Heal th Financi	al Systems	ST. VINCENT FISHE	RS HOSPI TAL	In Lieu	u of Form CMS-255	2-10
		ISC 1395g; 42 CFR 413.20(b)). Fai				
		the cost reporting period being			OMB NO. 0938-005 EXPIRES 03-31-20	
HOSPITAL AND F AND SETTLEMEN		MPLEX COST REPORT CERTIFICATION	Provider CCN: 15-0181	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepar 11/22/2019 3:53	ed:
PART I - COST	REPORT STATUS					
Provider use only	1. [ X ] Electronically 2. [ ] Manually submi			Date: 11/22/20	019 Time: 3:53	3 pm
5	3. 0 If this is an	amended report enter the number zation. Enter "F" for full or "I	of times the provider ro L" for low.	esubmitted this co	ost report	
Contractor use only	5. [ 1 ]Cost Report S (1) As Submitted (2) Settled without (3) Settled with Au (4) Reopened (5) Amended	7. Contractor No. t Audit 8. [ N ] Initial Report fo	11.( or this Provider CCN 12.		or Code: Iumn 1 is 4: Ente wes reopened = 0-9	
PART II - CER						
ADMI NI STRATI VE PROVI DED OR PE ADMI NI STRATI VE	E ACTION, FINE AND/OR I ROCURED THROUGH THE PAY E ACTION, FINES AND/OR	OF ANY INFORMATION CONTAINED IN T MPRISONMENT UNDER FEDERAL LAW. MENT DIRECTLY OR INDIRECTLY OF A IMPRISONMENT MAY RESULT.	FURTHERMORE, IF SERVICES A KICKBACK OR WERE OTHERV	S IDENTIFIED IN TH	IIS REPORT WERE	
CERTI	FICATION BY CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR OF	F PROVIDER(S)			
elect Expension complexcep healt laws	ronically filed or manuses prepared by ST. VII nding 06/30/2019 and to ete and prepared from t t as noted. I further h care services, and th and regulations.	e read the above certification si ually submitted cost report and to NCENT FISHERS HOSPITAL (15-0181 to the best of my knowledge and be the books and records of the provi- certify that I am familiar with nat the services identified in the	the Balance Sheet and Sta ) for the cost reporting elief, this report and so vider in accordance with the laws and regulations his cost report were prov	atement of Revenue g period beginning tatement are true, applicable instru s regarding the pr vided in complianc	e and g 07/01/2018 correct, uctions, rovision of ce with such	
[ ]	I nave read and agree	with the above certification sta	tement. I certify that I	intend my electro	DNIC	

signature on this certification statement to be the legally binding equivalent of my original signature. (Signed)

Officer or Administrator of Provider(s)

Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	8, 340	27, 653	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
12.00	CMHC	0		0		0	12.00
200.00	Total	0	8, 340	27, 653	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. 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-MEDI CARE.

SPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DAT	A	Provi der	CCN: 1	5-0181	Period: From 07/0	1/2019		eet S-2	2
								0/2019	Date/T	ime Pre 2019 3:	
	1.00	2.0	00	3.	00			4.00	11/22/	2019 3.	<u>55 p</u>
_	Hospital and Hospital Health Care Co										
	Street: 13861 OLIO RD City: FISHERS	PO Box: State: II	N 7i	ip Code:	46037	Coun	ty: HAMILT	N			1.
0		Component Nar		CCN	CBSA	Provi de	1	Paym	ent Sys <sup>.</sup>		
			Nu	umber   N	lumber	Туре	Certifie		Г, 0, or		-
		1.00		2.00	3.00	4.00	5.00	V 6. 00	XVIII 0 7.00		-
	Hospital and Hospital-Based Componer		4	2.00	3.00	4.00	5.00	0.00	5   7.00	0.00	
0	Hospi tal	ST. VINCENT FISHE	RS 15	50181	26900	1	05/13/20	13 N	Р	0	3
0	Subprovider - IPF	HOSPI TAL									4
0	Subprovider - IRF										5
0	Subprovider - (Other)										6
0	Swing Beds - SNF										7
) )	Swing Beds - NF Hospital-Based SNF										8
) 00	Hospi tal -Based NF										10
00	Hospi tal -Based OLTC										11.
00	Hospital-Based HHA										12.
00 00	Separately Certified ASC Hospital-Based Hospice										13
00	Hospital-Based Health Clinic - RHC										15
00	Hospital-Based Health Clinic - FQHC										16
00 00	Hospital-Based (CMHC) I										17
	Renal Dialysis Other										19
							Fro		To		
00	Cost Departing Depied (mm/dd (uuuu)						07/01			00 )/2019	20
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						1		06/30	0/2019	20
	Innationt DDC Information					1.00	2. (	00	3.	00	-
00	Inpatient PPS Information Does this facility qualify and is it	currently receivi	ng paymen	nts for		Y	N				22
	disproportionate share hospital adju	stment, in accorda	ance with	42 CFR							
	§412.106? In column 1, enter "Y" fo										
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo			ient							
01	Did this hospital receive interim ur			or this		Y	Y				22
	cost reporting period? Enter in colu										
	the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N				+						
	reporting period occurring on or aft										
02	Is this a newly merged hospital that					Ν	N				22
	payments to be determined at cost re Enter in column 1, "Y" for yes or "N										
	cost reporting period prior to Octob				s						
	or "N" for no, for the portion of th										
03	October 1. Did this hospital receive a geograph	i c. reclassi fi catio	on from ur	ban to		Ν	N			N	22
	rural as a result of the OMB standar	ds for delineating	g statisti	cal area	s				'	-	
	adopted by CMS in FY2015? Enter in c										
	for the portion of the cost reportin in column 2, "Y" for yes or "N" for										
	reporting period occurring on or aft										
	Does this hospital contain at least										
	counted in accordance with 42 CFR 41 yes or "N" for no.	2.105)? Enter in (	column 3,	"Y" for							
00	Which method is used to determine Me						3 N				23
	below? In column 1, enter 1 if date			2							
	if date of discharge. Is the method reporting period different from the				t						
	reporting period arreport roll me										
			In-State	In-Sta		ut-of	Out-of	Medi ca		)ther	
			Medicaid paid days	Medica eligib		State di cai d	State Medicaid	HMO da	2	di cai d days	
			para days	unpai		d days	eligible				
				days			unpai d				
20	If this provides is an LDDC has it i	optor the	1.00	2.00		3.00	4.00	5.00		6.00	
JU	If this provider is an IPPS hospital in-state Medicaid paid days in colum		88		4	0	0		511	C	24
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c	olumn 3,									
		olumn 3, d days in column									

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC			80/2019	Part Date/ 11/22	Time Pre /2019 3:	epared
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ays Me	Other edi cai d days	
00	If this provider is an LDE opter the instate	1.00	2.00	3.00	4.00	5.00	0	6.00	25.
5. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0	0				of Geogr	
					1.			. 00	-
. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	r rural. age) status r "2" for r ication in d	at the end ural. If ap column 2.	l of the cos pplicable,	he t	1			26. 27. 35.
. 00	effect in the cost reporting period.	e number of	perious so			0			55.
					Begi n			li ng:	_
. 00	Enter applicable beginning and ending dates of SCH st	tatus. Subs	cript line	36 for numh	1. er	00	2	. 00	36.
	of periods in excess of one and enter subsequent date	es.							
. 00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th		·		IS	0			37
0.	accordance with FY 2016 OPPS final rule? Enter "Y" fo								
00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38
					Y/ 1.			//N . 00	_
. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	), (ii), or the mileage	(iii)? Ent requiremen	er in colum its in	me M In			N	39.
. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	ber 1. Ente	r "Y" for y					N	40
						V	XVII 2.00	_	-
	Prospective Payment System (PPS)-Capital					11.00		, 0.00	
00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	·	·			N N	N	N	45
00	Is this facility eligible for additional payment exceptures pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.								40
00 00	Is this a new hospital under 42 CFR §412.300(b) PPS c Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N	47
00	Is this a hospital involved in training residents in or "N" for no.		1 3		2	N			56
00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. III If line 56 is yes, did this facility aloct cost reint	r yes or "N th of this Y", complet I, if appli	' for no in cost report e Worksheet cable.	i column 1. ing period? E-4. lf co	lf column 'Enter "Y lumn 2 is				57
00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			IIIS SELVICE	s ds				58
00	Are costs claimed on line 100 of Worksheet A? If yes			Pt. I. NAHE 413.8	35 Workst	N neet A		Through	
				Y/N	Lin	e #		ication ion Code	
. 00 . 00					Li n 2.		Cri ter		

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider C	F		11/22/2019 3:	pared
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
<ol> <li>Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>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)</li> </ol>	N			0.00	0. 00	61. (
1.02 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. (
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
<ol> <li>O4 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).</li> </ol>						61.0
<ul> <li>1. 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)</li> <li>1. 04 minus line 61.03 (SECO and the based of th</li></ul>						61.0
<ol> <li>D6 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)</li> </ol>						61.(
	Pro	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.
<ol> <li>10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> <li>1. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program name.</li> <li>Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count.</li> </ol>				0.00		61. :
					1.00	1
ACA Provisions Affecting the Health Resources and Ser						
<ol> <li>2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC program.</li> </ol>	tions) Teachi ram. (s	ng Health Cen ee instructio	ter (THC) into			62. ( 62. (
Teaching Hospitals that Claim Residents in Nonprovide 3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this c	<u>67. (see instru</u>	<u>ictions)</u>	N	63.
			Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	nprovid	er Settings	1.00 This base year	2.00	<u> </u>	
<ul> <li>4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see</li> </ul>	<u>e June</u> y train -primar all non non-pr column	30, 2010. ed residents y care provider imary care 3 the ratio	0. 00			64.0

	LEX IDENTIFICATION DA	TA Provider (		ri od:	Worksheet S-2	
			To	om 07/01/2018 06/30/2019	Date/Time Pre	
	Program Name	Program Code	Unweighted	Unweighted	11/22/2019 3: Ratio (col. 3/	
	5		FTĔs	FTEsin	(col. 3 + col.	
			Nonprovider Site	Hospi tal	4))	
	1.00	2.00	3.00	4.00	5.00	1
.00 Enter in column 1, if line 63			0.00	0.00		65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column						
4)). (see instructions)			Unweighted	Unweighted	Ratio (col. 1/	/
			FTĔs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te 1. 00	2.00	3.00	-
Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Settin				
beginning on or after July 1, 20 Enter in column 1 the number of a FTEs attributable to rotations of Enter in column 2 the number of a FTEs that trained in your hospita	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0. OC	0. 000000	66. (
(column 1 divided by (column 1 +	Column 2)). (see ins Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in			0.00	0.00	0. 000000	
your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column				1.00	0 2.00 3.00	-
your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		DE) or does it seed	tain an IDE outra		0 2.00 3.00	70
your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	ychiatric Facility (I	PF), or does it cont	tain an IPF subp		0 2.00 3.00	70. (
your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility P Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFI Column 3: If column 2 is Y, indice (see instructions)	ychiatric Facility (I the facility have ar efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	n approved GME teachi 004? Enter "Y" for y lity train residents (D)? Enter "Y" for y	ing program in th yes or "N" for no s in a new teach yes or "N" for no	rovider? N ne most p. (see ng p.	0 2.00 3.00	
your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility P 0.00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. .00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFI Column 3: If column 2 is Y, indice	ychiatric Facility (I the facility have ar efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye y PPS	n approved GME teachi 204? Enter "Y" for y lity train residents (D)? Enter "Y" for y ear began during this	ing program in th yes or "N" for n s in a new teach yes or "N" for n s cost reporting	rovider? N ne most p. (see ng p.		70.0

Health Financial Systems ST. VINCENT FISHERS HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0181 Peri od: Worksheet S-2 From 07/01/2018 Part I 06/30/2019 Date/Time Prepared: То 11/22/2019 3:53 pm 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 Ν 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Ν 85 00 85 00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87 00 Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν γ 90 00 ves or "N" for no in the applicable column. 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. 91 00 Ν γ 91 00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 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. 92.00 Ν 92.00 93.00 Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν Ν 94 00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0 00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν Ν 96.00 applicable column 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97.00 0 00 0.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Ν 98.00 Υ stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Υ 98.01 98.01 Ν C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation Ν γ 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and Ν 98.04 Ν in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in 98.05 γ 98.05 Ν column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, 98.06 Ν Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Ν 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R Ν 107.00 training programs? Enter "Y" for yes or "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. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 108.00 Ν CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Respi ratory Physi cal Occupati onal Speech 1 00 2 00 4 00 3 00 109.00 If this hospital qualifies as a CAH or a cost provider, are 109.00 therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, 110.00 Ν complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	RS HOSPITAL Provider CCN:	15-0181	Period: From 07/01, To 06/30,	/2018	u of For Workshe Part I Date/Ti 11/22/2	eet S-2 me Pre	2 epared:
			1.00	)	2.0	00	-
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	reporting per mn 1 is Y, ent cipating in co	iod? Enter er the lumn 2.	N				111.00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or " is yes, enter the method used (A, B, or E only) in column 2. I 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers) Pub.15-1, chapter 22, §2208.1.	f column 2 is for long term based on the	"E", enter care (incl definition	in column udes	N		0	115.00
16.00 Is this facility classified as a referral center? Enter "Y" fo 17.00 Is this facility legally-required to carry malpractice insuran			"N" for	N Y			116. 00 117. 00
no. 18.00 Is the malpractice insurance a claims-made or occurrence polic claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if	the policy	is	1			118.00
		Premi ums	Losse	s	Insur	ance	
		1.00	2.00		3. (		
18.01 List amounts of malpractice premiums and paid losses:			0	0	:	211, 114	118.0
18.02 Are malpractice premiums and paid losses reported in a cost ce	ntor other the	n the	1. OC	)	2. (	00	118. 0
Administrative and General? If yes, submit supporting schedul and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments	łarmless provis column 1, "Y" f ifies for the	sion in ACA For yes or Outpatient			Ν	I	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 21.00Did this facility incur and report costs for high cost implant	able devices c	charged to	Y				121.00
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defin Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included.	ned in §1903(w) s "Y", enter i	(3) of the n column 2	Y		5. (	00	122. 0
Transplant Center Information 25.00Does this facility operate a transplant center? Enter "Y" for	yes and "N" fo	orno.lf	N				125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter	er the certific	ation date					126. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter	the certifica	ntion date					127.0
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter	the certifica	ntion date					128.0
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter	the certificat	ion date i	n				129. 0
column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, en date in column 1 and termination date, if applicable, in colum		i cati on					130. 0
31.00 If this is a Medicare certified intestinal transplant center,	enter the cert	i fi cati on					131.0
date in column 1 and termination date, if applicable, in colum 32.00   f this is a Medicare certified islet transplant center, enter		ntion date					132. 0
in column 1 and termination date, if applicable, in column 2. 33.00 If this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certifica	ntion date					133. 0
34.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.	OPO number in	column 1					134. 0
All Providers 40.00Are there any related organization or home office costs as def	ined in CMS Pu	ıb. 15-1.	Y		15H	046	140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If ye							

ealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		FI SHERS HOSP Provi		: 15-018		ri od:	Lieu of Form CM Worksheet S	
					Fr To	om 07/01/20 06/30/20		repared
1.00						2.02	11/22/2019	3:53 pm
<u> </u>	in organization ontor	2.00	throug	b 1/2 +	ho nam	3.00		
home office and enter the home of 41.00 Name: ST. VINCENT HEALTH		nd contractor						141.0
41.00 Name: SI. VINCENT HEALTH 42.00 Street: 250 WEST 96TH STREET, SUIT		9: WP5		Contr	actor	s Number: 8	3101	141.
43. 00 City: INDIANAPOLIS	State:	IN		ZipC	Code:	4	16260	143.
							1.00	
44.00 Are provider based physicians' cos	sts included in Workshe	et A?					Y	144. (
						1.00	2.00	
<ul> <li>45.00 If costs for renal services are clipatient services only? Enter "Y' no, does the dialysis facility in period? Enter "Y" for yes or "N"</li> <li>46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in</li> </ul>	' for yes or "N" for no clude Medicare utilizat for no in column 2. gy changed from the pre n column 1. (See CMS Pu	o in column 1 ion for this eviously file	lf col cost re d cost i	lumn 1 i eportinç report?	9	Ν		145. 146.
yes, enter the approval date (mm/o	dd/yyyy) in column 2.							
							1.00	
47.00 Was there a change in the statist							N N	147.
48.00 Was there a change in the order of							N	148.
49.00 Was there a change to the simplifi	ea cost finding method	I? Enter "Y" Part		or "N" Part		o. Title V	N Title XIX	149.
		1.00				<u> </u>	4.00	
Does this facility contain a prov	ider that qualifies for							
or charges? Enter "Y" for yes or	"N" for no for each com	-	art <u>A</u> a		B. (Se			
55.00 Hospi tal		N		N		N	N	155.
56.00 Subprovider - IPF 57.00 Subprovider - IRF		N		N N		N N	N	156. 157.
57. 00 SUBPROVI DER		IN		IN		IN	IN IN	157.
59. 00 SNF		N		Ν		Ν	N	159.
60.00 HOME HEALTH AGENCY		N		Ν		Ν	N	160.
61.00 CMHC				N		N	N	161. (
							1.00	_
Multicampus					66	L 00001 0	N	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	s one or more	campuse	es in di	fferer	IT CBSAS?	N	165. (
	Name	County		State	Zip (	Code CBS	A FTE/Campus	6
	0	1.00		2.00	3.0	0 4.0		
166.00 If line 165 is yes, for each campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.	00 166. (
							1.00	
Used the Longerment and Talahard and (111)	T) incentive in the Ame					Act		
	r under §1886(n)? Ente					enter the	Y	167. 0168.
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10	D5 is "Y") and is a mea				6			110
67.001s this provider a meaningful use 68.001f this provider is a CAH (line 10 reasonable cost incurred for the 1	D5 is "Y") and is a mea HIT assets (see instruc	tions)	nul d	പംപ		hondol:		168.
67.00 is this provider a meaningful use 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the 1 68.01 if this provider is a CAH and is n	D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user,	ctions) does this pro				hardshi p		
<ul> <li>67.00 Is this provider a meaningful user</li> <li>68.00 If this provider is a CAH (line 10 reasonable cost incurred for the l</li> <li>68.01 If this provider is a CAH and is nexception under §413.70(a)(6)(i)</li> <li>69.00 If this provider is a meaningful to</li> </ul>	D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	ctions) does this pro "N" for no.	(see ins	structio	ons)		he 9.	99169.
67.00 is this provider a meaningful use 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the i 68.01 if this provider is a CAH and is exception under §413.70(a)(6)(ii) <sup>2</sup>	D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	ctions) does this pro "N" for no.	(see ins	structio	ons)	), enter t		99169.
<ul> <li>67.00 Is this provider a meaningful user</li> <li>68.00 If this provider is a CAH (line 10 reasonable cost incurred for the l</li> <li>68.01 If this provider is a CAH and is nexception under §413.70(a)(6)(i)</li> <li>69.00 If this provider is a meaningful to</li> </ul>	D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	ctions) does this pro "N" for no.	(see ins	structio	ons)			99169.
<ul> <li>67.00 is this provider a meaningful user</li> <li>68.00 if this provider is a CAH (line 10 reasonable cost incurred for the l</li> <li>68.01 if this provider is a CAH and is a exception under §413.70(a) (6) (ii)'</li> <li>69.00 if this provider is a meaningful of transition factor. (see instruction)</li> </ul>	D5 is "Y") and is a mea HIT assets (see instruct not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	tions) does this pro "N" for no. and is not a	(see ins CAH (li	structic ine 105	ons)	), enter t Beginning	g Ending 2.00	
<ul> <li>167.00 Is this provider a meaningful user is a CAH (line 10 reasonable cost incurred for the line 10 reasonable cost incurred for the line exception under §413.70(a) (6) (ii) (169.00) If this provider is a meaningful of transition factor. (see instruction 170.00 Enter in columns 1 and 2 the EHR I</li> </ul>	D5 is "Y") and is a mea HIT assets (see instruct not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	tions) does this pro "N" for no. and is not a	(see ins CAH (li	structic ine 105	ons)	), enter t Begi nni n <u>o</u> 1.00 10/01/201	g Endi ng 2.00 8 12/31/2018	
<ul> <li>167.00 Is this provider a meaningful user is a CAH (line 10 reasonable cost incurred for the line 10 reasonable cost incurred for the line exception under §413.70(a) (6) (ii) (169.00) If this provider is a meaningful of transition factor. (see instruction 170.00 Enter in columns 1 and 2 the EHR I</li> </ul>	D5 is "Y") and is a mea HT assets (see instruction to ta meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") ons) Deginning date and endi	tions) does this pro "N" for no. and is not a ng date for	(see ins CAH (li the repo	structi d i ne 105 orti ng	ons)	), enter t Beginning 1.00	g Ending 2.00	

