

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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 Date: 11/29/2017 Time: 10:59 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.		
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 ST. JOSEPH'S REG MED CENTER S. BEND (15-0012) (Provider Name(s) and Number(s); for the cost reporting period beginning 07/01/2016 and ending 06/30/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ECR Encryption: 11/29/2017 10:59
 EiEtm3W2zQFxl8xECimZ1iXDKE.my0
 y.xYV0lzUIGWoF9AQvsFc2qUzaWG2P
 77g01uy0500t13JK

(Signed) 
 Officer or Administrator of Provider(s)
 Title CFO
 Date 11/29/17

PI Encryption: 11/29/2017 10:59
 Ft9zsp2Y0dCAAdGr9k5bciBS0I2RRk0
 jdt.z0VhmZTedu6rMSd7YX.C0skSxh
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PART III - SETTLEMENT SUMMARY

		TITLE XVIII			HIT	TITLE XIX	
		TITLE V	PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL						
2	SUBPROVIDER - IPF		431,314	175,560		23,005,908	1
3	SUBPROVIDER - IRF		27,337	2,685		179	3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FOHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		458,651	178,245		23,006,087	200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

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

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2016	To: 06 / 30 / 2017	20
21	Type of control (see instructions)	1		21

Inpatient PPS Information

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
	1	2	3	4	5	6		
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,155	850	90	110	11,045	415	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.	52	7			304		25

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

		1	2		
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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	
		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N	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	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	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	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)	N	N		76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers

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

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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:				118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, 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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--	---------------------------------------	--	--

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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	HHH	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 transition factor. (see instructions)	9.99				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07 / 01 / 2015	06 / 30 / 2016			170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0			171

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	11/01/2017	Y	11/01/2017
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

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

Capital Related Cost		
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	27

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

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

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

Home Office Costs		Y/N	Date	
		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information			
41	First name: MAUREEN	Last name: DELAHANTY	Title: REIMBURSEMENT MANAGER
42	Employer: SAINT JOSEPH REGIONAL MEDICAL CENTER		
43	Phone number: 574-335-4652	E-mail Address: NIETCHC@SJRMC.COM	

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	213	77,745			22,266	1,728	51,423	1
2	HMO and other (see instructions)						9,875	11,304		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider						373	304		4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		213	77,745			22,266	1,728	51,423	7
8	Intensive Care Unit	31	28	10,220			1,795	190	4,716	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				544	1,174	12
13	Nursery	43						484	6,198	13
14	Total (see instructions)		253	92,345			24,061	2,946	63,511	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41	40	14,600			2,143	59	3,399	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							83	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)		293							27
28	Observation Bed Days							1,263	6,080	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								867	30
31	Employee discount days-IRF								105	31
32	Labor & delivery (see instructions)		4	1,460			3	415	732	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)					5,120	315	14,376	1
2	HMO and other (see instructions)					2,072	1,900		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider						13		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)	32.53	1,491.40	533.00		5,120	315	14,376	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF					173	3	270	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)	32.53	1,491.40	533.00					27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	89,488,923		89,488,923	3,272,356.00	27.35	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative		359,547		359,547	1,849.00	194.45	4
4.01	Physician-Part A - Teaching		2,236,531		2,236,531	27,857.00	80.29	4.01
5	Physician-Part B		169,223		169,223	2,230.00	75.88	5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21	1,557,222	343,253	1,900,475	71,050.00	26.75	7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		6,578,194	-202,214	6,375,980	207,251.00	30.76	10
OTHER WAGES & RELATED COSTS								
11	Contract labor (see instructions)		1,824,741		1,824,741	29,250.00	62.38	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		867,718		867,718	5,115.00	169.64	13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		47,955,859		47,955,859	596,622.00	80.38	14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
WAGE-RELATED COSTS								
17	Wage-related costs (core)(see instructions)		28,391,737		28,391,737			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		1,427,468	-43,880	1,383,588			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative		78,022		78,022			22
22.01	Physician Part A - Teaching		485,327		485,327			22.01
23	Physician Part B		36,721		36,721			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)		337,917	74,486	412,403			25
25.50	Home office wage-related		13,290,449		13,290,449			25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
OVERHEAD COSTS - DIRECT SALARIES								
26	Employee Benefits Department		63,136		63,136	117.00	539.62	26
27	Administrative & General		2,845,804	257,972	3,103,776	131,387.00	23.62	27
28	Administrative & General under contract (see instructions)		335,158		335,158	4,246.00	78.93	28
29	Maintenance & Repairs							29
30	Operation of Plant		1,852,911		1,852,911	73,015.00	25.38	30
31	Laundry & Linen Service							31
32	Housekeeping		1,429,279		1,429,279	114,150.00	12.52	32
33	Housekeeping under contract (see instructions)		124,800		124,800	2,080.00	60.00	33
34	Dietary		2,044,660	-695,184	1,349,476	95,374.00	14.15	34
35	Dietary under contract (see instructions)		256,161		256,161	6,240.00	41.05	35
36	Cafeteria			695,184	695,184	49,132.00	14.15	36
37	Maintenance of Personnel							37
38	Nursing Administration		2,572,641		2,572,641	90,172.00	28.53	38
39	Central Services and Supply		519,653		519,653	31,998.00	16.24	39
40	Pharmacy		3,409,296	-55,803	3,353,493	82,153.00	40.82	40
41	Medical Records & Medical Records Library		1,901,349		1,901,349	83,749.00	22.70	41
42	Social Service		2,089,746		2,089,746	62,023.00	33.69	42
43	Other General Service		752,528		752,528	45,258.00	16.63	43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		86,242,066	-343,253	85,898,813	3,183,785.00	26.98	1
2	Excluded area salaries (see instructions)		6,578,194	-202,214	6,375,980	207,251.00	30.76	2
3	Subtotal salaries (line 1 minus line 2)		79,663,872	-141,039	79,522,833	2,976,534.00	26.72	3
4	Subtotal other wages & related costs (see instructions)		50,648,318		50,648,318	630,987.00	80.27	4
5	Subtotal wage-related costs (see instructions)		41,760,208		41,760,208		52.51%	5
6	Total (sum of lines 3 through 5)		172,072,398	-141,039	171,931,359	3,607,521.00	47.66	6
7	Total overhead cost (see instructions)		20,197,122	202,169	20,399,291	871,094.00	23.42	7

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	1,091,798	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)	8,321,258	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees	393,456	7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	10,633,374	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan	2,922,642	9
10	Dental, Hearing and Vision Plan	591,307	10
11	Life Insurance (If employee is owner or beneficiary)	120,171	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	588,127	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	253,255	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	33,948	16
	TAXES		
17	FICA-Employers Portion Only	5,828,762	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	9,700	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	30,787,798	24

Part B - Other Than Core Related Cost

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

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)		0.295335	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		45,589,000	2
3	Did you receive DSH or supplemental payments from Medicaid?		Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid			5
6	Medicaid charges		182,440,000	6
7	Medicaid cost (line 1 times line 6)		53,880,917	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		8,291,917	8

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

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

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

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

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

17	Private grants, donations, or endowment income restricted to fundng charity care			17
18	Government grants, appropriations of transfers for support of hospital operations			18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		8,291,917	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	15,420,236	4,233,531	19,653,767	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,554,135	4,233,531	8,787,666	21
22	Payments received from patients for amounts previously written off as charity care	136,046	157,622	293,668	22
23	Cost of charity care (line 21 minus line 22)	4,418,089	4,075,909	8,493,998	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit			25
26	Total bad debt expense for the entire hospital complex (see instructions)		24,047,581	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		837,718	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,288,795	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)		22,758,786	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		7,172,543	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		15,666,541	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		23,958,458	31

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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				18,944,993	18,944,993	3,662,857	22,607,850	1
2	00200	Cap Rel Costs-Mvble Equip				12,036,162	12,036,162		12,036,162	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	63,136	2,825,259	2,888,395		2,888,395	680,376	3,568,771	4
5.01	00540	NONPATIENT TELEPHONES	229,086	65,924	295,010		295,010	10,617	305,627	5.01
5.04	00570	ADMITTING	1,092,070	395,018	1,487,088		1,487,088		1,487,088	5.04
5.06	00590	OTHER ADMINISTRATIVE & GENERAL	1,524,648	85,468,299	86,992,947	-18,607,387	68,385,560	25,816,624	94,202,184	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,852,911	7,233,090	9,086,001	-718,414	8,367,587	-603,987	7,763,600	7
8	00800	Laundry & Linen Service		1,025,597	1,025,597	-29,765	995,832		995,832	8
9	00900	Housekeeping	1,429,279	1,428,312	2,857,591	-1,599	2,855,992		2,855,992	9
10	01000	Dietary	2,044,660	3,460,230	5,504,890	-2,269,377	3,235,513	-264,918	2,970,595	10
11	01100	Cafeteria				2,079,276	2,079,276	-2,065,624	13,652	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	2,572,641	906,404	3,479,045	-276,892	3,202,153	-56,281	3,145,872	13
14	01400	Central Services & Supply	519,653	489,724	1,009,377	-10,193	999,184	-589	998,595	14
15	01500	Pharmacy	3,409,296	17,159,130	20,568,426	-16,723,419	3,845,007	-10,602	3,834,405	15
16	01600	Medical Records & Library	1,901,349	1,303,246	3,204,595	-22,076	3,182,519	-635	3,181,884	16
17	01700	Social Service	2,089,746	633,137	2,722,883	-250	2,722,633	-1,372	2,721,261	17
18	01850	STERILE SUPPLY	752,528	1,587,675	2,340,203	-122,511	2,217,692		2,217,692	18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	1,557,222	658,086	2,215,308	192,758	2,408,066	-179,760	2,228,306	21
22	02200	I&R Services-Other Prgm Costs Apprvd	2,059,572	625,699	2,685,271	88,603	2,773,874	-140,616	2,633,258	22
23	02300	PARAMED ED PRGM-(SPECIFY)	79,790	170,741	250,531	-618	249,913	-91,528	158,385	23
23.01	02301	CLINICAL PASTORAL EDUCATION	-7,831	-113	-7,944	7,944				23.01
23.02	02302	PHARMACY RESIDENCY PROGRAM	386,598	99,957	486,555	-229,964	256,591		256,591	23.02
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	21,136,065	8,230,303	29,366,368	-4,646,621	24,719,747	-15,882	24,703,865	30
31	03100	Intensive Care Unit	3,500,558	1,215,864	4,716,422	-162,554	4,553,868	-30,291	4,523,577	31
35	02060	NEONATAL INTENSIVE CARE UNIT	2,039,518	1,021,938	3,061,456	-82,088	2,979,368	-2,185	2,977,183	35
41	04100	Subprovider - IRF	1,577,753	2,442,631	4,020,384	-1,645,168	2,375,216	184,954	2,560,170	41
43	04300	Nursery				3,479,198	3,479,198		3,479,198	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	9,691,476	37,543,436	47,234,912	-21,106,217	26,128,695	-2,024,552	24,104,143	50
51	05100	Recovery Room	1,033,122	468,644	1,501,766	-4,795	1,496,971		1,496,971	51
52	05200	Delivery Room & Labor Room				1,009,022	1,009,022		1,009,022	52
54	05400	Radiology-Diagnostic	3,561,947	3,547,903	7,109,850	-1,549,151	5,560,699	-99,170	5,461,529	54
55	05500	Radiology-Therapeutic	232,399	180,986	413,385	-20,700	392,685	-121,866	270,819	55
57	05700	CT Scan	701,009	739,870	1,440,879	-288,595	1,152,284		1,152,284	57
58	05800	MRI		452,151	452,151		452,151		452,151	58
59	05900	Cardiac Catheterization	2,633,677	10,902,065	13,535,742	-5,757,549	7,778,193	-27,367	7,750,826	59
60	06000	Laboratory		11,795,812	11,795,812	-458,255	11,337,557		11,337,557	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	1,688,273	1,513,870	3,202,143	-257,939	2,944,204	-3,000	2,941,204	65
66	06600	Physical Therapy	2,535,148	882,077	3,417,225	-296,961	3,120,264	-3,199	3,117,065	66
67	06700	Occupational Therapy	734,881	364,441	1,099,322	-167,823	931,499		931,499	67
68	06800	Speech Pathology	409,367	91,334	500,701	-17,236	483,465		483,465	68
69	06900	Electrocardiology	893,188	833,209	1,726,397	-437,757	1,288,640	-196	1,288,444	69
71	07100	Medical Supplies Charged to Patients		-544,956	-544,956	544,956				71
72	07200	Impl. Dev. Charged to Patients				22,879,728	22,879,728		22,879,728	72
73	07300	Drugs Charged to Patients	342,429	402,780	745,209	16,362,601	17,107,810		17,107,810	73
74	07400	Renal Dialysis	-45	971,725	971,680	45	971,725		971,725	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				55,800	55,800		55,800	76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic								90
90.02	09001	MOBILE MEDICAL UNIT	82,658	138,041	220,699	-103,686	117,013	-58,620	58,393	90.02
90.03	09002	FAMILY MEDICINE CENTER	676,864	928,167	1,605,031	-309,657	1,295,374	-103,764	1,191,610	90.03
90.04	09003	WOUND HEALING CENTER	513,694	1,277,056	1,790,750	-387,798	1,402,952		1,402,952	90.04
90.05	09004	OUTPATIENT TREATMENT & INFUSION	549,432	118,189	667,621		667,621		667,621	90.05
90.06	09005	PEDIATRIC SPECIALTY CLINIC	274,840	420,431	695,271	-99,057	596,214	-262,235	333,979	90.06
90.07	09006	SPORTS MED FELLOWSHIP CLINIC	558,057	247,895	805,952	-159,858	646,094	-3,555	642,539	90.07
90.08	09007	PODIATRY RESIDENCY CLINIC	389,719	243,944	633,663	-384,614	249,049	-785	248,264	90.08
90.09	09008	FACULTY PRACTICE CLINIC	447,984	299,587	747,571	-69,868	677,703	-175	677,528	90.09
90.10	09009	OUR LADY OF ROSARY CLINIC	397,405	426,839	824,244	-211,698	612,546	-3,805	608,741	90.10
91	09100	Emergency	4,789,267	2,100,494	6,889,761	-31,311	6,858,450	-122,772	6,735,678	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	
113	11300	Interest Expense								113
118		SUBTOTALS (sum of lines 1-117)	84,947,039	214,792,141	299,739,180	11,665	299,750,845	24,056,097	323,806,942	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		1,538,235	1,538,235		1,538,235		1,538,235	192.01
192.02	19202	NEONATOLOGISTS	1,366,620	241,692	1,608,312		1,608,312		1,608,312	192.02
192.03	19203	HOSPITALISTS/INTENSIVISTS	349,189	5,211,862	5,561,051		5,561,051		5,561,051	192.03
194	07950	SPORTS MED-ATHLETIC TRAINERS	197,858	45,951	243,809		243,809		243,809	194
194.01	07951	OUTREACH SERVICES	2,251,021	861,754	3,112,775		3,112,775		3,112,775	194.01
194.02	07952	KINDRED/OUR LADY OF PEACE								194.02
194.03	07953	ADVANCED SPECIALTIES		144,531	144,531		144,531		144,531	194.03
194.04	07954	AMBULATORY PHARMACY SERVICES	377,196	56,549	433,745	-11,665	422,080		422,080	194.04
200		TOTAL (sum of lines 118-199)	89,488,923	222,892,715	312,381,638		312,381,638	24,056,097	336,437,735	200

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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		544,956	1
2			Renal Dialysis	74	45		2
500	Total reclassifications Code Letter - A				45	544,956	500
1	DEPRECIATION RECLASS	B	Cap Rel Costs-Bldg & Fixt	1		4,248,773	1
2			Cap Rel Costs-Mvble Equip	2		3,623,357	2
3			Cap Rel Costs-Bldg & Fixt	1		32,725	3
4			Cap Rel Costs-Mvble Equip	2		792	4
5			Cap Rel Costs-Bldg & Fixt	1		78,141	5
6			Cap Rel Costs-Mvble Equip	2		639,481	6
7			Cap Rel Costs-Mvble Equip	2		29,765	7
8			Cap Rel Costs-Mvble Equip	2		1,599	8
9			Cap Rel Costs-Bldg & Fixt	1		18,372	9
10			Cap Rel Costs-Mvble Equip	2		171,729	10
11			Cap Rel Costs-Bldg & Fixt	1		1,077	11
12			Cap Rel Costs-Mvble Equip	2		275,815	12
13			Cap Rel Costs-Mvble Equip	2		10,193	13
14			Cap Rel Costs-Bldg & Fixt	1		75	14
15			Cap Rel Costs-Mvble Equip	2		294,733	15
16			Cap Rel Costs-Bldg & Fixt	1		20,700	16
17			Cap Rel Costs-Mvble Equip	2		1,376	17
18			Cap Rel Costs-Mvble Equip	2		250	18
19			Cap Rel Costs-Bldg & Fixt	1		7,548	19
20			Cap Rel Costs-Mvble Equip	2		114,963	20
21			Cap Rel Costs-Bldg & Fixt	1		156,319	21
22			Cap Rel Costs-Mvble Equip	2		76	22
23			Cap Rel Costs-Mvble Equip	2		618	23
24			Cap Rel Costs-Mvble Equip	2		17,666	24
25			Cap Rel Costs-Bldg & Fixt	1		2,191	25
26			Cap Rel Costs-Mvble Equip	2		138,544	26
27			Cap Rel Costs-Bldg & Fixt	1		39,788	27
28			Cap Rel Costs-Mvble Equip	2		122,766	28
29			Cap Rel Costs-Bldg & Fixt	1		3,371	29
30			Cap Rel Costs-Mvble Equip	2		78,717	30
31			Cap Rel Costs-Bldg & Fixt	1		2,502	31
32			Cap Rel Costs-Bldg & Fixt	1		926,664	32
33			Cap Rel Costs-Bldg & Fixt	1		2,438	33
34			Cap Rel Costs-Mvble Equip	2		68,257	34
35			Cap Rel Costs-Mvble Equip	2		99,922	35
36			Cap Rel Costs-Mvble Equip	2		80,383	36
37			Cap Rel Costs-Bldg & Fixt	1		46,640	37
38			Cap Rel Costs-Mvble Equip	2		2,329,172	38
39			Cap Rel Costs-Mvble Equip	2		4,795	39
40			Cap Rel Costs-Bldg & Fixt	1		278,372	40
41			Cap Rel Costs-Bldg & Fixt	1		128,253	41
42			Cap Rel Costs-Mvble Equip	2		127,462	42
43			Cap Rel Costs-Mvble Equip	2		1,015,064	43
44			Cap Rel Costs-Bldg & Fixt	1		20,700	44
45			Cap Rel Costs-Mvble Equip	2		288,595	45
46			Cap Rel Costs-Mvble Equip	2		2,250	46
47			Cap Rel Costs-Bldg & Fixt	1		27,485	47
48			Cap Rel Costs-Mvble Equip	2		1,696,459	48
49			Cap Rel Costs-Bldg & Fixt	1		140,730	49
50			Cap Rel Costs-Mvble Equip	2		20,061	50
51			Cap Rel Costs-Bldg & Fixt	1		160,469	51
52			Cap Rel Costs-Mvble Equip	2		171	52
53			Cap Rel Costs-Mvble Equip	2		97,299	53
54			Cap Rel Costs-Bldg & Fixt	1		283,736	54
55			Cap Rel Costs-Mvble Equip	2		8,921	55
56			Cap Rel Costs-Mvble Equip	2		260	56
57			Cap Rel Costs-Mvble Equip	2		4,044	57
58			Cap Rel Costs-Bldg & Fixt	1		167,433	58
59			Cap Rel Costs-Mvble Equip	2		390	59
60			Cap Rel Costs-Bldg & Fixt	1		9,185	60
61			Cap Rel Costs-Mvble Equip	2		8,051	61
62			Cap Rel Costs-Bldg & Fixt	1		186,464	62
63			Cap Rel Costs-Bldg & Fixt	1		467	63
64			Cap Rel Costs-Mvble Equip	2		99,363	64
65			Cap Rel Costs-Mvble Equip	2		151,463	65
66			Cap Rel Costs-Mvble Equip	2		1,446	66
67			Cap Rel Costs-Mvble Equip	2		34,039	67
68			Cap Rel Costs-Mvble Equip	2		69,647	68
69			Cap Rel Costs-Bldg & Fixt	1		251,655	69
70			Cap Rel Costs-Bldg & Fixt	1		8,062	70
71			Cap Rel Costs-Mvble Equip	2		49,940	71

