OF PEACE		3,795				119,791	194.02
194.03	ADVANCED SPECIALTIES		2,770					194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	138,572	4,437,427	9,779,532	22,420	716,823	1,009,827	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	
	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	1,300,569						11
12	Maintenance of Personnel							12
13	Nursing Administration	40,283	314,472					13
14	Central Services & Supply	11,509		30,959				14
15	Pharmacy	42,585			690,023			15
16	Medical Records & Library	40,283				225,429		16
17	Social Service	31,076			1,610		150,330	17
18	STERILE SUPPLY	20,717			27			18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	37,981						21
22	I&R Services-Other Prgm Costs Apprvd	13,811						22
23	PARAMED ED PRGM-(SPECIFY)	1,151						23
23.01	CLINICAL PASTORAL EDUCATION	10,359						23.01
23.02	PHARMACY RESIDENCY PROGRAM	6,906						23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	374,056	127,595	3,774	79	27,063	119,851	30
31	Intensive Care Unit	64,453	21,986	679	17	4,868	13,104	31
35	NEONATAL INTENSIVE CARE UNIT	31,076	10,600	341	17	2,443	2,209	35
41	Subprovider - IRF		14,526	234		1,676		41
43	Nursery	37,981	12,956	146		1,045		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	143,868	49,075	5,873	7,282	45,532	589	50
51	Recovery Room	18,415	6,282	593		4,255		51
52	Delivery Room & Labor Room	11,509	3,926	276		1,978		52
54	Radiology-Diagnostic	61,000		1,833	30,683	13,144		54
55	Radiology-Therapeutic	2,302		26		188		55
57	CT Scan	10,359		1,948	7,469	13,967		57
58	MRI			149		1,068		58
59	Cardiac Catheterization	39,132	13,348	1,910	4,509	13,699		59
60	Laboratory			3,375		24,201		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	31,076		540	67	3,876		65
66	Physical Therapy	35,679		476	126	3,416		66
67	Occupational Therapy	11,509		192	6	1,377		67
68	Speech Pathology	4,604		96		691		68
69	Electrocardiology	14,962	5,104	728	11	5,223		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients			2,325		16,675		72
73	Drugs Charged to Patients	4,604		2,926	624,933	20,984		73
74	Renal Dialysis			69	36	491		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY			53		378		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT		785	14		103		90.02
90.03	FAMILY MEDICINE CENTER	16,113	5,496	92	2,888	662		90.03
90.04	WOUND HEALING CENTER	10,359	3,533	84	1,946	599		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	9,208	3,141	106		758		90.05
90.06	PEDIATRIC SPECIALTY CLINIC	4,604	1,570	9	44	65		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	3,453	1,178		330			90.07
90.08	PODIATRY RESIDENCY CLINIC	1,151	393		37			90.08
90.09	FACULTY PRACTICE CLINIC	5,755	1,963	24	2,405	170		90.09
90.10	OUR LADY OF ROSARY CLINIC		1,570		1,356	2		90.10
91	Emergency	86,321	29,445	2,068	3	14,832	14,577	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,290,210	314,472	30,959	685,881	225,429	150,330	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192

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**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
192.01	MATERNAL FETAL MEDICINE/LABORIST				30			192.01
192.02	NEONATOLOGISTS	8,057						192.02
192.03	HOSPITALISTS/INTENSIVISTS	2,302						192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES				4,112			194.01
194.02	KINDRED/OUR LADY OF PEACE							194.02
194.03	ADVANCED SPECIALTIES							194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,300,569	314,472	30,959	690,023	225,429	150,330	202

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	COST CENTER DESCRIPTIONS	STERILE SUPPLY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	CLINICAL PASTORAL EDUCATION	PHARMACY RESIDENCY PROGRAM	
		18	21	22	23	23.01	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	921,903						18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		87,474					21
22	I&R Services-Other Prgm Costs Apprvd			165,331				22
23	PARAMED ED PRGM-(SPECIFY)				39,940			23
23.01	CLINICAL PASTORAL EDUCATION					16,293		23.01
23.02	PHARMACY RESIDENCY PROGRAM						10,887	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	17,464						30
31	Intensive Care Unit							31
35	NEONATAL INTENSIVE CARE UNIT	1,069						35
41	Subprovider - IRF							41
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	820,996						50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic	2,917						54
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization	4,958						59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,410						65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT							90.02
90.03	FAMILY MEDICINE CENTER	6,113						90.03
90.04	WOUND HEALING CENTER	2,115						90.04
90.05	OUTPATIENT TREATMENT & INFUSION							90.05
90.06	PEDIATRIC SPECIALTY CLINIC							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	280						90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC	194						90.09
90.10	OUR LADY OF ROSARY CLINIC							90.10
91	Emergency	1,082						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	858,598						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192

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**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	STERILE SUPPLY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	CLINICAL PASTORAL EDUCATION	PHARMACY RESIDENCY PROGRAM	
		18	21	22	23	23.01	23.02	
192.01	MATERNAL FETAL MEDICINE/LABORIST	1,264						192.01
192.02	NEONATOLOGISTS							192.02
192.03	HOSPITALISTS/INTENSIVISTS							192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES	42,098						194.01
194.02	KINDRED/OUR LADY OF PEACE	19,943						194.02
194.03	ADVANCED SPECIALTIES							194.03
200	Cross Foot Adjustments		87,474	165,331	39,940	16,293	10,887	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	921,903	87,474	165,331	39,940	16,293	10,887	202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		24	25	26			
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	NONPATIENT TELEPHONES						5.01
5.04	ADMITTING						5.04
5.06	OTHER ADMINISTRATIVE & GENERAL						5.06
6	Maintenance & Repairs						6
7	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
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMED ED PRGM-(SPECIFY)						23
23.01	CLINICAL PASTORAL EDUCATION						23.01
23.02	PHARMACY RESIDENCY PROGRAM						23.02
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	14,622,897		14,622,897			30
31	Intensive Care Unit	1,849,165		1,849,165			31
35	NEONATAL INTENSIVE CARE UNIT	675,228		675,228			35
41	Subprovider - IRF	143,251		143,251			41
43	Nursery	118,914		118,914			43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,821,914		6,821,914			50
51	Recovery Room	413,772		413,772			51
52	Delivery Room & Labor Room	39,028		39,028			52
54	Radiology-Diagnostic	1,708,508		1,708,508			54
55	Radiology-Therapeutic	6,568		6,568			55
57	CT Scan	257,694		257,694			57
58	MRI	10,355		10,355			58
59	Cardiac Catheterization	1,856,095		1,856,095			59
60	Laboratory	541,824		541,824			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	501,811		501,811			65
66	Physical Therapy	465,052		465,052			66
67	Occupational Therapy	32,780		32,780			67
68	Speech Pathology	14,855		14,855			68
69	Electrocardiology	355,824		355,824			69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients	426,906		426,906			72
73	Drugs Charged to Patients	970,619		970,619			73
74	Renal Dialysis	145,576		145,576			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,414		4,414			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT	3,470		3,470			90.02
90.03	FAMILY MEDICINE CENTER	56,960		56,960			90.03
90.04	WOUND HEALING CENTER	45,597		45,597			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	200,164		200,164			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	14,708		14,708			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	16,271		16,271			90.07
90.08	PODIATRY RESIDENCY CLINIC	6,373		6,373			90.08
90.09	FACULTY PRACTICE CLINIC	21,837		21,837			90.09
90.10	OUR LADY OF ROSARY CLINIC	14,095		14,095			90.10
91	Emergency	2,264,105		2,264,105			91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	34,626,630		34,626,630			118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	209,657		209,657			190
192	Physicians' Private Offices	16,937		16,937			192