	Financial Systems ST. VINCENT FIS TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0181	Peri od:	eu of Form CMS- Worksheet S-2	
				From 07/01/2018 To 06/30/2019	Part II Date/Time Pre	epared
				N/ /b1	11/22/2019 3:	: 53 pr
				<u>Y/N</u> 1.00	Date	
	General Instruction: Enter Y for all YES responses. Enter M	for all NO ro	sponsos Ento		2.00	
	mm/dd/yyyy format.		sponses. Litte		.116	
	COMPLETED BY ALL HOSPITALS					-
	Provi der Organization and Operation					-
00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in o					
			Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare F	Program? If	N			2.
	yes, enter in column 2 the date of termination and in colum	nn 3, "V" for				
	voluntary or "I" for involuntary.					
00	Is the provider involved in business transactions, includir	ng management	N			3.
	contracts, with individuals or entities (e.g., chain home of	offices, drug				
	or medical supply companies) that are related to the provid	der or its				
	officers, medical staff, management personnel, or members of	of the board				
	of directors through ownership, control, or family and othe	er similar				
	relationships? (see instructions)					
			Y/N	Туре	Date	
	1		1.00	2.00	3.00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cert		Y	A		4.
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f					
	or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
~~	column 3. (see instructions) If no, see instructions.					
00	Are the cost report total expenses and total revenues diffe		Y			5.
	those on the filed financial statements? If yes, submit rec	conciliation.		N/ /NI		-
				Y/N	Legal Oper.	+
				1.00	2.00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lf yoo io th		S N	1	- ,
00	the legal operator of the program?	TT yes, is tr	ie provider is	N N		6.
00	Are costs claimed for Allied Health Programs? If "Y" see in	etructions		Ν		7.
00	Were nursing school and/or allied health programs approved		during the	N		8.
00	cost reporting period? If yes, see instructions.	and/or renewed	i dui ring the	IN		0.
00	Are costs claimed for Interns and Residents in an approved	araduate medic	al education	Ν		9.
00	program in the current cost report? If yes, see instruction			1		'
. 00	Was an approved Intern and Resident GME program initiated of		he current	Ν	1	10.
	cost reporting period? If yes, see instructions.					
. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	Ν		11.
	Teaching Program on Worksheet A? If yes, see instructions.					
				- <b>I</b>	Y/N	
					1.00	
	Bad Debts					
. 00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	ions.		Y	12
	If line 12 is yes, did the provider's bad debt collection p	oolicy change c	luring this co	st reporting	N	13
. 00	period? If yes, submit copy.					
		onte waivod2 lf	yes, see ins	tructions.	N	14
	If line 12 is yes, were patient deductibles and/or co-payme	ents warveur fi				
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement					
. 00	If line 12 is yes, were patient deductibles and/or co-payme	ng period?lf	yes, see inst		N	15.
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ng period? If Par	yes, see inst t A	Par	t B	15.
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ng period? If Par Y/N	yes, see inst t A Date	Par Y/N	t B Date	15.
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reporti	ng period? If Par	yes, see inst t A	Par	t B	15
00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reporti	ng period? If Par Y/N 1.00	yes, see inst t A Date 2.00	Par Y/N 3.00	t B Date 4.00	
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only?	ng period? If Par Y/N	yes, see inst t A Date	Par Y/N	t B Date	
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	ng period? If Par Y/N 1.00	yes, see inst t A Date 2.00	Par Y/N 3.00	t B Date 4.00	
00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reporti PS&R Data 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	ng period? If Par Y/N 1.00	yes, see inst t A Date 2.00	Par Y/N 3.00	t B Date 4.00	
00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reporti PS&R Data 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)	ng period? If Par Y/N 1.00 Y	yes, see inst t A Date 2.00	Par Y/N 3.00 Y	t B Date 4.00	16
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reporti PS&R Data 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) Was the cost report prepared using the PS&R Report for	ng period? If Par Y/N 1.00	yes, see inst t A Date 2.00	Par Y/N 3.00	t B Date 4.00	16
. 00	If line 12 is yes, were patient deductibles and/or co-paymed         Bed Complement         Did total beds available change from the prior cost reportion         PS&R Data         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)         Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	ng period? If Par Y/N 1.00 Y	yes, see inst t A Date 2.00	Par Y/N 3.00 Y	t B Date 4.00	16
. 00	If line 12 is yes, were patient deductibles and/or co-paymed         Bed Complement         Did total beds available change from the prior cost reporti         PS&R Data         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)         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	ng period? If Par Y/N 1.00 Y	yes, see inst t A Date 2.00	Par Y/N 3.00 Y	t B Date 4.00	16
. 00	If line 12 is yes, were patient deductibles and/or co-paymed         Bed Complement         Did total beds available change from the prior cost reportion         PS&R Data         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)         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)	ng period? If Par Y/N 1.00 Y N	yes, see inst t A Date 2.00	Par Y/N 3.00 Y N	t B Date 4.00	16
. 00	If line 12 is yes, were patient deductibles and/or co-paymed         Bed Complement         Did total beds available change from the prior cost reporti         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)         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)         If line 16 or 17 is yes, were adjustments made to PS&R	ng period? If Par Y/N 1.00 Y	yes, see inst t A Date 2.00	Par Y/N 3.00 Y	t B Date 4.00	16
. 00 . 00 . 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reporti PS&R Data 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) 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, were the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	ng period? If Par Y/N 1.00 Y N	yes, see inst t A Date 2.00	Par Y/N 3.00 Y N	t B Date 4.00	16.
. 00	If line 12 is yes, were patient deductibles and/or co-paymed         Bed Complement         Did total beds available change from the prior cost reporting         PS&R Data         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)         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)         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 this	ng period? If Par Y/N 1.00 Y N	yes, see inst t A Date 2.00	Par Y/N 3.00 Y N	t B Date 4.00	16.
. 00 . 00 . 00 . 00	If line 12 is yes, were patient deductibles and/or co-paymed         Bed Complement         Did total beds available change from the prior cost reporti         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)         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)         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 this cost report? If yes, see instructions.	ng period? If Par Y/N 1.00 Y N N	yes, see inst t A Date 2.00	Par Y/N 3.00 Y N N	t B Date 4.00	115. 116. 117. 118.
. 00	If line 12 is yes, were patient deductibles and/or co-paymed         Bed Complement         Did total beds available change from the prior cost reporting         PS&R Data         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)         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)         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 this	ng period? If Par Y/N 1.00 Y N	yes, see inst t A Date 2.00	Par Y/N 3.00 Y N	t B Date 4.00	16.

Health Financial Systems

In Lieu of Form CMS-2552-10

Health Financial Systems ST. VINCENT FIS	SHERS HOSPI TAL		In Lie	eu of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0181	Period: From 07/01/2018 To 06/30/2019		repared:
	Descri	iption	Y/N	Y/N	
	(	2	1.00	3.00	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPT CHILDRENS H	OSPI TALS)			_
22.00 Have assets been relifed for Medicare purposes? If yes, see	e instructions				22.00
23.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made duri	ng the cost		23.00
24.00 Were new leases and/or amendments to existing leases entero If yes, see instructions	ed into during	this cost rep	porting period?		24.00
<ul> <li>25.00 Have there been new capitalized leases entered into during instructions.</li> </ul>	the cost repor	ting period?	lf yes, see		25.00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	he cost reporti	ng period? It	f yes, see		26.00
<ul> <li>27.00 Has the provider's capitalization policy changed during the copy.</li> </ul>	e cost reportin	ng period? If	yes, submit		27.00
Interest Expense 28.00 Were new Loans, mortgage agreements or letters of credit e	ntered into dur	ing the cost	reporting		28.00
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or	bond funds (De	bt Service Re	eserve Fund)		29.00
treated as a funded depreciation account? If yes, see inst 30.00 Has existing debt been replaced prior to its scheduled matu	ructions				30.00
instructions. 31.00 Has debt been recalled before scheduled maturity without is					31.00
instructions. Purchased Services		debt: 11 yes,	366		
32.00 Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru		ed through cor	ntractual		32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competit	tive bidding? If		33.00
Provider-Based Physicians 34.00 Are services furnished at the provider facility under an a	rrangomont with	providor ba	od physicians?		34.00
If yes, see instructions.	0	•			
35.00 If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		its with the p			35.00
			Y/N 1.00	Date 2.00	
Home Office Costs					
<ul><li>36.00 Were home office costs claimed on the cost report?</li><li>37.00 If line 36 is yes, has a home office cost statement been provided in the statement been provided and the statem</li></ul>	repared by the	home office?	Y Y		36.00 37.00
If yes, see instructions.38.00If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	Ν		38.00
the provider? If yes, enter in column 2 the fiscal year end 39.00 If line 36 is yes, did the provider render services to othe			Ν		39.00
40.00 If line 36 is yes, did the provider render services to the	home office?	lf yes, see	N		40.00
instructions					
Cost Report Preparer Contact Information	1.	00	2.	00	
<ul> <li>41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,</li> </ul>	JILL		HILL		41.00
<ul><li>42.00 Enter the employer/company name of the cost report preparer.</li></ul>	ST. VINCENT HE	ALTH			42.00
43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519		JI LL. HI LL@ASCE	NSI ON. ORG	43.00

Heal th Fi	nancial Systems	ST. VINCENT FIS	HERS HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	IESTI ONNAI RE	Provider C		Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Pre	
						11/22/2019 3:	
					_		
			3.	00			
Co	st Report Preparer Contact Information						
	nter the first name, last name and the tit		REIMBURSEMENT	MANAGER			41.00
he	eld by the cost report preparer in columns	1, 2, and 3,					
re	especti vel y.						
42.00 En	nter the employer/company name of the cost	report					42.00
pr	reparer.						
43.00 En	nter the telephone number and email address	s of the cost					43.00
re	eport preparer in columns 1 and 2, respect	i vel y.					

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-0181	Period:	Worksheet S-3	
					From 07/01/2018 To 06/30/2019	Part I Date/Time Pre 11/22/2019 3:	
				I		I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	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. 00	46	16, 79	0.00	0	1.0
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	2.0 3.0 4.0
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		46	16, 79	0.00	0	6. 0 7. 0
8.00 9.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	31. 00 32. 00	0		0 0.00 0 0.00	0	8.0 9.0
10.00	BURN INTENSIVE CARE UNIT						10.0
11.00 12.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	34.00	0		0 0.00	0	11.0 12.0
13. 00 14. 00	NURSERY Total (see instructions)	43.00	46	16, 79	0.00	0	13.0 14.0
15.00 16.00	CAH visits SUBPROVIDER - IPF					0	15.0 16.0
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER						17.0 18.0
19.00 20.00	SKILLED NURSING FACILITY NURSING FACILITY						19. 0 20. 0
21.00	OTHER LONG TERM CARE						20.0
23.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)						23. (
24.00 24.10	HOSPICE HOSPICE (non-distinct part)	30. 00					24. ( 24. <sup>-</sup>
5.00	CMHC – CMHC RURAL HEALTH CLINIC	99.00				0	25. ( 26. (
6. 25 7. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	89.00	46			0	26. 2 27. 0
8.00	Observation Bed Days		40			0	28.
9.00 0.00	Ambulance Trips Employee discount days (see instruction)						29. 30.
1.00	Employee discount days - IRF Labor & delivery days (see instructions)		0		0		31. ( 32. (
32.00	Total ancillary labor & delivery room		0				32. (
33.00	outpatient days (see instructions) LTCH non-covered days						33. (

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0181	Period: From 07/01/2018 To 06/30/2019		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	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)	538	36	2, 20	59		1.00
2.00	HMO and other (see instructions)	214	511				2.00
. 00	HMO I PF Subprovi der	0	0				3.00
. 00	HMO I RF Subprovider	0	0		0		4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
o. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	538	0 36	2, 20	0 59		6.00 7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	0	0		0		8.00
00	CORONARY CARE UNIT	0	0		0		9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT	0	0		0		11.0
2.00	OTHER SPECIAL CARE (SPECIFY)		- /				12.0
3.00	NURSERY	500	56	1, 12		450.07	13.0
4.00	Total (see instructions)	538	92	3, 38	39 0.0C	152. 27	
5.00	CAH visits	0	0		0		15.0
6.00	SUBPROVIDER - IPF						16.0
7.00 8.00	SUBPROVI DER – I RF SUBPROVI DER						17.0
9.00	SUBPROVIDER SKILLED NURSING FACILITY						18.0
9.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						20.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P. )						23.0
4.00	HOSPI CE						24.0
4. 10	HOSPICE (non-distinct part)				0		24.
5.00	CMHC - CMHC	o	o		0 0.00	0.00	
6.00	RURAL HEALTH CLINIC		J		0.00	0.00	26.0
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
7.00	Total (sum of lines 14-26)		-		0.00	152.27	27.0
8.00	Observation Bed Days		0	63	39		28.0
9.00	Ambul ance Trips	0					29.0
0.00	Employee discount days (see instruction)			1!	59		30.0
1.00	Employee discount days - IRF				0		31. (
2.00	Labor & delivery days (see instructions)	О	о	4	-		32. (
2.01	Total ancillary labor & delivery room		Ĵ	•	0		32.0
	outpatient days (see instructions)						
3. 00	LTCH non-covered days	0					33.0
	LTCH site neutral days and discharges	0					33.0

HOSPI -	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0181	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part I Date/Time Pre 11/22/2019 3:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00		14.00	Patients	
1 00		11.00	12.00	13.00	14.00	15.00	1 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 16.00 20.00 21.00 23.00 24.00 23.00 24.00 25.00 24.00 25.00 24.00 25.00	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) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0. 00 0. 00 0. 00 0. 00	0	2	21 224 0 0	1, 204	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 12.00 20.00 21.00 20.00 21.00 22.00 24.00 24.00 24.00 25.00 24.00 25.00 24.00 25.00 24.00 25.00 24.00 25.00 24.00 25.00 26.00 27.00 20.00 27.00 20.00 27.0
28.00 29.00 30.00 31.00 32.00 32.01 33.00	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days				0		28. 0 29. 0 30. 0 31. 0 32. 0 32. 0 33. 0

PI T.	AL WAGE INDEX INFORMATION			Provider CC		eriod: rom 07/01/2018 o 06/30/2019	Worksheet S-3 Part II Date/Time Pre 11/22/2019 3:	pared
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
0	Total salaries (see	200. 00	12, 378, 517	8, 379	12, 386, 896	316, 789. 64	39.10	1.
0	instructions) Non-physician anesthetist Part		(	0	0	0.00	0.00	2.
0	A		C		0	0.00	0.00	Ζ.
0	Non-physician anesthetist Part		(	0 0	0	0.00	0.00	3.
0	Þ Physician-Part A - Administrative		302, 977	0	302, 977	2,023.00	149. 77	4.
1	Physicians - Part A - Teaching		)	0	0	0.00		
0	Physician and Non Physician-Part B		812, 220	0	812, 220	10, 428. 60	77.88	5.
0	Non-physician-Part B for hospital-based RHC and FQHC		(	0 0	0	0.00	0.00	6.
0	services Interns & residents (in an approved program)	21.00	(	0 0	0	0.00	0.00	7.
1	Contracted interns and residents (in an approved programs)		(	0	0	0.00	0.00	7.
0	Home office and/or related organization personnel		72, 748	3 O	72, 748			
0 00	SNF Excluded area salaries (see instructions)	44.00	3, 234	0 0 4 0	0 3, 234	0.00 91.70		
00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		81, 804	l O	81, 804	1, 334. 82	61.28	1 1 1
	Care		01,00		01,001			
00	Contract Labor: Top Level management and other management and administrative		(	0	0	0.00	0.00	12
00	services Contract Labor: Physician-Part A - Administrative		1, 588, 358	3 0	1, 588, 358	17, 461. 26	90. 96	13
00	Home office and/or related organization salaries and		C	0 0	0	0.00	0.00	14
01	wage-related costs Home office salaries		2, 968, 748	3 0	2, 968, 748	62, 609. 45	47.42	14
02	Related organization salaries		2,700,710	0	2, 700, 710	0.00		
00	Home office: Physician Part A - Administrative		(	0 0	0	0.00	0.00	15
00			(	0 0	0	0.00	0.00	16
	WAGE-RELATED COSTS		2 649 421		0 E40 421			1 17
00	Wage-related costs (core) (see instructions)		2, 568, 631	0	2, 568, 631			17
00	Wage-related costs (other)		(	0 0	0			18
00	(see instructions) Excluded areas		738	3 0	738			19
00	Non-physician anesthetist Part		(		0			20
00	A Non-physician anesthetist Part B		C	0 0	0			21
00	Physician Part A - Administrative		69, 115	5 O	69, 115			22
01	Physician Part A - Teaching		105 000		0			22
00 00	Physician Part B Wage-related costs (RHC/FQHC)		185, 282 (		185, 282 0			23
00	Interns & residents (in an		(		0			25.
50	approved program) Home office wage-related (core)		895, 887	0	895, 887			25.
51	Related organization wage-related (core)		(	0 0	0			25.
52	Home office: Physician Part A - Administrative -		(	0 0	0			25.
53	wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core)		(	0	0			25.
	OVERHEAD COSTS - DIRECT SALARIE						· · · · · · · · · · · · · · · · · · ·	1
00	Employee Benefits Department	4.00	10, 154	8, 379	18, 533	42.11	440. 11	26.