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
72			Cap Rel Costs-Bldg & Fixt	1		121,410	72
73			Cap Rel Costs-Bldg & Fixt	1		1,046	73
74			Cap Rel Costs-Mvble Equip	2		13,586	74
75			Cap Rel Costs-Bldg & Fixt	1		94,103	75
76			Cap Rel Costs-Bldg & Fixt	1		1,292	76
77			Cap Rel Costs-Mvble Equip	2		3,589	77
78			Cap Rel Costs-Mvble Equip	2		73	78
79			Cap Rel Costs-Bldg & Fixt	1		59,901	79
80			Cap Rel Costs-Mvble Equip	2		3,731	80
81			Cap Rel Costs-Bldg & Fixt	1		43,084	81
82			Cap Rel Costs-Bldg & Fixt	1		69,868	82
83			Cap Rel Costs-Bldg & Fixt	1		5,325	83
84			Cap Rel Costs-Mvble Equip	2		206,373	84
85			Cap Rel Costs-Mvble Equip	2		28,916	85
500	Total reclassifications					19,682,526	500
	Code Letter - B						
1	RECLASS CLOSED CPE PROG TO A&G	C	CLINICAL PASTORAL EDUCATION	23.01		7,831	113
500	Total reclassifications					7,831	113
	Code Letter - C						
1	RECLASS CAFETERIA FROM DIETARY	D	Cafeteria	11		695,184	1,384,092
500	Total reclassifications					695,184	1,384,092
	Code Letter - D						
1	RECLASS DRUGS	E	Drugs Charged to Patients	73			16,364,047
500	Total reclassifications						16,364,047
	Code Letter - E						
1	RECLASS INTEREST EXPENSE	F	Interest Expense	113			10,455,780
2			Interest Expense	113			545,385
3			Cap Rel Costs-Bldg & Fixt	1			10,455,780
4			Cap Rel Costs-Bldg & Fixt	1			545,385
500	Total reclassifications						22,002,330
	Code Letter - F						
1	RECLASS HYPERBARIC FROM WOUND CARE	G	HYPERBARIC OXYGEN THERAPY	76.98		54,762	1,038
500	Total reclassifications					54,762	1,038
	Code Letter - G						
1	OBSTETRIC RECLASS TO L&D AND NURSER	H	Delivery Room & Labor Room	52		629,878	379,144
2			Nursery	43		2,171,876	1,307,322
500	Total reclassifications					2,801,754	1,686,466
	Code Letter - H						
1	SBMF CAPITAL RECLASS	I	Cap Rel Costs-Bldg & Fixt	1			297,464
500	Total reclassifications						297,464
	Code Letter - I						
1	RECLASS IMPLANTS	J	Impl. Dev. Charged to Patient	72			18,650,022
2			Impl. Dev. Charged to Patient	72			4,031,355
3			Impl. Dev. Charged to Patient	72			195,956
4			Impl. Dev. Charged to Patient	72			2,395
500	Total reclassifications						22,879,728
	Code Letter - J						
1	RECLS 2ND YR PHARM RES TO A & G	K	OTHER ADMINISTRATIVE & GENERA	5.06		265,848	40,345
2	RECLS PHARM RES PRECEPTORS	K	PHARMACY RESIDENCY PROGRAM	23.02		55,803	8,761
3	RECLS PHARM RES PRECEPTORS	K	PHARMACY RESIDENCY PROGRAM	23.02		10,147	1,518
500	Total reclassifications					331,798	50,624
	Code Letter - K						
1	RESIDENT OT OTHER MEDICAL EDUCATION	M	I&R Services-Other Prgm Costs	22			244,998
500	Total reclassifications						244,998
	Code Letter - M						
1	RECLASS PODIATRY-SPS MED TO MED ED	N	I&R Services-Salary & Fringes	21		76,977	19,249
2			I&R Services-Salary & Fringes	21		266,276	75,254
500	Total reclassifications					343,253	94,503
	Code Letter - N						
	GRAND TOTAL (Increases)					4,234,627	85,232,885

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

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
		COST CENTER	LINE #	SALARY	OTHER	
	1	2	3	4	5	

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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		544,956	1	
2			OTHER ADMINISTRATIVE & GENERA	5.06	45		2	
500	Total reclassifications				45	544,956	500	
	Code letter - A							
1	DEPRECIATION RECLASS	B	OTHER ADMINISTRATIVE & GENERA	5.06		4,248,773	9	
2			OTHER ADMINISTRATIVE & GENERA	5.06		3,623,357	9	
3			OTHER ADMINISTRATIVE & GENERA	5.06		32,725	10	
4			Operation of Plant	7		792	10	
5			Operation of Plant	7		78,141	9	
6			Operation of Plant	7		639,481	9	
7			Laundry & Linen Service	8		29,765	9	
8			Housekeeping	9		1,599	9	
9			Dietary	10		18,372	9	
10			Dietary	10		171,729	9	
11			Nursing Administration	13		1,077	9	
12			Nursing Administration	13		275,815	9	
13			Central Services & Supply	14		10,193	9	
14			Pharmacy	15		75	9	
15			Pharmacy	15		294,733	9	
16			Medical Records & Library	16		20,700	10	
17			Medical Records & Library	16		1,376	9	
18			Social Service	17		250	10	
19			STERILE SUPPLY	18		7,548	9	
20			STERILE SUPPLY	18		114,963	9	
21			I&R Services-Other Prgm Costs	22		156,319	10	
22			I&R Services-Other Prgm Costs	22		76	9	
23			PARAMED ED PRGM-(SPECIFY)	23		618	9	
24			Adults & Pediatrics	30		17,666	10	
25			Adults & Pediatrics	30		2,191	9	
26			Adults & Pediatrics	30		138,544	9	
27			Intensive Care Unit	31		39,788	9	
28			Intensive Care Unit	31		122,766	9	
29			NEONATAL INTENSIVE CARE UNIT	35		3,371	9	
30			NEONATAL INTENSIVE CARE UNIT	35		78,717	9	
31			Subprovider - IRF	41		2,502	10	
32			Subprovider - IRF	41		926,664	14	
33			Subprovider - IRF	41		2,438	9	
34			Subprovider - IRF	41		68,257	9	
35			Subprovider - IRF	41		99,922	9	
36			Operating Room	50		80,383	10	
37			Operating Room	50		46,640	9	
38			Operating Room	50		2,329,172	9	
39			Recovery Room	51		4,795	9	
40			Radiology-Diagnostic	54		278,372	10	
41			Radiology-Diagnostic	54		128,253	9	
42			Radiology-Diagnostic	54		127,462	9	
43			Radiology-Diagnostic	54		1,015,064	9	
44			Radiology-Therapeutic	55		20,700	10	
45			CT Scan	57		288,595	9	
46			Cardiac Catheterization	59		2,250	10	
47			Cardiac Catheterization	59		27,485	9	
48			Cardiac Catheterization	59		1,696,459	9	
49			Laboratory	60		140,730	10	
50			Laboratory	60		20,061	9	
51			Respiratory Therapy	65		160,469	10	
52			Respiratory Therapy	65		171	10	
53			Respiratory Therapy	65		97,299	9	
54			Physical Therapy	66		283,736	10	
55			Physical Therapy	66		8,921	10	
56			Physical Therapy	66		260	9	
57			Physical Therapy	66		4,044	9	
58			Occupational Therapy	67		167,433	10	
59			Occupational Therapy	67		390	9	
60			Speech Pathology	68		9,185	10	
61			Speech Pathology	68		8,051	9	
62			Electrocardiology	69		186,464	10	
63			Electrocardiology	69		467	9	
64			Electrocardiology	69		99,363	9	
65			Electrocardiology	69		151,463	9	
66			Drugs Charged to Patients	73		1,446	9	
67			MOBILE MEDICAL UNIT	90.02		34,039	9	
68			MOBILE MEDICAL UNIT	90.02		69,647	9	
69			FAMILY MEDICINE CENTER	90.03		251,655	10	
70			FAMILY MEDICINE CENTER	90.03		8,062	9	

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	
71			FAMILY MEDICINE CENTER	90.03		49,940	9	71
72			WOUND HEALING CENTER	90.04		121,410	10	72
73			WOUND HEALING CENTER	90.04		1,046	9	73
74			WOUND HEALING CENTER	90.04		13,586	9	74
75			PEDIATRIC SPECIALTY CLINIC	90.06		94,103	10	75
76			PEDIATRIC SPECIALTY CLINIC	90.06		1,292	9	76
77			PEDIATRIC SPECIALTY CLINIC	90.06		3,589	9	77
78			PEDIATRIC SPECIALTY CLINIC	90.06		73	9	78
79			SPORTS MED FELLOWSHIP CLINIC	90.07		59,901	10	79
80			SPORTS MED FELLOWSHIP CLINIC	90.07		3,731	9	80
81			PODIATRY RESIDENCY CLINIC	90.08		43,084	10	81
82			FACULTY PRACTICE CLINIC	90.09		69,868	10	82
83			OUR LADY OF ROSARY CLINIC	90.10		5,325	10	83
84			OUR LADY OF ROSARY CLINIC	90.10		206,373	9	84
85			Emergency	91		28,916	9	85
500	Total reclassifications					19,682,526		500
	Code letter - B							
1	RECLASS CLOSED CPE PROG TO A&G	C	OTHER ADMINISTRATIVE & GENERA	5.06	7,831	113		1
500	Total reclassifications				7,831	113		500
	Code letter - C							
1	RECLASS CAFETERIA FROM DIETARY	D	Dietary	10	695,184	1,384,092		1
500	Total reclassifications				695,184	1,384,092		500
	Code letter - D							
1	RECLASS DRUGS	E	Pharmacy	15		16,364,047		1
500	Total reclassifications					16,364,047		500
	Code letter - E							
1	RECLASS INTEREST EXPENSE	F	OTHER ADMINISTRATIVE & GENERA	5.06		10,455,780	11	1
2			Subprovider - IRF	41		545,385	11	2
3			Interest Expense	113		10,455,780	11	3
4			Interest Expense	113		545,385	11	4
500	Total reclassifications					22,002,330		500
	Code letter - F							
1	RECLASS HYPERBARIC FROM WOUND CARE	G	WOUND HEALING CENTER	90.04	54,762	1,038		1
500	Total reclassifications				54,762	1,038		500
	Code letter - G							
1	OBSTETRIC RECLASS TO L&D AND NURSER	H	Adults & Pediatrics	30	629,878	379,144		1
2			Adults & Pediatrics	30	2,171,876	1,307,322		2
500	Total reclassifications				2,801,754	1,686,466		500
	Code letter - H							
1	SBMF CAPITAL RECLASS	I	Laboratory	60		297,464	9	1
500	Total reclassifications					297,464		500
	Code letter - I							
1	RECLASS IMPLANTS	J	Operating Room	50		18,650,022		1
2			Cardiac Catheterization	59		4,031,355		2
3			WOUND HEALING CENTER	90.04		195,956		3
4			Emergency	91		2,395		4
500	Total reclassifications					22,879,728		500
	Code letter - J							
1	RECLS 2ND YR PHARM RES TO A & G	K	PHARMACY RESIDENCY PROGRAM	23.02	265,848	40,345		1
2	RECLS PHARM RES PRECEPTORS	K	Pharmacy	15	55,803	8,761		2
3	RECLS PHARM RES PRECEPTORS	K	AMBULATORY PHARMACY SERVICES	194.04	10,147	1,518		3
500	Total reclassifications				331,798	50,624		500
	Code letter - K							
1	RESIDENT OT OTHER MEDICAL EDUCATION	M	I&R Services-Salary & Fringes	21		244,998		1
500	Total reclassifications					244,998		500
	Code letter - M							
1	RECLASS PODIATRY-SPS MED TO MED ED	N	SPORTS MED FELLOWSHIP CLINIC	90.07	76,977	19,249		1
2			PODIATRY RESIDENCY CLINIC	90.08	266,276	75,254		2
500	Total reclassifications				343,253	94,503		500
	Code letter - N							
	GRAND TOTAL (Decreases)				4,234,627	85,232,885		

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.
			COST CENTER	LINE #	SALARY	OTHER	
		1	6	7	8	9	10

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

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	820,349	-414,327		-414,327		406,022		1
2	Land Improvements								2
3	Buildings and Fixtures	205,768,521	3,531,063		3,531,063	132,437	209,167,147	2,347,453	3
4	Building Improvements	1,811,146	2,340,634		2,340,634		4,151,780	35,232	4
5	Fixed Equipment								5
6	Movable Equipment	194,021,332	5,992,871		5,992,871	724,251	199,289,952	32,672,526	6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	402,421,348	11,450,241		11,450,241	856,688	413,014,901	35,055,211	8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	402,421,348	11,450,241		11,450,241	856,688	413,014,901	35,055,211	10

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

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

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

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

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	8,575,340	2,104,681	11,001,165			926,664	22,607,850	1	
2	Cap Rel Costs-Mvble Equip	11,925,729	110,433					12,036,162	2	
3	Total (sum of lines 1-2)	20,501,069	2,215,114	11,001,165			926,664	34,644,012	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.)

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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
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)					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	12,417	NONPATIENT TELEPHONES	5.01	7
8	Television and radio service (chapter 21)	A	35,947	Operation of Plant	7	8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-2,502,707			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	17,654,081			12
13	Laundry and linen service					13
14	Cafeteria - employees and guests	B	-1,934,241	Cafeteria	11	14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients	B	-518	Pharmacy	15	17
18	Sale of medical records and abstracts					18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines	B	-131,383	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	966,145	OTHER ADMINISTRATIVE & GENERAL	5.06	33
33.01	DONATIONS	A	180	Social Service	17	33.01
34	MEDICAID PROVIDER BED TAX	A	14,080,871	OTHER ADMINISTRATIVE & GENERAL	5.06	34
34.01	PROPERTY TAX	A	193,963	Subprovider - IRF	41	34.01
35	PURCHASE DISCOUNTS	A	-6,980	OTHER ADMINISTRATIVE & GENERAL	5.06	35
35.01	PURCHASE DISCOUNTS	A	-589	Central Services & Supply	14	35.01
36	INTERNATIONAL MEDICINE	A	5,819	OTHER ADMINISTRATIVE & GENERAL	5.06	36
37	OTHER REVENUE	B	-1,800	NONPATIENT TELEPHONES	5.01	37
38	OTHER REVENUE	B	-2,540,079	OTHER ADMINISTRATIVE & GENERAL	5.06	38
39	OTHER REVENUE	B	-639,934	Operation of Plant	7	39
40	OTHER REVENUE	B	-264,918	Dietary	10	40
41	OTHER REVENUE	B	-55,927	Nursing Administration	13	41
42	OTHER REVENUE	B	-10,084	Pharmacy	15	42
43	OTHER REVENUE	B	-132	Medical Records & Library	16	43
44	OTHER REVENUE	B	-1,552	Social Service	17	44
45	OTHER REVENUE	B	-179,760	I&R Services-Salary & Fringes Apprvd	21	45
46	OTHER REVENUE	B	-140,616	I&R Services-Other Prgm Costs Apprvd	22	46
47	OTHER REVENUE	B	-38,187	PARAMED ED PRGM-(SPECIFY)	23	47
47.10	OTHER REVENUE	B	-15,882	Adults & Pediatrics	30	47.10
47.20	OTHER REVENUE	B	-1,566	Intensive Care Unit	31	47.20
47.30	OTHER REVENUE	B	-2,185	NEONATAL INTENSIVE CARE UNIT	35	47.30
47.40	OTHER REVENUE	B	-9,009	Subprovider - IRF	41	47.40
47.50	OTHER REVENUE	B	1,220	Operating Room	50	47.50
47.60	OTHER REVENUE	B	-6,522	Radiology-Diagnostic	54	47.60
47.70	OTHER REVENUE	B	-115,921	Radiology-Therapeutic	55	47.70
47.80	OTHER REVENUE	B	-1,886	Cardiac Catheterization	59	47.80
47.90	OTHER REVENUE	B	-3,000	Respiratory Therapy	65	47.90
48	OTHER REVENUE	B	-3,011	Physical Therapy	66	48
48.01	OTHER REVENUE	B	-196	Electrocardiology	69	48.01
48.02	OTHER REVENUE	B	-58,620	MOBILE MEDICAL UNIT	90.02	48.02
48.03	OTHER REVENUE	B	-103,764	FAMILY MEDICINE CENTER	90.03	48.03
48.04	OTHER REVENUE	B	-89,002	PEDIATRIC SPECIALTY CLINIC	90.06	48.04
48.05	OTHER REVENUE	B	-3,555	SPORTS MED FELLOWSHIP CLINIC	90.07	48.05

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION(1)		BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref. 5
				COST CENTER	LINE#	
		1	2	3	4	
48.06	OTHER REVENUE	B	-785	PODIATRY RESIDENCY CLINIC	90.08	48.06
48.07	OTHER REVENUE	B	-175	FACULTY PRACTICE CLINIC	90.09	48.07
48.08	OTHER REVENUE	B	-3,772	OUR LADY OF ROSARY CLINIC	90.10	48.08
48.09	OTHER REVENUE	B	-26,288	Emergency	91	48.09
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		24,056,097			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.