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		24	25	26			
192.01	MATERNAL FETAL MEDICINE/LABORIST	40,296		40,296			192.01
192.02	NEONATOLOGISTS	42,258		42,258			192.02
192.03	HOSPITALISTS/INTENSIVISTS	97,617		97,617			192.03
194	SPORTS MED-ATHLETIC TRAINERS	5,089		5,089			194
194.01	OUTREACH SERVICES	109,468		109,468			194.01
194.02	KINDRED/OUR LADY OF PEACE	143,819		143,819			194.02
194.03	ADVANCED SPECIALTIES	2,770		2,770			194.03
200	Cross Foot Adjustments	319,925		319,925			200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	35,614,466		35,614,466			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	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	482,492						1
2	Cap Rel Costs-Mvble Equip		482,492					2
4	Employee Benefits Department	316	316	79,633,467				4
5.01	NONPATIENT TELEPHONES	488	488	228,894	2,806			5.01
5.04	ADMITTING	1,866	1,866	1,139,641	39	897,074,192		5.04
5.06	OTHER ADMINISTRATIVE & GENERAL	60,049	60,049	1,462,746	355		-59,303,117	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	127,728	127,728	1,678,203	85			7
8	Laundry & Linen Service			108,678	5			8
9	Housekeeping	6,038	6,038	1,490,247	17			9
10	Dietary	8,568	8,568	1,276,106	24			10
11	Cafeteria	11,644	11,644	657,387	21			11
12	Maintenance of Personnel							12
13	Nursing Administration	1,901	1,901	2,201,351	28			13
14	Central Services & Supply			372,249	3			14
15	Pharmacy	5,087	5,087	3,167,578	57			15
16	Medical Records & Library	975	975	1,580,089	44			16
17	Social Service	593	593	1,796,878	36			17
18	STERILE SUPPLY	7,702	7,702	640,600	11			18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			1,926,788				21
22	I&R Services-Other Prgm Costs Apprvd	900	900	1,767,760	35			22
23	PARAMED ED PRGM-(SPECIFY)	321	321	72,489	6			23
23.01	CLINICAL PASTORAL EDUCATION			260,194	6			23.01
23.02	PHARMACY RESIDENCY PROGRAM			94,937	3			23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	113,795	113,795	16,758,671	548	107,820,233		30
31	Intensive Care Unit	14,308	14,308	3,503,959	45	19,395,138		31
35	NEONATAL INTENSIVE CARE UNIT	5,062	5,062	1,888,408	21	9,733,819		35
41	Subprovider - IRF			1,818,520	86	6,678,113		41
43	Nursery			1,934,157		4,162,746		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	47,775	47,775	7,342,539	250	180,346,820		50
51	Recovery Room	3,166	3,166	954,100	37	16,953,202		51
52	Delivery Room & Labor Room			575,826		7,881,752		52
54	Radiology-Diagnostic	13,348	13,348	3,084,793	141	52,365,845		54
55	Radiology-Therapeutic			52,576		748,981		55
57	CT Scan	1,706	1,706	604,137	9	55,646,943		57
58	MRI				13	4,255,974		58
59	Cardiac Catheterization	14,667	14,667	2,290,507	78	54,576,331		59
60	Laboratory	1,968	1,968		39	96,420,298		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,591	3,591	1,613,373	39	15,442,151		65
66	Physical Therapy	3,254	3,254	2,224,807	55	13,609,670		66
67	Occupational Therapy			657,125	9	5,484,230		67
68	Speech Pathology			326,944	4	2,752,622		68
69	Electrocardiology	2,690	2,690	814,358	32	20,809,131		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients					66,432,910		72
73	Drugs Charged to Patients	468	468	294,277	6	83,602,650		73
74	Renal Dialysis	1,133	1,133		1	1,957,334		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY			35,882	2	1,505,845		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT			78,550		410,020		90.02
90.03	FAMILY MEDICINE CENTER			583,201	56	2,637,031		90.03
90.04	WOUND HEALING CENTER			419,319	15	2,388,374		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	1,548	1,548	489,712	12	3,019,195		90.05
90.06	PEDIATRIC SPECIALTY CLINIC			233,370	17	257,146		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC			368,160	7	295		90.07
90.08	PODIATRY RESIDENCY CLINIC			106,040	16			90.08
90.09	FACULTY PRACTICE CLINIC			372,168		678,458		90.09
90.10	OUR LADY OF ROSARY CLINIC			314,665		9,445		90.10
91	Emergency	17,737	17,737	4,218,304	141	59,091,490		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	480,392	480,392	75,881,263	2,454	897,074,192	-59,303,117	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,883	1,883		5			190
192	Physicians' Private Offices	116	116		267			192

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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	RECON- CILIATION	
		1	2	4	5.01	5.04	5A.06	
192.01	MATERNAL FETAL MEDICINE/LABORIST	101	101					192.01
192.02	NEONATOLOGISTS			1,249,089	3			192.02
192.03	HOSPITALISTS/INTENSIVISTS			244,270	12			192.03
194	SPORTS MED-ATHLETIC TRAINERS			200,516				194
194.01	OUTREACH SERVICES			1,901,037	46			194.01
194.02	KINDRED/OUR LADY OF PEACE			157,109	19			194.02
194.03	ADVANCED SPECIALTIES			183				194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	22,788,998	12,825,468	2,740,322	307,385	1,776,494		202
203	Unit Cost Multiplier (Wkst. B, Part I)	47.231867	26.581722	0.034412	109.545617	0.001980		203
204	Cost to be allocated (Per Wkst. B, Part II)			23,325	36,088	138,572		204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000293	12.861012	0.000154		205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OTHER ADMIN & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY + LINEN SERVICE GROSS REVENUE	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	
		5.06	7	8	9	10	11	
	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	218,971,033						5.06
6	Maintenance & Repairs							6
7	Operation of Plant	17,265,596	292,045					7
8	Laundry & Linen Service	1,101,616		897,074,192				8
9	Housekeeping	3,369,839	6,038		286,007			9
10	Dietary	3,371,551	8,568		8,568	100,324		10
11	Cafeteria	1,061,968	11,644		11,644		1,130	11
12	Maintenance of Personnel							12
13	Nursing Administration	3,179,897	1,901		1,901		35	13
14	Central Services & Supply	952,475					10	14
15	Pharmacy	4,302,596	5,087		5,087		37	15
16	Medical Records & Library	3,802,441	975		975		35	16
17	Social Service	2,543,330	593		593		27	17
18	STERILE SUPPLY	2,719,074	7,702		7,702		18	18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	2,414,393					33	21
22	I&R Services-Other Prgm Costs Apprvd	2,552,441	900		900		12	22
23	PARAMED ED PRGM-(SPECIFY)	169,882	321		321		1	23
23.01	CLINICAL PASTORAL EDUCATION	285,269					9	23.01
23.02	PHARMACY RESIDENCY PROGRAM	193,117					6	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	32,121,647	113,795	107,820,233	113,795	77,038	325	30
31	Intensive Care Unit	6,145,024	14,308	19,395,138	14,308	4,306	56	31
35	NEONATAL INTENSIVE CARE UNIT	3,283,569	5,062	9,733,819	5,062	251	27	35
41	Subprovider - IRF	2,743,414		6,678,113		6,794		41
43	Nursery	3,230,907		4,162,746			33	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	22,928,160	47,775	180,346,820	47,775		125	50
51	Recovery Room	1,618,007	3,166	16,953,202	3,166		16	51
52	Delivery Room & Labor Room	975,039		7,881,752			10	52
54	Radiology-Diagnostic	5,978,149	13,348	52,365,845	13,348		53	54
55	Radiology-Therapeutic	192,620		748,981			2	55
57	CT Scan	1,301,116	1,706	55,646,943	1,706		9	57
58	MRI	405,148		4,255,974				58
59	Cardiac Catheterization	7,725,976	14,667	54,576,331	14,667		34	59
60	Laboratory	13,836,048	1,968	96,420,298	1,968			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,295,745	3,591	15,442,151	3,591		27	65
66	Physical Therapy	3,170,488	3,254	13,609,670	3,254		31	66
67	Occupational Therapy	908,196		5,484,230			10	67
68	Speech Pathology	435,430		2,752,622			4	68
69	Electrocardiology	1,482,405	2,690	20,809,131	2,690		13	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	19,541,784		66,432,910				72
73	Drugs Charged to Patients	12,368,823	468	83,602,650	468		4	73
74	Renal Dialysis	997,072	1,133	1,957,334	1,133			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	181,390		1,505,845				76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	121,980		410,020				90.02
90.03	FAMILY MEDICINE CENTER	1,195,796		2,637,031			14	90.03
90.04	WOUND HEALING CENTER	1,293,694		2,388,374			9	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	779,206	1,548	3,019,195	1,548	34	8	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	398,861		257,146			4	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	534,524		295			3	90.07
90.08	PODIATRY RESIDENCY CLINIC	224,777					1	90.08
90.09	FACULTY PRACTICE CLINIC	547,564		678,458			5	90.09
90.10	OUR LADY OF ROSARY CLINIC	546,447		9,445				90.10
91	Emergency	7,624,839	17,737	59,091,490	17,737		75	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	207,419,330	289,945	897,074,192	283,907	88,423	1,121	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	139,539	1,883		1,883			190
192	Physicians' Private Offices	37,811	116		116			192

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OTHER ADMIN & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY + LINEN SERVICE GROSS REVENUE	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	
		5.06	7	8	9	10	11	
192.01	MATERNAL FETAL MEDICINE/LABORIST	1,377,341	101		101			192.01
192.02	NEONATOLOGISTS	1,667,721					7	192.02
192.03	HOSPITALISTS/INTENSIVISTS	4,692,292					2	192.03
194	SPORTS MED-ATHLETIC TRAINERS	248,215						194
194.01	OUTREACH SERVICES	3,064,853						194.01
194.02	KINDRED/OUR LADY OF PEACE	187,262				11,901		194.02
194.03	ADVANCED SPECIALTIES	136,669						194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	59,303,117	21,941,568	1,399,962	4,736,119	5,070,257	2,417,218	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.270826	75.130778	0.001561	16.559451	50.538824	2,139.130973	203
204	Cost to be allocated (Per Wkst. B, Part II)	4,437,427	9,779,532	22,420	716,823	1,009,827	1,300,569	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.020265	33.486387	0.000025	2.506313	10.065657	1,150.946018	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY GROSS REVENUE	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	STERILE SUPPLY COSTED REQUIS	
		13	14	15	16	17	18	
	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	801						13
14	Central Services & Supply		897,074,192					14
15	Pharmacy			12,645,591				15
16	Medical Records & Library				897,074,192			16
17	Social Service			29,510		1,021		17
18	STERILE SUPPLY			488			75,858	18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	CLINICAL PASTORAL EDUCATION							23.01
23.02	PHARMACY RESIDENCY PROGRAM							23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	325	107,820,233	1,441	107,820,233	814	1,437	30
31	Intensive Care Unit	56	19,395,138	316	19,395,138	89		31
35	NEONATAL INTENSIVE CARE UNIT	27	9,733,819	303	9,733,819	15	88	35
41	Subprovider - IRF	37	6,678,113		6,678,113			41
43	Nursery	33	4,162,746		4,162,746			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	125	180,346,820	133,447	180,346,820	4	67,555	50
51	Recovery Room	16	16,953,202	4	16,953,202			51
52	Delivery Room & Labor Room	10	7,881,752		7,881,752			52
54	Radiology-Diagnostic		52,365,845	562,305	52,365,845		240	54
55	Radiology-Therapeutic		748,981		748,981			55
57	CT Scan		55,646,943	136,882	55,646,943			57
58	MRI		4,255,974		4,255,974			58
59	Cardiac Catheterization	34	54,576,331	82,639	54,576,331		408	59
60	Laboratory		96,420,298		96,420,298			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		15,442,151	1,236	15,442,151		116	65
66	Physical Therapy		13,609,670	2,309	13,609,670			66
67	Occupational Therapy		5,484,230	116	5,484,230			67
68	Speech Pathology		2,752,622		2,752,622			68
69	Electrocardiology	13	20,809,131	200	20,809,131			69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients		66,432,910		66,432,910			72
73	Drugs Charged to Patients		83,602,650	11,452,714	83,602,650			73
74	Renal Dialysis		1,957,334	666	1,957,334			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY		1,505,845		1,505,845			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	2	410,020		410,020			90.02
90.03	FAMILY MEDICINE CENTER	14	2,637,031	52,933	2,637,031		503	90.03
90.04	WOUND HEALING CENTER	9	2,388,374	35,665	2,388,374		174	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	8	3,019,195	2	3,019,195			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	4	257,146	806	257,146			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	3	295	6,049	295		23	90.07
90.08	PODIATRY RESIDENCY CLINIC	1		679				90.08
90.09	FACULTY PRACTICE CLINIC	5	678,458	44,082	678,458		16	90.09
90.10	OUR LADY OF ROSARY CLINIC	4	9,445	24,842	9,445			90.10
91	Emergency	75	59,091,490	50	59,091,490	99	89	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	801	897,074,192	12,569,684	897,074,192	1,021	70,649	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY GROSS REVENUE	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	STERILE SUPPLY COSTED REQUIS	
		13	14	15	16	17	18	
192.01	MATERNAL FETAL MEDICINE/LABORIST			543			104	192.01
192.02	NEONATOLOGISTS							192.02
192.03	HOSPITALISTS/INTENSIVISTS							192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES			75,364			3,464	194.01
194.02	KINDRED/OUR LADY OF PEACE						1,641	194.02
194.03	ADVANCED SPECIALTIES							194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	4,290,270	1,231,821	6,013,427	4,996,509	3,358,293	4,200,404	202
203	Unit Cost Multiplier (Wkst. B, Part I)	5,356,142322	0,001373	0,475535	0,005570	3,289,219393	55,371932	203
204	Cost to be allocated (Per Wkst. B, Part II)	314,472	30,959	690,023	225,429	150,330	921,903	204
205	Unit Cost Multiplier (Wkst. B, Part II)	392,599251	0,000035	0,054566	0,000251	147,238002	12,153010	205