Health Financial Systems	S	T. VINCENT FIS	HERS HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provider C		eriod:	Worksheet S-3	
					rom 07/01/2018		
				T	o 06/30/2019		pared:
	Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Paid Hours	11/22/2019 3: Average Hourly	
	Number		on of Salaries			Wage (col. 4 ÷	
	Number	Reported	(from Wkst.	$(col.2 \pm col.$	Salaries in	col. 5)	
			A-6)	3)	col. 4	001. 3)	
	1.00	2.00	3.00	4.00	5,00	6, 00	
28.00 Administrative & General under		426, 283		426, 283	2, 270. 78	187. 73	28.00
contract (see inst.)							
29.00 Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00 Operation of Plant	7.00	205, 430	0	205, 430	10, 155. 69	20. 23	30.00
31.00 Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00 Housekeepi ng	9.00	0	0	0	0.00	0.00	32.00
33.00 Housekeeping under contract		405, 652	0	405, 652	15, 278. 29	26.55	33.00
(see instructions)							
34.00 Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00 Dietary under contract (see		59, 196	0	59, 196	2, 340. 44	25. 29	35.00
instructions)							
36.00 Cafeteri a	11.00	0	0	0	0.00	0.00	36.00
37.00 Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00 Nursing Administration	13.00	897,004	0	897, 004	14, 868. 04	60.33	38.00
39.00 Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00 Pharmacy	15.00	557, 468	0	557, 468	12, 562. 70	44.37	40.00
41.00 Medical Records & Medical	16.00	0	0	0	0.00	0.00	41.00
Records Library							
42.00 Social Service	17.00	12, 720	0	12, 720	390.07		42.00
43.00 Other General Service	18.00	0	0	0	0.00	0.00	43.00

Heal th	Financial Systems	S	T. VINCENT FIS	HERS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 07/01/2018 To 06/30/2019		
		Worksheet A		Recl assi fi cati	5		Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		12, 384, 680	8, 379	12, 393, 05	9 324, 277. 51	38. 22	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		3, 234	0	3, 23	4 91.70	35. 27	2.00
3.00	Subtotal salaries (line 1 minus line 2)		12, 381, 446	8, 379	12, 389, 82	5 324, 185. 81	38. 22	3.00
4.00	Subtotal other wages & related costs (see inst.)		4, 638, 910	0	4, 638, 91	81, 405. 53	56.99	4.00
5.00	Subtotal wage-related costs (see inst.)		3, 533, 633	0	3, 533, 63	3 0.00	28. 52	5.00
6.00	Total (sum of lines 3 thru 5)		20, 553, 989	8, 379	20, 562, 36	8 405, 591. 34	50. 70	6.00
7.00	Total overhead cost (see instructions)		3, 183, 846	8, 379	3, 192, 22	5 80, 430. 45	39.69	7.00

Heal th	Financial Systems ST. VINCENT F	FI SHERS HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS	Provi der CCN: 15-0181	Period: From 07/01/2018 To 06/30/2019		pared:
				Amount	
				Reported 1.00	
	PART IV - WAGE RELATED COSTS			1.00	
	Part A - Core List				
	RETIREMENT COST				
1.00	401K Employer Contributions			386, 497	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	, ,		0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	)			
5.00	401K/TSA Plan Administration fees			0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan			0	6.00
7.00	Employee Managed Care Program Administration Fees			80, 600	7.00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0	8.00
8.01	Health Insurance (Self Funded without a Third Party Admin	ni strator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Adminis	trator)		1, 182, 076	8. 02
8.03	Health Insurance (Purchased)			0	8.03
9.00	Prescription Drug Plan			262, 755	9.00
10.00	Dental, Hearing and Vision Plan			40, 156	10.00
11.00	Life Insurance (If employee is owner or beneficiary)			20, 805	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			957	12.00
13.00	Disability Insurance (If employee is owner or beneficiary	y)		47, 356	13.00
14.00	Long-Term Care Insurance (If employee is owner or benefic	ci ary)		23, 829	14.00
15.00	'Workers' Compensation Insurance			98	15.00
16.00	Retirement Health Care Cost (Only current year, not the e	extraordinary accrual require	ed by FASB 106.	0	16.00
	Non cumulative portion)				
	TAXES				
17.00	FICA-Employers Portion Only			763, 660	
18.00	Medicare Taxes - Employers Portion Only			0	
19.00	Unemployment Insurance			0	
20.00	State or Federal Unemployment Taxes			12, 976	20.00
	OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Constructions))	ost Reported on lines 1 throu	ugh 4 above. (see	0	
22.00	Day Care Cost and Allowances			0	
23.00	Tuition Reimbursement			2, 000	
24.00	Total Wage Related cost (Sum of lines 1 -23)			2, 823, 765	24.00
	Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.00

Heal th	Financial Systems	ST. VINCENT FISHERS HOSPITAL	In Lie	u of Form CMS-2	2552-10
H0SPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0181	Period:	Worksheet S-3	
			From 07/01/2018 To 06/30/2019	Part V Date/Time Pre	narod
			10 00/30/2019	11/22/2019 3:	
	Cost Center Description		Contract Labor		
	· · · · · · · · · · · · · · · · · · ·		1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Ident				
1.00	Total facility's contract labor and benefit	cost	81, 804	2, 823, 765	
2.00	Hospi tal		81, 804	2, 823, 765	
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF				4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	1100
8.00	Hospital-Based SNF				8.00
9.00	Hospital-Based NF				9.00
10.00	Hospi tal -Based OLTC				10.00
11.00	Hospital-Based HHA				11.00
12.00	Separately Certified ASC				12.00
13.00	Hospital-Based Hospice				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospital-Based-CMHC		0	0	16.00
17.00	Renal Dialysis		0	0	17.00
18.00	Other		0	0	18.00

Heal th	Financial Systems ST. VINCENT FISHERS	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC		Period:	Worksheet S-1	0
				From 07/01/2018		
				To 06/30/2019	Date/Time Pre 11/22/2019 3:	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by lin	ne 202 column	8)	0. 220384	1.00
	Medicaid (see instructions for each line)				0.404.740	
2.00	Net revenue from Medicaid				2, 131, 748	
3.00	Did you receive DSH or supplemental payments from Medicaid?	-1		: -10	N	3.00
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplement If line 4 is no, then enter DSH and/or supplemental payments fr			10?	0	4.00 5.00
6.00	Medicaid charges		<i>.</i>		23, 871, 106	
7.00	Medicaid cost (line 1 times line 6)				5, 260, 810	
8.00	Difference between net revenue and costs for Medicaid program (	line 7 minu	us sum of lin	es 2 and 5 <sup>.</sup> if	3, 129, 062	
0.00	< zero then enter zero)				0, 12, 7, 002	0.00
	Children's Health Insurance Program (CHIP) (see instructions for	r each line	e)			
9.00	Net revenue from stand-alone CHIP				0	9.00
10.00	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP (	line 11 min	nus line 9; i	f < zero then	0	12.00
	enter zero)					
12 00	Other state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl			<u>\</u>	0	13.00
13.00 14.00	Charges for patients covered under state or local indigent care					
14.00	10)			III IIIles 0 01	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14	)			0	15.00
16.00	Difference between net revenue and costs for state or local ind		program (lin	e 15 minus line	0	
	13; if < zero then enter zero)	0				
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local indig	ent care progra	ms (see	
17 00	instructions for each line) Private grants, donations, or endowment income restricted to fu	ading chori	tu		0	17.00
17.00	Government grants, appropriations or transfers for support of h					
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local			(sum of lines	3, 129, 062	
17.00	8, 12 and 16)	rhargent e			0, 127, 002	17.00
			Uni nsured	Insured	Total (col. 1	
		_	patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac	i l i +v	5, 168, 01	4 1, 628, 432	6, 796, 446	20.00
20.00	(see instructions)	iiiiy	5, 106, 01	4 1, 020, 432	0, 790, 440	20.00
21.00	Cost of patients approved for charity care and uninsured discou	nts (see	1, 138, 94	8 1, 628, 432	2, 767, 380	21.00
21.00	instructions)		11 1001 71	1,020,102	2,707,000	2
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00
	charity care					
23.00	Cost of charity care (line 21 minus line 22)		1, 138, 94	8 1, 628, 432	2, 767, 380	23.00
					1.00	
24.00	Describe amount on line 20 column 2 include charges for notion	+ dava hava	and a langth	of atou limit	1.00 N	24.00
24.00	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care		ond a rength	or stay limit	IN	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond th		care program	's length of	0	25.00
20.00	Istav limit	ie margent	cure program	s rongen or	Ŭ	20.00
26.00	Total bad debt expense for the entire hospital complex (see ins	tructions)			1, 750, 249	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex	(see instr	ructions)		31, 872	
27.01	Medicare allowable bad debts for the entire hospital complex (s	ee instruct	ions)		49, 034	
28.00	Non-Medicare bad debt expense (see instructions)				1, 701, 215	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see i	nstructions)		392, 083	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	20)			3, 159, 463	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			6, 288, 525	31.00

	Financial Systems S SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	T. VINCENT FISH EXPENSES	IERS HOSPI TAL		eriod:	u of Form CMS-: Worksheet A	2552-10
					rom 07/01/2018 o 06/30/2019	Date/Time Pre 11/22/2019 3:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)		
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		5, 366, 235	5, 366, 235	0	5, 366, 235	1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT		5, 300, 235 1, 731, 952		0	1, 731, 952	2.00
3.00	00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	10, 154	2, 439, 012		0	2, 449, 166	
5.00	00500 ADMI NI STRATI VE & GENERAL	609, 939	12, 723, 260		0	13, 333, 199	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	205, 430	1, 714, 622 128, 140		0	1, 920, 052 128, 140	7.00 8.00
9.00	00900 HOUSEKEEPING	0	505, 697		0	505, 697	9.00
10.00	01000 DI ETARY	0	656, 379		-568, 381	87, 998	1
11.00	01100 CAFETERI A	0	0	0	568, 381	568, 381	11.00
13.00	01300 NURSING ADMINISTRATION	897, 004	174, 853		0	1, 071, 857	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	557, 468	2, 999 76, 483			2, 999 633, 951	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	70, 403 0	033, 731	0	033, 751	16.00
17.00	01700 SOCI AL SERVI CE	12, 720	2, 722	15, 442	0	15, 442	1
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	2, 049, 613	694, 445	2, 744, 058	413, 308		30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	0	0	0	0	31.00 32.00
32.00 34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0	0	34.00
43.00	04300 NURSERY	0	0	0	392, 352		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 711, 221	2,019,243	3, 730, 464	0	3, 730, 464	50.00
51.00	05100 RECOVERY ROOM	1 000 000	0		0		51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	1, 829, 083	1, 731, 656	3, 560, 739	-805, 660	2, 755, 079	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	674, 298	347, 832	1, 022, 130	0	1, 022, 130	
54.01	03630 ULTRA SOUND	177, 135	18, 366	195, 501	0	195, 501	54.01
56.00	05600 RADI OI SOTOPE	0	0	-	0	0	56.00
56.01	05601 ONCOLOGY	211, 347	72, 849		0	284, 196	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	420, 706 240, 562	150, 990 60, 213			571, 696 300, 775	
59.00	05900 CARDI AC CATHETERI ZATI ON	210,002	00,210	000,770	0	0	59.00
60.00	06000 LABORATORY	0	1, 376, 691	1, 376, 691	0	1, 376, 691	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	390, 392	62, 678	453, 070	0	0 453, 070	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	1, 016, 895	109, 270		0	1, 126, 165	
67.00	06700 OCCUPATI ONAL THERAPY	9, 089	847			9, 936	67.00
68.00	06800 SPEECH PATHOLOGY	85, 684	57, 621		0	143, 305	
		107, 147	34, 462	141, 609	0	141, 609 0	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	616, 672	616, 672	0	616, 672	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 191, 015		0	1, 191, 015	
	07300 DRUGS CHARGED TO PATIENTS	0	2, 866, 657		0	2, 866, 657	
	07400 RENAL DI ALYSI S	0	0	0	-	0	74.00
75.00	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	75.00
91.00	OUTPATIENT SERVICE COST CENTERS	1, 159, 396	463, 969	1, 623, 365	0	1, 623, 365	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 137, 370	403, 707	1, 023, 303	0	1, 023, 303	92.00
	OTHER REIMBURSABLE COST CENTERS						
99.00	09900 CMHC	0	0	0	0	0	99.00
440.00	SPECIAL PURPOSE COST CENTERS	40.075.000	07 007 000	40 770 440		40.770.440	110.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	12, 375, 283	37, 397, 830	49, 773, 113	0	49, 773, 113	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 544	2, 544	0	2,544	190.00
	19100 RESEARCH	0	_, 511	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 474, 550	1, 474, 550	0	1, 474, 550	
	19300 NONPALD WORKERS	0	0	0	0		193.00
	07950 COMMUNI TY EDUCATI ON 07951 MARKETI NG	3, 234	223 0		0		194. 00 194. 01
	07951 MARKETING 07952 SC MGMT SVH TANDEM CASTLETON	0	130	-	0		194.01
200.00		12, 378, 517	38, 875, 277				
	· · · · · · · · · · · · · · · · · · ·			-			

	Financial Systems S SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	T. VINCENT FISH F EXPENSES	Provi der CCN: 15-018	From 07/01/2018	
	Orat Conton Day 1	0-11-1-1	National Suma		019 3:53 pm
	Cost Center Description		Net Expenses For Allocation		
		6.00	7.00		
00	GENERAL SERVICE COST CENTERS	F (00	E 240 E4E		1.0
. 00 . 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	-5, 690 -780	5, 360, 545 1, 731, 172		1.00
. 00	00300 OTHER CAP REL COSTS	- /80	0		3.00
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	2, 449, 166		4.00
. 00	00500 ADMINI STRATI VE & GENERAL	-4,085,869	9, 247, 330		5.0
. 00	00700 OPERATION OF PLANT	-1,015	1, 919, 037		7.0
. 00	00800 LAUNDRY & LINEN SERVICE	0	128, 140		8.0
. 00	00900 HOUSEKEEPI NG	0	505, 697		9.0
0.00	01000 DI ETARY	0	87, 998		10.0
1.00		-122, 891	445, 490		11.0
	01300 NURSI NG ADMI NI STRATI ON	-175	1,071,682		13.0
4.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	-1, 886	2, 999 632, 065		14. 0 15. 0
	01600 MEDICAL RECORDS & LIBRARY	- 1, 880	032,005		16.0
	01700 SOCIAL SERVICE	-1, 289	14, 153		17.0
	INPATIENT ROUTINE SERVICE COST CENTERS	1/20/	11, 100		
0. 00	03000 ADULTS & PEDI ATRI CS	-1, 285, 310	1, 872, 056		30.0
1. 00	03100 I NTENSI VE CARE UNI T	0	0		31.0
2.00	03200 CORONARY CARE UNI T	0	0		32.0
	03400 SURGICAL INTENSIVE CARE UNIT	0	0		34.0
3.00	04300 NURSERY	0	392, 352		43.0
	ANCI LLARY SERVI CE COST CENTERS	444 975			
	05000 OPERATING ROOM	-116, 075	3, 614, 389		50.0
	05100 RECOVERY ROOM	442 495	2 211 504		51.0
2.00 3.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	-443, 485	2, 311, 594		52. 0 53. 0
4.00	05400 RADI OLOGY-DI AGNOSTI C	- 19, 975	1,002,155		54.0
4.00	03630 ULTRA SOUND	-17, 773	195, 501		54.0
	05600 RADI OI SOTOPE	0	0		56.0
6. 01	05601 ONCOLOGY	-5, 872	278, 324		56.0
7.00	05700 CT SCAN	-25, 897	545, 799		57.0
8.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	300, 775		58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	0	0		59.0
0.00	06000 LABORATORY	0	1, 376, 691		60.0
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.0
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.0
4.00 5.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	453, 070		64. 0 65. 0
6.00	06600 PHYSI CAL THERAPY	-162	1, 126, 003		66.0
7.00	06700 OCCUPATI ONAL THERAPY	0	9, 936		67.0
8.00	06800 SPEECH PATHOLOGY	-150	143, 155		68.0
9.00	06900 ELECTROCARDI OLOGY	0	141, 609		69.0
0. 00	07000 ELECTROENCEPHALOGRAPHY	0	o		70.0
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	О	616, 672		71.0
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 191, 015		72.0
	07300 DRUGS CHARGED TO PATIENTS	0	2, 866, 657		73.0
	07400 RENAL DI ALYSI S	0	0		74.0
5.00	07500 ASC (NON-DI STI NCT PART)	0	0		75.00
1 00	OUTPATIENT SERVICE COST CENTERS	-535	1, 622, 830		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-035	1,022,030		91.00
∠. 00	OTHER REIMBURSABLE COST CENTERS				72.00
9.00	09900 CMHC	0	0		99.00
	SPECIAL PURPOSE COST CENTERS		-1		
18.00		-6, 117, 056	43, 656, 057		118. 00
	NONREIMBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 544		190. 0
	19100 RESEARCH	0	0		191. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 474, 550		192.0
	19300 NONPAID WORKERS	0	0		193.0
	07950 COMMUNITY EDUCATION	0	3, 457		194.0
94.01	07951 MARKETI NG	0	0		194. 0
	07952 SC MGMT SVH TANDEM CASTLETON		130		194. 02