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

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

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
				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			SJRCM - INC		PARENT COMPANY	7
8	G	SJRCM- PLYMOUTH CAMPUS				HOSPITAL	8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

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

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	13	Nursing Administrati A	606		606	174,600	3	252	13	1
2	16	Medical Records & Li B	1,091		1,091	174,600	7	588	29	2
3	23	PARAMED ED PRGM-(SPE C	112,269		112,269	174,600	702	58,928	2,946	3
4	31	Intensive Care Unit D	56,678		56,678	174,600	333	27,953	1,398	4
5	50	Operating Room E	2,055,347	1,826,129	229,218	240,300	256	29,575	1,479	5
6	54	Radiology-Diagnostic F	135,394	63,200	72,194	240,300	370	42,746	2,137	6
7	55	Radiology-Therapeuti G	5,945	5,945		174,600				7
8	59	Cardiac Catheterizat H	41,262		41,262	174,600	188	15,781	789	8
9	66	Physical Therapy I	188	188		174,600	463	38,865	1,943	9
10	90.06	PEDIATRIC SPECIALTY J	199,331	164,931	34,400	165,500	328	26,098	1,305	10
11	90.10	OUR LADY OF ROSARY C K	235	33	202	174,600	3	252	13	11
12	91	Emergency L	203,007		203,007	174,600	1,269	106,523	5,326	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,811,353	2,060,426	750,927		3,922	347,561	17,378	200

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	13	Nursing Administrati A					252	354	354	1
2	16	Medical Records & Li B					588	503	503	2
3	23	PARAMED ED PRGM-(SPE C					58,928	53,341	53,341	3
4	31	Intensive Care Unit D					27,953	28,725	28,725	4
5	50	Operating Room E					29,575	199,643	2,025,772	5
6	54	Radiology-Diagnostic F					42,746	29,448	92,648	6
7	55	Radiology-Therapeuti G							5,945	7
8	59	Cardiac Catheterizat H					15,781	25,481	25,481	8
9	66	Physical Therapy I					38,865		188	9
10	90.06	PEDIATRIC SPECIALTY J					26,098	8,302	173,233	10
11	90.10	OUR LADY OF ROSARY C K					252		33	11
12	91	Emergency L					106,523	96,484	96,484	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					347,561	442,281	2,502,707	200

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	22,607,850	22,607,850					1
2	Cap Rel Costs-Mvble Equip	12,036,162		12,036,162				2
4	Employee Benefits Department	3,568,771	14,807	7,883	3,591,461			4
5.01	NONPATIENT TELEPHONES	305,627	22,866	12,174	9,200	349,867		5.01
5.04	ADMITTING	1,487,088	87,434	46,549	43,859	4,863	1,669,793	5.04
5.06	OTHER ADMINISTRATIVE & GENERAL	94,202,184	2,851,588	1,518,153	71,592	45,011		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	7,763,600	5,962,012	3,174,107	74,415	10,598		7
8	Laundry & Linen Service	995,832				623		8
9	Housekeeping	2,855,992	282,919	150,623	57,401	2,120		9
10	Dietary	2,970,595	401,466	213,736	54,196	2,992		10
11	Cafeteria	13,652	545,596	290,469	27,919	2,618		11
12	Maintenance of Personnel							12
13	Nursing Administration	3,145,872	89,074	47,422	103,320	3,491		13
14	Central Services & Supply	998,595			20,870	374		14
15	Pharmacy	3,834,405	238,359	126,899	134,680	7,107		15
16	Medical Records & Library	3,181,884	45,685	24,322	76,360	5,486		16
17	Social Service	2,721,261	27,786	14,793	83,926	4,489		17
18	STERILE SUPPLY	2,217,692	360,888	192,133	30,222	1,372		18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	2,228,306	42,171	22,451	76,325			21
22	I&R Services-Other Prgm Costs Apprvd	2,633,258			82,714	4,364		22
23	PARAMED ED PRGM-(SPECIFY)	158,385			3,204	748		23
23.01	CLINICAL PASTORAL EDUCATION							23.01
23.02	PHARMACY RESIDENCY PROGRAM	256,591			7,498	374		23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	24,703,865	5,332,027	2,838,710	736,357	68,329	198,860	30
31	Intensive Care Unit	4,523,577	670,422	356,925	140,586	5,611	33,215	31
35	NEONATAL INTENSIVE CARE UNIT	2,977,183	237,187	126,276	81,909	2,618	18,371	35
41	Subprovider - IRF	2,560,170			63,364	10,723	9,975	41
43	Nursery	3,479,198			87,225		8,235	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	24,104,143	2,238,566	1,191,787	389,219	31,171	346,678	50
51	Recovery Room	1,496,971	148,347	78,978	41,491	4,613	28,187	51
52	Delivery Room & Labor Room	1,009,022			25,297		15,703	52
54	Radiology-Diagnostic	5,461,529	625,440	332,977	143,051	17,581	96,489	54
55	Radiology-Therapeutic	270,819			9,333		1,288	55
57	CT Scan	1,152,284	79,937	42,558	28,153	1,122	116,044	57
58	MRI	452,151				1,621	9,797	58
59	Cardiac Catheterization	7,750,826	687,243	365,880	105,771	9,725	94,543	59
60	Laboratory	11,337,557	92,213	49,093		4,863	173,413	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,941,204	168,261	89,580	67,803	4,863	27,231	65
66	Physical Therapy	3,117,065	152,471	81,174	101,814	6,858	24,665	66
67	Occupational Therapy	931,499			29,514	1,122	9,220	67
68	Speech Pathology	483,465			16,441	499	5,150	68
69	Electrocardiology	1,288,444	126,044	67,104	35,871	3,990	37,320	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	22,879,728					125,697	72
73	Drugs Charged to Patients	17,107,810	21,929	11,675	13,752	748	151,915	73
74	Renal Dialysis	971,725	53,088	28,264		125	2,543	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	55,800			2,199	249	1,719	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT	58,393			3,320		668	90.02
90.03	FAMILY MEDICINE CENTER	1,191,610			27,184	6,982	5,643	90.03
90.04	WOUND HEALING CENTER	1,402,952			18,431	1,870	6,201	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	667,621	72,534	38,616	22,066	1,496	6,766	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	333,979			11,038	2,120	489	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	642,539			19,321	873		90.07
90.08	PODIATRY RESIDENCY CLINIC	248,264			4,958	1,995		90.08
90.09	FACULTY PRACTICE CLINIC	677,528			17,991		1,272	90.09
90.10	OUR LADY OF ROSARY CLINIC	608,741			15,960		876	90.10
91	Emergency	6,735,678	831,092	442,464	192,342	17,581	111,620	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)	323,806,942	22,509,452	11,983,775	3,409,462	305,978	1,669,793	118

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		88,231	46,973		623		190
192	Physicians' Private Offices		5,435	2,894		33,291		192
192.01	MATERNAL FETAL MEDICINE/LABORIST	1,538,235	4,732	2,520				192.01
192.02	NEONATOLOGISTS	1,608,312			54,885	374		192.02
192.03	HOSPITALISTS/INTENSIVISTS	5,561,051			14,024	1,496		192.03
194	SPORTS MED-ATHLETIC TRAINERS	243,809			7,946			194
194.01	OUTREACH SERVICES	3,112,775			90,403	5,736		194.01
194.02	KINDRED/OUR LADY OF PEACE					2,369		194.02
194.03	ADVANCED SPECIALTIES	144,531						194.03
194.04	AMBULATORY PHARMACY SERVICES	422,080			14,741			194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	336,437,735	22,607,850	12,036,162	3,591,461	349,867	1,669,793	202

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	98,688,528	98,688,528					5.06
6	Maintenance & Repairs							6
7	Operation of Plant	16,984,732	7,050,277	24,035,009				7
8	Laundry & Linen Service	996,455	413,623		1,410,078			8
9	Housekeeping	3,349,055	1,390,176	497,468		5,236,699		9
10	Dietary	3,642,985	1,512,185	705,914		157,054	6,018,138	10
11	Cafeteria	880,254	365,389	959,344		213,438		11
12	Maintenance of Personnel							12
13	Nursing Administration	3,389,179	1,406,831	156,623		34,846		13
14	Central Services & Supply	1,019,839	423,330					14
15	Pharmacy	4,341,450	1,802,114	419,116		93,246		15
16	Medical Records & Library	3,333,737	1,383,818	80,330		17,872		16
17	Social Service	2,852,255	1,183,957	48,857		10,870		17
18	STERILE SUPPLY	2,802,307	1,163,224	634,564		141,180		18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	2,369,253	983,465	74,151		16,497		21
22	I&R Services-Other Prgm Costs Apprvd	2,720,336	1,129,198					22
23	PARAMED ED PRGM-(SPECIFY)	162,337	67,385					23
23.01	CLINICAL PASTORAL EDUCATION							23.01
23.02	PHARMACY RESIDENCY PROGRAM	264,463	109,777					23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	33,878,148	14,062,675	9,375,516	167,901	2,085,892	4,800,412	30
31	Intensive Care Unit	5,730,336	2,378,634	1,178,830	28,044	262,269	287,945	31
35	NEONATAL INTENSIVE CARE UNIT	3,443,544	1,429,398	417,056	15,511	92,788	13,459	35
41	Subprovider - IRF	2,644,232	1,097,607		8,422		347,042	41
43	Nursery	3,574,658	1,483,823		6,953			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	28,301,564	11,747,838	3,936,161	292,945	875,728		50
51	Recovery Room	1,798,587	746,584	260,845	23,799	58,034		51
52	Delivery Room & Labor Room	1,050,022	435,859		13,258			52
54	Radiology-Diagnostic	6,677,067	2,771,617	1,099,736	81,467	244,672		54
55	Radiology-Therapeutic	281,440	116,824		1,088			55
57	CT Scan	1,420,098	589,476	140,557	97,978	31,271		57
58	MRI	463,569	192,425		8,272			58
59	Cardiac Catheterization	9,013,988	3,741,661	1,208,408	79,824	268,850		59
60	Laboratory	11,657,139	4,838,820	162,143	146,416	36,074		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,298,942	1,369,374	295,861	22,992	65,824		65
66	Physical Therapy	3,484,047	1,446,210	268,096	20,825	59,647		66
67	Occupational Therapy	971,355	403,205		7,785			67
68	Speech Pathology	505,555	209,853		4,348			68
69	Electrocardiology	1,558,773	647,039	221,628	31,510	49,308		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	23,005,425	9,549,437		106,128			72
73	Drugs Charged to Patients	17,307,829	7,184,393	38,558	128,265	8,579		73
74	Renal Dialysis	1,055,745	438,234	93,347	2,147	20,768		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	59,967	24,892		1,452			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT	62,381	25,894		564			90.02
90.03	FAMILY MEDICINE CENTER	1,231,419	511,156		4,765			90.03
90.04	WOUND HEALING CENTER	1,429,454	593,359		5,236			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	809,099	335,853	127,539	5,713	28,375	7,192	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	347,626	144,298		413			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	662,733	275,097					90.07
90.08	PODIATRY RESIDENCY CLINIC	255,217	105,939					90.08
90.09	FACULTY PRACTICE CLINIC	696,791	289,234		1,074			90.09
90.10	OUR LADY OF ROSARY CLINIC	625,577	259,674		740			90.10
91	Emergency	8,330,777	3,458,064	1,461,343	94,243	325,124		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)	323,430,269	93,289,195	23,861,991	1,410,078	5,198,206	5,456,050	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	135,827	56,381	155,140		34,516		190

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	Physicians' Private Offices	41,620	17,276	9,557		2,126		192
192.01	MATERNAL FETAL MEDICINE/LABORIST	1,545,487	641,524	8,321		1,851		192.01
192.02	NEONATOLOGISTS	1,663,571	690,540					192.02
192.03	HOSPITALISTS/INTENSIVISTS	5,576,571	2,314,807					192.03
194	SPORTS MED-ATHLETIC TRAINERS	251,755	104,502					194
194.01	OUTREACH SERVICES	3,208,914	1,332,004					194.01
194.02	KINDRED/OUR LADY OF PEACE	2,369	983				562,088	194.02
194.03	ADVANCED SPECIALTIES	144,531	59,994					194.03
194.04	AMBULATORY PHARMACY SERVICES	436,821	181,322					194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	336,437,735	98,688,528	24,035,009	1,410,078	5,236,699	6,018,138	202

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	2,418,425						11
12	Maintenance of Personnel							12
13	Nursing Administration	82,731	5,070,210					13
14	Central Services & Supply	28,859		1,472,028				14
15	Pharmacy	75,035			6,730,961			15
16	Medical Records & Library	76,959				4,892,716		16
17	Social Service	57,719	169,007		6,923		4,329,588	17
18	STERILE SUPPLY	42,327			24			18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	65,415						21
22	I&R Services-Other Prgm Costs Apprvd	25,012						22
23	PARAMED ED PRGM-(SPECIFY)	1,924			232			23
23.01	CLINICAL PASTORAL EDUCATION							23.01
23.02	PHARMACY RESIDENCY PROGRAM	5,772						23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	677,232	1,983,013	175,267	1,070	582,724	3,463,670	30
31	Intensive Care Unit	109,666	321,113	29,275	57	97,332	389,663	31
35	NEONATAL INTENSIVE CARE UNIT	57,719	169,007	16,191		53,832	43,296	35
41	Subprovider - IRF		169,007	8,792	2	29,231		41
43	Nursery	67,339	197,175	7,258		24,131		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	315,530	923,905	305,892	51,407	1,015,561		50
51	Recovery Room	32,707	95,771	24,843		82,598		51
52	Delivery Room & Labor Room	19,240	56,336	13,840		46,013		52
54	Radiology-Diagnostic	115,438		85,041	228,707	282,744		54
55	Radiology-Therapeutic	7,696		1,136		3,775		55
57	CT Scan	21,164		102,276	53,597	340,045		57
58	MRI			8,635		28,710		58
59	Cardiac Catheterization	73,111	214,076	83,326	48,810	277,041		59
60	Laboratory			152,838		508,154		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	55,795		24,000	193	79,796		65
66	Physical Therapy	65,415		21,738	837	72,275		66
67	Occupational Therapy	19,240		8,126	143	27,018		67
68	Speech Pathology	9,620		4,539		15,092		68
69	Electrocardiology	26,936		32,892	115	109,358		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients			110,784		368,332		72
73	Drugs Charged to Patients	9,620		133,891	6,227,776	445,160		73
74	Renal Dialysis			2,241		7,452		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,924	5,634	1,515		5,039		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT			589		1,958		90.02
90.03	FAMILY MEDICINE CENTER	32,707	95,771	4,974	35,081	16,537		90.03
90.04	WOUND HEALING CENTER	15,392	45,069	5,465	12,270	18,171		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	17,316	50,702	5,963		19,827		90.05
90.06	PEDIATRIC SPECIALTY CLINIC	7,696	22,534	431	275	1,434		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	5,772	16,901		960			90.07
90.08	PODIATRY RESIDENCY CLINIC	3,848	11,267		384			90.08
90.09	FACULTY PRACTICE CLINIC	9,620	28,168	1,121	22,300	3,726		90.09
90.10	OUR LADY OF ROSARY CLINIC		28,168	772	9,377	2,568		90.10
91	Emergency	159,689	467,586	98,377	212	327,082	432,959	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)	2,399,185	5,070,210	1,472,028	6,700,752	4,892,716	4,329,588	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11	13	14	15	16	17	
192	Physicians' Private Offices							192
192.01	MATERNAL FETAL MEDICINE/LABORIST							192.01
192.02	NEONATOLOGISTS	15,392						192.02
192.03	HOSPITALISTS/INTENSIVISTS	3,848						192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES				30,209			194.01
194.02	KINDRED/OUR LADY OF PEACE							194.02
194.03	ADVANCED SPECIALTIES							194.03
194.04	AMBULATORY PHARMACY SERVICES							194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,418,425	5,070,210	1,472,028	6,730,961	4,892,716	4,329,588	202

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	PHARMACY RESIDENCY PROGRAM	SUBTOTAL	
		18	21	22	23	23.02	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							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	4,783,626						18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		3,508,781					21
22	I&R Services-Other Prgm Costs Apprvd			3,874,546				22
23	PARAMED ED PRGM-(SPECIFY)				231,878			23
23.01	CLINICAL PASTORAL EDUCATION							23.01
23.02	PHARMACY RESIDENCY PROGRAM					380,012		23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	78,446	1,874,789	2,070,223			75,276,978	30
31	Intensive Care Unit	725	166,266	183,598			11,163,753	31
35	NEONATAL INTENSIVE CARE UNIT	4,082	120,399	132,950			6,009,232	35
41	Subprovider - IRF	12,327					4,316,662	41
43	Nursery		126,133	139,281			5,626,751	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,345,448	91,733	101,295			52,305,007	50
51	Recovery Room						3,123,768	51
52	Delivery Room & Labor Room		22,933	25,324			1,682,825	52
54	Radiology-Diagnostic	4,216	28,667	31,655			11,651,027	54
55	Radiology-Therapeutic						411,959	55
57	CT Scan						2,796,462	57
58	MRI						701,611	58
59	Cardiac Catheterization	23,364					15,032,459	59
60	Laboratory						17,501,584	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	8,889					5,221,666	65
66	Physical Therapy						5,439,090	66
67	Occupational Therapy						1,436,872	67
68	Speech Pathology						749,007	68
69	Electrocardiology						2,677,559	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients						33,140,106	72
73	Drugs Charged to Patients					380,012	31,864,083	73
74	Renal Dialysis		34,400	37,986			1,692,320	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY						100,423	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		756,796	835,686			1,592,482	90
90.02	MOBILE MEDICAL UNIT						91,386	90.02
90.03	FAMILY MEDICINE CENTER	24,761					1,957,171	90.03
90.04	WOUND HEALING CENTER	17,161					2,141,577	90.04
90.05	OUTPATIENT TREATMENT & INFUSION						1,407,579	90.05
90.06	PEDIATRIC SPECIALTY CLINIC						524,707	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	1,209					962,672	90.07
90.08	PODIATRY RESIDENCY CLINIC						376,655	90.08
90.09	FACULTY PRACTICE CLINIC	779					1,052,813	90.09
90.10	OUR LADY OF ROSARY CLINIC						926,876	90.10
91	Emergency	4,216	286,665	316,548	231,878		15,994,763	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)	4,525,623	3,508,781	3,874,546	231,878	380,012	316,949,885	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						381,864	190