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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	CLINICAL PASTORAL EDUCATION TIME SPENT	PHARMACY RESIDENCY PROGRAM PATIENT DAYS		
	21	22	23	23.01	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
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd	755					21
22	I&R Services-Other Prgm Costs Apprvd		755				22
23	PARAMED ED PRGM-(SPECIFY)			100			23
23.01	CLINICAL PASTORAL EDUCATION				850		23.01
23.02	PHARMACY RESIDENCY PROGRAM					100	23.02
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	446	446		549		30
31	Intensive Care Unit	40	40		206		31
35	NEONATAL INTENSIVE CARE UNIT	27	27				35
41	Subprovider - IRF				7		41
43	Nursery	29	29		21		43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	30	30		9		50
51	Recovery Room						51
52	Delivery Room & Labor Room	6	6				52
54	Radiology-Diagnostic	5	5		3		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					100	73
74	Renal Dialysis						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT						90.02
90.03	FAMILY MEDICINE CENTER	124	124				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	48	48	100	55		91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	755	755	100	850	100	118
NONREIMBURSABLE COST CENTERS							

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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	CLINICAL PASTORAL EDUCATION TIME SPENT	PHARMACY RESIDENCY PROGRAM PATIENT DAYS		
		21	22	23	23.01	23.02		
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
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
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,138,864	3,351,900	247,462	381,779	258,253		202
203	Unit Cost Multiplier (Wkst. B, Part I)	4,157,435762	4,439,602649	2,474,620000	449,151765	2,582,530000		203
204	Cost to be allocated (Per Wkst. B, Part II)	87,474	165,331	39,940	16,293	10,887		204
205	Unit Cost Multiplier (Wkst. B, Part II)	115.859603	218.981457	399.400000	19.168235	108.870000		205

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

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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	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	61,505,518		61,505,518		61,505,518	30
31	Intensive Care Unit	10,308,868		10,308,868	18,474	10,327,342	31
35	NEONATAL INTENSIVE CARE UNIT	4,989,170		4,989,170		4,989,170	35
41	Subprovider - IRF	4,087,875		4,087,875	49,967	4,137,842	41
43	Nursery	4,398,096		4,398,096		4,398,096	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	39,809,666		39,809,666	38,148	39,847,814	50
51	Recovery Room	2,610,592		2,610,592		2,610,592	51
52	Delivery Room & Labor Room	1,381,083		1,381,083		1,381,083	52
54	Radiology-Diagnostic	9,661,794		9,661,794	25,856	9,687,650	54
55	Radiology-Therapeutic	255,434		255,434		255,434	55
57	CT Scan	2,367,480		2,367,480		2,367,480	57
58	MRI	551,066		551,066		551,066	58
59	Cardiac Catheterization	11,944,037		11,944,037		11,944,037	59
60	Laboratory	18,583,614		18,583,614		18,583,614	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	4,713,666		4,713,666		4,713,666	65
66	Physical Therapy	4,510,647		4,510,647		4,510,647	66
67	Occupational Therapy	1,222,243		1,222,243		1,222,243	67
68	Speech Pathology	585,321		585,321		585,321	68
69	Electrocardiology	2,405,021		2,405,021		2,405,021	69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients	25,399,152		25,399,152		25,399,152	72
73	Drugs Charged to Patients	22,185,472		22,185,472		22,185,472	73
74	Renal Dialysis	1,387,951		1,387,951		1,387,951	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	243,322		243,322		243,322	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT	169,214		169,214		169,214	90.02
90.03	FAMILY MEDICINE CENTER	1,700,031		1,700,031		1,700,031	90.03
90.04	WOUND HEALING CENTER	1,758,422		1,758,422	1,948	1,760,370	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	1,219,527		1,219,527		1,219,527	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	539,434		539,434	3,771	543,205	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	705,925		705,925		705,925	90.07
90.08	PODIATRY RESIDENCY CLINIC	293,470		293,470		293,470	90.08
90.09	FACULTY PRACTICE CLINIC	760,955		760,955		760,955	90.09
90.10	OUR LADY OF ROSARY CLINIC	727,758		727,758		727,758	90.10
91	Emergency	12,983,565		12,983,565	94,075	13,077,640	91
92	Observation Beds (Non-Distinct Part)	6,052,380		6,052,380		6,052,380	92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	262,017,769		262,017,769	232,239	262,250,008	200
201	Less Observation Beds	6,052,380		6,052,380		6,052,380	201
202	Total (line 200 minus line 201)	255,965,389		255,965,389		256,197,628	202

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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	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	97,592,689		97,592,689				30
31	Intensive Care Unit	19,395,138		19,395,138				31
35	NEONATAL INTENSIVE CARE UNIT	9,733,819		9,733,819				35
41	Subprovider - IRF	6,678,113		6,678,113				41
43	Nursery	4,162,746		4,162,746				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	93,028,671	87,318,149	180,346,820	0.220739	0.220739	0.220951	50
51	Recovery Room	7,848,766	9,104,436	16,953,202	0.153988	0.153988	0.153988	51
52	Delivery Room & Labor Room	7,849,120	32,632	7,881,752	0.175225	0.175225	0.175225	52
54	Radiology-Diagnostic	11,830,611	40,535,234	52,365,845	0.184506	0.184506	0.184999	54
55	Radiology-Therapeutic	646,965	102,016	748,981	0.341042	0.341042	0.341042	55
57	CT Scan	16,109,041	39,537,902	55,646,943	0.042545	0.042545	0.042545	57
58	MRI	3,293,620	962,354	4,255,974	0.129481	0.129481	0.129481	58
59	Cardiac Catheterization	20,200,397	34,375,934	54,576,331	0.218850	0.218850	0.218850	59
60	Laboratory	57,650,379	38,769,919	96,420,298	0.192735	0.192735	0.192735	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	9,622,263	5,819,888	15,442,151	0.305247	0.305247	0.305247	65
66	Physical Therapy	5,624,235	7,985,435	13,609,670	0.331430	0.331430	0.331430	66
67	Occupational Therapy	4,395,989	1,088,241	5,484,230	0.222865	0.222865	0.222865	67
68	Speech Pathology	2,210,340	542,282	2,752,622	0.212641	0.212641	0.212641	68
69	Electrocardiology	7,169,716	13,639,415	20,809,131	0.115575	0.115575	0.115575	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	51,372,787	15,060,123	66,432,910	0.382328	0.382328	0.382328	72
73	Drugs Charged to Patients	54,994,670	28,607,980	83,602,650	0.265368	0.265368	0.265368	73
74	Renal Dialysis	1,336,821	620,513	1,957,334	0.709103	0.709103	0.709103	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	16,940	1,488,905	1,505,845	0.161585	0.161585	0.161585	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT		410,020	410,020	0.412697	0.412697	0.412697	90.02
90.03	FAMILY MEDICINE CENTER		2,637,031	2,637,031	0.644676	0.644676	0.644676	90.03
90.04	WOUND HEALING CENTER	15,286	2,373,088	2,388,374	0.736242	0.736242	0.737058	90.04
90.05	OUTPATIENT TREATMENT & INFUSION		3,019,195	3,019,195	0.403925	0.403925	0.403925	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	258	256,888	257,146	2.097773	2.097773	2.112438	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	295		295	2,392.966102	2,392.966102	2,392.966102	90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC	93,046	585,412	678,458	1.121595	1.121595	1.121595	90.09
90.10	OUR LADY OF ROSARY CLINIC	9,445		9,445	77.052197	77.052197	77.052197	90.10
91	Emergency	14,982,669	44,108,821	59,091,490	0.219720	0.219720	0.221312	91
92	Observation Beds (Non-Distinct Part)	1,714,734	8,512,810	10,227,544	0.591773	0.591773	0.591773	92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	509,579,569	387,494,623	897,074,192				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	509,579,569	387,494,623	897,074,192				202