Heal th	Financial Systems		ST. VINCENT FI	SHERS HOSPI TAL		In Lieu	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (	CCN: 15-0181	Peri od:	Worksheet A-	6
						From 07/01/2018 To 06/30/2019	Date/Time Pr 11/22/2019 3	epared: 53 pm
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	A - GENERAL SALARY ACCRUAL							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	8, 379	0				1.00
	0 — — — — — — —		8, 379					
	B - CAFETERIA RECLASS							1
1.00	CAFETERI A	11.00	0	568, 381				1.00
	0 — — — — — — —		0	568, 381				
	C – NURSERY RECLASS							1
1.00	ADULTS & PEDIATRICS	30.00	324, 272	89, 036				1.00
2.00	NURSERY	43.00	311, 497	80, 855				2.00
	0 — — — — — —		635, 769	169, 891				1
500.00	Grand Total: Increases		644, 148	738, 272	1			500.00
		•	•					•

Heal th	Financial Systems	:	ST. VINCENT FISH	ERS HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (	CN: 15-0181	Period: From 07/01/2018	Worksheet A-	6
						To 06/30/2019	Date/Time Pr 11/22/2019 3	epared: :53 pm
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	A - GENERAL SALARY ACCRUAL		· · · · ·					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8, 379		0		1.00
	0	T		8, 379		7		
	B - CAFETERIA RECLASS							1
1.00	DI ETARY	10.00	0	568, 381		0		1.00
	0			568, 381		1		
	C - NURSERY RECLASS							1
1.00	DELIVERY ROOM & LABOR ROOM	52.00	635, 769	169, 891		0		1.00
2.00		0.00	0	0		0		2.00
	0		635, 769	169, 891		7		1
500.00	Grand Total: Decreases		635, 769	746, 651				500.00

Hool th	Financial Systems	ST. VINCENT FISI			In Lie	eu of Form CMS-2	DEED 10
	Financial Systems SILIATION OF CAPITAL COSTS CENTERS	Provi der C		Period: From 07/01/2018 To 06/30/2019	Worksheet A-7 Part I	pared:	
			Acqui si ti ons				
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	10, 871, 320	0		0 0	0	1.00
2.00	Land Improvements	22, 176	0		0 0	0	
3.00	Buildings and Fixtures	45, 069, 555	236, 851		0 236, 851	0	3.00
4.00	Building Improvements	853, 803	0		0 0	0	4.00
5.00	Fixed Equipment	1, 897, 164	0		0 0	0	5.00
6.00	Movable Equipment	18, 730, 797	1, 106, 088 0 1, 106, 088		0	6.00	
7.00	HIT designated Assets	0	0 0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	77, 444, 815	1, 342, 939 0 1, 342, 939		0	8.00	
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	77, 444, 815	1, 342, 939		0 1, 342, 939	0	10.00
		Ending Balance	Fully				
		U	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	10, 871, 320	0				1.00
2.00	Land Improvements	22, 176	0				2.00
3.00	Buildings and Fixtures	45, 306, 406	0				3.00
4.00	Building Improvements	853, 803	0				4.00
5.00	Fixed Equipment	1, 897, 164	0				5.00
6.00	Movable Equipment	19, 836, 885	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	78, 787, 754	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	78, 787, 754	0				10.00

Heal th	Financial Systems	ST. VINCENT FIS	HERS HOSPITAL		In Lieu of Form CMS-2552-10			
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0181	Peri od:	Worksheet A-7		
					From 07/01/2018 To 06/30/2019		narod	
					10 00/30/2017	11/22/2019 3:		
			SU	JMMARY OF CAP	ITAL			
		D						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)			
		9.00	10.00	11.00	12.00	instructions) 13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK				12.00	13.00		
1.00	CAP REL COSTS-BLDG & FIXT	1, 671, 861			0 0	1, 062	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	1, 624, 365			0 0	3, 852		
3.00	Total (sum of lines 1-2)	3, 296, 226			0 0	4, 914	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description		Total (1) (sum					
		Capi tal -Rel ate						
		d Costs (see	through 14)					
		instructions)						
	<b>_</b>	14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK							
1.00	CAP REL COSTS-BLDG & FIXT	1, 539					1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 731, 952				2.00	
3.00	Total (sum of lines 1-2)	1, 539	7, 098, 187				3.00	

Health Financial Systems	ST. VINCENT FIS	HERS HOSPITAL		In Lie	u of Form CMS-2	2552-10	
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F T	Period: From 07/01/2018 To 06/30/2019		pared: 53 pm	
	COM	COMPUTATION OF RATIOS ALLOCATION OF					
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance		
PART III - RECONCILIATION OF CAPITAL COS	1.00	2.00	3.00	4.00	5.00		
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	58, 950, 869 19, 836, 885 78, 787, 754	0	58, 950, 869 19, 836, 885 78, 787, 754 CAPI TAL	0. 251776		1.00 2.00 3.00	
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COST 1.00 CAP REL COSTS-BLDG & FIXT	IS CENTERS			1, 666, 171	3, 691, 773	1.00	
2.00 CAP REL COSTS-BUBB & TTAT 3.00 Total (sum of lines 1-2)	0	, s		1, 608, 171 1, 623, 585 3, 289, 756	103, 735	2.00 3.00	
		SI	IMMARY OF CAPI		0,170,000	0100	
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COST1.00CAP REL COSTS-BLDG & FIXT2.00CAP REL COSTS-MVBLE EQUIP3.00Total (sum of lines 1-2)	IS CENTERS	0	3, 852	2 0	1, 731, 172	1.00 2.00 3.00	

	Financial Systems MENTS TO EXPENSES	S	T. VINCENT FIS	SHERS HOSPITAL Provider CCN: 15-0181	In Lie Period:	u of Form CMS-2 Worksheet A-8	2552-10
					From 07/01/2018 To 06/30/2019		
				Expense Classification o To/From Which the Amount is			oo piii
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00 C	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2)	В					
	Investment income - other (chapter 2)	Б	-12, 334	ADMI NI STRATI VE & GENERAL	5.00		
4.00	Trade, quantity, and time discounts (chapter 8)		C		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		C		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		C		0.00	0	6.00
7.00	Tel ephone servi ces (pay		C		0.00	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service (chapter 21)		C		0.00	0	8.00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	C -1, 896, 357		0.00	0	
11.00	adjustment Sale of scrap, waste, etc.		., ,		0.00		11.00
	(chapter 23)	101	1 000 400		0.00		
12.00	Related organization transactions (chapter 10)	A-8-1	-1, 929, 438				12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	C -122, 891	CAFETERI A	0.00 11.00		13.00 14.00
15.00	Rental of quarters to employee and others		C		0.00	0	15.00
16.00	Sale of medical and surgical		C		0.00	0	16.00
	supplies to other than patients						
17.00	Sale of drugs to other than patients	В	C	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		C		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees,		C		0.00	0	19.00
20.00	books, etc.)		~		0.00		20.00
20. 00 21. 00	Vending machines Income from imposition of		C		0.00 0.00		
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	C	RESPI RATORY THERAPY	65.00		23. 00
23.00	therapy costs in excess of	A-0-3	C	RESETRATORT THERAFT	05.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
	COSTS-BLDG & FIXT						
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP	2.00		
28.00 29.00	Non-physician Anesthetist Physicians' assistant		C	*** Cost Center Deleted ***	19.00 0.00		28. 00 29. 00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		r	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31.00	Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for		C		0.00	0	32.00
	Depreciation and Interest MISC INCOME - AUDIOLOGY	В	-150	SPEECH PATHOLOGY	68.00	0	33.00
			100	1	00.00	ч Ч	

Health Financial Systems	S	T. VINCENT FIS	SHERS HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0181	Peri od:	Worksheet A-8	
				From 07/01/2018 To 06/30/2019	Date/Time Pre	narod
				10 00/ 30/ 2019	11/22/2019 3:	
			Expense Classification of			
			To/From Which the Amount i	s to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 MISC INCOME - YMCA FISHERS	В	-90	PHYSI CAL THERAPY	66.00	9	33.01
33.02 MISC INCOME - QUALITY MGMT	В	-250	ADMI NI STRATI VE & GENERAL	5.00	9	33.02
33.03 MISC INCOME - MED STAFF DUES	В	-200	ADMI NI STRATI VE & GENERAL	5.00	0	33.03
33.04 MISC INCOME - UNCLAIMED PROP	В	-4,811	ADMI NI STRATI VE & GENERAL	5.00	0	33.04
EXEMPT						
33.05 MISC INCOME - LATE PENALTY	В	-118	ADULTS & PEDIATRICS	30.00	0	33.05
FEES	_				_	
33.06 MISC INCOME - LATE PENALTY	В	-1, 015	OPERATION OF PLANT	7.00	0	33.06
FEES	D D	700	CAD DEL COSTO MUDI E FOULD	2.00		22.07
33.07 MISC INCOME - GAIN ON SALE	B		CAP REL COSTS-MVBLE EQUIP	2.00 91.00	9	33.07 33.08
33.08 PROMOTIONAL ITEMS - ED 33.09 COMMUNITY BENEFIT - ADMIN	A		EMERGENCY ADMI NI STRATI VE & GENERAL	5.00	0	
33. 10 ENTERTAL MENT - ADMIN	A		ADMINISTRATIVE & GENERAL	5.00	0	
33. 11 ENTERTAI NMENT - NURS ADMIN	A		NURSING ADMINISTRATION	13.00	0	•
33. 14 ENTERTAL MENT - SURGERY	A		OPERATING ROOM	50.00	0	33.14
33. 15 ENTERTAL MENT - PED REHAB	A		PHYSICAL THERAPY	66.00	0	33.15
33. 16 LATE PENALTY FEES	A		ADMINISTRATIVE & GENERAL	5.00	0	
33. 17 CHARITABLE COSTS - CASE MGMT	A		NURSING ADMINISTRATION	13.00	0	
33. 19 MARKETING - ADMIN	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 21 MARKETING - ED	A		EMERGENCY	91.00	0	33.21
33.23 CORP SPONSORHSIP - A&G	A	-6, 500	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24 CHARITABLE COSTS - ADMIN	A	-960	ADMINISTRATIVE & GENERAL	5.00	0	33. 24
33.26 CHARITABLE OTHER COSTS - PHARM	A	-1, 886	PHARMACY	15.00	0	33.26
33. 27 CHARI TABLE OTHER COSTS - SOC	A	-1, 289	SOCIAL SERVICE	17.00	0	33. 27
SVC						

А

А

В

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

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

A. Costs - if cost, including applicable overhead, can be determined.

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

-591 ADMI NI STRATI VE & GENERAL

-5, 690 CAP REL COSTS-BLDG & FIXT

-2, 070, 686 ADMI NI STRATI VE & GENERAL

0

-6, 117, 056

33.28

33. 29

33.31

50.00

BLDG

(3)

LOBBYING EXPENSE

MEDICAID PROVIDER TAX

33.30 MISC INCOME - RENTAL INCOME -

OTHER ADJUSTMENTS (SPECIFY)

(Transfer to Worksheet A, column 6, line 200.)

TOTAL (sum of lines 1 thru 49)

(2) Basis for adjustment (see instructions).

B. Amount Received - if cost cannot be determined.

0 33. 28

0 33. 29

Q 33.30

0

5.00

5.00

1.00

0.00

33. 31

50.00

Heal th	Health Financial Systems ST. VINCENT FISHERS HOSPITAL In Lieu of Form CMS-2552-10								
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	8-1			
OFFICE	COSTS			From 07/01/2018 To 06/30/2019		narod			
				10 00/30/2019	11/22/2019 3:				
	Line No.	Cost Center	Expense Items	Amount of	Amount				
				Allowable Cost					
					Wks. A, column				
					5				
	1.00	2.00	3.00	4.00	5.00				
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED				
1 00	HOME OFFICE COSTS:			1 071 00/	1 071 00/	1 00			
1.00			HOME OFFICE - BENEFITS	1, 971, 006	1, 971, 006	1.00			
2.00 3.00			HOME OFFICE - CAPITAL HOME OFFICE - INTEREST	875, 323	0	2.00 3.00			
3.00			HOME OFFICE - INTEREST HOME OFFICE - OTHER	12, 334 7, 350, 499	10 147 504	3.00			
3.01			ST. VINCENT HEALTH CHARGEBAC			3.01			
3.02			ST. VINCENT HEALTH CHARGEBAC			3.02			
3.05			ST. VINCENT HEALTH CHARGEBAC						
3. 10			ST. VINCENT HEALTH CHARGEBAC		52,677	3. 07			
3.10			ST VINCENT HEALTH CHARGEBACK		36, 297	3.10			
3.12			ST VINCENT HEALTH CHARGEBACK			3.12			
3.15			ST VINCENT HEALTH CHARGEBACK		1, 463, 895	3.15			
3.15	0.00		ST VINCENT HEALTH CHARGEDACK	1,403,075	1, 403, 075	3.15			
4.00	0.00			0	0	4.00			
5.00	TOTALS (sum of lines 1-4).			13, 274, 584	15, 204, 022	5.00			
0.00	Transfer column 6, line 5 to			10,274,004	10, 204, 022	0.00			
	Worksheet A-8, column 2,								
	line 12.								

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

					Related Organization	(s) and/or	Home Office	
	Symbo	(1)	Name	Percentage of	Name	P	ercentage of	
				Ownershi p			Ownershi p	
	1.	00	2.00	3.00	4.00		5.00	
-		ONCLUD TO DELAT		ND /OD HOME OFFLOE.				

B. INTERRELATIONSHIP TO 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

rerinbur					
6.00	В	ST. VINCENT HEA	100.00 ST. VINCENT HEA	100.00	6.00
7.00	В	ASCENSION HEALT	100.00 ASCENSION HEALT	100.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

0.01	2,017,070	0
3 02		0

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

0

Wkst. A-7 Ref

7.00

	Ű	0	11.00
2.00	875, 323	0	2.00
3.00	12, 334	0	3.00
3.01	-2, 817, 095	0	3.01
3.02	0	0	3.02
3.05	0	0	3.05
3.07	0	0	3.07
3.10	0	0	3.10
3.12	0	0	3.12
3.13	0	0	3.13
3.15	0	0	3.15
3.16	0	0	3.16
4.00	0	0	4.00
5.00	-1, 929, 438		5.00

COSTS I NCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED

ST. VINCENT FISHERS HOSPITAL

Provider CCN: 15-0181

Peri od:

То

From 07/01/2018

06/30/2019

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

1103 1101	been posted to worksheet A,	cor units		, the		arrowabre	Shourd	i be i	nui cateo	or unitri 4	this part.	
	Rel ated Organi zati on(s)											
	and/or Home Office											
	Type of Business											
	6.00											
	B. INTERRELATIONSHIP TO RELA	TED ORGAN	IZATION(S	) AND,	OR HOME	OFFICE:						

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

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

reriibu									
6.00	HOME OFFICE	6.00							
7.00	HOME OFFICE	7.00							
8.00		8.00							
9.00 10.00		9.00							
10.00		10.00							
100.00		100.00							
(4) 11									

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

R Corporation, partnership, or other organization has financial interest in provider.

С. Provider has financial interest in corporation, partnership, or other organization.

Director, officer, administrator, or key person of provider or relative of such person has financial interest in related D. organi zati on.

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 provi der

Health Financial Systems

Net

Adjustments (col. 4 minus col. 5)\* 6.00

HOME OFFICE COSTS:

0

OFFICE COSTS

1.00

In Lieu of Form CMS-2552-10

Worksheet A-8-1

Date/Time Prepared: 11/22/2019 3:53 pm

1.00

Health Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT

## ST. VINCENT FISHERS HOSPITAL Provider CCN: 15

In Lieu of Form CMS-2552-10 Worksheet A-8-2

Heal th	Financial Syste	ems	ST. VINCENT FI	SHERS HOSPITAL		In Li	eu of Form CMS-	2552-10
PROVIDER BASED PHYSICIAN ADJUSTMENT			Provider (	Provider CCN: 15-0181 Period: Worksheet			3-2	
				From 07/01/2018				
						To 06/30/2019		
							11/22/2019 3:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1, 285, 192	1, 285, 192	0	0	0	1.00
2.00	50.00	OPERATING ROOM	641, 270	115, 936	525, 334	246, 400	19, 659	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	1, 412, 973	395, 201	1, 017, 772	237, 100	8, 505	3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	19, 975	19, 975	C	0	0	4.00
5.00		ONCOLOGY	21, 938		21, 938	211, 500	158	5.00
6.00		CT SCAN	25, 897				0	
7.00	0.00	61 30AN	20,077	23,077			0	
8.00	0.00		0	0			0	8.00
8.00 9.00	0.00		0	0				
			0	0			-	
10.00	0.00		0	0	(	0	0	
200.00			3, 407, 245	1, 842, 201			28, 322	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	2, 328, 835	116, 442	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	969, 488	48, 474	0	0	0	3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	0 0	0	4.00
5.00	56.01	ONCOLOGY	16,066	803	0	0 0	0	5.00
6.00		CT SCAN	0	0			0	
7.00	0.00		0	0			0	
8.00	0.00		0				0	
9.00	0.00		0				0	
7.00 10.00	0.00		0	0			0	
	0.00		0 2 214 200					
200.00			3, 314, 389				0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
			14				4	
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0		-	.,,		1.00
2.00		OPERATING ROOM	0			110/ / 00		2.00
3.00		DELIVERY ROOM & LABOR ROOM	0	969, 488	48, 284	443, 485		3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	19, 975		4.00
5.00	56.01	ONCOLOGY	0	16, 066	5, 872	5, 872		5.00
6.00	57.00	CT SCAN	0	0	0	25, 897		6.00
7.00	0, 00		0	0	(	0	, I	7.00
8.00	0,00		0	n			,	8.00
9.00	0.00		0	0 0			1	9.00
10.00	0.00		0	-				10.00
200.00			0	-	54, 156	1, 896, 357		200.00
200.00	I		1 0	3, 314, 309	54, 150	1,070,337	1	200.00