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	PHARMACY RESIDENCY PROGRAM	SUBTOTAL	
		18	21	22	23	23.02	24	
192	Physicians' Private Offices						70,579	192
192.01	MATERNAL FETAL MEDICINE/LABORIST						2,197,183	192.01
192.02	NEONATOLOGISTS						2,369,503	192.02
192.03	HOSPITALISTS/INTENSIVISTS						7,895,226	192.03
194	SPORTS MED-ATHLETIC TRAINERS						356,257	194
194.01	OUTREACH SERVICES	184,875					4,756,002	194.01
194.02	KINDRED/OUR LADY OF PEACE						565,440	194.02
194.03	ADVANCED SPECIALTIES	73,128					277,653	194.03
194.04	AMBULATORY PHARMACY SERVICES						618,143	194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,783,626	3,508,781	3,874,546	231,878	380,012	336,437,735	202

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	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	-3,945,012	71,331,966				30
31	Intensive Care Unit	-349,864	10,813,889				31
35	NEONATAL INTENSIVE CARE UNIT	-253,349	5,755,883				35
41	Subprovider - IRF		4,316,662				41
43	Nursery	-265,414	5,361,337				43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	-193,028	52,111,979				50
51	Recovery Room		3,123,768				51
52	Delivery Room & Labor Room	-48,257	1,634,568				52
54	Radiology-Diagnostic	-60,322	11,590,705				54
55	Radiology-Therapeutic		411,959				55
57	CT Scan		2,796,462				57
58	MRI		701,611				58
59	Cardiac Catheterization		15,032,459				59
60	Laboratory		17,501,584				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		5,221,666				65
66	Physical Therapy		5,439,090				66
67	Occupational Therapy		1,436,872				67
68	Speech Pathology		749,007				68
69	Electrocardiology		2,677,559				69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients		33,140,106				72
73	Drugs Charged to Patients		31,864,083				73
74	Renal Dialysis	-72,386	1,619,934				74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY		100,423				76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	-1,592,482					90
90.02	MOBILE MEDICAL UNIT		91,386				90.02
90.03	FAMILY MEDICINE CENTER		1,957,171				90.03
90.04	WOUND HEALING CENTER		2,141,577				90.04
90.05	OUTPATIENT TREATMENT & INFUSION		1,407,579				90.05
90.06	PEDIATRIC SPECIALTY CLINIC		524,707				90.06
90.07	SPORTS MED FELLOWSHIP CLINIC		962,672				90.07
90.08	PODIATRY RESIDENCY CLINIC		376,655				90.08
90.09	FACULTY PRACTICE CLINIC		1,052,813				90.09
90.10	OUR LADY OF ROSARY CLINIC		926,876				90.10
91	Emergency	-603,213	15,391,550				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)	-7,383,327	309,566,558				118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		381,864				190

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
192	Physicians' Private Offices		70,579				192
192.01	MATERNAL FETAL MEDICINE/LABORIST		2,197,183				192.01
192.02	NEONATOLOGISTS		2,369,503				192.02
192.03	HOSPITALISTS/INTENSIVISTS		7,895,226				192.03
194	SPORTS MED-ATHLETIC TRAINERS		356,257				194
194.01	OUTREACH SERVICES		4,756,002				194.01
194.02	KINDRED/OUR LADY OF PEACE		565,440				194.02
194.03	ADVANCED SPECIALTIES		277,653				194.03
194.04	AMBULATORY PHARMACY SERVICES		618,143				194.04
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	-7,383,327	329,054,408				202

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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		14,807	7,883	22,690	22,690		4
5.01	NONPATIENT TELEPHONES		22,866	12,174	35,040	58	35,098	5.01
5.04	ADMITTING		87,434	46,549	133,983	277	488	5.04
5.06	OTHER ADMINISTRATIVE & GENERAL		2,851,588	1,518,153	4,369,741	453	4,515	5.06
6	Maintenance & Repairs							6
7	Operation of Plant		5,962,012	3,174,107	9,136,119	471	1,063	7
8	Laundry & Linen Service						63	8
9	Housekeeping		282,919	150,623	433,542	363	213	9
10	Dietary		401,466	213,736	615,202	343	300	10
11	Cafeteria		545,596	290,469	836,065	177	263	11
12	Maintenance of Personnel							12
13	Nursing Administration		89,074	47,422	136,496	653	350	13
14	Central Services & Supply					132	38	14
15	Pharmacy		238,359	126,899	365,258	852	713	15
16	Medical Records & Library		45,685	24,322	70,007	483	550	16
17	Social Service		27,786	14,793	42,579	531	450	17
18	STERILE SUPPLY		360,888	192,133	553,021	191	138	18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		42,171	22,451	64,622	483		21
22	I&R Services-Other Prgm Costs Apprvd					523	438	22
23	PARAMED ED PRGM-(SPECIFY)					20	75	23
23.01	CLINICAL PASTORAL EDUCATION							23.01
23.02	PHARMACY RESIDENCY PROGRAM					47	38	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		5,332,027	2,838,710	8,170,737	4,631	6,848	30
31	Intensive Care Unit		670,422	356,925	1,027,347	889	563	31
35	NEONATAL INTENSIVE CARE UNIT		237,187	126,276	363,463	518	263	35
41	Subprovider - IRF					401	1,076	41
43	Nursery					552		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		2,238,566	1,191,787	3,430,353	2,462	3,127	50
51	Recovery Room		148,347	78,978	227,325	262	463	51
52	Delivery Room & Labor Room					160		52
54	Radiology-Diagnostic		625,440	332,977	958,417	905	1,764	54
55	Radiology-Therapeutic					59		55
57	CT Scan		79,937	42,558	122,495	178	113	57
58	MRI						163	58
59	Cardiac Catheterization		687,243	365,880	1,053,123	669	976	59
60	Laboratory		92,213	49,093	141,306		488	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		168,261	89,580	257,841	429	488	65
66	Physical Therapy		152,471	81,174	233,645	644	688	66
67	Occupational Therapy					187	113	67
68	Speech Pathology					104	50	68
69	Electrocardiology		126,044	67,104	193,148	227	400	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		21,929	11,675	33,604	87	75	73
74	Renal Dialysis		53,088	28,264	81,352		13	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY					14	25	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT					21		90.02
90.03	FAMILY MEDICINE CENTER					172	700	90.03
90.04	WOUND HEALING CENTER					117	188	90.04
90.05	OUTPATIENT TREATMENT & INFUSION		72,534	38,616	111,150	140	150	90.05
90.06	PEDIATRIC SPECIALTY CLINIC					70	213	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC					122	88	90.07
90.08	PODIATRY RESIDENCY CLINIC					31	200	90.08
90.09	FACULTY PRACTICE CLINIC					114		90.09
90.10	OUR LADY OF ROSARY CLINIC					101		90.10
91	Emergency		831,092	442,464	1,273,556	1,216	1,764	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)		22,509,452	11,983,775	34,493,227	21,539	30,694	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		88,231	46,973	135,204		63	190

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	Physicians' Private Offices		5,435	2,894	8,329		3,340	192
192.01	MATERNAL FETAL MEDICINE/LABORIST		4,732	2,520	7,252			192.01
192.02	NEONATOLOGISTS					347	38	192.02
192.03	HOSPITALISTS/INTENSIVISTS					89	150	192.03
194	SPORTS MED-ATHLETIC TRAINERS					50		194
194.01	OUTREACH SERVICES					572	575	194.01
194.02	KINDRED/OUR LADY OF PEACE						238	194.02
194.03	ADVANCED SPECIALTIES							194.03
194.04	AMBULATORY PHARMACY SERVICES					93		194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		22,607,850	12,036,162	34,644,012	22,690	35,098	202

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	134,748						5.04
5.06	OTHER ADMINISTRATIVE & GENERAL		4,374,709					5.06
6	Maintenance & Repairs							6
7	Operation of Plant		312,536	9,450,189				7
8	Laundry & Linen Service		18,336		18,399			8
9	Housekeeping		61,626	195,597		691,341		9
10	Dietary		67,035	277,554		20,734	981,168	10
11	Cafeteria		16,198	377,199		28,178		11
12	Maintenance of Personnel							12
13	Nursing Administration		62,364	61,582		4,600		13
14	Central Services & Supply		18,766					14
15	Pharmacy		79,887	164,790		12,310		15
16	Medical Records & Library		61,344	31,584		2,359		16
17	Social Service		52,484	19,210		1,435		17
18	STERILE SUPPLY		51,565	249,501		18,638		18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		43,597	29,155		2,178		21
22	I&R Services-Other Prgm Costs Apprvd		50,057					22
23	PARAMED ED PRGM-(SPECIFY)		2,987					23
23.01	CLINICAL PASTORAL EDUCATION							23.01
23.02	PHARMACY RESIDENCY PROGRAM		4,866					23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	16,104	623,277	3,686,305	2,247	275,378	782,636	30
31	Intensive Care Unit	2,690	105,444	463,497	375	34,624	46,945	31
35	NEONATAL INTENSIVE CARE UNIT	1,488	63,365	163,980	208	12,250	2,194	35
41	Subprovider - IRF	808	48,657		113		56,580	41
43	Nursery	667	65,777		93			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	27,601	520,777	1,547,637	3,448	115,612		50
51	Recovery Room	2,283	33,096	102,560	319	7,662		51
52	Delivery Room & Labor Room	1,272	19,321		177			52
54	Radiology-Diagnostic	7,814	122,865	432,399	1,090	32,301		54
55	Radiology-Therapeutic	104	5,179		15			55
57	CT Scan	9,397	26,131	55,265	1,311	4,128		57
58	MRI	793	8,530		111			58
59	Cardiac Catheterization	7,656	165,866	475,127	1,068	35,493		59
60	Laboratory	14,043	214,503	63,752	1,959	4,762		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,205	60,704	116,328	308	8,690		65
66	Physical Therapy	1,997	64,110	105,411	279	7,874		66
67	Occupational Therapy	747	17,874		104			67
68	Speech Pathology	417	9,303		58			68
69	Electrocardiology	3,022	28,683	87,141	422	6,510		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	10,179	423,323		1,420			72
73	Drugs Charged to Patients	12,302	318,481	15,161	1,717	1,133		73
74	Renal Dialysis	206	19,427	36,703	29	2,742		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	139	1,103		19			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT	54	1,148		8			90.02
90.03	FAMILY MEDICINE CENTER	457	22,659		64			90.03
90.04	WOUND HEALING CENTER	502	26,303		70			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	548	14,888	50,146	76	3,746	1,173	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	40	6,397		6			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC		12,195					90.07
90.08	PODIATRY RESIDENCY CLINIC		4,696					90.08
90.09	FACULTY PRACTICE CLINIC	103	12,822		14			90.09
90.10	OUR LADY OF ROSARY CLINIC	71	11,511		10			90.10
91	Emergency	9,039	153,295	574,577	1,261	42,922		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)	134,748	4,135,358	9,382,161	18,399	686,259	889,528	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,499	60,998		4,557		190

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	Physicians' Private Offices		766	3,758		281		192
192.01	MATERNAL FETAL MEDICINE/LABORIST		28,439	3,272		244		192.01
192.02	NEONATOLOGISTS		30,611					192.02
192.03	HOSPITALISTS/INTENSIVISTS		102,614					192.03
194	SPORTS MED-ATHLETIC TRAINERS		4,633					194
194.01	OUTREACH SERVICES		59,047					194.01
194.02	KINDRED/OUR LADY OF PEACE		44				91,640	194.02
194.03	ADVANCED SPECIALTIES		2,660					194.03
194.04	AMBULATORY PHARMACY SERVICES		8,038					194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	134,748	4,374,709	9,450,189	18,399	691,341	981,168	202

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	1,258,080						11
12	Maintenance of Personnel							12
13	Nursing Administration	43,037	309,082					13
14	Central Services & Supply	15,013		33,949				14
15	Pharmacy	39,034			662,844			15
16	Medical Records & Library	40,034				206,361		16
17	Social Service	30,026	10,303		682		157,700	17
18	STERILE SUPPLY	22,019			2			18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	34,029						21
22	I&R Services-Other Prgm Costs Apprvd	13,011						22
23	PARAMED ED PRGM-(SPECIFY)	1,001			23			23
23.01	CLINICAL PASTORAL EDUCATION							23.01
23.02	PHARMACY RESIDENCY PROGRAM	3,003						23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	352,300	120,886	3,995	105	24,592	126,160	30
31	Intensive Care Unit	57,049	19,575	667	6	4,108	14,193	31
35	NEONATAL INTENSIVE CARE UNIT	30,026	10,303	369		2,272	1,577	35
41	Subprovider - IRF		10,303	200		1,234		41
43	Nursery	35,030	12,020	165		1,018		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	164,141	56,322	7,372	5,062	42,735		50
51	Recovery Room	17,015	5,838	566		3,486		51
52	Delivery Room & Labor Room	10,009	3,434	315		1,942		52
54	Radiology-Diagnostic	60,052		1,938	22,522	11,932		54
55	Radiology-Therapeutic	4,003		26		159		55
57	CT Scan	11,009		2,331	5,278	14,351		57
58	MRI			197		1,212		58
59	Cardiac Catheterization	38,033	13,050	1,899	4,807	11,692		59
60	Laboratory			3,483		21,445		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	29,025		547	19	3,368		65
66	Physical Therapy	34,029		495	82	3,050		66
67	Occupational Therapy	10,009		185	14	1,140		67
68	Speech Pathology	5,004		103		637		68
69	Electrocardiology	14,012		750	11	4,615		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients			2,525		15,544		72
73	Drugs Charged to Patients	5,004		3,052	613,293	18,787		73
74	Renal Dialysis			51		314		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,001	343	35		213		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT			13		83		90.02
90.03	FAMILY MEDICINE CENTER	17,015	5,838	113	3,455	698		90.03
90.04	WOUND HEALING CENTER	8,007	2,747	125	1,208	767		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	9,008	3,091	136		837		90.05
90.06	PEDIATRIC SPECIALTY CLINIC	4,003	1,374	10	27	61		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	3,003	1,030		95			90.07
90.08	PODIATRY RESIDENCY CLINIC	2,002	687		38			90.08
90.09	FACULTY PRACTICE CLINIC	5,004	1,717	26	2,196	157		90.09
90.10	OUR LADY OF ROSARY CLINIC		1,717	18	923	108		90.10
91	Emergency	83,071	28,504	2,242	21	13,804	15,770	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)	1,248,071	309,082	33,949	659,869	206,361	157,700	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11	13	14	15	16	17	
192	Physicians' Private Offices							192
192.01	MATERNAL FETAL MEDICINE/LABORIST							192.01
192.02	NEONATOLOGISTS	8,007						192.02
192.03	HOSPITALISTS/INTENSIVISTS	2,002						192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES				2,975			194.01
194.02	KINDRED/OUR LADY OF PEACE							194.02
194.03	ADVANCED SPECIALTIES							194.03
194.04	AMBULATORY PHARMACY SERVICES							194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,258,080	309,082	33,949	662,844	206,361	157,700	202

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	STERILE SUPPLY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	PHARMACY RESIDENCY PROGRAM	SUBTOTAL	
		18	21	22	23	23.02	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							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	895,075						18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		174,064					21
22	I&R Services-Other Prgm Costs Apprvd			64,029				22
23	PARAMED ED PRGM-(SPECIFY)				4,106			23
23.01	CLINICAL PASTORAL EDUCATION							23.01
23.02	PHARMACY RESIDENCY PROGRAM					7,954		23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	14,678					14,210,879	30
31	Intensive Care Unit	136					1,778,108	31
35	NEONATAL INTENSIVE CARE UNIT	764					653,040	35
41	Subprovider - IRF	2,306					121,678	41
43	Nursery						115,322	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	813,087					6,739,736	50
51	Recovery Room						400,875	51
52	Delivery Room & Labor Room						36,630	52
54	Radiology-Diagnostic	789					1,654,788	54
55	Radiology-Therapeutic						9,545	55
57	CT Scan						251,987	57
58	MRI						11,006	58
59	Cardiac Catheterization	4,372					1,813,831	59
60	Laboratory						465,741	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,663					481,615	65
66	Physical Therapy						452,304	66
67	Occupational Therapy						30,373	67
68	Speech Pathology						15,676	68
69	Electrocardiology						338,941	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients						452,991	72
73	Drugs Charged to Patients						1,022,696	73
74	Renal Dialysis						140,837	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY						2,892	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT						1,327	90.02
90.03	FAMILY MEDICINE CENTER	4,633					55,804	90.03
90.04	WOUND HEALING CENTER	3,211					43,245	90.04
90.05	OUTPATIENT TREATMENT & INFUSION						195,089	90.05
90.06	PEDIATRIC SPECIALTY CLINIC						12,201	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	226					16,759	90.07
90.08	PODIATRY RESIDENCY CLINIC						7,654	90.08
90.09	FACULTY PRACTICE CLINIC	146					22,299	90.09
90.10	OUR LADY OF ROSARY CLINIC						14,459	90.10
91	Emergency	789					2,201,831	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)	846,800					33,772,159	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						203,321	190

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	STERILE SUPPLY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	PHARMACY RESIDENCY PROGRAM	SUBTOTAL	
		18	21	22	23	23.02	24	
192	Physicians' Private Offices						16,474	192
192.01	MATERNAL FETAL MEDICINE/LABORIST						39,207	192.01
192.02	NEONATOLOGISTS						39,003	192.02
192.03	HOSPITALISTS/INTENSIVISTS						104,855	192.03
194	SPORTS MED-ATHLETIC TRAINERS						4,683	194
194.01	OUTREACH SERVICES	34,592					97,761	194.01
194.02	KINDRED/OUR LADY OF PEACE						91,922	194.02
194.03	ADVANCED SPECIALTIES	13,683					16,343	194.03
194.04	AMBULATORY PHARMACY SERVICES						8,131	194.04
200	Cross Foot Adjustments		174,064	64,029	4,106	7,954	250,153	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	895,075	174,064	64,029	4,106	7,954	34,644,012	202