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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

(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	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	14,622,897		14,622,897	56,126	260.54	21,334	5,558,360	30
31	Intensive Care Unit	1,849,165		1,849,165	4,909	376.69	1,781	670,885	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	NEONATAL INTENSIVE CARE UNIT	675,228		675,228	1,010	668.54			35
40	Subprovider - IPF								40
41	Subprovider - IRF	143,251		143,251	4,538	31.57	2,888	91,174	41
42	Subprovider I								42
43	Nursery	118,914		118,914	5,885	20.21			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	17,409,455		17,409,455	72,468		26,003	6,320,419	200

(A) Worksheet A line numbers

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ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0012

**WORKSHEET D
PART II**

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

(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	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,821,914	180,346,820	0.037827	29,899,690	1,131,016	50
51	Recovery Room	413,772	16,953,202	0.024407	3,042,759	74,265	51
52	Delivery Room & Labor Room	39,028	7,881,752	0.004952	40,428	200	52
54	Radiology-Diagnostic	1,708,508	52,365,845	0.032626	5,591,217	182,419	54
55	Radiology-Therapeutic	6,568	748,981	0.008769	148,747	1,304	55
57	CT Scan	257,694	55,646,943	0.004631	7,699,763	35,658	57
58	MRI	10,355	4,255,974	0.002433	1,776,674	4,323	58
59	Cardiac Catheterization	1,856,095	54,576,331	0.034009	7,602,020	258,537	59
60	Laboratory	541,824	96,420,298	0.005619	25,682,508	144,310	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	501,811	15,442,151	0.032496	3,982,095	129,402	65
66	Physical Therapy	465,052	13,609,670	0.034171	1,796,644	61,393	66
67	Occupational Therapy	32,780	5,484,230	0.005977	1,313,358	7,850	67
68	Speech Pathology	14,855	2,752,622	0.005397	586,368	3,165	68
69	Electrocardiology	355,824	20,809,131	0.017099	4,314,875	73,780	69
71	Medical Supplies Charged to Pat						71
72	Impl. Dev. Charged to Patients	426,906	66,432,910	0.006426	20,041,907	128,789	72
73	Drugs Charged to Patients	970,619	83,602,650	0.011610	25,305,710	293,799	73
74	Renal Dialysis	145,576	1,957,334	0.074375	509,252	37,876	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,414	1,505,845	0.002931	15,059	44	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT	3,470	410,020	0.008463			90.02
90.03	FAMILY MEDICINE CENTER	56,960	2,637,031	0.021600			90.03
90.04	WOUND HEALING CENTER	45,597	2,388,374	0.019091			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	200,164	3,019,195	0.066297			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	14,708	257,146	0.057197	258	15	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	16,271	295	55.155932			90.07
90.08	PODIATRY RESIDENCY CLINIC	6,373					90.08
90.09	FACULTY PRACTICE CLINIC	21,837	678,458	0.032186			90.09
90.10	OUR LADY OF ROSARY CLINIC	14,095	9,445	1.492324			90.10
91	Emergency	2,264,105	59,091,490	0.038315	4,897,717	187,656	91
92	Observation Beds (Non-Distinct)	1,438,947	10,227,544	0.140693	1,029,121	144,790	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	18,656,122	759,511,687		145,276,170	2,900,591	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Nursing School	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.)	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)		246,586			246,586	30
31	Intensive Care Unit		92,525			92,525	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		3,144			3,144	41
42	Subprovider I						42
43	Nursery		9,432			9,432	43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)		351,687			351,687	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(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)	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	56,126	4.39	21,334	93,656	30
31	Intensive Care Unit	4,909	18.85	1,781	33,572	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	NEONATAL INTENSIVE CARE UNIT	1,010				35
40	Subprovider - IPF					40
41	Subprovider - IRF	4,538	0.69	2,888	1,993	41
42	Subprovider I					42
43	Nursery	5,885	1.60			43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	72,468		26,003	129,221	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			4,042		4,042	4,042	50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic			1,347		1,347	1,347	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			258,253		258,253	258,253	73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	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			272,165		272,165	272,165	91
92	Observation Beds (Non-Distinct			24,264		24,264	24,264	92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			560,071		560,071	560,071	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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			
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	180,346,820	0.000022	0.000022	29,899,690	658	14,713,159	324	50
51	Recovery Room	16,953,202			3,042,759		1,814,830		51
52	Delivery Room & Labor Room	7,881,752			40,428				52
54	Radiology-Diagnostic	52,365,845	0.000026	0.000026	5,591,217	145	9,334,513	243	54
55	Radiology-Therapeutic	748,981			148,747		58,672		55
57	CT Scan	55,646,943			7,699,763		10,560,327		57
58	MRI	4,255,974			1,776,674		427,216		58
59	Cardiac Catheterization	54,576,331			7,602,020		11,338,907		59
60	Laboratory	96,420,298			25,682,508		8,772,599		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	15,442,151			3,982,095		492,942		65
66	Physical Therapy	13,609,670			1,796,644		13,075		66
67	Occupational Therapy	5,484,230			1,313,358				67
68	Speech Pathology	2,752,622			586,368				68
69	Electrocardiology	20,809,131			4,314,875		5,777,000		69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	66,432,910			20,041,907		3,205,203		72
73	Drugs Charged to Patients	83,602,650	0.003089	0.003089	25,305,710	78,169	10,456,334	32,300	73
74	Renal Dialysis	1,957,334			509,252		30,002		74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,505,845			15,059		687,283		76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90.02	MOBILE MEDICAL UNIT	410,020							90.02
90.03	FAMILY MEDICINE CENTER	2,637,031							90.03
90.04	WOUND HEALING CENTER	2,388,374					25,295		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	3,019,195							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	257,146			258		2,150		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	295							90.07
90.08	PODIATRY RESIDENCY CLINIC								90.08
90.09	FACULTY PRACTICE CLINIC	678,458							90.09
90.10	OUR LADY OF ROSARY CLINIC	9,445							90.10
91	Emergency	59,091,490	0.004606	0.004606	4,897,717	22,559	7,360,683	33,903	91
92	Observation Beds (Non-Distinct	10,227,544	0.002372	0.002372	1,029,121	2,441	1,407,961	3,340	92
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	759,511,687			145,276,170	103,972	86,478,151	70,110	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.220739	14,713,159			3,247,768			50
51	Recovery Room	0.153988	1,814,830			279,462			51
52	Delivery Room & Labor Room	0.175225							52
54	Radiology-Diagnostic	0.184506	9,334,513			1,722,274			54
55	Radiology-Therapeutic	0.341042	58,672			20,010			55
57	CT Scan	0.042545	10,560,327			449,289			57
58	MRI	0.129481	427,216			55,316			58
59	Cardiac Catheterization	0.218850	11,338,907			2,481,520			59
60	Laboratory	0.192735	8,772,599			1,690,787			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.305247	492,942			150,469			65
66	Physical Therapy	0.331430	13,075			4,333			66
67	Occupational Therapy	0.222865							67
68	Speech Pathology	0.212641							68
69	Electrocardiology	0.115575	5,777,000			667,677			69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	0.382328	3,205,203			1,225,439			72
73	Drugs Charged to Patients	0.265368	10,456,334		167,884	2,774,776		44,551	73
74	Renal Dialysis	0.709103	30,002			21,275			74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.161585	687,283			111,055			76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	MOBILE MEDICAL UNIT	0.412697							90.02
90.03	FAMILY MEDICINE CENTER	0.644676							90.03
90.04	WOUND HEALING CENTER	0.736242	25,295			18,623			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.403925							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.097773	2,150			4,510			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	2,392.966102							90.07
90.08	PODIATRY RESIDENCY CLINIC								90.08
90.09	FACULTY PRACTICE CLINIC	1.121595							90.09
90.10	OUR LADY OF ROSARY CLINIC	77.052197							90.10
91	Emergency	0.219720	7,360,683			1,617,289			91
92	Observation Beds (Non-Distinct	0.591773	1,407,961			833,193			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		86,478,151		167,884	17,375,065		44,551	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		86,478,151		167,884	17,375,065		44,551	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,821,914	180,346,820	0.037827			50
51	Recovery Room	413,772	16,953,202	0.024407			51
52	Delivery Room & Labor Room	39,028	7,881,752	0.004952			52
54	Radiology-Diagnostic	1,708,508	52,365,845	0.032626	51,349	1,675	54
55	Radiology-Therapeutic	6,568	748,981	0.008769	22,121	194	55
57	CT Scan	257,694	55,646,943	0.004631	28,515	132	57
58	MRI	10,355	4,255,974	0.002433	29,946	73	58
59	Cardiac Catheterization	1,856,095	54,576,331	0.034009	7,489	255	59
60	Laboratory	541,824	96,420,298	0.005619	641,185	3,603	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	501,811	15,442,151	0.032496			65
66	Physical Therapy	465,052	13,609,670	0.034171	1,247,547	42,630	66
67	Occupational Therapy	32,780	5,484,230	0.005977	1,259,883	7,530	67
68	Speech Pathology	14,855	2,752,622	0.005397	674,747	3,642	68
69	Electrocardiology	355,824	20,809,131	0.017099	264	5	69
71	Medical Supplies Charged to Pat						71
72	Impl. Dev. Charged to Patients	426,906	66,432,910	0.006426			72
73	Drugs Charged to Patients	970,619	83,602,650	0.011610	683,326	7,933	73
74	Renal Dialysis	145,576	1,957,334	0.074375	23,536	1,750	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,414	1,505,845	0.002931			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT	3,470	410,020	0.008463			90.02
90.03	FAMILY MEDICINE CENTER	56,960	2,637,031	0.021600			90.03
90.04	WOUND HEALING CENTER	45,597	2,388,374	0.019091			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	200,164	3,019,195	0.066297			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	14,708	257,146	0.057197			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	16,271	295	55.155932			90.07
90.08	PODIATRY RESIDENCY CLINIC	6,373					90.08
90.09	FACULTY PRACTICE CLINIC	21,837	678,458	0.032186			90.09
90.10	OUR LADY OF ROSARY CLINIC	14,095	9,445	1.492324			90.10
91	Emergency	2,264,105	59,091,490	0.038315	17,060	654	91
92	Observation Beds (Non-Distinct)		10,227,544				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	17,217,175	759,511,687		4,686,968	70,076	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			4,042		4,042	4,042	50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic			1,347		1,347	1,347	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			258,253		258,253	258,253	73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	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			272,165		272,165	272,165	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			535,807		535,807	535,807	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	180,346,820	0.000022	0.000022					50
51	Recovery Room	16,953,202							51
52	Delivery Room & Labor Room	7,881,752							52
54	Radiology-Diagnostic	52,365,845	0.000026	0.000026	51,349	1			54
55	Radiology-Therapeutic	748,981			22,121				55
57	CT Scan	55,646,943			28,515				57
58	MRI	4,255,974			29,946				58
59	Cardiac Catheterization	54,576,331			7,489				59
60	Laboratory	96,420,298			641,185				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	15,442,151							65
66	Physical Therapy	13,609,670			1,247,547				66
67	Occupational Therapy	5,484,230			1,259,883				67
68	Speech Pathology	2,752,622			674,747				68
69	Electrocardiology	20,809,131			264				69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	66,432,910							72
73	Drugs Charged to Patients	83,602,650	0.003089	0.003089	683,326	2,111			73
74	Renal Dialysis	1,957,334			23,536				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,505,845							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	MOBILE MEDICAL UNIT	410,020							90.02
90.03	FAMILY MEDICINE CENTER	2,637,031							90.03
90.04	WOUND HEALING CENTER	2,388,374							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	3,019,195							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	257,146							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	295							90.07