COST A	Financial Systems S LLOCATION - GENERAL SERVICE COSTS	ST. VINCENT FIS	Provi der C	F	Period: From 07/01/2018 Fo 06/30/2019	u of Form CMS- Worksheet B Part I Date/Time Pre	epared:
			CAPI TAL REL	ATED COSTS		11/22/2019 3:	53 pili
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	-					
1.00	00100 CAP REL COSTS-BLDG & FIXT	5, 360, 545	5, 360, 545				1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 731, 172 2, 449, 166	52, 995	1, 731, 172 17, 114			2.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL	9, 247, 330		152, 010		9, 994, 273	
7.00	00700 OPERATION OF PLANT	1, 919, 037	706, 299	228, 09		2, 895, 276	
8.00	00800 LAUNDRY & LINEN SERVICE	128, 140		(	0 0	128, 140	
9.00	00900 HOUSEKEEPING	505, 697	60, 954	19, 685		586, 336	
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	87, 998 445, 490		8, 253 53, 298		121, 807 663, 824	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 071, 682	17, 216	5, 560		1, 277, 166	
14.00	01400 CENTRAL SERVICES & SUPPLY	2,999		8, 713		38, 692	
15.00	01500 PHARMACY	632, 065	47, 629	15, 382		808, 625	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	6, 357	2, 053		8, 410	
17.00	01700 SOCIAL SERVICE	14, 153	3, 967	1, 281	1 2, 591	21, 992	17.00
30.00	03000 ADULTS & PEDIATRICS	1, 872, 056	793, 217	256, 167	7 483, 530	3, 404, 970	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	(		0	
32.00	03200 CORONARY CARE UNI T	0	0	(	0 0	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	(		0	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	392, 352	68, 278	22, 050	63, 448	546, 128	43.00
50.00	05000 OPERATING ROOM	3, 614, 389	533, 379	172, 253	3 348, 553	4, 668, 574	50.00
51.00	05100 RECOVERY ROOM	0	0	(	0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 311, 594	467, 950	151, 123	3 243, 063	3, 173, 730	
53.00	05300 ANESTHESI OLOGY	1 000 155	0	(		0	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	1, 002, 155 195, 501	248, 037 22, 530	80, 103 7, 276		1, 467, 641 261, 387	1
56.00	05600 RADI OI SOTOPE	0	22, 330	7,270		201, 307	1
56.01	05601 ONCOLOGY	278, 324	103, 395	33, 391	1 43, 049	458, 159	
57.00	05700 CT SCAN	545, 799		18, 29		706, 444	
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	300, 775	35, 220	11, 374	4 48, 999	396, 368 0	
60.00	06000 LABORATORY	1, 376, 691	54, 470	17, 59	1 0	1, 448, 752	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	(	0 0	0	
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	453, 070 1, 126, 003		3, 646 77, 270		547, 525 1, 649, 665	
67.00	06700 OCCUPATI ONAL THERAPY	9, 936				1, 049, 005	
68.00	06800 SPEECH PATHOLOGY	143, 155		13, 033		213, 997	
69.00	06900 ELECTROCARDI OLOGY	141, 609	79, 975	25, 828	3 21, 824	269, 236	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0 0	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	616, 672 1, 191, 015	0			616, 672 1, 191, 015	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 866, 657	0	(	0	2, 866, 657	
74.00	07400 RENAL DI ALYSI S	0	0	(	0 0	0	
75.00	07500 ASC (NON-DISTINCT PART)	0	0	(	0 0	0	75.00
01 00	OUTPATIENT SERVICE COST CENTERS	1 ( 22 020	207 10/	105 04	1 00/ 154	0 071 011	01 00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 622, 830	387, 186	125, 041	1 236, 154	2, 371, 211 0	1
72.00	OTHER REIMBURSABLE COST CENTERS					0	72.00
99.00	09900 CMHC	0	0	(	0 0	0	99.00
	SPECIAL PURPOSE COST CENTERS	1					
118.00		43, 656, 057	4, 727, 508	1, 526, 735	5 2, 518, 616	42, 817, 924	118.00
190 00	NONREIMBURSABLE COST CENTERS	2, 544	0	(		2 544	190.00
	19100 RESEARCH	2, 344	0	(	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 474, 550	633, 037	204, 43	7 0	2, 312, 024	
193.00	19300 NONPAI D WORKERS	0	0	(	0 0		193.00
	07950 COMMUNITY EDUCATION	3, 457	0	(	659		194.00
	07951 MARKETING 07952 SC MGMT SVH TANDEM CASTLETON	130					194.01 194.02
200.00		130	0				200.00
201.00	Negative Cost Centers		0	(	o c	0	201.00
202.00	TOTAL (sum lines 118 through 201)					45, 136, 738	

		ST. VINCENT FIS				u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 07/01/2018	Worksheet B Part I	
				T		Date/Time Pre 11/22/2019 3:	pared:
	Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	· · · · · · · · · · · · · · · · · · ·	& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	9, 994, 273					5.00
7.00	00700 OPERATION OF PLANT	823, 396	3, 718, 672				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	36, 442	0				8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	166, 750 34, 641	54, 876 23, 008			184, 553	9.00
11.00	01100 CAFETERI A	188, 787	148, 579			0, 004	11.00
13.00	01300 NURSING ADMINI STRATION	363, 217	15, 499			0	
14.00	01400 CENTRAL SERVICES & SUPPLY	11, 004	24, 290			0	
15.00	01500 PHARMACY	229, 967	42, 880			0	
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	2, 392 6, 254	5, 723 3, 571	0		0	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0,234	3, 371	0	771	0	17.00
30.00	03000 ADULTS & PEDIATRICS	968, 350	714, 118	37, 571	158, 212	152, 677	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	1
32.00	03200 CORONARY CARE UNI T	0	0	-		0	32.00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	155 215	0	-	-	0	34.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	155, 315	61, 469	3, 644	13, 618	0	43.00
50.00	05000 OPERATI NG ROOM	1, 327, 712	480, 193	33, 410	106, 386	0	50.00
51.00	05100 RECOVERY ROOM	0	0			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	902, 587	421, 288	24, 970	93, 336	31, 876	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	-	0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	417, 387	223, 304			0	54.00 54.01
56.00	05600 RADI OI SOTOPE	74, 337	20, 284 0			0	56.00
56.01	05601 ONCOLOGY	130, 297	93, 085			0	56.01
57.00	05700 CT SCAN	200, 908	51,007			0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	112, 724	31, 708			0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	-	-	0	59.00
60.00 62.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	412, 015	49, 038 0			0	60.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	-	-	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	-	-	0	64.00
65.00	06500 RESPI RATORY THERAPY	155, 712	10, 165	0	2, 252	0	65.00
66.00	06600 PHYSI CAL THERAPY	469, 153	215, 406			0	
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	4, 338	2, 358			0	67.00
68.00 69.00	06900 ELECTROCARDI OLOGY	60, 859 76, 569	36, 332 72, 000			0	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0,00,007	, 2, 000			0	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	175, 377	0			0	•
	07200 IMPL. DEV. CHARGED TO PATIENTS	338, 716	0	0	-	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	815, 257	0			0	•
74.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0		-	0	
75.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	75.00
91.00	09100 EMERGENCY	674, 356	348, 578	37, 926	77, 227	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	1		I			
99.00	09900 CMHC	0	0	0	0	0	99.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	9, 334, 819	3, 148, 759	164, 582	685, 445	184, 553	1118 00
110.00	NONREI MBURSABLE COST CENTERS	7, 334, 017	3, 140, 737	104, 302	003, 443	104, 333	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	723	0	0	0	0	190.00
191.00	19100 RESEARCH	0	0	-	-		191.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	657, 523	569, 913				192.00
193.00	19300 NONPALD WORKERS	0	0	0	-		193.00 194.00
104 00		4 4 7 4 1				()	1194 ()()
	07950 COMMUNI TY EDUCATI ON	1, 171	0	, s	0		
194.01	07950 COMMUNI TY EDUCATI ON 07951 MARKETI NG	0	0		0	0	194. 01
194.01	07950 COMMUNI TY EDUCATI ON 07951 MARKETI NG 07952 SC MGMT SVH TANDEM CASTLETON	1, 171 0 37	0	0	0	0	
194.01 194.02	07950 COMMUNITY EDUCATION 07951 MARKETING 07952 SC MGMT SVH TANDEM CASTLETON Cross Foot Adjustments Negative Cost Centers	0	0	0	0	000000000000000000000000000000000000000	194. 01 194. 02 200. 00 201. 00

	Financial Systems S NLLOCATION - GENERAL SERVICE COSTS	T. VINCENT FIS	Provider CC		Period: From 07/01/2018	u of Form CMS-: Worksheet B Part I	2002-10
					To 06/30/2019		pared: 53 pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00
9.00	01000 DI ETARY						9.00
11.00	01100 CAFETERIA	1,034,108					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	54, 124	1				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	79, 36	7		14.00
15.00	01500 PHARMACY	45, 733	17, 578	15	6 1, 154, 439		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	17, 793	•
17.00	01700 SOCIAL SERVICE	1, 420	0 0		0 0	0	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	194, 919	392, 241	2, 65	2 0	1, 027	30.00
31.00	03100 I NTENSI VE CARE UNI T	194, 919	0 372, 241		0 0	0	31.00
32.00	03200 CORONARY CARE UNIT	0	0		0 0	0	•
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	0	0		0 0	0	34.00
43.00	04300 NURSERY	35, 056	79, 855	85	4 0	360	43.00
	ANCI LLARY SERVI CE COST CENTERS		1				
50.00	05000 OPERATING ROOM	150, 211	311, 048	24, 80		4, 879	•
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	106, 793	232, 532	88	0 0	0 1, 033	51.00 52.00
52.00	05300 ANESTHESI OLOGY	100, 793	232, 532		0 0	1,033	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	68, 536	156, 193	3, 80	-	1, 085	•
54.01	03630 ULTRA SOUND	13, 728		7		274	54.01
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
56.01	05601 ONCOLOGY	25, 402	0	38		194	56.01
57.00	05700 CT SCAN	40, 531		1, 09		570	•
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	22, 650	51, 730	84		247	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0 0	0 1, 338	59.00 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	•
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	37, 943	86, 551	53	5 0	179	65.00
66.00	06600 PHYSI CAL THERAPY	108, 744	1	21		512	•
67.00	06700 OCCUPATIONAL THERAPY	677	1		0 0	6	67.00
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	8, 336		1, 10 41		69 289	•
69.00 70.00	07000 ELECTROENCEPHALOGRAPHY	9, 811			9 0		69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	13, 01	6 0	519	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	25, 51		476	•
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 154, 439	1, 431	73.00
	07400 RENAL DI ALYSI S	0	0		0 0	0	•
75.00	07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0	75.00
91.00	OUTPATIENT SERVICE COST CENTERS	109, 159	248, 771	2 02	7 0	2 205	91.00
		109, 139	240, 771	2, 92	/	3, 305	91.00
72.00	OTHER REIMBURSABLE COST CENTERS		I I			L	72.00
99.00	09900 CMHC	0	0		0 0	0	99.00
	SPECIAL PURPOSE COST CENTERS						
118.00		1, 033, 773	1, 713, 440	79, 28	6 1, 154, 439	17, 793	118.00
	NONREI MBURSABLE COST CENTERS		-1		-1 -1	-	
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00 191.00
			n ()		0 0		
191.00	19100 RESEARCH	0		0	1 0	∩	102 00
191.00 192.00	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	8	1 0		192.00 193.00
191.00 192.00 193.00	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES 19300 NONPALD WORKERS	0 0 335		8	1 0 0 0 0 0	0	193.00
191.00 192.00 193.00 194.00	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0 0 0 335 0		8	1 0 0 0 0 0 0 0	0 0	
191.00 192.00 193.00 194.00 194.01	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES 19300 NONPALD WORKERS 07950 COMMUNI TY EDUCATI ON	0 0 0 335 0 0 0		8	1 0 0 0 0 0 0 0 0 0 0 0	0 0 0	193. 00 194. 00
191.00 192.00 193.00 194.00 194.01 194.02 200.00	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19200 NONPAID WORKERS 07950 COMMUNITY EDUCATION 07951 MARKETING 07952 SC MGMT SVH TANDEM CASTLETON Cross Foot Adjustments	0 0 335 0 0		8	1 0 0 0 0 0 0 0 0 0	0 0 0	193.00 194.00 194.01 194.02 200.00
191.00 192.00 193.00 194.00 194.01 194.02	19100       RESEARCH         19200       PHYSICLANS' PRIVATE OFFICES         19300       NONPALD WORKERS         07950       COMMUNITY EDUCATION         07951       MARKETING         07952       SC MGMT SVH TANDEM CASTLETON         Cross Foot Adjustments         Negative Cost Centers	0 0 335 0 0 0 1,034,108		8 79, 36		0 0 0 0	193.00 194.00 194.01 194.02 200.00 201.00

Health Financial Systems	ST. VINCENT FISH	RS HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0181	Period:	Worksheet B
				From 07/01/2018 To 06/30/2019	Date/Time Prepared:
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &	Total	11/22/2019 3:53 pm
			Residents Cos		
			& Post Stepdown		
			Adjustments		
GENERAL SERVICE COST CENTERS	17.00	24.00	25.00	26.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL					4.00
7.00 00700 OPERATION OF PLANT					7.00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING					8.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY					13.00
15. 00 01500 PHARMACY					15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	34, 028				16.00 17.00
INPATIENT ROUTINE SERVICE COST CENTERS	34, 020		I		17.00
30. 00 03000 ADULTS & PEDIATRICS	22, 782	6, 049, 519		0 6, 049, 519	30.00
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	0	0		0 0	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0 0	34.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	11, 246	907, 545		0 907, 545	43.00
50. 00 05000 OPERATING ROOM	0	7, 107, 215		0 7, 107, 215	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	4, 989, 031 0		0 4, 989, 031 0 0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 406, 038		0 2, 406, 038	54.00
54. 01 03630 ULTRA SOUND	0	410, 586		0 410, 586	54.01
56. 00 05600 RADI OI SOTOPE 56. 01 05601 0NCOLOGY	0	0 728, 146		0 0 0 728, 146	56. 00 56. 01
57. 00 05700 CT SCAN	0	1, 104, 263		0 1, 104, 263	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0	623, 300		0 623, 300 0 0	58.00 59.00
60. 00 06000 LABORATORY	0	1, 922, 011		0 1, 922, 011	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	63.00 64.00
65. 00 06500 RESPIRATORY THERAPY	0	840, 862		0 840, 862	65.00
66.00 06600 PHYSI CAL THERAPY	0	2, 491, 414		0 2, 491, 414	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	23, 153 328, 746		0 23, 153 0 328, 746	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	457, 501		0 457, 501	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0 0 805, 584	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	805, 584 1, 555, 720		0 1, 555, 720	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4,837,784		0 4, 837, 784	73.00
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT PART)	0	0			74.00
OUTPATI ENT SERVICE COST CENTERS		0		0 0	/3.00
91.00 09100 EMERGENCY	0	3, 873, 460		0 3, 873, 460	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0	92.00
99. 00 09900 CMHC	0	0		0 0	99.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)	34, 028	41, 461, 878		0 41, 461, 878	118.00
NONREI MBURSABLE COST CENTERS	34,028	41,401,078	1	<u>v</u> 41, 401, 878	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 267		0 3, 267	190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0 3, 665, 804		0 0 0 3, 665, 804	191.00 192.00
193. 00 19300 NONPAI D WORKERS	0	0,000,004		0 0	193.00
194. 00 07950 COMMUNI TY EDUCATI ON	0	5, 622		0 5, 622	194.00
194.0107951 MARKETING 194.0207952 SC MGMT SVH TANDEM CASTLETON	0	0 167		0 0 167	194. 01 194. 02
200.00 Cross Foot Adjustments		0		0 0	200.00
201.00 Negative Cost Centers	0	0 45 124 720		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	201.00
202.00  TOTAL (sum lines 118 through 201)	34, 028	45, 136, 738	1	0 45, 136, 738	202.00

Heal th	Fina	nci	al	Syste	ems		
	TLON	OF	C A		DEL	ATED	0

	Financial Systems S TION OF CAPITAL RELATED COSTS	ST. VINCENT FIS	Provider CO	CN: 15-0181 Pe Fr Tc	eriod: rom 07/01/2018	u of Form CMS- Worksheet B Part II Date/Time Pre 11/22/2019 3:	pared:
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL REI BLDG & FI XT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	OFNERAL CERVICOE COST CENTERS	0	1.00	2.00	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00 4.00 5.00 7.00 8.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 875, 323 0 0	52, 995 470, 696 706, 299 0	152, 010 228, 097 0	70, 109 1, 498, 029 934, 396 0	70, 109 3, 457 1, 164 0	1.00 2.00 4.00 5.00 7.00 8.00
9.00 10.00 11.00 13.00 14.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY		60, 954 25, 556 165, 036 17, 216 26, 980	8, 253 53, 298 5, 560	80, 639 33, 809 218, 334 22, 776 35, 693	0 0 0 5, 084 0	9.00 10.00 11.00 13.00 14.00
15. 00 16. 00 17. 00	01500 PHARMACY 01500 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	47, 629 6, 357 3, 967	15, 382 2, 053	63, 013 63, 011 8, 410 5, 248	3, 160 0 72	15.00 16.00
30.00 31.00 32.00 34.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04300 NURSERY	0 0 0 0	793, 217 0 0 0	0 0 0	1, 049, 384 0 0 0 0	13, 459 0 0 1 7(/	31.00 32.00 34.00
43.00	ANCI LLARY SERVI CE COST CENTERS	0	68, 278	22, 050	90, 328	1, 766	43.00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	000	533, 379 0	0	705, 632 0	9, 699 0	51.00
52.00 53.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC	0	467, 950 0 248, 037	0	619, 073 0 328, 140	6, 764 0 3, 822	52.00 53.00 54.00
54. 01 56. 00 56. 01	03630 ULTRA SOUND 05600 RADI 0I SOTOPE 05601 ONCOLOGY	0 0 0	22, 530 0 103, 395	0	29, 806 0 136, 786	1, 004 0 1, 198	54.01 56.00 56.01
57.00 58.00 59.00 60.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY	000000000000000000000000000000000000000	56, 656 35, 220 0 54, 470	11, 374 0	74, 953 46, 594 0 72, 061	2, 385 1, 364 0 0	57.00 58.00 59.00 60.00
62.00 63.00 64.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 0 0 11, 291	0 0 0 3, 646	0 0 0 14, 937	0 0 0 2, 213	62.00 63.00 64.00
66. 00 67. 00 68. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0 0 0	239, 264 2, 619 40, 356	77, 270 846 13, 033	316, 534 3, 465 53, 389	5, 764 52 486	66.00 67.00 68.00
69.00 70.00 71.00 72.00 73.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	79, 975 0 0 0	25, 828 0 0 0	105, 803 0 0 0	607 0 0 0 0	71.00
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00 75.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0	387, 186	125, 041	512, 227 0	6, 571	91.00 92.00
99. 00	09900 CMHC SPECIAL PURPOSE COST CENTERS	0	0		0	0	
118.00 190.00	SUBTOTALS (SUM OF LINES 1 through 117)           NONREI MBURSABLE COST CENTERS           19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	875, 323	4, 727, 508		7, 129, 566		118.00 190.00
191.00 192.00 193.00	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES 19300 NONPAI D WORKERS 07950 COMMUNI TY EDUCATI ON		0 633, 037 0 0	0	0 837, 474 0 0	0 0 0	191.00 192.00 193.00 194.00
194.01 194.02 200.00	07951 MARKETING 207952 SC MGMT SVH TANDEM CASTLETON Cross Foot Adjustments	0	0	0	000000000000000000000000000000000000000	0 0	194. 01 194. 02 200. 00
201.00 202.00		875, 323	0 5, 360, 545	0 1, 731, 172	0 7, 967, 040		201. 00 202. 00