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	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		14,210,879				30
31	Intensive Care Unit		1,778,108				31
35	NEONATAL INTENSIVE CARE UNIT		653,040				35
41	Subprovider - IRF		121,678				41
43	Nursery		115,322				43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		6,739,736				50
51	Recovery Room		400,875				51
52	Delivery Room & Labor Room		36,630				52
54	Radiology-Diagnostic		1,654,788				54
55	Radiology-Therapeutic		9,545				55
57	CT Scan		251,987				57
58	MRI		11,006				58
59	Cardiac Catheterization		1,813,831				59
60	Laboratory		465,741				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		481,615				65
66	Physical Therapy		452,304				66
67	Occupational Therapy		30,373				67
68	Speech Pathology		15,676				68
69	Electrocardiology		338,941				69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients		452,991				72
73	Drugs Charged to Patients		1,022,696				73
74	Renal Dialysis		140,837				74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY		2,892				76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
90.02	MOBILE MEDICAL UNIT		1,327				90.02
90.03	FAMILY MEDICINE CENTER		55,804				90.03
90.04	WOUND HEALING CENTER		43,245				90.04
90.05	OUTPATIENT TREATMENT & INFUSION		195,089				90.05
90.06	PEDIATRIC SPECIALTY CLINIC		12,201				90.06
90.07	SPORTS MED FELLOWSHIP CLINIC		16,759				90.07
90.08	PODIATRY RESIDENCY CLINIC		7,654				90.08
90.09	FACULTY PRACTICE CLINIC		22,299				90.09
90.10	OUR LADY OF ROSARY CLINIC		14,459				90.10
91	Emergency		2,201,831				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)		33,772,159				118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		203,321				190

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
192	Physicians' Private Offices		16,474				192
192.01	MATERNAL FETAL MEDICINE/LABORIST		39,207				192.01
192.02	NEONATOLOGISTS		39,003				192.02
192.03	HOSPITALISTS/INTENSIVISTS		104,855				192.03
194	SPORTS MED-ATHLETIC TRAINERS		4,683				194
194.01	OUTREACH SERVICES		97,761				194.01
194.02	KINDRED/OUR LADY OF PEACE		91,922				194.02
194.03	ADVANCED SPECIALTIES		16,343				194.03
194.04	AMBULATORY PHARMACY SERVICES		8,131				194.04
200	Cross Foot Adjustments		250,153				200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)		34,644,012				202

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	89,425,787				4
5.01	NONPATIENT TELEPHONES	488	488	229,086	2,806			5.01
5.04	ADMITTING	1,866	1,866	1,092,070	39	1,048,187,426		5.04
5.06	OTHER ADMINISTRATIVE & GENERAL	60,858	60,858	1,782,620	361		-98,688,528	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	127,240	127,240	1,852,911	85			7
8	Laundry & Linen Service				5			8
9	Housekeeping	6,038	6,038	1,429,279	17			9
10	Dietary	8,568	8,568	1,349,476	24			10
11	Cafeteria	11,644	11,644	695,184	21			11
12	Maintenance of Personnel							12
13	Nursing Administration	1,901	1,901	2,572,641	28			13
14	Central Services & Supply			519,653	3			14
15	Pharmacy	5,087	5,087	3,353,493	57			15
16	Medical Records & Library	975	975	1,901,349	44			16
17	Social Service	593	593	2,089,746	36			17
18	STERILE SUPPLY	7,702	7,702	752,528	11			18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	900	900	1,900,475				21
22	I&R Services-Other Prgm Costs Apprvd			2,059,572	35			22
23	PARAMED ED PRGM-(SPECIFY)			79,790	6			23
23.01	CLINICAL PASTORAL EDUCATION							23.01
23.02	PHARMACY RESIDENCY PROGRAM			186,700	3			23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	113,795	113,795	18,334,311	548	124,833,819		30
31	Intensive Care Unit	14,308	14,308	3,500,558	45	20,850,842		31
35	NEONATAL INTENSIVE CARE UNIT	5,062	5,062	2,039,518	21	11,532,051		35
41	Subprovider - IRF			1,577,753	86	6,261,979		41
43	Nursery			2,171,876		5,169,457		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	47,775	47,775	9,691,476	250	217,605,688		50
51	Recovery Room	3,166	3,166	1,033,122	37	17,694,452		51
52	Delivery Room & Labor Room			629,878		9,857,215		52
54	Radiology-Diagnostic	13,348	13,348	3,561,947	141	60,570,592		54
55	Radiology-Therapeutic			232,399		808,796		55
57	CT Scan	1,706	1,706	701,009	9	72,846,043		57
58	MRI				13	6,150,297		58
59	Cardiac Catheterization	14,667	14,667	2,633,677	78	59,348,933		59
60	Laboratory	1,968	1,968		39	108,859,116		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,591	3,591	1,688,273	39	17,094,304		65
66	Physical Therapy	3,254	3,254	2,535,148	55	15,483,176		66
67	Occupational Therapy			734,881	9	5,787,965		67
68	Speech Pathology			409,367	4	3,233,078		68
69	Electrocardiology	2,690	2,690	893,188	32	23,427,200		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients					78,905,819		72
73	Drugs Charged to Patients	468	468	342,429	6	95,364,144		73
74	Renal Dialysis	1,133	1,133		1	1,596,404		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY			54,762	2	1,079,372		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT			82,658		419,354		90.02
90.03	FAMILY MEDICINE CENTER			676,864	56	3,542,661		90.03
90.04	WOUND HEALING CENTER			458,932	15	3,892,637		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	1,548	1,548	549,432	12	4,247,356		90.05
90.06	PEDIATRIC SPECIALTY CLINIC			274,840	17	307,189		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC			481,080	7			90.07
90.08	PODIATRY RESIDENCY CLINIC			123,443	16			90.08
90.09	FACULTY PRACTICE CLINIC			447,984		798,238		90.09
90.10	OUR LADY OF ROSARY CLINIC			397,405		550,184		90.10
91	Emergency	17,737	17,737	4,789,267	141	70,069,065		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	84,894,050	2,454	1,048,187,426	-98,688,528	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,883	1,883		5			190

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	Physicians' Private Offices	116	116		267			192
192.01	MATERNAL FETAL MEDICINE/LABORIST	101	101					192.01
192.02	NEONATOLOGISTS			1,366,620	3			192.02
192.03	HOSPITALISTS/INTENSIVISTS			349,189	12			192.03
194	SPORTS MED-ATHLETIC TRAINERS			197,858				194
194.01	OUTREACH SERVICES			2,251,021	46			194.01
194.02	KINDRED/OUR LADY OF PEACE				19			194.02
194.03	ADVANCED SPECIALTIES							194.03
194.04	AMBULATORY PHARMACY SERVICES			367,049				194.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	22,607,850	12,036,162	3,591,461	349,867	1,669,793		202
203	Unit Cost Multiplier (Wkst. B, Part I)	46.856425	24.945827	0.040161	124.685317	0.001593		203
204	Cost to be allocated (Per Wkst. B, Part II)			22,690	35,098	134,748		204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000254	12.508197	0.000129		205

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	237,749,207						5.06
6	Maintenance & Repairs							6
7	Operation of Plant	16,984,732	291,724					7
8	Laundry & Linen Service	996,455		1,048,187,426				8
9	Housekeeping	3,349,055	6,038		285,686			9
10	Dietary	3,642,985	8,568		8,568	227,604		10
11	Cafeteria	880,254	11,644		11,644		1,257	11
12	Maintenance of Personnel							12
13	Nursing Administration	3,389,179	1,901		1,901		43	13
14	Central Services & Supply	1,019,839					15	14
15	Pharmacy	4,341,450	5,087		5,087		39	15
16	Medical Records & Library	3,333,737	975		975		40	16
17	Social Service	2,852,255	593		593		30	17
18	STERILE SUPPLY	2,802,307	7,702		7,702		22	18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	2,369,253	900		900		34	21
22	I&R Services-Other Prgm Costs Apprvd	2,720,336					13	22
23	PARAMED ED PRGM-(SPECIFY)	162,337					1	23
23.01	CLINICAL PASTORAL EDUCATION							23.01
23.02	PHARMACY RESIDENCY PROGRAM	264,463					3	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	33,878,148	113,795	124,833,819	113,795	181,550	352	30
31	Intensive Care Unit	5,730,336	14,308	20,850,842	14,308	10,890	57	31
35	NEONATAL INTENSIVE CARE UNIT	3,443,544	5,062	11,532,051	5,062	509	30	35
41	Subprovider - IRF	2,644,232		6,261,979		13,125		41
43	Nursery	3,574,658		5,169,457			35	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	28,301,564	47,775	217,605,688	47,775		164	50
51	Recovery Room	1,798,587	3,166	17,694,452	3,166		17	51
52	Delivery Room & Labor Room	1,050,022		9,857,215			10	52
54	Radiology-Diagnostic	6,677,067	13,348	60,570,592	13,348		60	54
55	Radiology-Therapeutic	281,440		808,796			4	55
57	CT Scan	1,420,098	1,706	72,846,043	1,706		11	57
58	MRI	463,569		6,150,297				58
59	Cardiac Catheterization	9,013,988	14,667	59,348,933	14,667		38	59
60	Laboratory	11,657,139	1,968	108,859,116	1,968			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,298,942	3,591	17,094,304	3,591		29	65
66	Physical Therapy	3,484,047	3,254	15,483,176	3,254		34	66
67	Occupational Therapy	971,355		5,787,965			10	67
68	Speech Pathology	505,555		3,233,078			5	68
69	Electrocardiology	1,558,773	2,690	23,427,200	2,690		14	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	23,005,425		78,905,819				72
73	Drugs Charged to Patients	17,307,829	468	95,364,144	468		5	73
74	Renal Dialysis	1,055,745	1,133	1,596,404	1,133			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	59,967		1,079,372			1	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT	62,381		419,354				90.02
90.03	FAMILY MEDICINE CENTER	1,231,419		3,542,661			17	90.03
90.04	WOUND HEALING CENTER	1,429,454		3,892,637			8	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	809,099	1,548	4,247,356	1,548	272	9	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	347,626		307,189			4	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	662,733					3	90.07
90.08	PODIATRY RESIDENCY CLINIC	255,217					2	90.08
90.09	FACULTY PRACTICE CLINIC	696,791		798,238			5	90.09
90.10	OUR LADY OF ROSARY CLINIC	625,577		550,184				90.10
91	Emergency	8,330,777	17,737	70,069,065	17,737		83	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	224,741,741	289,624	1,048,187,426	283,586	206,346	1,247	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	135,827	1,883		1,883			190

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	Physicians' Private Offices	41,620	116		116			192
192.01	MATERNAL FETAL MEDICINE/LABORIST	1,545,487	101		101			192.01
192.02	NEONATOLOGISTS	1,663,571					8	192.02
192.03	HOSPITALISTS/INTENSIVISTS	5,576,571					2	192.03
194	SPORTS MED-ATHLETIC TRAINERS	251,755						194
194.01	OUTREACH SERVICES	3,208,914						194.01
194.02	KINDRED/OUR LADY OF PEACE	2,369				21,258		194.02
194.03	ADVANCED SPECIALTIES	144,531						194.03
194.04	AMBULATORY PHARMACY SERVICES	436,821						194.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	98,688,528	24,035,009	1,410,078	5,236,699	6,018,138	2,418,425	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.415095	82.389550	0.001345	18.330261	26.441266	1,923.965792	203
204	Cost to be allocated (Per Wkst. B, Part II)	4,374,709	9,450,189	18,399	691,341	981,168	1,258,080	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.018401	32.394280	0.000018	2.419933	4.310856	1,000.859189	205

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION FTE'S	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	900						13
14	Central Services & Supply		1,048,187,426					14
15	Pharmacy			17,689,904				15
16	Medical Records & Library				1,048,187,426			16
17	Social Service	30		18,195		100		17
18	STERILE SUPPLY			64			178,123	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)			611				23
23.01	CLINICAL PASTORAL EDUCATION							23.01
23.02	PHARMACY RESIDENCY PROGRAM							23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	352	124,833,819	2,813	124,833,819	80	2,921	30
31	Intensive Care Unit	57	20,850,842	151	20,850,842	9	27	31
35	NEONATAL INTENSIVE CARE UNIT	30	11,532,051		11,532,051	1	152	35
41	Subprovider - IRF	30	6,261,979	6	6,261,979		459	41
43	Nursery	35	5,169,457		5,169,457			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	164	217,605,688	135,106	217,605,688		161,807	50
51	Recovery Room	17	17,694,452	1	17,694,452			51
52	Delivery Room & Labor Room	10	9,857,215		9,857,215			52
54	Radiology-Diagnostic		60,570,592	601,074	60,570,592		157	54
55	Radiology-Therapeutic		808,796		808,796			55
57	CT Scan		72,846,043	140,861	72,846,043			57
58	MRI		6,150,297		6,150,297			58
59	Cardiac Catheterization	38	59,348,933	128,280	59,348,933		870	59
60	Laboratory		108,859,116		108,859,116			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		17,094,304	506	17,094,304		331	65
66	Physical Therapy		15,483,176	2,201	15,483,176			66
67	Occupational Therapy		5,787,965	377	5,787,965			67
68	Speech Pathology		3,233,078		3,233,078			68
69	Electrocardiology		23,427,200	302	23,427,200			69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients		78,905,819		78,905,819			72
73	Drugs Charged to Patients		95,364,144	16,367,455	95,364,144			73
74	Renal Dialysis		1,596,404		1,596,404			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	1	1,079,372		1,079,372			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT		419,354		419,354			90.02
90.03	FAMILY MEDICINE CENTER	17	3,542,661	92,197	3,542,661		922	90.03
90.04	WOUND HEALING CENTER	8	3,892,637	32,246	3,892,637		639	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	9	4,247,356		4,247,356			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	4	307,189	724	307,189			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	3		2,523			45	90.07
90.08	PODIATRY RESIDENCY CLINIC	2		1,008				90.08
90.09	FACULTY PRACTICE CLINIC	5	798,238	58,608	798,238		29	90.09
90.10	OUR LADY OF ROSARY CLINIC	5	550,184	24,645	550,184			90.10
91	Emergency	83	70,069,065	556	70,069,065	10	157	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	900	1,048,187,426	17,610,510	1,048,187,426	100	168,516	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION FTE'S	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	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			79,394			6,884	194.01
194.02	KINDRED/OUR LADY OF PEACE							194.02
194.03	ADVANCED SPECIALTIES						2,723	194.03
194.04	AMBULATORY PHARMACY SERVICES							194.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	5,070,210	1,472,028	6,730,961	4,892,716	4,329,588	4,783,626	202
203	Unit Cost Multiplier (Wkst. B, Part I)	5,633,566667	0,001404	0,380497	0,004668	43,295.880000	26,855746	203
204	Cost to be allocated (Per Wkst. B, Part II)	309,082	33,949	662,844	206,361	157,700	895,075	204
205	Unit Cost Multiplier (Wkst. B, Part II)	343.424444	0.000032	0.037470	0.000197	1,577.000000	5.025039	205

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	PHARMACY RESIDENCY PROGRAM PATIENT DAYS
	21	22	23	23.02

GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt					1
2	Cap Rel Costs-Mvble Equip					2
4	Employee Benefits Department					4
5.01	NONPATIENT TELEPHONES					5.01
5.04	ADMITTING					5.04
5.06	OTHER ADMINISTRATIVE & GENERAL					5.06
6	Maintenance & Repairs					6
7	Operation of Plant					7
8	Laundry & Linen Service					8
9	Housekeeping					9
10	Dietary					10
11	Cafeteria					11
12	Maintenance of Personnel					12
13	Nursing Administration					13
14	Central Services & Supply					14
15	Pharmacy					15
16	Medical Records & Library					16
17	Social Service					17
18	STERILE SUPPLY					18
19	Nonphysician Anesthetists					19
20	Nursing School					20
21	I&R Services-Salary & Fringes Apprvd	612				21
22	I&R Services-Other Prgm Costs Apprvd		612			22
23	PARAMED ED PRGM-(SPECIFY)			100		23
23.01	CLINICAL PASTORAL EDUCATION					23.01
23.02	PHARMACY RESIDENCY PROGRAM				100	23.02
INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	327	327			30
31	Intensive Care Unit	29	29			31
35	NEONATAL INTENSIVE CARE UNIT	21	21			35
41	Subprovider - IRF					41
43	Nursery	22	22			43
ANCILLARY SERVICE COST CENTERS						
50	Operating Room	16	16			50
51	Recovery Room					51
52	Delivery Room & Labor Room	4	4			52
54	Radiology-Diagnostic	5	5			54
55	Radiology-Therapeutic					55
57	CT Scan					57
58	MRI					58
59	Cardiac Catheterization					59
60	Laboratory					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy					65
66	Physical Therapy					66
67	Occupational Therapy					67
68	Speech Pathology					68
69	Electrocardiology					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	6	6			74
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	Clinic	132	132			90
90.02	MOBILE MEDICAL UNIT					90.02
90.03	FAMILY MEDICINE CENTER					90.03
90.04	WOUND HEALING CENTER					90.04
90.05	OUTPATIENT TREATMENT & INFUSION					90.05
90.06	PEDIATRIC SPECIALTY CLINIC					90.06
90.07	SPORTS MED FELLOWSHIP CLINIC					90.07
90.08	PODIATRY RESIDENCY CLINIC					90.08
90.09	FACULTY PRACTICE CLINIC					90.09
90.10	OUR LADY OF ROSARY CLINIC					90.10
91	Emergency	50	50	100		91
92	Observation Beds (Non-Distinct Part)					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	612	612	100	100	118

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	PHARMACY RESIDENCY PROGRAM PATIENT DAYS		
		21	22	23	23.02		
	NONREIMBURSABLE COST CENTERS						
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
194.04	AMBULATORY PHARMACY SERVICES						194.04
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	3,508,781	3,874,546	231,878	380,012		202
203	Unit Cost Multiplier (Wkst. B, Part I)	5,733.302288	6,330.957516	2,318.780000	3,800.120000		203
204	Cost to be allocated (Per Wkst. B, Part II)	174,064	64,029	4,106	7,954		204
205	Unit Cost Multiplier (Wkst. B, Part II)	284.418301	104.622549	41.060000	79.540000		205