90.08	PODIATRY RESIDENCY CLINIC								90.08
90.09	FACULTY PRACTICE CLINIC	678,458							90.09
90.10	OUR LADY OF ROSARY CLINIC	9,445							90.10
91	Emergency	59,091,490	0.004606	0.004606	17,060	79			91
92	Observation Beds (Non-Distinct)	10,227,544							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	759,511,687			4,686,968	2,191			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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 [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [] Title XIX - O/P [XX] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.220739							50
51	Recovery Room	0.153988							51
52	Delivery Room & Labor Room	0.175225							52
54	Radiology-Diagnostic	0.184506							54
55	Radiology-Therapeutic	0.341042							55
57	CT Scan	0.042545							57
58	MRI	0.129481							58
59	Cardiac Catheterization	0.218850							59
60	Laboratory	0.192735							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.305247							65
66	Physical Therapy	0.331430							66
67	Occupational Therapy	0.222865							67
68	Speech Pathology	0.212641							68
69	Electrocardiology	0.115575							69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	0.382328							72
73	Drugs Charged to Patients	0.265368							73
74	Renal Dialysis	0.709103							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.161585							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	MOBILE MEDICAL UNIT	0.412697							90.02
90.03	FAMILY MEDICINE CENTER	0.644676							90.03
90.04	WOUND HEALING CENTER	0.736242							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.403925							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.097773							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	2,392.966102							90.07
90.08	PODIATRY RESIDENCY CLINIC								90.08
90.09	FACULTY PRACTICE CLINIC	1.121595							90.09
90.10	OUR LADY OF ROSARY CLINIC	77.052197							90.10
91	Emergency	0.219720							91
92	Observation Beds (Non-Distinct	0.591773							92
	OTHER REIMBURSABLE COST CENTERS								
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. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(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	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	14,622,897		14,622,897	56,126	260.54	3,065	798,555	30
31	Intensive Care Unit	1,849,165		1,849,165	4,909	376.69	396	149,169	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	NEONATAL INTENSIVE CARE UNIT	675,228		675,228	1,010	668.54	758	506,753	35
40	Subprovider - IPF								40
41	Subprovider - IRF	143,251		143,251	4,538	31.57	137	4,325	41
42	Subprovider I								42
43	Nursery	118,914		118,914	5,885	20.21	447	9,034	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	17,409,455		17,409,455	72,468		4,803	1,467,836	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,821,914	180,346,820	0.037827	5,705,786	215,833	50
51	Recovery Room	413,772	16,953,202	0.024407	876,364	21,389	51
52	Delivery Room & Labor Room	39,028	7,881,752	0.004952	3,581,080	17,734	52
54	Radiology-Diagnostic	1,708,508	52,365,845	0.032626	1,547,106	50,476	54
55	Radiology-Therapeutic	6,568	748,981	0.008769	122,783	1,077	55
57	CT Scan	257,694	55,646,943	0.004631	1,594,568	7,384	57
58	MRI	10,355	4,255,974	0.002433	428,615	1,043	58
59	Cardiac Catheterization	1,856,095	54,576,331	0.034009	736,226	25,038	59
60	Laboratory	541,824	96,420,298	0.005619	6,850,084	38,491	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	501,811	15,442,151	0.032496	1,961,493	63,741	65
66	Physical Therapy	465,052	13,609,670	0.034171	198,330	6,777	66
67	Occupational Therapy	32,780	5,484,230	0.005977	197,070	1,178	67
68	Speech Pathology	14,855	2,752,622	0.005397	103,076	556	68
69	Electrocardiology	355,824	20,809,131	0.017099			69
71	Medical Supplies Charged to Pat						71
72	Impl. Dev. Charged to Patients	426,906	66,432,910	0.006426	1,872,928	12,035	72
73	Drugs Charged to Patients	970,619	83,602,650	0.011610	8,794,784	102,107	73
74	Renal Dialysis	145,576	1,957,334	0.074375	109,178	8,120	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,414	1,505,845	0.002931			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT	3,470	410,020	0.008463			90.02
90.03	FAMILY MEDICINE CENTER	56,960	2,637,031	0.021600			90.03
90.04	WOUND HEALING CENTER	45,597	2,388,374	0.019091			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	200,164	3,019,195	0.066297			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	14,708	257,146	0.057197			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	16,271	295	55.155932			90.07
90.08	PODIATRY RESIDENCY CLINIC	6,373					90.08
90.09	FACULTY PRACTICE CLINIC	21,837	678,458	0.032186			90.09
90.10	OUR LADY OF ROSARY CLINIC	14,095	9,445	1.492324			90.10
91	Emergency	2,264,105	59,091,490	0.038315	1,043,847	39,995	91
92	Observation Beds (Non-Distinct)	1,438,947	10,227,544	0.140693	183,794	25,859	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	18,656,122	759,511,687		35,907,112	638,833	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Nursing School	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.)	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)		246,586			246,586	30
31	Intensive Care Unit		92,525			92,525	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		3,144			3,144	41
42	Subprovider I						42
43	Nursery		9,432			9,432	43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)		351,687			351,687	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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)	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	56,126	4.39	3,065	13,455	30
31	Intensive Care Unit	4,909	18.85	396	7,465	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	NEONATAL INTENSIVE CARE UNIT	1,010		758		35
40	Subprovider - IPF					40
41	Subprovider - IRF	4,538	0.69	137	95	41
42	Subprovider I					42
43	Nursery	5,885	1.60	447	715	43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	72,468		4,803	21,730	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			4,042		4,042	4,042	50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic			1,347		1,347	1,347	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			258,253		258,253	258,253	73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	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			272,165		272,165	272,165	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			535,807		535,807	535,807	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	180,346,820	0.000022	0.000022	5,705,786	126			50
51	Recovery Room	16,953,202			876,364				51
52	Delivery Room & Labor Room	7,881,752			3,581,080				52
54	Radiology-Diagnostic	52,365,845	0.000026	0.000026	1,547,106	40			54
55	Radiology-Therapeutic	748,981			122,783				55
57	CT Scan	55,646,943			1,594,568				57
58	MRI	4,255,974			428,615				58
59	Cardiac Catheterization	54,576,331			736,226				59
60	Laboratory	96,420,298			6,850,084				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	15,442,151			1,961,493				65
66	Physical Therapy	13,609,670			198,330				66
67	Occupational Therapy	5,484,230			197,070				67
68	Speech Pathology	2,752,622			103,076				68
69	Electrocardiology	20,809,131							69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	66,432,910			1,872,928				72
73	Drugs Charged to Patients	83,602,650	0.003089	0.003089	8,794,784	27,167			73
74	Renal Dialysis	1,957,334			109,178				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,505,845							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	MOBILE MEDICAL UNIT	410,020							90.02
90.03	FAMILY MEDICINE CENTER	2,637,031							90.03
90.04	WOUND HEALING CENTER	2,388,374							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	3,019,195							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	257,146							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	295							90.07
90.08	PODIATRY RESIDENCY CLINIC								90.08
90.09	FACULTY PRACTICE CLINIC	678,458							90.09
90.10	OUR LADY OF ROSARY CLINIC	9,445							90.10
91	Emergency	59,091,490	0.004606	0.004606	1,043,847	4,808			91
92	Observation Beds (Non-Distinct)	10,227,544			183,794				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	759,511,687			35,907,112	32,141			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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 [] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [XX] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost		
			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
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.220739		13,508,408			2,981,832	50
51	Recovery Room	0.153988		1,687,441			259,846	51
52	Delivery Room & Labor Room	0.175225		5,266			923	52
54	Radiology-Diagnostic	0.184506		6,300,934			1,162,560	54
55	Radiology-Therapeutic	0.341042		39,224			13,377	55
57	CT Scan	0.042545		5,447,140			231,749	57
58	MRI	0.129481		256,580			33,222	58
59	Cardiac Catheterization	0.218850		678,299			148,446	59
60	Laboratory	0.192735		6,856,531			1,321,494	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.305247		2,662,434			812,700	65
66	Physical Therapy	0.331430		1,243,759			412,219	66
67	Occupational Therapy	0.222865		619,280			138,016	67
68	Speech Pathology	0.212641		540,585			114,951	68
69	Electrocardiology	0.115575						69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients	0.382328		1,606,266			614,120	72
73	Drugs Charged to Patients	0.265368		8,507,432			2,257,600	73
74	Renal Dialysis	0.709103		13,958			9,898	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.161585		84,748			13,694	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	0.412697						90.02
90.03	FAMILY MEDICINE CENTER	0.644676						90.03
90.04	WOUND HEALING CENTER	0.736242		13,916			10,246	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.403925		557,656			225,251	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.097773		9,432			19,786	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	2,392.966102						90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC	1.121595						90.09
90.10	OUR LADY OF ROSARY CLINIC	77.052197						90.10
91	Emergency	0.219720		8,303,212			1,824,382	91
92	Observation Beds (Non-Distinct	0.591773		1,244,571			736,504	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)			60,187,072			13,342,816	200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)			60,187,072			13,342,816	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,821,914	180,346,820	0.037827	1,028	39	50
51	Recovery Room	413,772	16,953,202	0.024407			51
52	Delivery Room & Labor Room	39,028	7,881,752	0.004952			52
54	Radiology-Diagnostic	1,708,508	52,365,845	0.032626	4,786	156	54
55	Radiology-Therapeutic	6,568	748,981	0.008769			55
57	CT Scan	257,694	55,646,943	0.004631	5,149	24	57
58	MRI	10,355	4,255,974	0.002433			58
59	Cardiac Catheterization	1,856,095	54,576,331	0.034009			59
60	Laboratory	541,824	96,420,298	0.005619	47,849	269	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	501,811	15,442,151	0.032496			65
66	Physical Therapy	465,052	13,609,670	0.034171	115,482	3,946	66
67	Occupational Therapy	32,780	5,484,230	0.005977	116,211	695	67
68	Speech Pathology	14,855	2,752,622	0.005397	92,114	497	68
69	Electrocardiology	355,824	20,809,131	0.017099			69
71	Medical Supplies Charged to Pat						71
72	Impl. Dev. Charged to Patients	426,906	66,432,910	0.006426			72
73	Drugs Charged to Patients	970,619	83,602,650	0.011610	65,557	761	73
74	Renal Dialysis	145,576	1,957,334	0.074375			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,414	1,505,845	0.002931			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	MOBILE MEDICAL UNIT	3,470	410,020	0.008463			90.02
90.03	FAMILY MEDICINE CENTER	56,960	2,637,031	0.021600			90.03
90.04	WOUND HEALING CENTER	45,597	2,388,374	0.019091			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	200,164	3,019,195	0.066297			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	14,708	257,146	0.057197			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	16,271	295	55.155932			90.07
90.08	PODIATRY RESIDENCY CLINIC	6,373					90.08
90.09	FACULTY PRACTICE CLINIC	21,837	678,458	0.032186			90.09
90.10	OUR LADY OF ROSARY CLINIC	14,095	9,445	1.492324			90.10
91	Emergency	2,264,105	59,091,490	0.038315			91
92	Observation Beds (Non-Distinct)		10,227,544				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	17,217,175	759,511,687		448,176	6,387	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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 [XX] PPS
Applicable [] Title XVIII, Part A [] IPF [] SNF [] TEFRA
Boxes: [XX] Title XIX [XX] IRF [] NF [] Other