Health Financial Systems	ST. VINCENT FISH				u of Form CMS-25	52-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	F	eriod: rom 07/01/2018	Worksheet B Part II	
			Т	06/30/2019	Date/Time Prepa 11/22/2019 3:53	red: pm
Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	5.00	7.00	8. 00	9.00	10.00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	1, 501, 486					5.00
7.00 00700 OPERATION OF PLANT	123, 704	1, 059, 264	E 47E			7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG	5, 475 25, 052	0 15, 631	5, 475 125	121, 447		8.00 9.00
10. 00 01000 DI ETARY	5, 204	6, 554	0	763	46, 330 1	10.00
11. 00 01100 CAFETERI A	28, 363	42, 323	0	4, 925		11.00
13. 00 01300 NURSING ADMINISTRATION	54, 568	4,415	0	514		13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	1, 653 34, 549	6, 919 12, 214	0	805 1, 421		14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	359	1, 630	0	190		16.00
17.00 01700 SOCIAL SERVICE	940	1, 017	0	118	0 1	17.00
INPATI ENT ROUTINE SERVICE COST CENTERS           30.00         O3000         ADULTS & PEDIATRICS	145, 481	203, 419	1, 250	23, 671	38, 328 3	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0	203, 419	1, 250	23, 071		31.00
32. 00 03200 CORONARY CARE UNI T	0	0	0	0	0 3	32.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0		34.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	23, 334	17, 510	121	2, 038	0 4	43.00
50. 00 05000 OPERATI NG ROOM	199, 457	136, 783	1, 111	15, 917	0 5	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	135, 601	120, 004	831	13, 965		52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	62, 706	0 63, 608	0 619	0 7, 402		53.00 54.00
54. 01  03630  ULTRA SOUND	11, 168	5, 778	156	672		54.01
56. 00 05600 RADI OI SOTOPE	0	0	0	0		56.00
56. 01 05601 0NC0L0GY	19, 575	26, 515	0	3, 086		56.01
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	30, 184 16, 935	14, 529 9, 032	0	1, 691 1, 051		57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0		59.00
60. 00 06000 LABORATORY	61, 899	13, 968	0	1, 626		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		52.00 53.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0		53.00 64.00
65. 00 06500 RESPI RATORY THERAPY	23, 394	2, 895	0	337		65.00
66. 00 06600 PHYSI CAL THERAPY	70, 484	61, 358	0	7, 140		66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	652 9, 143	672 10, 349	0	78 1, 204		67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	11, 503	20, 509	0	2, 387		58.00 59.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0		0		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	50, 887 122, 481	0	0	0		72.00 73.00
74. 00 07400 RENAL DI ALYSI S	0	0	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0 7	75.00
	101 212	00,000	1 0/0	11 555		21 00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	101, 312	99, 292	1, 262	11, 555		91.00 92.00
OTHER REI MBURSABLE COST CENTERS						/2.00
99. 00 09900 CMHC	0	0	0	0	0 9	99.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 11		896, 924	E 47E	102, 556	46, 330 11	10 00
NONREIMBURSABLE COST CENTERS	7) 1, 402, 411	890, 924	5, 475	102, 550	40, 330 11	18.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	109	0	0	0	0 19	90.00
191.00 19100 RESEARCH	0	0	0	0		91.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 193.00 19300 NONPALD WORKERS	98, 784	162, 340	0	18, 891		92.00 93.00
193. 00 19300 NONPATE WORKERS 194. 00 07950 COMMUNITY EDUCATION	176	0	0	0		93.00 94.00
194. 01 07951 MARKETI NG	0	0	0	0	0 19	94.01
194.0207952 SC MGMT SVH TANDEM CASTLETON	6	0	0	0		94.02
200.00Cross Foot Adjustments201.00Negative Cost Centers		0	~	~		00.00 01.00
202.00 TOTAL (sum lines 118 through 201)	1, 501, 486	1, 059, 264	5, 475	121, 447		

	· · · · · · · · · · · · · · · · · · ·	ST. VINCENT FIS				u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 07/01/2018	Worksheet B Part II	
					To 06/30/2019	Date/Time Pre	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	11/22/2019 3: MEDI CAL	55 pill
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
		11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16. 00	
	GENERAL SERVICE COST CENTERS			11100	10100	10100	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL						4.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	293, 945 15, 385					11.00 13.00
13.00	01400 CENTRAL SERVICES & SUPPLY	10, 300	102, 742	45, 070			14.00
15.00	01500 PHARMACY	13,000	1, 054	89			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	C	0	(	0 0	10, 589	16.00
17.00	01700 SOCIAL SERVICE	404	0	(	0 0	0	17.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	55, 406	23, 520	1, 506	5 0	605	30.00
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	55,400		1, 500	1	005	30.00
32.00	03200 CORONARY CARE UNIT	C		(		0	32.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	C	0	(	0 0	0	34.00
43.00	04300 NURSERY	9, 965	4, 788	485	5 0	212	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	40.407	10 (54	14.00		0.070	50.00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	42, 697		14, 084		2, 979 0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	30, 356	-	503		609	52.00
53.00	05300 ANESTHESI OLOGY	C		(		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 481	9, 366	2, 16	1 0	639	54.00
54.01	03630 ULTRA SOUND	3, 902		42		162	54.01
56. 00 56. 01	05600 RADI OI SOTOPE 05601 ONCOLOGY	C 7 221	-	( 219		0	56.00 56.01
56. 01 57. 00	05700 CT SCAN	7, 221 11, 521	-	62		114 336	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	6, 438		482	-	146	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	C		(		0	59.00
60.00	06000 LABORATORY	C	-	2	2 0	788	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	(		0	62.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY		Ű	(		0	63.00 64.00
65.00	06500 RESPI RATORY THERAPY	10, 785	Ű	304		105	65.00
66.00	06600 PHYSI CAL THERAPY	30, 910		120		302	66.00
67.00	06700 OCCUPATI ONAL THERAPY	192		(		3	67.00
68.00	06800 SPEECH PATHOLOGY	2, 370		62		41	68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	2, 789 C		238		170 0	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			7, 392		306	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	14, 48		281	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	0	(		843	
74.00	07400 RENAL DI ALYSI S	C	-	(		0	74.00
75.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	C	0	(	0 0	0	75.00
91.00	09100 EMERGENCY	31, 028	14, 917	1, 662	2 0	1, 948	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	01,020	,	.,		17710	92.00
	OTHER REIMBURSABLE COST CENTERS						]
99.00	09900 CMHC	C	0	(	0 0	0	99.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	293, 850	102, 742	45, 024	128, 498	10, 589	110 00
118.00	NONREIMBURSABLE COST CENTERS	293, 850	102, 742	45, 024	128, 498	10, 589	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	(	0 0	0	190.00
	19100 RESEARCH	C		(		0	191.00
191.00		C	-	46			192.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES			(		0	193.00
192.00 193.00	19300 NONPAID WORKERS	C				~	101 00
192.00 193.00 194.00	19300 NONPALD WORKERS 07950 COMMUNITY EDUCATION	95 0		(	0		194.00 194.01
192.00 193.00 194.00 194.01	19300 NONPALD WORKERS 07950 COMMUNI TY EDUCATI ON 07951 MARKETI NG	-		(		0	194.01
192.00 193.00 194.00 194.01	19300 NONPALD WORKERS 07950 COMMUNITY EDUCATION 07951 MARKETING 07952 SC MGMT SVH TANDEM CASTLETON	-		(	0 0 0 0 0 0	0	
192.00 193.00 194.00 194.01 194.02	19300 NONPAID WORKERS 07950 COMMUNITY EDUCATION 07951 MARKETING 07952 SC MGMT SVH TANDEM CASTLETON Cross Foot Adjustments Negative Cost Centers	-	0 0 0	( ( ( ( ( 45, 07(	0 0 0 0 0 0 0 0 128, 498	0 0 0	194. 01 194. 02

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ALL 00A	TLON	05	0 A D I -	T A 1	DEL	ATED	_

Health Finan	ncial Systems	ST. VINCENT FISH	ERS HOSPITAL		In Lie	u of Form CMS-2552-	-10
	OF CAPITAL RELATED COSTS		Provider C		eriod: om 07/01/2018	Worksheet B Part II	d:
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
	AL SERVICE COST CENTERS	1		1			~~
	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP					1.	
	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL					4. 5.	
7.00 00700	OPERATION OF PLANT					7.	00
	LAUNDRY & LINEN SERVICE HOUSEKEEPING					8. 9.	
10.00 01000	DI ETARY					10.	
						11.	
	NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY					13. 14.	
	PHARMACY					15.	
	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	7, 799				16. 17.	
I NPAT	IENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	5, 222	1, 561, 251	0	1, 561, 251 0	30. 31.	
	CORONARY CARE UNI T	0	C	0	0	32.	
	SURGICAL INTENSIVE CARE UNIT	0 2, 577	C 153, 124	0	0 153, 124	34. 43.	
	LARY SERVICE COST CENTERS	2,377	155, 124	. 0	155, 124	43.	00
	OPERATING ROOM	0	1, 147, 010		1, 147, 010	50.	
	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	949, 651	0	0 949, 651	51. 52.	
53.00 05300	ANESTHESI OLOGY	0	C	0	0	53.	00
	RADI OLOGY-DI AGNOSTI C ULTRA SOUND	0	497, 944 54, 567		497, 944 54, 567	54. 54.	
	RADI OI SOTOPE	0	04, 307 C		0	56.	
	ONCOLOGY	0	194, 714		194, 714	56.	
	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	141, 761 85, 144		141, 761 85, 144	57. 58.	
	CARDI AC CATHETERI ZATI ON	0	C	0	0	59.	
	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	150, 344 C	0	150, 344 0	60. 62.	
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	C	0	0	63.	00
	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0	C 60, 160		0 60, 160	64. 65.	
	PHYSI CAL THERAPY	0	492, 612		492, 612	66.	
	OCCUPATIONAL THERAPY	0	5, 114		5, 114	67.	
	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	77, 609 144, 799		77, 609 144, 799	68. 69.	
70.00 07000	ELECTROENCEPHALOGRAPHY	0	C	0 0	0	70.	00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	34, 046 65, 655	-	34, 046 65, 655	71. 72.	
73.00 07300	DRUGS CHARGED TO PATIENTS	0	251, 822		251, 822	73.	00
	RENAL DIALYSIS ASC (NON-DISTINCT PART)	0	C	-	0	74. 75.	
	TIENT SERVICE COST CENTERS	0		<u>, 0</u>	0	/5.	00
		0	781, 774		781, 774		
	OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS			0		92.	00
99.00 09900		0	C	0	0	99.	00
118.00	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	7, 799	6, 849, 101	0	6, 849, 101	118.	00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	109	0	109	190.	00
191.0019100		0	1 117 505	0	0	191.	
	PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS	0	1, 117, 535 C	0	1, 117, 535 0	192. 193.	
194.0007950	COMMUNITY EDUCATION	0	289	0	289	194.	00
194.0107951	MARKETING SC MGMT SVH TANDEM CASTLETON	0	C	0	0	194. 194.	
200.00	Cross Foot Adjustments		C		6 0	200.	
201.00	Negative Cost Centers	0	C	0	0	201.	00
202.00	TOTAL (sum lines 118 through 201)	7, 799	7, 967, 040	0	7, 967, 040	202.	00

		ST. VINCENT FIS				u of Form CMS-	
IST ALL	LOCATION - STATISTICAL BASIS		Provider CC	CN: 15-0181   P   F   T	eriod: rom 07/01/2018 o 06/30/2019	Worksheet B-1 Date/Time Pre 11/22/2019 3:	pare
		CAPI TAL REI	ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
GI	ENERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FIXT	210, 802					1.
	0200 CAP REL COSTS-MVBLE EQUIP		210, 802				2.
	0400 EMPLOYEE BENEFITS DEPARTMENT	2, 084		12, 368, 363			4.
	0500 ADMINISTRATIVE & GENERAL	18, 510		609, 939			
	0700 OPERATION OF PLANT	27, 775		205, 430		_, ,	
	0800 LAUNDRY & LINEN SERVICE	0	-	0	0		
	0900 HOUSEKEEPI NG 1000 DI ETARY	2, 397		0	0	586, 336	
	1100 CAFETERIA	1,005 6,490		0	0	121, 807 663, 824	
	1300 NURSI NG ADMI NI STRATI ON	677		897, 004	-		
	1400 CENTRAL SERVICES & SUPPLY	1,061		077,004	0		
	1500 PHARMACY	1,873		557, 468	-		
	1600 MEDICAL RECORDS & LIBRARY	250		0	0		
. 00 0	1700 SOCIAL SERVICE	156	156	12, 720	0	21, 992	17
11	NPATIENT ROUTINE SERVICE COST CENTERS					•	
. 00 0	3000 ADULTS & PEDIATRICS	31, 193	31, 193	2, 373, 885	0	3, 404, 970	30
	3100 INTENSIVE CARE UNIT	0	0	0	0	0	31
	3200 CORONARY CARE UNI T	0	0	0	0	0	
	3400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0		
	4300 NURSERY	2, 685	2, 685	311, 497	0	546, 128	43
	NCI LLARY SERVICE COST CENTERS	00.075	00.075	4 744 004		4 ( ( 0 574	1 50
	5000 OPERATING ROOM	20, 975	20, 975	1, 711, 221			
	5100 RECOVERY ROOM 5200 DELIVERY ROOM & LABOR ROOM	18, 402	18, 402	1, 193, 314	0		
	5300 ANESTHESI OLOGY	10,402	10, 402	1, 173, 314	0		
	5400 RADI OLOGY-DI AGNOSTI C	9, 754	9, 754	674, 298	-		
	3630 ULTRA SOUND	886		177, 135			
	5600 RADI OI SOTOPE	000		0			
	5601 ONCOLOGY	4,066	-	211, 347	-	-	
	5700 CT SCAN	2, 228		420, 706			
	5800 MAGNETIC RESONANCE IMAGING (MRI)	1, 385		240, 562			
. 00 0	5900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59
. 00  0	6000 LABORATORY	2, 142	2, 142	0	0	1, 448, 752	60
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	-	
	6300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
	6400 I NTRAVENOUS THERAPY	0	0	0	0		
	6500 RESPI RATORY THERAPY	444		390, 392			
	6600 PHYSI CAL THERAPY	9, 409		1, 016, 895			
	6700 OCCUPATIONAL THERAPY	103		9, 089 85, 684			
	6800 SPEECH PATHOLOGY 6900 ELECTROCARDI OLOGY	1, 587 3, 145					
	7000 ELECTROENCEPHALOGRAPHY	3, 143		107, 147 0			
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-	0	-		
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0		
	7300 DRUGS CHARGED TO PATIENTS	0	0	0	-		
	7400 RENAL DI ALYSI S	0	0	0	-		
00 0	7500 ASC (NON-DISTINCT PART)	0	0	0	0		
O	UTPATIENT SERVICE COST CENTERS						
	9100 EMERGENCY	15, 226	15, 226	1, 159, 396	0	2, 371, 211	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	THER REIMBURSABLE COST CENTERS	1				I	
	9900 CMHC	0	0	0	0	0	99
_	PECIAL PURPOSE COST CENTERS	10	10	40.017	0.05	00.005.00	1
3.00	SUBTOTALS (SUM OF LINES 1 through 117)	185, 908	185, 908	12, 365, 129	-9, 994, 273	32, 823, 651	1118
	ONREIMBURSABLE COST CENTERS					2 544	1100
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9100 RESEARCH	0	0	0			190
	9100 RESEARCH 9200 PHYSICIANS' PRIVATE OFFICES	24, 894	24, 894	0	0		
	9300 NONPAID WORKERS	24,094	24,074	0	0		192
	7950 COMMUNITY EDUCATION			3, 234	-	4, 116	
	7950 COMMONT TY EDUCATION 7951 MARKETING			3, 234 ∩	0		194
	7951 MARKETING 7952 SC MGMT SVH TANDEM CASTLETON			0	0		194
	Cross Foot Adjustments			0		.30	200
	, 5, 555 , 551 , Mg 45 (morres	1					200
0. 00	Negative Cost Centers						
0. 00 1. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	5, 360, 545	1, 731, 172	2, 519, 275		9, 994, 273	
0.00 1.00 2.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	5, 360, 545	1, 731, 172	2, 519, 275		9, 994, 273	