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	71,331,966		71,331,966		71,331,966	30
31	Intensive Care Unit	10,813,889		10,813,889	28,725	10,842,614	31
35	NEONATAL INTENSIVE CARE UNIT	5,755,883		5,755,883		5,755,883	35
41	Subprovider - IRF	4,316,662		4,316,662		4,316,662	41
43	Nursery	5,361,337		5,361,337		5,361,337	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	52,111,979		52,111,979	199,643	52,311,622	50
51	Recovery Room	3,123,768		3,123,768		3,123,768	51
52	Delivery Room & Labor Room	1,634,568		1,634,568		1,634,568	52
54	Radiology-Diagnostic	11,590,705		11,590,705	29,448	11,620,153	54
55	Radiology-Therapeutic	411,959		411,959		411,959	55
57	CT Scan	2,796,462		2,796,462		2,796,462	57
58	MRI	701,611		701,611		701,611	58
59	Cardiac Catheterization	15,032,459		15,032,459	25,481	15,057,940	59
60	Laboratory	17,501,584		17,501,584		17,501,584	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	5,221,666		5,221,666		5,221,666	65
66	Physical Therapy	5,439,090		5,439,090		5,439,090	66
67	Occupational Therapy	1,436,872		1,436,872		1,436,872	67
68	Speech Pathology	749,007		749,007		749,007	68
69	Electrocardiology	2,677,559		2,677,559		2,677,559	69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients	33,140,106		33,140,106		33,140,106	72
73	Drugs Charged to Patients	31,864,083		31,864,083		31,864,083	73
74	Renal Dialysis	1,619,934		1,619,934		1,619,934	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	100,423		100,423		100,423	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
90.02	MOBILE MEDICAL UNIT	91,386		91,386		91,386	90.02
90.03	FAMILY MEDICINE CENTER	1,957,171		1,957,171		1,957,171	90.03
90.04	WOUND HEALING CENTER	2,141,577		2,141,577		2,141,577	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	1,407,579		1,407,579		1,407,579	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	524,707		524,707	8,302	533,009	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	962,672		962,672		962,672	90.07
90.08	PODIATRY RESIDENCY CLINIC	376,655		376,655		376,655	90.08
90.09	FACULTY PRACTICE CLINIC	1,052,813		1,052,813		1,052,813	90.09
90.10	OUR LADY OF ROSARY CLINIC	926,876		926,876		926,876	90.10
91	Emergency	15,391,550		15,391,550	96,484	15,488,034	91
92	Observation Beds (Non-Distinct Part)	7,542,179		7,542,179		7,542,179	92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	317,108,737		317,108,737	388,083	317,496,820	200
201	Less Observation Beds	7,542,179		7,542,179		7,542,179	201
202	Total (line 200 minus line 201)	309,566,558		309,566,558		309,954,641	202

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	115,224,633		115,224,633				30
31	Intensive Care Unit	20,850,842		20,850,842				31
35	NEONATAL INTENSIVE CARE UNIT	11,532,051		11,532,051				35
41	Subprovider - IRF	6,261,979		6,261,979				41
43	Nursery	5,169,457		5,169,457				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	105,202,306	112,403,382	217,605,688	0.239479	0.239479	0.240396	50
51	Recovery Room	7,389,468	10,304,984	17,694,452	0.176539	0.176539	0.176539	51
52	Delivery Room & Labor Room	9,838,580	18,635	9,857,215	0.165825	0.165825	0.165825	52
54	Radiology-Diagnostic	12,631,468	47,939,124	60,570,592	0.191359	0.191359	0.191845	54
55	Radiology-Therapeutic	656,220	152,576	808,796	0.509348	0.509348	0.509348	55
57	CT Scan	20,436,402	52,409,641	72,846,043	0.038389	0.038389	0.038389	57
58	MRI	4,514,923	1,635,374	6,150,297	0.114078	0.114078	0.114078	58
59	Cardiac Catheterization	23,764,564	35,584,369	59,348,933	0.253289	0.253289	0.253719	59
60	Laboratory	63,509,546	45,349,570	108,859,116	0.160773	0.160773	0.160773	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	10,472,866	6,621,438	17,094,304	0.305462	0.305462	0.305462	65
66	Physical Therapy	5,905,425	9,577,751	15,483,176	0.351290	0.351290	0.351290	66
67	Occupational Therapy	4,366,552	1,421,413	5,787,965	0.248252	0.248252	0.248252	67
68	Speech Pathology	2,448,125	784,953	3,233,078	0.231670	0.231670	0.231670	68
69	Electrocardiology	8,661,623	14,765,577	23,427,200	0.114293	0.114293	0.114293	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients	58,502,791	20,403,028	78,905,819	0.419996	0.419996	0.419996	72
73	Drugs Charged to Patients	52,427,885	42,936,259	95,364,144	0.334131	0.334131	0.334131	73
74	Renal Dialysis	1,254,511	341,893	1,596,404	1.014739	1.014739	1.014739	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,835	1,074,537	1,079,372	0.093038	0.093038	0.093038	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT		419,354	419,354	0.217921	0.217921	0.217921	90.02
90.03	FAMILY MEDICINE CENTER	628,464	2,914,197	3,542,661	0.552458	0.552458	0.552458	90.03
90.04	WOUND HEALING CENTER	27,731	3,864,906	3,892,637	0.550161	0.550161	0.550161	90.04
90.05	OUTPATIENT TREATMENT & INFUSION	30,425	4,216,931	4,247,356	0.331401	0.331401	0.331401	90.05
90.06	PEDIATRIC SPECIALTY CLINIC	402	306,787	307,189	1.708092	1.708092	1.735117	90.06
90.07	SPORTS MED FELLOWSHIP CLINIC							90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC	99,958	698,280	798,238	1.318921	1.318921	1.318921	90.09
90.10	OUR LADY OF ROSARY CLINIC	40,142	510,042	550,184	1.684665	1.684665	1.684665	90.10
91	Emergency	15,855,885	54,213,180	70,069,065	0.219663	0.219663	0.221040	91
92	Observation Beds (Non-Distinct Part)	2,328,058	7,281,128	9,609,186	0.784893	0.784893	0.784893	92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	570,038,117	478,149,309	1,048,187,426				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	570,038,117	478,149,309	1,048,187,426				202

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	14,210,879		14,210,879	57,503	247.13	22,266	5,502,597	30
31	Intensive Care Unit	1,778,108		1,778,108	4,716	377.04	1,795	676,787	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	NEONATAL INTENSIVE CARE UNIT	653,040		653,040	1,174	556.25			35
40	Subprovider - IPF								40
41	Subprovider - IRF	121,678		121,678	3,399	35.80	2,143	76,719	41
42	Subprovider I								42
43	Nursery	115,322		115,322	6,198	18.61			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	16,879,027		16,879,027	72,990		26,204	6,256,103	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	6,739,736	217,605,688	0.030972	38,032,365	1,177,938	50
51	Recovery Room	400,875	17,694,452	0.022655	3,144,225	71,232	51
52	Delivery Room & Labor Room	36,630	9,857,215	0.003716	55,158	205	52
54	Radiology-Diagnostic	1,654,788	60,570,592	0.027320	6,167,059	168,484	54
55	Radiology-Therapeutic	9,545	808,796	0.011801	120,910	1,427	55
57	CT Scan	251,987	72,846,043	0.003459	9,406,708	32,538	57
58	MRI	11,006	6,150,297	0.001790	2,428,948	4,348	58
59	Cardiac Catheterization	1,813,831	59,348,933	0.030562	8,616,776	263,346	59
60	Laboratory	465,741	108,859,116	0.004278	28,629,885	122,479	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	481,615	17,094,304	0.028174	4,562,077	128,532	65
66	Physical Therapy	452,304	15,483,176	0.029213	2,070,365	60,482	66
67	Occupational Therapy	30,373	5,787,965	0.005248	1,491,516	7,827	67
68	Speech Pathology	15,676	3,233,078	0.004849	753,755	3,655	68
69	Electrocardiology	338,941	23,427,200	0.014468	5,012,687	72,524	69
71	Medical Supplies Charged to Pat						71
72	Impl. Dev. Charged to Patients	452,991	78,905,819	0.005741	25,093,197	144,060	72
73	Drugs Charged to Patients	1,022,696	95,364,144	0.010724	23,014,287	246,805	73
74	Renal Dialysis	140,837	1,596,404	0.088221	570,099	50,295	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	2,892	1,079,372	0.002679	4,835	13	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
90.02	MOBILE MEDICAL UNIT	1,327	419,354	0.003164			90.02
90.03	FAMILY MEDICINE CENTER	55,804	3,542,661	0.015752			90.03
90.04	WOUND HEALING CENTER	43,245	3,892,637	0.011109			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	195,089	4,247,356	0.045932			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	12,201	307,189	0.039718			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	16,759					90.07
90.08	PODIATRY RESIDENCY CLINIC	7,654					90.08
90.09	FACULTY PRACTICE CLINIC	22,299	798,238	0.027935			90.09
90.10	OUR LADY OF ROSARY CLINIC	14,459	550,184	0.026280			90.10
91	Emergency	2,201,831	70,069,065	0.031424	5,139,745	161,511	91
92	Observation Beds (Non-Distinct)	1,502,568	9,609,186	0.156368	1,414,778	221,226	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	18,395,700	889,148,464		165,729,375	2,938,927	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	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)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	NEONATAL INTENSIVE CARE UNIT						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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