		Non Physician Anesthetist Cost	Nursing School	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	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			4,042		4,042	4,042	50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic			1,347		1,347	1,347	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			258,253		258,253	258,253	73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	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			272,165		272,165	272,165	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			535,807		535,807	535,807	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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, 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			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	180,346,820	0.000022	0.000022	1,028				50
51	Recovery Room	16,953,202							51
52	Delivery Room & Labor Room	7,881,752							52
54	Radiology-Diagnostic	52,365,845	0.000026	0.000026	4,786				54
55	Radiology-Therapeutic	748,981							55
57	CT Scan	55,646,943			5,149				57
58	MRI	4,255,974							58
59	Cardiac Catheterization	54,576,331							59
60	Laboratory	96,420,298			47,849				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	15,442,151							65
66	Physical Therapy	13,609,670			115,482				66
67	Occupational Therapy	5,484,230			116,211				67
68	Speech Pathology	2,752,622			92,114				68
69	Electrocardiology	20,809,131							69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	66,432,910							72
73	Drugs Charged to Patients	83,602,650	0.003089	0.003089	65,557	203			73
74	Renal Dialysis	1,957,334							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,505,845							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	MOBILE MEDICAL UNIT	410,020							90.02
90.03	FAMILY MEDICINE CENTER	2,637,031							90.03
90.04	WOUND HEALING CENTER	2,388,374							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	3,019,195							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	257,146							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	295							90.07
90.08	PODIATRY RESIDENCY CLINIC								90.08
90.09	FACULTY PRACTICE CLINIC	678,458							90.09
90.10	OUR LADY OF ROSARY CLINIC	9,445							90.10
91	Emergency	59,091,490	0.004606	0.004606					91
92	Observation Beds (Non-Distinct	10,227,544							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	759,511,687			448,176	203			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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 Reimbursed Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Not Subject to Ded. & Coins. (see inst.)
1	2	3	4	5	6	7		
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.220739					50	
51	Recovery Room	0.153988					51	
52	Delivery Room & Labor Room	0.175225					52	
54	Radiology-Diagnostic	0.184506					54	
55	Radiology-Therapeutic	0.341042					55	
57	CT Scan	0.042545					57	
58	MRI	0.129481					58	
59	Cardiac Catheterization	0.218850					59	
60	Laboratory	0.192735					60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30	
65	Respiratory Therapy	0.305247					65	
66	Physical Therapy	0.331430					66	
67	Occupational Therapy	0.222865					67	
68	Speech Pathology	0.212641					68	
69	Electrocardiology	0.115575					69	
71	Medical Supplies Charged to Pat						71	
72	Impl. Dev. Charged to Patients	0.382328					72	
73	Drugs Charged to Patients	0.265368					73	
74	Renal Dialysis	0.709103					74	
76.97	CARDIAC REHABILITATION						76.97	
76.98	HYPERBARIC OXYGEN THERAPY	0.161585					76.98	
76.99	LITHOTRIPSY						76.99	
	OUTPATIENT SERVICE COST CENTERS							
90.02	MOBILE MEDICAL UNIT	0.412697					90.02	
90.03	FAMILY MEDICINE CENTER	0.644676					90.03	
90.04	WOUND HEALING CENTER	0.736242					90.04	
90.05	OUTPATIENT TREATMENT & INFUSION	0.403925					90.05	
90.06	PEDIATRIC SPECIALTY CLINIC	2.097773					90.06	
90.07	SPORTS MED FELLOWSHIP CLINIC	2,392.966102					90.07	
90.08	PODIATRY RESIDENCY CLINIC						90.08	
90.09	FACULTY PRACTICE CLINIC	1.121595					90.09	
90.10	OUR LADY OF ROSARY CLINIC	77.052197					90.10	
91	Emergency	0.219720					91	
92	Observation Beds (Non-Distinct)	0.591773					92	
	OTHER REIMBURSABLE COST CENTERS							
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. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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)	56,126	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	56,126	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)	50,603	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)	21,334	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)	61,505,518	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)	61,505,518	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)	61,505,518	37

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,095.85	38
39	Program general inpatient routine service cost (line 9 x line 38)					23,378,864	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)					23,378,864	41
		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	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	10,327,342	4,909	2,103.76	1,781	3,746,797	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	NEONATAL INTENSIVE CARE UNIT	4,989,170	1,010	4,939.77			47

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					34,500,342	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					61,626,003	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					6,356,473	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,004,563	51
52	Total Program excludable cost (sum of lines 50 and 51)					9,361,036	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					52,264,967	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. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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)					5,523	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,095.85	88
89	Observation bed cost (line 87 x line 88) (see instructions)					6,052,380	89
		Cost	Routine Cost (from line 27)	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	14,622,897	61,505,518	0.237749	6,052,380	1,438,947	90
91	Nursing School						91
92	Allied Health	246,586	61,505,518	0.004009	6,052,380	24,264	92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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)	4,538	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,538	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)	4,538	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)	2,888	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)	4,137,842	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)	4,137,842	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)	4,137,842	37

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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) [XX] PPS
Applicable [XX] Title XVIII, Part A [] IPF [] TEFRA
Boxes: [] Title XIX - I/P [XX] 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)	911.82	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,633,336	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)	2,633,336	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,186,919	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	3,820,255	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	93,167	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	72,267	51
52	Total Program excludable cost (sum of lines 50 and 51)	165,434	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	3,654,821	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. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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)	56,126	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	56,126	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)	50,603	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)	3,065	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)	5,885	15
16	Nursery days (title V or XIX only)	447	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)	61,505,518	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)	61,505,518	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)	61,505,518	37

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,095.85	38
39	Program general inpatient routine service cost (line 9 x line 38)						3,358,780	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)						3,358,780	41
		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		
42	Nursery (Titles V and XIX only)	4,398,096	5,885	747.34	447	334,061		42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	10,327,342	4,909	2,103.76	396	833,089		43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	NEONATAL INTENSIVE CARE UNIT	4,989,170	1,010	4,939.77	758	3,744,346		47
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					8,153,379		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					16,423,655		49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,485,146		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					670,974		51
52	Total Program excludable cost (sum of lines 50 and 51)					2,156,120		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					14,267,535		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. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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)					5,523	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 27)	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. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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)	4,538	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,538	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)	4,538	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)	137	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)	4,137,842	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)	4,137,842	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)	4,137,842	37