Health Financial Systems	ST. VINCENT FIS	HERS HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 07/01/2018 To 06/30/2019		
	CAPI TAL RE	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
204.00 Cost to be allocated (per Wkst. B, Part II)			70, 10	9	1, 501, 486	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 00566	3	0. 042726	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)	1					206. 00
207.00 NÄHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	LLOCATION - STATISTICAL BASIS Cost Center Description	OPERATI ON OF	Provider CC	F	Period: From 07/01/2018 To 06/30/2019	Worksheet B-1 Date/Time Pre	
	Cost Center Description						
	bost benter beschiption		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	11/22/2019 3: CAFETERI A	53 pm
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF LAUNDRY)		(MEALS SERVED)		
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	1			1		1
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMI NI STRATI VE & GENERAL						5.00
	00700 OPERATION OF PLANT	162, 433					7.00
	00800 LAUNDRY & LINEN SERVICE	0	197, 303				8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 397 1, 005	4, 491 0	160, 036			9.00
	01100 CAFETERIA	6, 490	0	6, 490		284, 070	1
	01300 NURSI NG ADMI NI STRATI ON	677	0	677		14, 868	
	01400 CENTRAL SERVICES & SUPPLY	1, 061	0	1, 061	0	0	1
	01500 PHARMACY	1, 873	0	1, 873		12, 563	
	01600 MEDICAL RECORDS & LIBRARY	250	0			0	
17.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	156	0	156	0	390	17.00
30.00	03000 ADULTS & PEDIATRICS	31, 193	45, 041	31, 193	5, 671	53, 544	30.00
	03100 I NTENSI VE CARE UNI T	0	43, 041	(		00,044	1
32.00	03200 CORONARY CARE UNI T	0	0	0	0 0	0	32.00
	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	°	0	
	04300 NURSERY	2, 685	4, 368	2, 685	5 0	9, 630	43.00
	ANCI LLARY SERVI CE COST CENTERS	20, 975	40, 052	20, 975	i ol	41, 263	50.00
	05100 RECOVERY ROOM	20, 975	40, 052	20, 973		41,203	
	05200 DELIVERY ROOM & LABOR ROOM	18, 402	29, 934	18, 402	-	29, 336	
	05300 ANESTHESI OLOGY	0	0		0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	9, 754	22, 314	9, 754		18, 827	54.00
	03630 ULTRA SOUND	886	5, 637	886		3, 771	
	05600 RADI OI SOTOPE 05601 ONCOLOGY	0 4, 066	0	4, 066	-	0 6, 978	
	05700 CT SCAN	2, 228	0	2, 228		11, 134	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 385	0	1, 385		6, 222	1
	05900 CARDI AC CATHETERI ZATI ON	0	0			0	
	06000 LABORATORY	2, 142	0	2, 142		0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	-	0	
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		-	0	
	06500 RESPIRATORY THERAPY	444	0	444	-	10, 423	1
	06600 PHYSI CAL THERAPY	9, 409	0			29, 872	
	06700 OCCUPATIONAL THERAPY	103	0	103		186	67.00
	06800 SPEECH PATHOLOGY	1, 587	0			2, 290	
		3, 145	0	3, 145	5 0		69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	-	-	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	1
	07400 RENAL DIALYSIS	0	0	0	0 0	0	74.00
	07500 ASC (NON-DI STI NCT PART)	0	0	(	0 0	0	75.00
	OUTPATIENT SERVICE COST CENTERS	15, 226	45, 466	15, 226	ol ol	29, 986	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	15, 220	43, 400	15, 220		29, 900	91.00
	OTHER REIMBURSABLE COST CENTERS						72.00
99.00	09900 CMHC	0	0	(	0 0	0	99.00
	SPECIAL PURPOSE COST CENTERS	- -					
118.00		137, 539	197, 303	135, 142	6, 855	283, 978	118.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0			0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00 191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	24, 894	0	24, 894	0		192.00
	19300 NONPAI D WORKERS	0	0		0		193.00
194.00	07950 COMMUNI TY EDUCATI ON	0	0	(	0	92	194.00
	07951 MARKETI NG	0	0	(	0		194.01
	07952 SC MGMT SVH TANDEM CASTLETON	0	0		ן ע	0	194.02
200.00 201.00							200.00
		3, 718, 672	164, 582	811, 708	184, 553	1, 034, 108	1
201.00			.,			, ,	
	Part I)						1
202.00 203.00	Unit cost multiplier (Wkst. B, Part I)	22. 893575	0. 834159			3. 640328	
202.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	22. 893575 1, 059, 264	0. 834159 5, 475			3. 640328 293, 945	
202.00 203.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	1		121, 447	46, 330		204.00

Health Financial Systems	ST. VINCENT FIS	HERS HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period:	Worksheet B-1	
				From 07/01/2018 To 06/30/2019		
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(MEALS SERVED)	
	(SQUARE FEET)	(POUNDS OF				
		LAUNDRY)				
	7.00	8.00	9.00	10.00	11.00	
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

IST ALLUCA	TION - STATISTICAL BASIS		HERS HOSPITAL Provider CC		eri od:	worksheet B-1	
				Fr   To	om 07/01/2018 06/30/2019	Date/Time Pre	par
			CENTRAL	DUADMACY	MEDLOAL	11/22/2019 3:	53
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDICAL RECORDS &	SOCIAL SERVICE	
			SUPPLY	REQUIS.)		(TOTAL PATIENT	
		(DI RECT NURS.	(COSTED	,	(GROSS	DAYS)	
		HRS. )	REQUIS.)		CHARGES)		
		13.00	14.00	15.00	16.00	17.00	-
	RAL SERVICE COST CENTERS	1				1	4.
	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP						
	EMPLOYEE BENEFITS DEPARTMENT						
	ADMINISTRATIVE & GENERAL						5
	OPERATION OF PLANT						
	LAUNDRY & LINEN SERVICE						8
	HOUSEKEEPING						9
. 00 01000	DIETARY						10
. 00 01100	CAFETERI A						11
	NURSING ADMINISTRATION	10, 235					13
	CENTRAL SERVICES & SUPPLY	0	3, 704, 914				14
	PHARMACY	105	7, 293	2, 866, 657	100 101 051		15
	MEDICAL RECORDS & LIBRARY	0	0	0	188, 134, 856		16
	SOCIAL SERVICE	0	0	0	0	3, 389	17
	ADULTS & PEDIATRICS	2, 343	123, 782	0	10, 811, 120	2, 269	30
	INTENSIVE CARE UNIT	2, 343	123, 702	0	0,011,120		
	CORONARY CARE UNI T	0	0	0	0	o o	
	SURGICAL INTENSIVE CARE UNIT	0	o	0	0	0	
	NURSERY	477	39, 859	0	3, 790, 369	1, 120	
	LARY SERVICE COST CENTERS		· .				
. 00 05000	OPERATING ROOM	1, 858	1, 157, 759	0	52, 205, 163	0	50
	RECOVERY ROOM	0	0	0	0	0	51
	DELIVERY ROOM & LABOR ROOM	1, 389	41, 338	0	10, 869, 150	0	
	ANESTHESI OLOGY	0	0	0	0	0	
	RADI OLOGY-DI AGNOSTI C	933	177, 681	0	11, 418, 464		-
	ULTRA SOUND	187	3, 453	0	2, 884, 444		
	RADI OI SOTOPE	0	10,022	0	2 020 022	0	
		0 552	18, 022 51, 045	0	2,038,833		
	DCT SCAN MAGNETIC RESONANCE IMAGING (MRI)	309	51,045 39,585	0	6, 003, 674 2, 599, 543		
	CARDI AC CATHETERI ZATI ON	0	37, 383	0	2, 399, 343	0	
	LABORATORY	0	166	0	14, 080, 248		
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	000,210	0	
	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
	INTRAVENOUS THERAPY	0	0	0	0	0	64
. 00 06500	RESPI RATORY THERAPY	517	24, 978	0	1, 883, 345	0	65
. 00 06600	PHYSI CAL THERAPY	0	9, 840	0	5, 391, 902	0	60
	OCCUPATIONAL THERAPY	0	0	0	58, 934	0	6
. 00 06800	SPEECH PATHOLOGY	0	51, 515	0	729, 818	0	68
	ELECTROCARDI OLOGY	79	19, 536	0	3, 043, 515	0	
	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	607, 612	0	5, 467, 121		
	IMPL. DEV. CHARGED TO PATIENTS	0	1, 191, 015	0	5, 010, 188		
	DRUGS CHARGED TO PATIENTS	0	0	2, 866, 657	15, 058, 836		
	RENAL DIALYSIS	0	0	0	0	0	
	ATLENT SERVICE COST CENTERS	0	0	0	0	0	0 7!
	EMERGENCY	1, 486	136, 651	0	34, 790, 189	0	9.
	OBSERVATION BEDS (NON-DISTINCT PART)	1,400	130, 031	0	54,770,107		92
	REIMBURSABLE COST CENTERS	1 1					- ''
. 00 09900		0	0	0	0	0	99
	AL PURPOSE COST CENTERS						
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	10, 235	3, 701, 130	2, 866, 657	188, 134, 856	3, 389	118
NONRE	EIMBURSABLE COST CENTERS					_	
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190
1.00 19100	RESEARCH	0	0	0	0		191
	PHYSICIANS' PRIVATE OFFICES	0	3, 784	0	0		192
	NONPAID WORKERS	0	0	0	0		193
		0	0	0	0		194
	MARKETING	0	0	0	0		194
	SC MGMT SVH TANDEM CASTLETON	0	0	0	0	0	194
0.00	Cross Foot Adjustments						200
1.00	Negative Cost Centers	1 712 440	70 2/7	1 154 420	17 700	24 020	201
2.00	Cost to be allocated (per Wkst. B, Part I)	1, 713, 440	79, 367	1, 154, 439	17, 793	34, 028	202
3.00	Unit cost multiplier (Wkst. B, Part I)	167. 409868	0. 021422	0. 402713	0.000095	10. 040720	1/201
	Cost to be allocated (per Wkst. B,	107, 40,808	45, 070	128, 498	10, 589		
4.00							

Health Financial Systems	ST. VINCENT FIS	HERS HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO	CN: 15-0181	Period: From 07/01/2018	Worksheet B-1	
				To 06/30/2019		pared: 53 pm
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY	(TOTAL PATIENT	
	(DI RECT NURS.	(COSTED		(GROSS	DAYS)	
	HRS.)	REQUIS.)		CHARGES)		
	13.00	14.00	15.00	16.00	17.00	
205.00 Unit cost multiplier (Wkst. B, Part	10. 038300	0. 012165	0.04482	0. 000056	2. 301269	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0181	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Pre 11/22/2019 3:	pared: 53 pm
			Title	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	s RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 049, 519		6, 049, 5	19 0	6, 049, 519	30.00
31.00	03100 INTENSIVE CARE UNIT	0			0 0	0	31.00
	03200 CORONARY CARE UNI T	0			0 0	0	32.00
	03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	34.00
	04300 NURSERY	907, 545		907, 5	45 0	907, 545	43.00
	ANCI LLARY SERVICE COST CENTERS	1 1		1			
	05000 OPERATI NG ROOM	7, 107, 215		7, 107, 2		7, 107, 215	
	05100 RECOVERY ROOM	0			0 0	0	
	05200 DELIVERY ROOM & LABOR ROOM	4, 989, 031		4, 989, 0		5, 037, 315	
	05300 ANESTHESI OLOGY	0			0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	2, 406, 038		2, 406, 0		2, 406, 038	
	03630 ULTRA SOUND	410, 586		410, 5		410, 586	
	05600 RADI OI SOTOPE	720 144		700 1	0 0	0	
	05601 ONCOLOGY 05700 CT SCAN	728, 146		728, 1		734, 018	
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 104, 263 623, 300		1, 104, 2 623, 3		1, 104, 263 623, 300	
	05900 CARDI AC CATHETERI ZATI ON	023, 300		023, 3	0 0	023, 300	
	06000 LABORATORY	1,922,011		1, 922, 0		1, 922, 011	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 722, 011		1, 722, 0	0 0	0	
	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0			0 0	0	1
	06400 I NTRAVENOUS THERAPY	0			0 0	0	
	06500 RESPI RATORY THERAPY	840, 862	0	840, 8	-	840, 862	
	06600 PHYSI CAL THERAPY	2, 491, 414	0			2, 491, 414	
	06700 OCCUPATI ONAL THERAPY	23, 153	0	23, 1		23, 153	
	06800 SPEECH PATHOLOGY	328, 746	0	328, 7		328, 746	
69.00	06900 ELECTROCARDI OLOGY	457, 501		457, 5	01 0	457, 501	69.00
	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	805, 584		805, 5	84 0	805, 584	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 555, 720		1, 555, 7	20 0	1, 555, 720	72.00
	07300 DRUGS CHARGED TO PATIENTS	4, 837, 784		4, 837, 7		4, 837, 784	
	07400 RENAL DIALYSIS	0			0 0	0	
75.00	07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
	OUTPATIENT SERVICE COST CENTERS				[		
	09100 EMERGENCY	3, 873, 460		3, 873, 4		3, 873, 460	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 329, 312		1, 329, 3	12	1, 329, 312	92.00
	OTHER REI MBURSABLE COST CENTERS			1	0		00.00
	09900 CMHC	0	0	40 701 1		0 42 045 244	
200.00 201.00	Subtotal (see instructions) Less Observation Beds	42, 791, 190 1, 329, 312	0	42, 791, 1 1, 329, 3		42, 845, 346 1, 329, 312	

	Financial Systems	ST. VINCENT FISH	Provi der C	CN: 15-0181	Peri od:	u of Form CMS-: Worksheet C	2002 10
001111 01	ATTON OF INTER OF COSTS TO CHARGES		TTOVIDET O		From 07/01/2018	Part I	
					To 06/30/2019	Date/Time Pre	
						11/22/2019 3:	53 pm
				XVIII	Hospi tal	PPS	
	Cont. Conton December 1 an	Long the set	Charges	Tatal (asl		TEEDA	
	Cost Center Description	I npati ent	Outpati ent	Total (col. (	6 Cost or Other Ratio	TEFRA Inpatient	
				+ col. 7)	Ratio	Ratio	
		6.00	7.00	8.00	9,00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30, 00	03000 ADULTS & PEDIATRICS	8, 453, 209		8, 453, 20	19		30.00
31.00	03100 I NTENSI VE CARE UNI T	0			0		31.00
32.00	03200 CORONARY CARE UNI T	0			0		32.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0			0		34.00
43.00	04300 NURSERY	3, 790, 369		3, 790, 36	9		43.00
101.00	ANCI LLARY SERVICE COST CENTERS	0,,,0,00,		0,,,0,00			101.00
50.00	05000 OPERATING ROOM	7, 273, 046	44, 932, 117	52, 205, 16	0, 136140	0, 000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0.000000	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 535, 980	333, 170	10, 869, 15	0. 459008	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0.000000	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	285, 149	11, 133, 315	11, 418, 46		0.000000	54.00
54.01	03630 ULTRA SOUND	96, 643	2, 787, 801	2, 884, 44		0.000000	
56.00	05600 RADI OI SOTOPE	0	0		0 0.000000	0.000000	56.00
56.01	05601 ONCOLOGY	627	2, 038, 206	2, 038, 83	0. 357139	0.000000	56.01
57.00	05700 CT SCAN	316, 410	5, 687, 264	6, 003, 67	4 0. 183931	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	36, 807	2, 562, 736	2, 599, 54	3 0. 239773	0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.000000	59.00
60.00	06000 LABORATORY	3, 733, 165	10, 347, 083	14, 080, 24	8 0. 136504	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0.000000	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0.000000	0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0.000000	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	447, 444	1, 435, 901	1, 883, 34	5 0. 446473	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	227, 768	5, 164, 134	5, 391, 90	0. 462066	0.00000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	46, 362	12, 572	58, 93	4 0. 392863	0.00000	67.00
68.00	06800 SPEECH PATHOLOGY	7, 555	722, 263	729, 81	8 0. 450449	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	217, 085	2, 826, 430	3, 043, 51	5 0. 150320	0.00000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0.000000	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 327, 898	4, 139, 223	5, 467, 12	0. 147351	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 867, 612	3, 142, 576	5, 010, 18	0. 310511	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 351, 877	12, 706, 959	15, 058, 83	0. 321259	0.000000	73.00
74.00	07400 RENAL DI ALYSI S	0	0		0 0.000000	0.000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0.000000	0.000000	75.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2, 118, 997	32, 671, 192	34, 790, 18	0. 111338	0.00000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	345, 819	2, 012, 092	2, 357, 91	1 0. 563767	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
99.00	09900 CMHC	0	0		0		99.00
200.00		43, 479, 822	144, 655, 034	188, 134, 85	6		200.00
201.00							201.00
202.00	) Total (see instructions)	43, 479, 822	144, 655, 034	188, 134, 85	6		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0181	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepa 11/22/2019 3:53	ared:
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				3	30. 00
31.00 03100 INTENSIVE CARE UNIT				3	31.00
32.00 03200 CORONARY CARE UNI T				3	32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				3	34.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 136140			5	50. OC
51.00 05100 RECOVERY ROOM	0. 000000				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 463451				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53. OC
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 210715				53.00 54.00
54. 01 03630 ULTRA SOUND	0. 142345				54. 00 54. 01
56. 00 05600 RADIOI SOTOPE	0. 142345				54. 01 56. 00
56. 01 05601 ONCOLOGY	0. 360019				56.01
57. 00 05700 CT SCAN	0. 183931				57.OC
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 239773				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. OC
60. 00 06000 LABORATORY	0. 136504				60. OC
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000				64.00
65. 00 06500 RESPI RATORY THERAPY	0. 446473				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 462066				66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 392863				67.00
68.00 06800 SPEECH PATHOLOGY	0. 450449			6	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 150320			6	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			7	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 147351			7	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 310511			7	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 321259			7	73.00
74.00 07400 RENAL DIALYSIS	0. 000000			7	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			7	75.00
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	0. 111338			9	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 563767			9	92.00
OTHER REI MBURSABLE COST CENTERS					20
99. 00 09900 CMHC				g	99.00
200.00 Subtotal (see instructions)					00.00
201.00 Less Observation Beds					00.00 01.00
202.00 Total (see instructions)					02.00
	1 1			120	

		Provider C		Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Pre 11/22/2019 3:	pared: 53 pm
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	s RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENT	ERS					
30. 00 03000 ADULTS & PEDI ATRI CS	6, 049, 519		6, 049, 5	19 0	6, 049, 519	30.00
31.00 03100 INTENSIVE CARE UNIT	0			0 0		
32. 00 03200 CORONARY CARE UNI T	0			0 0	0	32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	34.00
43. 00 04300 NURSERY	907, 545		907, 5	45 0	907, 545	43.00
ANCI LLARY SERVI CE COST CENTERS		I	1			
50.00 05000 OPERATING ROOM	7, 107, 215		7, 107, 2			
51.00 05100 RECOVERY ROOM	0			0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 989, 031		4, 989, 0		5, 037, 315	
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 406, 038		2, 406, 0		_,,	
54. 01 03630 ULTRA SOUND	410, 586		410, 5		410, 586	
56. 00 05600 RADI 0I SOTOPE	720 144		720 1	0 0	0 724 010	
56. 01 05601 0NC0L0GY 57. 00 05700 CT SCAN	728, 146		728, 1		734, 018	
58.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (N	RI) 1, 104, 263 81) 623, 300		1, 104, 2			
59. 00 05900 CARDI AC CATHETERI ZATI ON	KT) 023, 300		023, 3	0 0	023, 300	
50. 00 06000 LABORATORY	1, 922, 011		1, 922, 0			
52. 00 06200 WHOLE BLOOD & PACKED RED BLOO			1, 722, 0	0 0	0	
53. 00 06300 BLOOD STORING, PROCESSING & T				0 0	0	
54. 00 06400 I NTRAVENOUS THERAPY				0 0	0	
55. 00 06500 RESPI RATORY THERAPY	840, 862	l a	840, 8	-	840, 862	
56. 00 06600 PHYSI CAL THERAPY	2, 491, 414					
57.00 06700 OCCUPATIONAL THERAPY	23, 153		23, 1		23, 153	
58.00 06800 SPEECH PATHOLOGY	328, 746		328, 7		328, 746	
59. 00 06900 ELECTROCARDI OLOGY	457, 501		457, 5	01 0	457, 501	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO F	ATI ENTS 805, 584		805, 5	84 0	805, 584	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	S 1, 555, 720		1, 555, 7	20 0	1, 555, 720	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 837, 784		4, 837, 7	84 0	4, 837, 784	73.00
74.00 07400 RENAL DIALYSIS	0			0 0		
75.00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
OUTPATIENT SERVICE COST CENTERS		1	1			
91.00 09100 EMERGENCY	3, 873, 460		3, 873, 4			
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NO	T PART) 1, 329, 312		1, 329, 3	12	1, 329, 312	92.00
OTHER REIMBURSABLE COST CENTERS	~		1			00.00
79.00 09900 CMHC	0		40 701 1	0	0	
200.00 Subtotal (see instructions)	42, 791, 190		1 .=, , .			
201.00Less Observation Beds202.00Total (see instructions)	1, 329, 312 41, 461, 878		1, 329, 3 41, 461, 8		1, 329, 312 41, 516, 034	