	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)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	57,503		22,266		30
31	Intensive Care Unit	4,716		1,795		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	NEONATAL INTENSIVE CARE UNIT	1,174				35
40	Subprovider - IPF					40
41	Subprovider - IRF	3,399		2,143		41
42	Subprovider I					42
43	Nursery	6,198				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	72,990		26,204		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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			380,012		380,012	380,012	73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT							90.02
90.03	FAMILY MEDICINE CENTER							90.03
90.04	WOUND HEALING CENTER							90.04
90.05	OUTPATIENT TREATMENT & INFUSION							90.05
90.06	PEDIATRIC SPECIALTY CLINIC							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC							90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC							90.09
90.10	OUR LADY OF ROSARY CLINIC							90.10
91	Emergency			231,878		231,878	231,878	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			611,890		611,890	611,890	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	217,605,688			38,032,365		19,463,901		50
51	Recovery Room	17,694,452			3,144,225		2,159,695		51
52	Delivery Room & Labor Room	9,857,215			55,158				52
54	Radiology-Diagnostic	60,570,592			6,167,059		11,038,177		54
55	Radiology-Therapeutic	808,796			120,910		90,721		55
57	CT Scan	72,846,043			9,406,708		13,898,799		57
58	MRI	6,150,297			2,428,948		689,319		58
59	Cardiac Catheterization	59,348,933			8,616,776		12,343,355		59
60	Laboratory	108,859,116			28,629,885		9,655,327		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	17,094,304			4,562,077		541,141		65
66	Physical Therapy	15,483,176			2,070,365		150,203		66
67	Occupational Therapy	5,787,965			1,491,516		96,823		67
68	Speech Pathology	3,233,078			753,755		19,784		68
69	Electrocardiology	23,427,200			5,012,687		6,567,303		69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	78,905,819			25,093,197		4,569,394		72
73	Drugs Charged to Patients	95,364,144	0.003985	0.003985	23,014,287	91,712	19,014,756	75,774	73
74	Renal Dialysis	1,596,404			570,099		45,856		74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,079,372			4,835		519,351		76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
90.02	MOBILE MEDICAL UNIT	419,354							90.02
90.03	FAMILY MEDICINE CENTER	3,542,661							90.03
90.04	WOUND HEALING CENTER	3,892,637					35,616		90.04
90.05	OUTPATIENT TREATMENT & INFUSION	4,247,356							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	307,189					1,911		90.06
90.07	SPORTS MED FELLOWSHIP CLINIC								90.07
90.08	PODIATRY RESIDENCY CLINIC								90.08
90.09	FACULTY PRACTICE CLINIC	798,238							90.09
90.10	OUR LADY OF ROSARY CLINIC	550,184							90.10
91	Emergency	70,069,065	0.003309	0.003309	5,139,745	17,007	9,292,383	30,748	91
92	Observation Beds (Non-Distinct	9,609,186			1,414,778		2,133,512		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	889,148,464			165,729,375	108,719	112,327,327	106,522	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	0.239479	19,463,901			4,661,196		50	
51	Recovery Room	0.176539	2,159,695			381,270		51	
52	Delivery Room & Labor Room	0.165825						52	
54	Radiology-Diagnostic	0.191359	11,038,177			2,112,255		54	
55	Radiology-Therapeutic	0.509348	90,721			46,209		55	
57	CT Scan	0.038389	13,898,799			533,561		57	
58	MRI	0.114078	689,319			78,636		58	
59	Cardiac Catheterization	0.253289	12,343,355			3,126,436		59	
60	Laboratory	0.160773	9,655,327			1,552,316		60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
65	Respiratory Therapy	0.305462	541,141			165,298		65	
66	Physical Therapy	0.351290	150,203			52,765		66	
67	Occupational Therapy	0.248252	96,823			24,037		67	
68	Speech Pathology	0.231670	19,784			4,583		68	
69	Electrocardiology	0.114293	6,567,303			750,597		69	
71	Medical Supplies Charged to Pat							71	
72	Impl. Dev. Charged to Patients	0.419996	4,569,394			1,919,127		72	
73	Drugs Charged to Patients	0.334131	19,014,756		131,983	6,353,419		73	
74	Renal Dialysis	1.014739	45,856			46,532		74	
76.97	CARDIAC REHABILITATION							76.97	
76.98	HYPERBARIC OXYGEN THERAPY	0.093038	519,351			48,319		76.98	
76.99	LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS									
90	Clinic							90	
90.02	MOBILE MEDICAL UNIT	0.217921						90.02	
90.03	FAMILY MEDICINE CENTER	0.552458						90.03	
90.04	WOUND HEALING CENTER	0.550161	35,616			19,595		90.04	
90.05	OUTPATIENT TREATMENT & INFUSION	0.331401						90.05	
90.06	PEDIATRIC SPECIALTY CLINIC	1.708092	1,911			3,264		90.06	
90.07	SPORTS MED FELLOWSHIP CLINIC							90.07	
90.08	PODIATRY RESIDENCY CLINIC							90.08	
90.09	FACULTY PRACTICE CLINIC	1.318921						90.09	
90.10	OUR LADY OF ROSARY CLINIC	1.684665						90.10	
91	Emergency	0.219663	9,292,383			2,041,193		91	
92	Observation Beds (Non-Distinct	0.784893	2,133,512			1,674,579		92	
OTHER REIMBURSABLE COST CENTERS									
200	Subtotal (see instructions)		112,327,327		131,983	25,595,187		200	
201	Less PBP Clinic Lab. Services-Program Only Charges							201	
202	Net Charges (line 200 - line 201)		112,327,327		131,983	25,595,187		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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	6,739,736	217,605,688	0.030972			50
51	Recovery Room	400,875	17,694,452	0.022655			51
52	Delivery Room & Labor Room	36,630	9,857,215	0.003716			52
54	Radiology-Diagnostic	1,654,788	60,570,592	0.027320	38,866	1,062	54
55	Radiology-Therapeutic	9,545	808,796	0.011801			55
57	CT Scan	251,987	72,846,043	0.003459	44,149	153	57
58	MRI	11,006	6,150,297	0.001790	26,275	47	58
59	Cardiac Catheterization	1,813,831	59,348,933	0.030562	1,129	35	59
60	Laboratory	465,741	108,859,116	0.004278	416,936	1,784	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	481,615	17,094,304	0.028174	648	18	65
66	Physical Therapy	452,304	15,483,176	0.029213	1,131,903	33,066	66
67	Occupational Therapy	30,373	5,787,965	0.005248	1,020,027	5,353	67
68	Speech Pathology	15,676	3,233,078	0.004849	716,883	3,476	68
69	Electrocardiology	338,941	23,427,200	0.014468	3,586	52	69
71	Medical Supplies Charged to Pat						71
72	Impl. Dev. Charged to Patients	452,991	78,905,819	0.005741			72
73	Drugs Charged to Patients	1,022,696	95,364,144	0.010724	203,384	2,181	73
74	Renal Dialysis	140,837	1,596,404	0.088221	6,460	570	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	2,892	1,079,372	0.002679			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
90.02	MOBILE MEDICAL UNIT	1,327	419,354	0.003164			90.02
90.03	FAMILY MEDICINE CENTER	55,804	3,542,661	0.015752			90.03
90.04	WOUND HEALING CENTER	43,245	3,892,637	0.011109			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	195,089	4,247,356	0.045932			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	12,201	307,189	0.039718			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	16,759					90.07
90.08	PODIATRY RESIDENCY CLINIC	7,654					90.08
90.09	FACULTY PRACTICE CLINIC	22,299	798,238	0.027935			90.09
90.10	OUR LADY OF ROSARY CLINIC	14,459	550,184	0.026280			90.10
91	Emergency	2,201,831	70,069,065	0.031424			91
92	Observation Beds (Non-Distinct		9,609,186				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	16,893,132	889,148,464		3,610,246	47,797	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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 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							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			380,012		380,012	380,012	73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT							90.02
90.03	FAMILY MEDICINE CENTER							90.03
90.04	WOUND HEALING CENTER							90.04
90.05	OUTPATIENT TREATMENT & INFUSION							90.05
90.06	PEDIATRIC SPECIALTY CLINIC							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC							90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC							90.09
90.10	OUR LADY OF ROSARY CLINIC							90.10
91	Emergency			231,878		231,878	231,878	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			611,890		611,890	611,890	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	217,605,688							50
51	Recovery Room	17,694,452							51
52	Delivery Room & Labor Room	9,857,215							52
54	Radiology-Diagnostic	60,570,592			38,866				54
55	Radiology-Therapeutic	808,796							55
57	CT Scan	72,846,043			44,149				57
58	MRI	6,150,297			26,275				58
59	Cardiac Catheterization	59,348,933			1,129				59
60	Laboratory	108,859,116			416,936				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	17,094,304			648				65
66	Physical Therapy	15,483,176			1,131,903				66
67	Occupational Therapy	5,787,965			1,020,027				67
68	Speech Pathology	3,233,078			716,883				68
69	Electrocardiology	23,427,200			3,586				69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	78,905,819							72
73	Drugs Charged to Patients	95,364,144	0.003985	0.003985	203,384	810			73
74	Renal Dialysis	1,596,404			6,460				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,079,372							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
90.02	MOBILE MEDICAL UNIT	419,354							90.02
90.03	FAMILY MEDICINE CENTER	3,542,661							90.03
90.04	WOUND HEALING CENTER	3,892,637							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	4,247,356							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	307,189							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC								90.07
90.08	PODIATRY RESIDENCY CLINIC								90.08
90.09	FACULTY PRACTICE CLINIC	798,238							90.09
90.10	OUR LADY OF ROSARY CLINIC	550,184							90.10
91	Emergency	70,069,065	0.003309	0.003309					91
92	Observation Beds (Non-Distinct)	9,609,186							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	889,148,464			3,610,246	810			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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	0.239479							50
51	Recovery Room	0.176539							51
52	Delivery Room & Labor Room	0.165825							52
54	Radiology-Diagnostic	0.191359							54
55	Radiology-Therapeutic	0.509348							55
57	CT Scan	0.038389							57
58	MRI	0.114078							58
59	Cardiac Catheterization	0.253289							59
60	Laboratory	0.160773							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.305462							65
66	Physical Therapy	0.351290							66
67	Occupational Therapy	0.248252							67
68	Speech Pathology	0.231670							68
69	Electrocardiology	0.114293							69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	0.419996							72
73	Drugs Charged to Patients	0.334131			2,071			692	73
74	Renal Dialysis	1.014739							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.093038							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
90.02	MOBILE MEDICAL UNIT	0.217921							90.02
90.03	FAMILY MEDICINE CENTER	0.552458							90.03
90.04	WOUND HEALING CENTER	0.550161							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.331401							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	1.708092							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC								90.07
90.08	PODIATRY RESIDENCY CLINIC								90.08
90.09	FACULTY PRACTICE CLINIC	1.318921							90.09
90.10	OUR LADY OF ROSARY CLINIC	1.684665							90.10
91	Emergency	0.219663							91
92	Observation Beds (Non-Distinct	0.784893							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)				2,071			692	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)				2,071			692	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)	14,210,879		14,210,879	57,503	247.13	1,728	427,041	30
31	Intensive Care Unit	1,778,108		1,778,108	4,716	377.04	190	71,638	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	NEONATAL INTENSIVE CARE UNIT	653,040		653,040	1,174	556.25	544	302,600	35
40	Subprovider - IPF								40
41	Subprovider - IRF	121,678		121,678	3,399	35.80	59	2,112	41
42	Subprovider I								42
43	Nursery	115,322		115,322	6,198	18.61	484	9,007	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	16,879,027		16,879,027	72,990		3,005	812,398	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	6,739,736	217,605,688	0.030972	11,363,334	351,945	50
51	Recovery Room	400,875	17,694,452	0.022655	643,366	14,575	51
52	Delivery Room & Labor Room	36,630	9,857,215	0.003716			52
54	Radiology-Diagnostic	1,654,788	60,570,592	0.027320	1,737,018	47,455	54
55	Radiology-Therapeutic	9,545	808,796	0.011801	192,077	2,267	55
57	CT Scan	251,987	72,846,043	0.003459	2,588,385	8,953	57
58	MRI	11,006	6,150,297	0.001790	613,957	1,099	58
59	Cardiac Catheterization	1,813,831	59,348,933	0.030562	2,852,267	87,171	59
60	Laboratory	465,741	108,859,116	0.004278	9,091,557	38,894	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	481,615	17,094,304	0.028174	1,591,122	44,828	65
66	Physical Therapy	452,304	15,483,176	0.029213	334,444	9,770	66
67	Occupational Therapy	30,373	5,787,965	0.005248	182,922	960	67
68	Speech Pathology	15,676	3,233,078	0.004849	115,579	560	68
69	Electrocardiology	338,941	23,427,200	0.014468	1,003,979	14,526	69
71	Medical Supplies Charged to Pat						71
72	Impl. Dev. Charged to Patients	452,991	78,905,819	0.005741			72
73	Drugs Charged to Patients	1,022,696	95,364,144	0.010724	8,126,384	87,147	73
74	Renal Dialysis	140,837	1,596,404	0.088221	131,889	11,635	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	2,892	1,079,372	0.002679			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
90.02	MOBILE MEDICAL UNIT	1,327	419,354	0.003164			90.02
90.03	FAMILY MEDICINE CENTER	55,804	3,542,661	0.015752			90.03
90.04	WOUND HEALING CENTER	43,245	3,892,637	0.011109			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	195,089	4,247,356	0.045932			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	12,201	307,189	0.039718			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	16,759					90.07
90.08	PODIATRY RESIDENCY CLINIC	7,654					90.08
90.09	FACULTY PRACTICE CLINIC	22,299	798,238	0.027935			90.09
90.10	OUR LADY OF ROSARY CLINIC	14,459	550,184	0.026280			90.10
91	Emergency	2,201,831	70,069,065	0.031424	2,221,813	69,818	91
92	Observation Beds (Non-Distinct	1,502,568	9,609,186	0.156368			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	18,395,700	889,148,464		42,790,093	791,603	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	NEONATAL INTENSIVE CARE UNIT						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	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)	57,503		1,728		30
31	Intensive Care Unit	4,716		190		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	NEONATAL INTENSIVE CARE UNIT	1,174		544		35
40	Subprovider - IPF					40
41	Subprovider - IRF	3,399		59		41
42	Subprovider I					42
43	Nursery	6,198		484		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	72,990		3,005		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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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 Anesth- etist 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							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			380,012		380,012	380,012	73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT							90.02
90.03	FAMILY MEDICINE CENTER							90.03
90.04	WOUND HEALING CENTER							90.04
90.05	OUTPATIENT TREATMENT & INFUSION							90.05
90.06	PEDIATRIC SPECIALTY CLINIC							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC							90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC							90.09
90.10	OUR LADY OF ROSARY CLINIC							90.10
91	Emergency			231,878		231,878	231,878	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			611,890		611,890	611,890	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	217,605,688			11,363,334				50
51	Recovery Room	17,694,452			643,366				51
52	Delivery Room & Labor Room	9,857,215							52
54	Radiology-Diagnostic	60,570,592			1,737,018				54
55	Radiology-Therapeutic	808,796			192,077				55
57	CT Scan	72,846,043			2,588,385				57
58	MRI	6,150,297			613,957				58
59	Cardiac Catheterization	59,348,933			2,852,267				59
60	Laboratory	108,859,116			9,091,557				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	17,094,304			1,591,122				65
66	Physical Therapy	15,483,176			334,444				66
67	Occupational Therapy	5,787,965			182,922				67
68	Speech Pathology	3,233,078			115,579				68
69	Electrocardiology	23,427,200			1,003,979				69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	78,905,819							72
73	Drugs Charged to Patients	95,364,144	0.003985	0.003985	8,126,384	32,384			73
74	Renal Dialysis	1,596,404			131,889				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,079,372							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
90.02	MOBILE MEDICAL UNIT	419,354							90.02
90.03	FAMILY MEDICINE CENTER	3,542,661							90.03
90.04	WOUND HEALING CENTER	3,892,637							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	4,247,356							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	307,189							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC								90.07
90.08	PODIATRY RESIDENCY CLINIC								90.08
90.09	FACULTY PRACTICE CLINIC	798,238							90.09
90.10	OUR LADY OF ROSARY CLINIC	550,184							90.10
91	Emergency	70,069,065	0.003309	0.003309	2,221,813	7,352			91
92	Observation Beds (Non-Distinct	9,609,186							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	889,148,464			42,790,093	39,736			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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	0.239479		24,849,737		5,950,990		50	
51	Recovery Room	0.176539		2,514,566		443,919		51	
52	Delivery Room & Labor Room	0.165825		11,505		1,908		52	
54	Radiology-Diagnostic	0.191359		9,560,265		1,829,443		54	
55	Radiology-Therapeutic	0.509348		18,427		9,386		55	
57	CT Scan	0.038389		9,524,460		365,634		57	
58	MRI	0.114078		575,886		65,696		58	
59	Cardiac Catheterization	0.253289		2,646,840		670,415		59	
60	Laboratory	0.160773		11,056,016		1,777,509		60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
65	Respiratory Therapy	0.305462		1,518,466		463,834		65	
66	Physical Therapy	0.351290		3,654,694		1,283,857		66	
67	Occupational Therapy	0.248252		239,675		59,500		67	
68	Speech Pathology	0.231670		113,647		26,329		68	
69	Electrocardiology	0.114293		2,279,341		260,513		69	
71	Medical Supplies Charged to Pat							71	
72	Impl. Dev. Charged to Patients	0.419996		3,381,489		1,420,212		72	
73	Drugs Charged to Patients	0.334131		6,106,371		2,040,328		73	
74	Renal Dialysis	1.014739		25,226		25,598		74	
76.97	CARDIAC REHABILITATION							76.97	
76.98	HYPERBARIC OXYGEN THERAPY	0.093038						76.98	
76.99	LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS									
90	Clinic							90	
90.02	MOBILE MEDICAL UNIT	0.217921		33,700		7,344		90.02	
90.03	FAMILY MEDICINE CENTER	0.552458						90.03	
90.04	WOUND HEALING CENTER	0.550161		528,336		290,670		90.04	
90.05	OUTPATIENT TREATMENT & INFUSION	0.331401		429,655		142,388		90.05	
90.06	PEDIATRIC SPECIALTY CLINIC	1.708092		34,446		58,837		90.06	
90.07	SPORTS MED FELLOWSHIP CLINIC							90.07	
90.08	PODIATRY RESIDENCY CLINIC							90.08	
90.09	FACULTY PRACTICE CLINIC	1.318921						90.09	
90.10	OUR LADY OF ROSARY CLINIC	1.684665						90.10	
91	Emergency	0.219663		15,975,507		3,509,228		91	
92	Observation Beds (Non-Distinct	0.784893		2,882,729		2,262,634		92	
OTHER REIMBURSABLE COST CENTERS									
200	Subtotal (see instructions)			97,960,984		22,966,172		200	
201	Less PBP Clinic Lab. Services-Program Only Charges							201	
202	Net Charges (line 200 - line 201)			97,960,984		22,966,172		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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	6,739,736	217,605,688	0.030972			50
51	Recovery Room	400,875	17,694,452	0.022655			51
52	Delivery Room & Labor Room	36,630	9,857,215	0.003716			52
54	Radiology-Diagnostic	1,654,788	60,570,592	0.027320	3,241	89	54
55	Radiology-Therapeutic	9,545	808,796	0.011801			55
57	CT Scan	251,987	72,846,043	0.003459	7,387	26	57
58	MRI	11,006	6,150,297	0.001790	4,074	7	58
59	Cardiac Catheterization	1,813,831	59,348,933	0.030562	1,650	50	59
60	Laboratory	465,741	108,859,116	0.004278	60,056	257	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	481,615	17,094,304	0.028174			65
66	Physical Therapy	452,304	15,483,176	0.029213	182,139	5,321	66
67	Occupational Therapy	30,373	5,787,965	0.005248	164,291	862	67
68	Speech Pathology	15,676	3,233,078	0.004849	102,839	499	68
69	Electrocardiology	338,941	23,427,200	0.014468			69
71	Medical Supplies Charged to Pat						71
72	Impl. Dev. Charged to Patients	452,991	78,905,819	0.005741			72
73	Drugs Charged to Patients	1,022,696	95,364,144	0.010724	44,930	482	73
74	Renal Dialysis	140,837	1,596,404	0.088221	8,492	749	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	2,892	1,079,372	0.002679			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
90.02	MOBILE MEDICAL UNIT	1,327	419,354	0.003164			90.02
90.03	FAMILY MEDICINE CENTER	55,804	3,542,661	0.015752			90.03
90.04	WOUND HEALING CENTER	43,245	3,892,637	0.011109			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	195,089	4,247,356	0.045932			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	12,201	307,189	0.039718			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC	16,759					90.07
90.08	PODIATRY RESIDENCY CLINIC	7,654					90.08
90.09	FACULTY PRACTICE CLINIC	22,299	798,238	0.027935			90.09
90.10	OUR LADY OF ROSARY CLINIC	14,459	550,184	0.026280			90.10
91	Emergency	2,201,831	70,069,065	0.031424			91
92	Observation Beds (Non-Distinct		9,609,186				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	16,893,132	889,148,464		579,099	8,342	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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 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							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			380,012		380,012	380,012	73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.02	MOBILE MEDICAL UNIT							90.02
90.03	FAMILY MEDICINE CENTER							90.03
90.04	WOUND HEALING CENTER							90.04
90.05	OUTPATIENT TREATMENT & INFUSION							90.05
90.06	PEDIATRIC SPECIALTY CLINIC							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC							90.07
90.08	PODIATRY RESIDENCY CLINIC							90.08
90.09	FACULTY PRACTICE CLINIC							90.09
90.10	OUR LADY OF ROSARY CLINIC							90.10
91	Emergency			231,878		231,878	231,878	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			611,890		611,890	611,890	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	217,605,688							50
51	Recovery Room	17,694,452							51
52	Delivery Room & Labor Room	9,857,215							52
54	Radiology-Diagnostic	60,570,592			3,241				54
55	Radiology-Therapeutic	808,796							55
57	CT Scan	72,846,043			7,387				57
58	MRI	6,150,297			4,074				58
59	Cardiac Catheterization	59,348,933			1,650				59
60	Laboratory	108,859,116			60,056				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	17,094,304							65
66	Physical Therapy	15,483,176			182,139				66
67	Occupational Therapy	5,787,965			164,291				67
68	Speech Pathology	3,233,078			102,839				68
69	Electrocardiology	23,427,200							69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	78,905,819							72
73	Drugs Charged to Patients	95,364,144	0.003985	0.003985	44,930	179			73
74	Renal Dialysis	1,596,404			8,492				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,079,372							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
90.02	MOBILE MEDICAL UNIT	419,354							90.02
90.03	FAMILY MEDICINE CENTER	3,542,661							90.03
90.04	WOUND HEALING CENTER	3,892,637							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	4,247,356							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	307,189							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC								90.07
90.08	PODIATRY RESIDENCY CLINIC								90.08
90.09	FACULTY PRACTICE CLINIC	798,238							90.09
90.10	OUR LADY OF ROSARY CLINIC	550,184							90.10
91	Emergency	70,069,065	0.003309	0.003309					91
92	Observation Beds (Non-Distinct	9,609,186							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	889,148,464			579,099	179			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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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: [XX] 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	0.239479							50
51	Recovery Room	0.176539							51
52	Delivery Room & Labor Room	0.165825							52
54	Radiology-Diagnostic	0.191359							54
55	Radiology-Therapeutic	0.509348							55
57	CT Scan	0.038389							57
58	MRI	0.114078							58
59	Cardiac Catheterization	0.253289							59
60	Laboratory	0.160773							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.305462							65
66	Physical Therapy	0.351290							66
67	Occupational Therapy	0.248252							67
68	Speech Pathology	0.231670							68
69	Electrocardiology	0.114293							69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients	0.419996							72
73	Drugs Charged to Patients	0.334131							73
74	Renal Dialysis	1.014739							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.093038							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
90.02	MOBILE MEDICAL UNIT	0.217921							90.02
90.03	FAMILY MEDICINE CENTER	0.552458							90.03
90.04	WOUND HEALING CENTER	0.550161							90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.331401							90.05
90.06	PEDIATRIC SPECIALTY CLINIC	1.708092							90.06
90.07	SPORTS MED FELLOWSHIP CLINIC								90.07
90.08	PODIATRY RESIDENCY CLINIC								90.08
90.09	FACULTY PRACTICE CLINIC	1.318921							90.09
90.10	OUR LADY OF ROSARY CLINIC	1.684665							90.10
91	Emergency	0.219663							91
92	Observation Beds (Non-Distinct	0.784893							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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)	57,503	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	57,503	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)	51,423	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	22,266	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)	71,331,966	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)	71,331,966	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)	71,331,966	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)						1,240.49	38
39	Program general inpatient routine service cost (line 9 x line 38)						27,620,750	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)						27,620,750	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	10,842,614	4,716	2,299.11	1,795	4,126,902	43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	NEONATAL INTENSIVE CARE UNIT	5,755,883	1,174	4,902.80			47	
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						42,672,082	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						74,419,734	49
	PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						6,179,384	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						3,047,646	51
52	Total Program excludable cost (sum of lines 50 and 51)						9,227,030	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						65,192,704	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0012

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					6,080	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,240.49	88
89	Observation bed cost (line 87 x line 88) (see instructions)					7,542,179	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	14,210,879	71,331,966	0.199222	7,542,179	1,502,568	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)	3,399	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,399	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)	3,399	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)	2,143	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)	4,316,662	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)	4,316,662	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)	4,316,662	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	1,269.98	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,721,567	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)	2,721,567	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	971,516	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	3,693,083	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	76,719	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	48,607	51
52	Total Program excludable cost (sum of lines 50 and 51)	125,326	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	3,567,757	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)	57,503	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	57,503	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)	51,423	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,728	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)	6,198	15
16	Nursery days (title V or XIX only)	484	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)	71,331,966	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)	71,331,966	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)	71,331,966	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)						1,240.49	38
39	Program general inpatient routine service cost (line 9 x line 38)						2,143,567	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)						2,143,567	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)	5,361,337	6,198	865.01	484	418,665		42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	10,842,614	4,716	2,299.11	190	436,831		43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	NEONATAL INTENSIVE CARE UNIT	5,755,883	1,174	4,902.80	544	2,667,123		47

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					9,761,776		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					15,427,962		49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					810,286		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					831,339		51
52	Total Program excludable cost (sum of lines 50 and 51)					1,641,625		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					13,786,337		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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0012