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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)	911.82	38
39	Program general inpatient routine service cost (line 9 x line 38)	124,919	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)	124,919	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	111,710	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	236,629	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	4,420	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	6,590	51
52	Total Program excludable cost (sum of lines 50 and 51)	11,010	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	225,619	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. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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/TID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		39,097,394		30
31	Intensive Care Unit		6,945,550		31
35	NEONATAL INTENSIVE CARE UNIT				35
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.220951	29,899,690	6,606,366	50
51	Recovery Room	0.153988	3,042,759	468,548	51
52	Delivery Room & Labor Room	0.175225	40,428	7,084	52
54	Radiology-Diagnostic	0.184999	5,591,217	1,034,370	54
55	Radiology-Therapeutic	0.341042	148,747	50,729	55
57	CT Scan	0.042545	7,699,763	327,586	57
58	MRI	0.129481	1,776,674	230,046	58
59	Cardiac Catheterization	0.218850	7,602,020	1,663,702	59
60	Laboratory	0.192735	25,682,508	4,949,918	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.305247	3,982,095	1,215,523	65
66	Physical Therapy	0.331430	1,796,644	595,462	66
67	Occupational Therapy	0.222865	1,313,358	292,702	67
68	Speech Pathology	0.212641	586,368	124,686	68
69	Electrocardiology	0.115575	4,314,875	498,692	69
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.382328	20,041,907	7,662,582	72
73	Drugs Charged to Patients	0.265368	25,305,710	6,715,326	73
74	Renal Dialysis	0.709103	509,252	361,112	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.161585	15,059	2,433	76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.02	MOBILE MEDICAL UNIT	0.412697			90.02
90.03	FAMILY MEDICINE CENTER	0.644676			90.03
90.04	WOUND HEALING CENTER	0.737058			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.403925			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.112438	258	545	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	2,392.966102			90.07
90.08	PODIATRY RESIDENCY CLINIC				90.08
90.09	FACULTY PRACTICE CLINIC	1.121595			90.09
90.10	OUR LADY OF ROSARY CLINIC	77.052197			90.10
91	Emergency	0.221312	4,897,717	1,083,924	91
92	Observation Beds (Non-Distinct Part)	0.591773	1,029,121	609,006	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		145,276,170	34,500,342	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		145,276,170		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
35	NEONATAL INTENSIVE CARE UNIT				35
41	Subprovider - IRF		4,214,477		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.220951			50
51	Recovery Room	0.153988			51
52	Delivery Room & Labor Room	0.175225			52
54	Radiology-Diagnostic	0.184999	51,349	9,500	54
55	Radiology-Therapeutic	0.341042	22,121	7,544	55
57	CT Scan	0.042545	28,515	1,213	57
58	MRI	0.129481	29,946	3,877	58
59	Cardiac Catheterization	0.218850	7,489	1,639	59
60	Laboratory	0.192735	641,185	123,579	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.305247			65
66	Physical Therapy	0.331430	1,247,547	413,475	66
67	Occupational Therapy	0.222865	1,259,883	280,784	67
68	Speech Pathology	0.212641	674,747	143,479	68
69	Electrocardiology	0.115575	264	31	69
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.382328			72
73	Drugs Charged to Patients	0.265368	683,326	181,333	73
74	Renal Dialysis	0.709103	23,536	16,689	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.161585			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.02	MOBILE MEDICAL UNIT	0.412697			90.02
90.03	FAMILY MEDICINE CENTER	0.644676			90.03
90.04	WOUND HEALING CENTER	0.737058			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.403925			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.112438			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	2,392.966102			90.07
90.08	PODIATRY RESIDENCY CLINIC				90.08
90.09	FACULTY PRACTICE CLINIC	1.121595			90.09
90.10	OUR LADY OF ROSARY CLINIC	77.052197			90.10
91	Emergency	0.221312	17,060	3,776	91
92	Observation Beds (Non-Distinct Part)	0.591773			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,686,968	1,186,919	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,686,968		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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/TID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		10,973,261		30
31	Intensive Care Unit		2,159,181		31
35	NEONATAL INTENSIVE CARE UNIT		4,404,802		35
41	Subprovider - IRF				41
43	Nursery		2,558,319		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.220951	5,705,786	1,260,699	50
51	Recovery Room	0.153988	876,364	134,950	51
52	Delivery Room & Labor Room	0.175225	3,581,080	627,495	52
54	Radiology-Diagnostic	0.184999	1,547,106	286,213	54
55	Radiology-Therapeutic	0.341042	122,783	41,874	55
57	CT Scan	0.042545	1,594,568	67,841	57
58	MRI	0.129481	428,615	55,497	58
59	Cardiac Catheterization	0.218850	736,226	161,123	59
60	Laboratory	0.192735	6,850,084	1,320,251	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.305247	1,961,493	598,740	65
66	Physical Therapy	0.331430	198,330	65,733	66
67	Occupational Therapy	0.222865	197,070	43,920	67
68	Speech Pathology	0.212641	103,076	21,918	68
69	Electrocardiology	0.115575			69
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.382328	1,872,928	716,073	72
73	Drugs Charged to Patients	0.265368	8,794,784	2,333,854	73
74	Renal Dialysis	0.709103	109,178	77,418	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.161585			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.02	MOBILE MEDICAL UNIT	0.412697			90.02
90.03	FAMILY MEDICINE CENTER	0.644676			90.03
90.04	WOUND HEALING CENTER	0.737058			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.403925			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.112438			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	2,392.966102			90.07
90.08	PODIATRY RESIDENCY CLINIC				90.08
90.09	FACULTY PRACTICE CLINIC	1.121595			90.09
90.10	OUR LADY OF ROSARY CLINIC	77.052197			90.10
91	Emergency	0.221312	1,043,847	231,016	91
92	Observation Beds (Non-Distinct Part)	0.591773	183,794	108,764	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		35,907,112	8,153,379	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		35,907,112		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
35	NEONATAL INTENSIVE CARE UNIT				35
41	Subprovider - IRF		411,129		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.220951	1,028	227	50
51	Recovery Room	0.153988			51
52	Delivery Room & Labor Room	0.175225			52
54	Radiology-Diagnostic	0.184999	4,786	885	54
55	Radiology-Therapeutic	0.341042			55
57	CT Scan	0.042545	5,149	219	57
58	MRI	0.129481			58
59	Cardiac Catheterization	0.218850			59
60	Laboratory	0.192735	47,849	9,222	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.305247			65
66	Physical Therapy	0.331430	115,482	38,274	66
67	Occupational Therapy	0.222865	116,211	25,899	67
68	Speech Pathology	0.212641	92,114	19,587	68
69	Electrocardiology	0.115575			69
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.382328			72
73	Drugs Charged to Patients	0.265368	65,557	17,397	73
74	Renal Dialysis	0.709103			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.161585			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.02	MOBILE MEDICAL UNIT	0.412697			90.02
90.03	FAMILY MEDICINE CENTER	0.644676			90.03
90.04	WOUND HEALING CENTER	0.737058			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.403925			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	2.112438			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	2,392.966102			90.07
90.08	PODIATRY RESIDENCY CLINIC				90.08
90.09	FACULTY PRACTICE CLINIC	1.121595			90.09
90.10	OUR LADY OF ROSARY CLINIC	77.052197			90.10
91	Emergency	0.221312			91
92	Observation Beds (Non-Distinct Part)	0.591773			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		448,176	111,710	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		448,176		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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)	10,434,110			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	31,076,333			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)	970,500			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	17,266,357			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	256.87			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
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	25.17			10
11	FTE count for residents in dental and podiatric programs	5.00			11
12	Current year allowable FTE (see instructions)	27.46			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	26.46			14
15	Sum of lines 12 through 14 divided by 3	27.13			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	27.13			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.105618			19
20	Prior year resident to bed ratio (see instructions)	0.118118			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.105618			21
22	IME payment adjustment (see instructions)	3,293,147			22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
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)	2.71			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)	3,293,147			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0355			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1863			31
32	Sum of lines 30 and 31	0.2218			32
33	Allowable disproportionate share percentage (see instructions)	0.0751			33
34	Disproportionate share adjustment (see instructions)	779,359			34
		Prior to October 1	On or after October 1		
	Uncompensated Care Adjustment				
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,607,154	2,541,556		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	657,146	1,900,944		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,558,090			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
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

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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)	49,111,539			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)	49,111,539			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	3,852,951			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)	1,657,312			52
53	Nursing and allied health managed care payment	394,438			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).	127,228			57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	103,972			58
59	Total (sum of amounts on lines 49 through 58)	55,247,440			59
60	Primary payer payments	57,175			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	55,190,265			61
62	Deductibles billed to program beneficiaries	4,793,752			62
63	Coinsurance billed to program beneficiaries	185,593			63
64	Allowable bad debts (see instructions)	586,581			64
65	Adjusted reimbursable bad debts (see instructions)	381,278			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	138,715			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	50,592,198			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)	59,987			70.93
71	Amount due provider (see instructions)	50,652,185			71
71.01	Sequestration adjustment (see instructions)	1,013,044			71.01
72	Interim payments	48,550,802			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	1,088,339			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	1,048,723			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

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

HSP Bonus Payment Amount

Prior to 10/1 On or After 10/1

100	HSP bonus amount (see instructions)				100
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HVBP Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

HRR Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

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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)	44,551			1
2	Medical and other services reimbursed under OPPS (see instructions)	17,304,955			2
3	PPS payments	17,824,222			3
4	Outlier payment (see instructions)	124,243			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 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	70,110			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	44,551			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	167,884			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)	167,884			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such 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)	167,884			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	123,333			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 (line 11 minus line 20) (for CAH, see instructions)	44,551			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, 8 and 9)	18,018,575			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	3,553,790			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)	14,509,336			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	441,439			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	14,950,775			30
31	Primary payer payments	5,810			31
32	Subtotal (line 30 minus line 31)	14,944,965			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	724,879			34
35	Adjusted reimbursable bad debts (see instructions)	471,171			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	471,276			36
37	Subtotal (see instructions)	15,416,136			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)	15,416,136			40
40.01	Sequestration adjustment (see instructions)	308,323			40.01
41	Interim payments	15,186,297			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-78,484			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. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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 OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such 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 (line 11 minus line 20) (for CAH, 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, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				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)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				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)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				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. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider		48,446,202		15,078,497	1
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					2
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	02/06/2015	02/06/2015	54,500	3.01
		.02		06/05/2015	53,300	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	104,600		107,800	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)		48,550,802		15,186,297	4
TO BE COMPLETED BY CONTRACTOR						
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	1,088,339			6.01
		.02			-78,484	6.02
7	Total Medicare program liability (see instructions)		49,639,141		15,107,813	7
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. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		3,544,231		1
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				2
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)		3,544,231		4
TO BE COMPLETED BY CONTRACTOR					
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	-81,164		6.02
7	Total Medicare program liability (see instructions)		3,463,067		7
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. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

Check applicable box: Hospital CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	14,271	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	23,115	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	9,939	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	56,522	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	897,074,192	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	13,063,825	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	686,030	8
9	Sequestration adjustment amount (see instructions)	13,721	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	672,309	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	638,500	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	33,809	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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)	3,465,022		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.018200		2
3	Inpatient Rehabilitation LIP payments (see instructions)	70,340		3
4	Outlier payments	21,926		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)	0.80		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)	12,432877		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	3,557,288		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)	3,557,288		17
18	Primary payer payments	11,553		18
19	Subtotal (line 17 less line 18)	3,545,735		19
20	Deductibles	18,548		20
21	Subtotal (line 19 minus line 20)	3,527,187		21
22	Coinsurance			22
23	Subtotal (line 21 minus line 22)	3,527,187		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,648		24
25	Adjusted reimbursable bad debts (see instructions)	2,371		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,432		26
27	Subtotal (sum of lines 23 and 25)	3,529,558		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)	4,184		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)	3,533,742		32
32.01	Sequestration adjustment (see instructions)	70,675		32.01
33	Interim payments	3,544,231		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	-81,164		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)			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. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2		13,342,816	2
3			3
4		13,342,816	4
5			5
6			6
7		13,342,816	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9	35,907,112	60,187,072	9
10			10
11			11
12	35,907,112	60,187,072	12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	35,907,112	60,187,072	16
17	35,907,112	46,844,256	17
18			18
19			19
20			20
21		13,342,816	21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26	32,141		26
27	32,141		27
28			28
29	32,141	13,342,816	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	32,141	13,342,816	31
32			32
33			33
34			34
35			35
36	32,141	13,342,816	36
37			37
38	32,141	13,342,816	38
39			39
40	32,141	13,342,816	40
41			41
42	32,141	13,342,816	42
43			43

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T012

WORKSHEET E-3
PART VII

Check Title V Hospital NF PPS
 Applicable Title XIX 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	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9	448,176		9
10			10
11			11
12	448,176		12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	448,176		16
17	448,176		17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26	203		26
27	203		27
28			28
29	203		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	203		31
32			32
33			33
34			34
35			35
36	203		36
37			37
38	203		38
39			39
40	203		40
41			41
42	203		42
43			43

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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 cal (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)			27.40	6
7	Enter the lesser of line 5 or line 6			27.40	7
		Primary Care 1	Other 2	Total 3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	26.40	1.00	27.40	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	26.40	1.00	27.40	9
10	Weighted dental and podiatric resident FTE count for the current year		5.00		10
11	Total weighted FTE count	26.40	6.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	26.67	4.25		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	24.96	4.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	26.01	4.75		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
17	Adjusted rolling average FTE count	26.01	4.75		17
18	Per resident amount	122,929.61	116,767.11		18
19	Approved amount for resident costs	3,197,399	554,644	3,752,043	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)			3,752,043	25
COMPUTATION OF PROGRAM PATIENT LOAD					
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	26,006	9,939		26
27	Total inpatient days (see instructions)	61,750	61,750		27
28	Ratio of inpatient days to total inpatient days	0.421150	0.160955		28
29	Program direct GME amount	1,580,173	603,910		29
30	Reduction for direct GME payments for Medicare Advantage		85,332		30
31	Net Program direct GME amount			2,098,751	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)			1,957,334	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)			65,446,258	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)			68,728	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			65,377,530	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			17,419,616	42
43	Primary payer payments (see instructions)			5,810	43
44	Total Part B reasonable cost (line 42 minus line 43)			17,413,806	44
45	Total reasonable cost (sum of lines 41 and 44)			82,791,336	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.789666	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.210334	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)			2,098,751	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			1,657,312	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			441,439	50

KPMG LLP Compu-Max 2552-10

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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

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				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 cal (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
		Primary Care 1	Other 2	Total 3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
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
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
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
COMPUTATION OF PROGRAM PATIENT LOAD					
26	Inpatient days (see instructions)	4,733	6,791		26
27	Total inpatient days (see instructions)	61,750	61,750		27
28	Ratio of inpatient days to total inpatient days	0.076648	0.109976		28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				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)				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)				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
Part B Reasonable Cost					
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
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART 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

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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	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	43,134,164				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	50,235,297				4
5	Other receivables	3,415,995				5
6	Allowances for uncollectible notes and accounts receivable	-8,568,127				6
7	Inventory	5,634,532				7
8	Prepaid expenses	1,791,607				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	95,643,468				11
FIXED ASSETS						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	312,075,185				15
16	Accumulated depreciation					16
17	Leasehold improvements					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					23
24	Accumulated depreciation					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)	312,075,185				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	3,178,012				34
35	Total other assets (sum of lines 31-34)	3,178,012				35
36	Total assets (sum of lines 11, 30 and 35)	410,896,665				36
Liabilities and Fund Balances (Omit Cents)						
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	12,835,791				37
38	Salaries, wages and fees payable	8,169,366				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	7,446,345				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	2,467,527				44
45	Total current liabilities (sum of lines 37 thru 44)	30,919,029				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	310,343,838				47
48	Unsecured loans					48
49	Other long term liabilities	3,106,795				49
50	Total long term liabilities (sum of lines 46 thru 49)	313,450,633				50
51	Total liabilities (sum of lines 45 and 50)	344,369,662				51
CAPITAL ACCOUNTS						
52	General fund balance	66,527,003				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)	66,527,003				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	410,896,665				60

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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		68,528,022		
2	Net income (loss) (from Worksheet G-3, line 29)		16,723,497		
3	Total (sum of line 1 and line 2)		85,251,519		
4	Additions (credit adjustments) (specify)	1,300,571			
5					
6					
7					
8					
9					
10	Total additions (sum of lines 4-9)		1,300,571		
11	Subtotal (line 3 plus line 10)		86,552,090		
12	Deductions (debit adjustments) (specify)	20,025,087			
13					
14					
15					
16					
17					
18	Total deductions (sum of lines 12-17)		20,025,087		
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		66,527,003		

		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					
6					
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)				

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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	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	469,864,629		469,864,629	1
2	Subprovider IPF				2
3	Subprovider IRF	14,308,521		14,308,521	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)	484,173,150		484,173,150	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	19,376,034		19,376,034	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	NEONATAL INTENSIVE CARE UNIT	8,988,852		8,988,852	15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	28,364,886		28,364,886	16
17	Total inpatient routine care services (sum of lines 10 and 16)	512,538,036		512,538,036	17
18	Ancillary services		383,959,580	383,959,580	18
19	Outpatient services		7,771,902	7,771,902	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
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	512,538,036	391,731,482	904,269,518	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		284,093,053	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)		284,093,053	43

KPMG LLP Compu-Max 2552-10

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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)	904,269,518	1
2	Less contractual allowances and discounts on patients' accounts	608,764,891	2
3	Net patient revenues (line 1 minus line 2)	295,504,627	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	284,093,053	4
5	Net income from service to patients (line 3 minus line 4)	11,411,574	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 (OTHER REVENUE)	5,902,784	24
24.01	Other (NON-OPERATING ITEMS)	-590,861	24.01
25	Total other income (sum of lines 6-24)	5,311,923	25
26	Total (line 5 plus line 25)	16,723,497	26
29	Net income (or loss) for the period (line 26 minus line 28)	16,723,497	29

KPMG LLP Compu-Max 2552-10

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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	3,295,294	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	241,309	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)	156.75	3
4	Number of interns & residents (see instructions)	27.13	4
5	Indirect medical education percentage (see instructions)	5.01	5
6	Indirect medical education adjustment (see instructions)	165,094	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0355	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1863	8
9	Sum of lines 7 and 8	0.2218	9
10	Allowable disproportionate share percentage (see instructions)	0.0459	10
11	Disproportionate share adjustment (see instructions)	151,254	11
12	Total prospective capital payments (see instructions)	3,852,951	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

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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

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ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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	
	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
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMED ED PRGM-(SPECIFY)						23
23.01	CLINICAL PASTORAL EDUCATION						23.01
23.02	PHARMACY RESIDENCY PROGRAM						23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
35	NEONATAL INTENSIVE CARE UNIT						35
41	Subprovider - IRF						41
43	Nursery						43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
51	Recovery Room						51
52	Delivery Room & Labor Room						52
54	Radiology-Diagnostic						54
55	Radiology-Therapeutic						55
57	CT Scan						57
58	MRI						58
59	Cardiac Catheterization						59
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology						69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	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
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192

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ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 15:32 Version: 2015.10 (11/24/2015)
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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		
192.01	MATERNAL FETAL MEDICINE/LABORIST	0						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
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202