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					6,080	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)	3,399	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,399	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)	3,399	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)	59	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)	4,316,662	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)	4,316,662	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)	4,316,662	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	1,269.98	38
39	Program general inpatient routine service cost (line 9 x line 38)	74,929	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)	74,929	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	163,670	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	238,599	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	2,112	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,521	51
52	Total Program excludable cost (sum of lines 50 and 51)	10,633	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	227,966	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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		50,166,541		30
31	Intensive Care Unit		7,997,936		31
35	NEONATAL INTENSIVE CARE UNIT				35
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.240396	38,032,365	9,142,828	50
51	Recovery Room	0.176539	3,144,225	555,078	51
52	Delivery Room & Labor Room	0.165825	55,158	9,147	52
54	Radiology-Diagnostic	0.191845	6,167,059	1,183,119	54
55	Radiology-Therapeutic	0.509348	120,910	61,585	55
57	CT Scan	0.038389	9,406,708	361,114	57
58	MRI	0.114078	2,428,948	277,090	58
59	Cardiac Catheterization	0.253719	8,616,776	2,186,240	59
60	Laboratory	0.160773	28,629,885	4,602,913	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.305462	4,562,077	1,393,541	65
66	Physical Therapy	0.351290	2,070,365	727,299	66
67	Occupational Therapy	0.248252	1,491,516	370,272	67
68	Speech Pathology	0.231670	753,755	174,622	68
69	Electrocardiology	0.114293	5,012,687	572,915	69
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.419996	25,093,197	10,539,042	72
73	Drugs Charged to Patients	0.334131	23,014,287	7,689,787	73
74	Renal Dialysis	1.014739	570,099	578,502	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.093038	4,835	450	76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic				90
90.02	MOBILE MEDICAL UNIT	0.217921			90.02
90.03	FAMILY MEDICINE CENTER	0.552458			90.03
90.04	WOUND HEALING CENTER	0.550161			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.331401			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	1.735117			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC				90.07
90.08	PODIATRY RESIDENCY CLINIC				90.08
90.09	FACULTY PRACTICE CLINIC	1.318921			90.09
90.10	OUR LADY OF ROSARY CLINIC	1.684665			90.10
91	Emergency	0.221040	5,139,745	1,136,089	91
92	Observation Beds (Non-Distinct Part)	0.784893	1,414,778	1,110,449	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		165,729,375	42,672,082	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		165,729,375		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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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		3,832,266		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.240396			50
51	Recovery Room	0.176539			51
52	Delivery Room & Labor Room	0.165825			52
54	Radiology-Diagnostic	0.191845	38,866	7,456	54
55	Radiology-Therapeutic	0.509348			55
57	CT Scan	0.038389	44,149	1,695	57
58	MRI	0.114078	26,275	2,997	58
59	Cardiac Catheterization	0.253719	1,129	286	59
60	Laboratory	0.160773	416,936	67,032	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.305462	648	198	65
66	Physical Therapy	0.351290	1,131,903	397,626	66
67	Occupational Therapy	0.248252	1,020,027	253,224	67
68	Speech Pathology	0.231670	716,883	166,080	68
69	Electrocardiology	0.114293	3,586	410	69
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.419996			72
73	Drugs Charged to Patients	0.334131	203,384	67,957	73
74	Renal Dialysis	1.014739	6,460	6,555	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.093038			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic				90
90.02	MOBILE MEDICAL UNIT	0.217921			90.02
90.03	FAMILY MEDICINE CENTER	0.552458			90.03
90.04	WOUND HEALING CENTER	0.550161			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.331401			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	1.735117			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC				90.07
90.08	PODIATRY RESIDENCY CLINIC				90.08
90.09	FACULTY PRACTICE CLINIC	1.318921			90.09
90.10	OUR LADY OF ROSARY CLINIC	1.684665			90.10
91	Emergency	0.221040			91
92	Observation Beds (Non-Distinct Part)	0.784893			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,610,246	971,516	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,610,246		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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0012

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		23,857,220		30
31	Intensive Care Unit		3,247,098		31
35	NEONATAL INTENSIVE CARE UNIT		6,998,371		35
41	Subprovider - IRF				41
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.240396	11,363,334	2,731,700	50
51	Recovery Room	0.176539	643,366	113,579	51
52	Delivery Room & Labor Room	0.165825			52
54	Radiology-Diagnostic	0.191845	1,737,018	333,238	54
55	Radiology-Therapeutic	0.509348	192,077	97,834	55
57	CT Scan	0.038389	2,588,385	99,366	57
58	MRI	0.114078	613,957	70,039	58
59	Cardiac Catheterization	0.253719	2,852,267	723,674	59
60	Laboratory	0.160773	9,091,557	1,461,677	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.305462	1,591,122	486,027	65
66	Physical Therapy	0.351290	334,444	117,487	66
67	Occupational Therapy	0.248252	182,922	45,411	67
68	Speech Pathology	0.231670	115,579	26,776	68
69	Electrocardiology	0.114293	1,003,979	114,748	69
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.419996			72
73	Drugs Charged to Patients	0.334131	8,126,384	2,715,277	73
74	Renal Dialysis	1.014739	131,889	133,833	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.093038			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic				90
90.02	MOBILE MEDICAL UNIT	0.217921			90.02
90.03	FAMILY MEDICINE CENTER	0.552458			90.03
90.04	WOUND HEALING CENTER	0.550161			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.331401			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	1.735117			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC				90.07
90.08	PODIATRY RESIDENCY CLINIC				90.08
90.09	FACULTY PRACTICE CLINIC	1.318921			90.09
90.10	OUR LADY OF ROSARY CLINIC	1.684665			90.10
91	Emergency	0.221040	2,221,813	491,110	91
92	Observation Beds (Non-Distinct Part)	0.784893			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		42,790,093	9,761,776	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		42,790,093		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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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		610,392		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.240396			50
51	Recovery Room	0.176539			51
52	Delivery Room & Labor Room	0.165825			52
54	Radiology-Diagnostic	0.191845	3,241	622	54
55	Radiology-Therapeutic	0.509348			55
57	CT Scan	0.038389	7,387	284	57
58	MRI	0.114078	4,074	465	58
59	Cardiac Catheterization	0.253719	1,650	419	59
60	Laboratory	0.160773	60,056	9,655	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.305462			65
66	Physical Therapy	0.351290	182,139	63,984	66
67	Occupational Therapy	0.248252	164,291	40,786	67
68	Speech Pathology	0.231670	102,839	23,825	68
69	Electrocardiology	0.114293			69
71	Medical Supplies Charged to Patients				71
72	Impl. Dev. Charged to Patients	0.419996			72
73	Drugs Charged to Patients	0.334131	44,930	15,013	73
74	Renal Dialysis	1.014739	8,492	8,617	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.093038			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic				90
90.02	MOBILE MEDICAL UNIT	0.217921			90.02
90.03	FAMILY MEDICINE CENTER	0.552458			90.03
90.04	WOUND HEALING CENTER	0.550161			90.04
90.05	OUTPATIENT TREATMENT & INFUSION	0.331401			90.05
90.06	PEDIATRIC SPECIALTY CLINIC	1.735117			90.06
90.07	SPORTS MED FELLOWSHIP CLINIC				90.07
90.08	PODIATRY RESIDENCY CLINIC				90.08
90.09	FACULTY PRACTICE CLINIC	1.318921			90.09
90.10	OUR LADY OF ROSARY CLINIC	1.684665			90.10
91	Emergency	0.221040			91
92	Observation Beds (Non-Distinct Part)	0.784893			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		579,099	163,670	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		579,099		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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)	10,682,445			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	34,700,878			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	1,644,340			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	19,216,677			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	240.34			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	26.25			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)	0.112882			19
20	Prior year resident to bed ratio (see instructions)	0.107665			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.107665			21
22	IME payment adjustment (see instructions)	2,590,525			22
22.01	IME payment adjustment - Managed Care (see instructions)	1,096,907			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)	3.79			24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	2,590,525			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	1,096,907			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0361			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2252			31
32	Sum of lines 30 and 31	0.2613			32
33	Allowable disproportionate share percentage (see instructions)	0.1077			33
34	Disproportionate share adjustment (see instructions)	1,221,946			34
		Prior to		On or after	
		October 1 (1.00)	(1.01)	October 1 (2.00)	
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)	2,093,738		1,849,006	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	526,295		1,382,955	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,909,250			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

KPMG LLP Compu-Max 2552-10

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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)	52,749,384			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)	53,846,291			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	4,530,541			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)	1,640,854			52
53	Nursing and allied health managed care payment	297,369			53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	108,719			58
59	Total (sum of amounts on lines 49 through 58)	60,423,774			59
60	Primary payer payments	24,427			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	60,399,347			61
62	Deductibles billed to program beneficiaries	5,067,720			62
63	Coinsurance billed to program beneficiaries	98,126			63
64	Allowable bad debts (see instructions)	478,204			64
65	Adjusted reimbursable bad debts (see instructions)	310,833			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	187,875			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	55,544,334			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)	-357,381			70.93
70.94	HRR adjustment amount (see instructions)	-13,882			70.94
71	Amount due provider (see instructions)	55,173,071			71
71.01	Sequestration adjustment (see instructions)	1,103,461			71.01
72	Interim payments	53,638,296			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	431,314			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	782,869			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

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)	44,100			1
2	Medical and other services reimbursed under OPSS (see instructions)	25,488,665			2
3	PPS payments	22,002,313			3
4	Outlier payment (see instructions)	91,767			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	106,522			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	44,100			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	131,983			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)	131,983			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)	131,983			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	87,883			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)	44,100			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)	22,200,602			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	167,471			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	3,793,386			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)	18,283,845			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	538,669			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	18,822,514			30
31	Primary payer payments	4,675			31
32	Subtotal (line 30 minus line 31)	18,817,839			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)	807,441			34
35	Adjusted reimbursable bad debts (see instructions)	524,837			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	612,525			36
37	Subtotal (see instructions)	19,342,676			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)	19,342,676			40
40.01	Sequestration adjustment (see instructions)	386,854			40.01
41	Interim payments	18,780,262			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	175,560			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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)	692			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)	692			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	2,071			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)	2,071			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)	2,071			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	1,379			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)	692			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)	692			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)	692			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	692			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)	3,150			34
35	Adjusted reimbursable bad debts (see instructions)	2,048			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	2,740			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)	2,740			40
40.01	Sequestration adjustment (see instructions)	55			40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	2,685			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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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		53,866,496		18,780,262	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	12/21/2016	228,200		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		-228,200		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)			53,638,296	18,780,262	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		431,314	175,560	6.01
		.02				6.02
7	Total Medicare program liability (see instructions)			54,069,610	18,955,822	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-T012

WORKSHEET E-1
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		2,949,555		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)		2,949,555		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	27,337		2,685
		.02			6.02
7	Total Medicare program liability (see instructions)		2,976,892		2,685
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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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)	14,376	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	24,061	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	9,875	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	57,313	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	1,048,187,426	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	19,653,767	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)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T012

WORKSHEET E-3
PART III

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	2,891,193		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.017800		2
3	Inpatient Rehabilitation LIP payments (see instructions)	107,263		3
4	Outlier payments	57,349		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	9,312329		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	3,055,805		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)	3,055,805		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	3,055,805		19
20	Deductibles	9,100		20
21	Subtotal (line 19 minus line 20)	3,046,705		21
22	Coinsurance	9,870		22
23	Subtotal (line 21 minus line 22)	3,036,835		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)			24
25	Adjusted reimbursable bad debts (see instructions)			25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)			26
27	Subtotal (sum of lines 23 and 25)	3,036,835		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)	810		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)	3,037,645		32
32.01	Sequestration adjustment (see instructions)	60,753		32.01
33	Interim payments	2,949,555		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	27,337		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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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		22,966,172	2
3			3
4		22,966,172	4
5			5
6			6
7		22,966,172	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9	42,790,093	97,960,984	9
10			10
11			11
12	42,790,093	97,960,984	12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	42,790,093	97,960,984	16
17	42,790,093	74,994,812	17
18			18
19			19
20			20
21		22,966,172	21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26	39,736		26
27	39,736		27
28			28
29	39,736	22,966,172	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	39,736	22,966,172	31
32			32
33			33
34			34
35			35
36	39,736	22,966,172	36
37			37
38	39,736	22,966,172	38
39			39
40	39,736	22,966,172	40
41			41
42	39,736	22,966,172	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			22.87	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA			2.14	3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			7.00	4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			27.73	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			26.25	6
7	Enter the lesser of line 5 or line 6			26.25	7
		Primary Care 1	Other 2	Total 3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	26.25	0.00	26.25	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	26.25	0.00	26.25	9
10	Weighted dental and podiatric resident FTE count for the current year		5.00		10
10.01	Unweighted dental and podiatric resident FTE count for the current year		5.00		10.01
11	Total weighted FTE count	26.25	5.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	27.59	5.49		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	25.26	4.50		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	26.37	5.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	26.37	5.00		17
18	Per resident amount	122,929.61	116,767.11		18
19	Approved amount for resident costs	3,241,654	583,836	3,825,490	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)			3,825,490	25
COMPUTATION OF PROGRAM PATIENT LOAD					
26	Inpatient days (see instructions)	26,207	10,248		26
27	Total inpatient days (see instructions)	61,444	61,444		27
28	Ratio of inpatient days to total inpatient days	0.426518	0.166786		28
29	Program direct GME amount	1,631,640	638,038		29
30	Reduction for direct GME payments for Medicare Advantage		90,155		30
31	Net Program direct GME amount			2,179,523	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)			1,596,404	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)			78,112,817	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)			24,427	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			78,088,390	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			25,639,979	42
43	Primary payer payments (see instructions)			4,675	43
44	Total Part B reasonable cost (line 42 minus line 43)			25,635,304	44
45	Total reasonable cost (sum of lines 41 and 44)			103,723,694	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.752850	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.247150	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)			2,179,523	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			1,640,854	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			538,669	50

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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: [XX] 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 cap (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6
7	Enter the lesser of line 5 or line 6			7
		Primary Care	Other	Total
		1	2	3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00 8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00 9
10	Weighted dental and podiatric resident FTE count for the current year		0.00	10
10.01	Unweighted dental and podiatric resident FTE count for the current year			10.01
11	Total weighted FTE count	0.00	0.00	11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00	12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00	13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00	14
15	Adjustment for residents in initial years of new programs	0.00	0.00	15
15.01	Unweighted adjustment for residents in initial years of new programs			15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	16
16.01	Unweighted adjustment for residents displaced by program or hospital closure			16.01
17	Adjusted rolling average FTE count	0.00	0.00	17
18	Per resident amount	0.00	0.00	18
19	Approved amount for resident costs			19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			20
21	Direct GME FTE unweighted resident count over cap (see instructions)			21
22	Allowable additional direct GME FTE resident count (see instructions)			22
23	Enter the locality adjustment national average per resident amount (see instructions)			23
24	Multiply line 22 times line 23			24
25	Total direct GME amount (sum of lines 19 and 24)			25
COMPUTATION OF PROGRAM PATIENT LOAD				
		Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	2,936	11,608	26
27	Total inpatient days (see instructions)	61,444	61,444	27
28	Ratio of inpatient days to total inpatient days	0.047783	0.188920	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

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	4,709,136				1
2	Temporary investments	28,652,835				2
3	Notes receivable					3
4	Accounts receivable	54,923,295				4
5	Other receivables	11,707,235				5
6	Allowances for uncollectible notes and accounts receivable	-8,637,871				6
7	Inventory	6,449,082				7
8	Prepaid expenses	655,615				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	98,459,327				11
FIXED ASSETS						
12	Land	406,021				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation					16
17	Leasehold improvements	213,318,926				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	199,289,954				23
24	Accumulated depreciation	-139,306,326				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)	273,708,575				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	22,994,442				34
35	Total other assets (sum of lines 31-34)	22,994,442				35
36	Total assets (sum of lines 11, 30 and 35)	395,162,344				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	18,071,350				37
38	Salaries, wages and fees payable	4,969,236				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	6,948,798				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	-247,596				44
45	Total current liabilities (sum of lines 37 thru 44)	29,741,788				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	289,986,790				47
48	Unsecured loans					48
49	Other long term liabilities	12,434,190				49
50	Total long term liabilities (sum of lines 46 thru 49)	302,420,980				50
51	Total liabilities (sum of lines 45 and 50)	332,162,768				51
CAPITAL ACCOUNTS						
52	General fund balance	62,999,576				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)	62,999,576				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	395,162,344				60

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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		63,009,888		
2	Net income (loss) (from Worksheet G-3, line 29)		27,626,771		
3	Total (sum of line 1 and line 2)		90,636,659		
4	Additions (credit adjustments) (specify)				
5	TOTAL UNREST EQ TRANSFERS - EXT	-27,796,000			
6	NA REL FROM REST FOR CAP ACQ	782,870			
7					
8					
9					
10	Total additions (sum of lines 4-9)		-27,013,130		
11	Subtotal (line 3 plus line 10)		63,623,529		
12	Deductions (debit adjustments) (specify)				
13	TOTAL UNREST NA ACTIVITY	623,953			
14					
15					
16					
17					
18	Total deductions (sum of lines 12-17)		623,953		
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		62,999,576		

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

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	540,211,557		540,211,557	1
2	Subprovider IPF				2
3	Subprovider IRF	6,261,979		6,261,979	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)	546,473,536		546,473,536	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	21,351,014		21,351,014	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	NEONATAL INTENSIVE CARE UNIT	11,664,374		11,664,374	15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	33,015,388		33,015,388	16
17	Total inpatient routine care services (sum of lines 10 and 16)	579,488,924		579,488,924	17
18	Ancillary services		9,681,090	9,681,090	18
19	Outpatient services		486,937,834	486,937,834	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)	579,488,924	496,618,924	1,076,107,848	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		312,381,638	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	NON OPERATING INVESTMENT EARNINGS			38
39	NON OPERATING DERIVATIVES			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)		312,381,638	43

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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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	1,076,107,848	1
2	Less contractual allowances and discounts on patients' accounts	743,309,611	2
3	Net patient revenues (line 1 minus line 2)	332,798,237	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	312,381,638	4
5	Net income from service to patients (line 3 minus line 4)	20,416,599	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)	7,210,172	24
25	Total other income (sum of lines 6-24)	7,210,172	25
26	Total (line 5 plus line 25)	27,626,771	26
29	Net income (or loss) for the period (line 26 minus line 28)	27,626,771	29

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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	3,651,804	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	502,966	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)	161.40	3
4	Number of interns & residents (see instructions)	27.13	4
5	Indirect medical education percentage (see instructions)	4.86	5
6	Indirect medical education adjustment (see instructions)	177,478	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0361	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.2252	8
9	Sum of lines 7 and 8	0.2613	9
10	Allowable disproportionate share percentage (see instructions)	0.0543	10
11	Disproportionate share adjustment (see instructions)	198,293	11
12	Total prospective capital payments (see instructions)	4,530,541	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: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0012

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

KPMG LLP Compu-Max 2552-10

ST. JOSEPH'S REG MED CENTER S. BEND Provider CCN: 15-0012	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 10:59 Version: 2017.10 (10/12/2017)
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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	Clinic						90
90.02	MOBILE MEDICAL UNIT						90.02
90.03	FAMILY MEDICINE CENTER						90.03
90.04	WOUND HEALING CENTER						90.04
90.05	OUTPATIENT TREATMENT & INFUSION						90.05
90.06	PEDIATRIC SPECIALTY CLINIC						90.06
90.07	SPORTS MED FELLOWSHIP CLINIC						90.07
90.08	PODIATRY RESIDENCY CLINIC						90.08
90.09	FACULTY PRACTICE CLINIC						90.09
90.10	OUR LADY OF ROSARY CLINIC						90.10
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	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

KPMG LLP Compu-Max 2552-10

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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)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
192	Physicians' Private Offices							192
192.01	MATERNAL FETAL MEDICINE/LABORIST							192.01
192.02	NEONATOLOGISTS							192.02
192.03	HOSPITALISTS/INTENSIVISTS							192.03
194	SPORTS MED-ATHLETIC TRAINERS							194
194.01	OUTREACH SERVICES							194.01
194.02	KINDRED/OUR LADY OF PEACE							194.02
194.03	ADVANCED SPECIALTIES							194.03
194.04	AMBULATORY PHARMACY SERVICES							194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202