	2	ST. VINCENT FISH		N 15 0101		u of Form CMS-2	2002-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	JN: 15-0181	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Pre 11/22/2019 3:	epared: 53 pm
			Titl	e XIX	Hospi tal	Cost	00 pm
	· · · ·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30, 00	03000 ADULTS & PEDIATRICS	8, 453, 209		8, 453, 20	19		30.00
31.00	03100 I NTENSI VE CARE UNI T	0		-//	0		31.00
32.00	03200 CORONARY CARE UNIT	0			0		32.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0			0		34.00
43.00	04300 NURSERY	3, 790, 369		3, 790, 36	0		43.00
40.00	ANCI LLARY SERVICE COST CENTERS	3,770,307		3,770,30	,,,		+5.00
50.00	05000 OPERATING ROOM	7, 273, 046	44, 932, 117	52, 205, 16	0. 136140	0.000000	50.00
51.00	05100 RECOVERY ROOM	, 2, 0, 0 10	11, 702, 117	02,200,10	0 0.000000	0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 535, 980	333, 170	10, 869, 15		0.000000	
53.00	05300 ANESTHESI OLOGY	10, 333, 700	000, 170	10,007,10	0 0.000000	0.000000	
53.00 54.00	05400 RADI OLOGY - DI AGNOSTI C	285, 149	11, 133, 315	11, 418, 46		0.000000	
54.00 54.01	03630 ULTRA SOUND	96, 643	2, 787, 801	2, 884, 44		0.000000	
56.00	05600 RADI OI SOTOPE	90, 043	2, 707, 001	2,004,44	0 0. 000000	0.000000	•
56. 00 56. 01	05601 ONCOLOGY	627	2, 038, 206	2, 038, 83		0.000000	
57.00	05700 CT SCAN	316, 410	5, 687, 264	6, 003, 67		0.000000	•
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	36, 807	2, 562, 736	2, 599, 54		0.000000	
58.00 59.00	05900 CARDI AC CATHETERI ZATI ON	30, 007	2, 302, 730	2, 399, 34	0 0. 239773	0.000000	•
60.00	06000 LABORATORY	2 722 145	10 247 002	14 000 24		0.000000	•
		3, 733, 165	10, 347, 083	14, 080, 24			
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0.000000	0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0.000000	0.000000	
64.00	06400 I NTRAVENOUS THERAPY		1 425 001	1 000 04	0 0.000000	0.000000	
65.00	06500 RESPI RATORY THERAPY	447, 444	1, 435, 901	1, 883, 34		0.000000	
66.00	06600 PHYSI CAL THERAPY	227, 768	5, 164, 134	5, 391, 90		0.000000	
67.00	06700 OCCUPATIONAL THERAPY	46, 362	12, 572	58, 93		0.000000	
68.00	06800 SPEECH PATHOLOGY	7, 555	722, 263	729, 81		0.000000	
69.00	06900 ELECTROCARDI OLOGY	217, 085	2, 826, 430	3, 043, 51		0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0.000000	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 327, 898	4, 139, 223	5, 467, 12		0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 867, 612	3, 142, 576	5, 010, 18		0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 351, 877	12, 706, 959	15, 058, 83		0.000000	
74.00	07400 RENAL DIALYSIS	0	0		0 0.000000	0.00000	
75.00	07500 ASC (NON-DI STINCT PART)	0	0		0 0.000000	0.000000	75.00
	OUTPATIENT SERVICE COST CENTERS	i					
91.00	09100 EMERGENCY	2, 118, 997	32, 671, 192			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	345, 819	2, 012, 092	2, 357, 91	1 0. 563767	0.00000	92.00
	OTHER REIMBURSABLE COST CENTERS	,		1			
99.00	09900 CMHC	0	0		0		99.00
200.00		43, 479, 822	144, 655, 034	188, 134, 85	6		200.00
		1		1			1201 00
201.00 202.00		43, 479, 822	144, 655, 034	188, 134, 85			201.00

lealth Financial Systems	ST. VINCENT FISHE	RS HUSPITAL	In Lieu	L OT FORM CMS-2	<u>2552-1</u>
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0181	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prep 11/22/2019 3:5	pared: 53 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
32. 00 03200 CORONARY CARE UNIT					32.0
34. 00 03400 SURGICAL INTENSIVE CARE UNIT					34.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS					1010
50. 00 05000 OPERATI NG ROOM	0. 000000				50.0
51.00 05100 RECOVERY ROOM	0. 000000				51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.0
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.0
54. 01  03630 ULTRA SOUND	0. 000000				54.0
56. 00 05600 RADI OI SOTOPE	0. 000000				56. C
56. 01 05601 0NCOLOGY	0. 000000				56. C
57. 00 05700 CT SCAN	0. 000000				57.0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. C
50. 00 06000 LABORATORY	0. 000000				60.0
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62. C
53.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63. C
54. 00 06400 I NTRAVENOUS THERAPY	0. 000000				64. C
5. 00 06500 RESPI RATORY THERAPY	0. 000000				65. C
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.0
57.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. C
58.00 06800 SPEECH PATHOLOGY	0. 000000				68.0
59. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. C
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. C
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72. C
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. C
74.00 07400 RENAL DIALYSIS	0. 000000				74.0
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000				75.0
OUTPATIENT SERVICE COST CENTERS	·				
91. 00 09100 EMERGENCY	0. 000000				91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.0
OTHER REI MBURSABLE COST CENTERS					
99. 00 09900 CMHC					99.00
200.00 Subtotal (see instructions)					200. 0
201.00 Less Observation Beds					201.0
					202.00

Health Financial Systems	ST. VINCENT FIS			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 07/01/2018 To 06/30/2019		pared: 53 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			·			
30. 00 ADULTS & PEDIATRICS	1, 561, 251	0	1, 561, 25	1 2, 908	536.88	30.00
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	31.00
32.00 CORONARY CARE UNIT	0			0 0	0.00	32.00
34.00 SURGI CAL I NTENSI VE CARE UNI T	0			0 0	0.00	34.00
43.00 NURSERY	153, 124		153, 12	4 1, 120	136.72	43.00
200.00 Total (lines 30 through 199)	1, 714, 375		1, 714, 37	5 4,028		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	538	288, 841				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
32.00 CORONARY CARE UNIT	0	0				32.00
34.00 SURGI CAL I NTENSI VE CARE UNI T	0	0				34.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	538	288, 841				200. 00

Health Financial Systems	ST. VINCENT FIS			Inlie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.		Provi der C	CN: 15-0181	Period: From 07/01/2018 To 06/30/2019	Worksheet D	pared:
		Title	xviii	Hospi tal	PPS	<u>55 piii</u>
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	J		
	26)	, í	, í			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		•	•	·		
50.00 05000 OPERATING ROOM	1, 147, 010	52, 205, 163	0. 0219	2, 050, 057	45, 042	50.00
51.00 05100 RECOVERY ROOM	0	0	0.0000	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	949, 651	10, 869, 150	0.0873	1, 889	165	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	497, 944	11, 418, 464	0.04360	09 134, 718	5, 875	54.00
54.01 03630 ULTRA SOUND	54, 567	2, 884, 444	0. 0189	0 8	0	54.01
56. 00 05600 RADI OI SOTOPE	0	0	0.0000	0 0	0	56.00
56. 01 05601 ONCOLOGY	194, 714	2, 038, 833	0. 09550	03 0	0	56.01
57.00 05700 CT SCAN	141, 761	6, 003, 674	0. 0236	115, 600	2, 730	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	85, 144	2, 599, 543	0. 03275	53 13, 300	436	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000	0 0	0	59.00
60. 00 06000 LABORATORY	150, 344	14, 080, 248	0. 0106	863, 965	9, 225	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.0000	0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.0000	0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.0000	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	60, 160	1, 883, 345	0. 03194	117, 790	3, 763	65.00
66. 00 06600 PHYSI CAL THERAPY	492, 612	5, 391, 902	0. 09130	51 98, 123	8, 965	66.00
67.00 06700 OCCUPATI ONAL THERAPY	5, 114	58, 934	0. 0867	22, 810	1, 979	67.00
68.00 06800 SPEECH PATHOLOGY	77,609	729, 818	0. 10634	40 3, 076		68.00
69. 00 06900 ELECTROCARDI OLOGY	144, 799	3, 043, 515	0.0475	76 160, 733	7, 647	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	34, 046	5, 467, 121	0.00622	27 291, 826	1, 817	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	65, 655	5, 010, 188	0. 01310	602, 709	7, 898	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	251, 822	15, 058, 836	0. 01672	513, 732	8, 591	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.0000	0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	0 0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	781, 774					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	343, 068					
200.00  Total (lines 50 through 199)	5, 477, 794	175, 891, 278		5, 781, 370	132, 253	200.00

Health Financial Systems	ST. VINCENT FISH	HERS HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COST			Period: From 07/01/2018 To 06/30/2019	Date/Time Pre 11/22/2019 3:	
			XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdow		Medi cal	
	Adj ustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0		o o	0	32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		o o	l o	34.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	Per Diem (col.	Inpati ent	200100
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	l sajo			
	instructions)					
	4,00	5.00	6,00	7.00	8,00	<u> </u>
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	2,90	8 0.00	538	30.00
31.00 03100 INTENSIVE CARE UNIT		0		0 0.00		31.00
32. 00 03200 CORONARY CARE UNIT		0		0 0.00		
34. 00 03400 SURGICAL INTENSIVE CARE UNIT		0		0 0.00		
43. 00 04300 NURSERY		0	1, 12			
200.00 Total (lines 30 through 199)		0				200.00
Cost Center Description	I npati ent	0	4, 02	0	530	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					
32.00 03200 CORONARY CARE UNI T	0					32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
34.00         O3400         SURGI CAL         INTENSI VE         CARE         UNI T           43.00         04300         NURSERY         200.00         Total         (lines 30 through 199)	0					34.00 43.00 200.00

IPPORT ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CON: 15-0181         Period: For 06/30/2019         Worksheet D Part IV Date/Time Prepared: 11/22/2019 3:53 pm           Cost Center Description         Non Physician Nursing School Mursing School All II ed Healt In Anesthetist         Norsing School Mursing School All II ed Healt In Post-Stepdown Adjustments         All II ed Healt In All II ed Healt In Discover Algustments         Post-Stepdown Algustments           50:00         05000 (PECOVERY ROOM 00 00 0         0	Health Financial Systems	ST. VINCENT FIS	HERS HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
Cost Center Description         Non Physic clan         Post-Stepdown Adjustments         Al I i deal th Post-Stepdown Adjustments         Al I i deal th Post-Stepdown Adjustments           50.00         05000 (PERATING ROOM         0         0         0         0         0         0         0         0         0         50.00           50.00         05000 (PERATING ROOM         0		VICE OTHER PASS	S Provider C		From 07/01/2018	Part IV Date/Time Pre	pared:
Cost Center Description         Non Physician Nursing School Nursing School Nursing School All Lied Health Post-Stepdown Adjustments         All ied Health Post-Stepdown Adjustments           ARCILLARY SERVICE COST CENTERS         1.00         2A         2.00         3A         3.00           ANCILLARY SERVICE COST CENTERS         0			Title	XVIII	Hospi tal		<u>55 piii</u>
Amesthetist         Post-Stepdown Adjustments         Post-Stepdown Adjustments           ANCILLARY SERVICE COST CENTERS         0         0         3A         3.00           ANCILLARY SERVICE COST CENTERS         0 </td <td>Cost Center Description</td> <td>Non Physician</td> <td></td> <td></td> <td></td> <td></td> <td></td>	Cost Center Description	Non Physician					
Cost         Adjustments         Adjustments           ANCILLARY SERVICE COST CENTERS         2.00         3         3.00           50.00         05000 OPERATING ROOM         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
I.OO         2A         2.00         3A         3.00           50.00         05000         OPERATI NG ROOM         0							
50.00       OPERATING ROOM       0		1.00		2.00		3.00	
51.00       05100       RECOVERY ROOM       0	ANCILLARY SERVICE COST CENTERS						
52.00       05200       DELIVERY ROM & LABOR ROOM       0       0       0       0       52.00         53.00       05300       ANESTHESI OLOGY       0       0       0       0       53.00         54.00       05400       RADI LOGY-DI AGNOSTI C       0       0       0       0       54.00         54.01       05300       ANESTHESI OLOGY-DI AGNOSTI C       0       0       0       0       54.01         56.01       05600       RADI OLSOTOPE       0       0       0       0       56.01         55.01       05610       NCOLOGY       0       0       0       0       56.01         57.00       05700       CT SCAN       0       0       0       0       57.00         58.00       05800       MAGNETI C RESONANCE I MAGING (MRI )       0       0       0       0       57.00         60.00       CARDI AC CATHETERI ZATI ON       0       0       0       0       60.00       59.00         62.00       06300       BLABORATORY       0       0       0       0       62.00         63.00       06300       BLODD STORI NG, PROCESSI NG & TRANS.       0       0       0       63.00	50.00 05000 OPERATI NG ROOM	0	C	1	0 0	0	50.00
53.00       05300       ANESTHESI OLOGY       0       0       0       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       0       54.00         54.01       03630       ULTRA SOUND       0       0       0       0       0       54.01         56.00       05600       RADI OLOGY-DI AGNOSTI C       0       0       0       0       56.00         56.01       05601       NICOLOGY       0       0       0       0       56.00         57.00       CT SCAN       0       0       0       0       0       57.00         59.00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       0       58.00         59.00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       0       0       60.00         60.00       06000       LABORTORY       0       0       0       0       0       0       62.00         63.00       BLODD STORING, PROCESSING & TRANS.       0       0       0       0       0       63.00         64.00       OSCON       RESPI RATORY THERAPY       0       0       0	51.00 05100 RECOVERY ROOM	0	C		o o	0	51.00
53.00       05300       ANESTHESI OLOGY       0       0       0       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       0       54.00         54.01       03630       ULTRA SOUND       0       0       0       0       0       54.01         56.00       05600       RADI OLOGY-DI AGNOSTI C       0       0       0       0       56.00         56.01       05601       NICOLOGY       0       0       0       0       56.00         57.00       CT SCAN       0       0       0       0       0       57.00         59.00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       0       58.00         59.00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       0       0       60.00         60.00       06000       LABORTORY       0       0       0       0       0       0       62.00         63.00       BLODD STORING, PROCESSING & TRANS.       0       0       0       0       0       63.00         64.00       OSCON       RESPI RATORY THERAPY       0       0       0	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	l a		o o	0	52.00
54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       0       0       54.00         54.01       03630       ULTRA SOUND       0       0       0       0       54.01         56.00       RADI OLOGY-DI AGNOSTI C       0       0       0       0       0       54.01         56.01       05601       RADI OLOGY       0       0       0       0       56.01         57.00       05700       CT SCAN       0       0       0       0       57.00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0       0       0       58.00       05800       0       0       0       58.00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       0       58.00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       0       60.00       62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       0       62.00       063200       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       0       63.00       64.00       65.00       65.00       06000       0       64.00       65.00       66.00       66.00       67.0	53. 00 05300 ANESTHESI OLOGY	0	l a		o o	0	53.00
54.01       03630       ULTRA SOUND       0       0       0       0       0       0       54.01         56.00       05600       RADI 01 SOTOPE       0       0       0       0       56.00       56.01       05600       RCOLOGY       0       0       0       0       56.01       05600       RCOLOGY       0       0       0       0       57.00       58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0       0       0       0       57.00       58.00       05800       ARDI AC CATHETERI ZATI ON       0       0       0       0       59.00       0500       ARDI AC CATHETERI ZATI ON       0       0       0       0       59.00       00       0		0	0		0 0	0	
56.01       05601       0NCOLOGY       0		0	0		0 0	0	
56.01       05601       0NCOLOGY       0	56. 00 05600 RADI OI SOTOPE	0	l d		0 0	0	56.00
57.00       05700       CT SCAN       0       0       0       0       57.00         58.00       05800       MAGNETIC RESONANCE IMAGING (MRI)       0       0       0       0       58.00         59.00       CARDIAC CATHETERIZATION       0       0       0       0       0       59.00         60.00       CABORATORY       0       0       0       0       0       0       60.00         62.00       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       0       62.00         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0       0       0       0       63.00         64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       06700       0       0       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0		0			0 0	0	
58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       0       0       0       58.00         59.00       CARDI AC CATHETERI ZATI ON       0       0       0       0       59.00         60.00       LABORATORY       0       0       0       0       0       0         62.00       LABORATORY       0       0       0       0       0       60.00         62.00       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       0       62.00         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       0       63.00         64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       65.00         66.00       06400       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       0CCUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       68.00         69.00       ELECTROCARDI O		0			0 0	0	
59.00       05900       CARDIAC CATHETERIZATION       0       0       0       0       59.00         60.00       06000       LABORATORY       0       0       0       0       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       0       62.00         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0       0       0       63.00         64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       63.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       06700       0       0       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0       69.00         70.00       07100       ELCTROCARDI OLOGY       0       0       0       0       0       71.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATI ENTS       0       0 <td< td=""><td></td><td>0</td><td></td><td></td><td>0 0</td><td>0</td><td></td></td<>		0			0 0	0	
60.00       06000       LABORATORY       0		0			0 0	0	
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       0       0       62.00         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0       0       0       0       63.00         64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       69.00         71.00       07100       KEDTROENCEPHALOGRAPHY       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0 <td></td> <td>0</td> <td></td> <td></td> <td>0 0</td> <td>0</td> <td></td>		0			0 0	0	
63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       0       0       64.00         64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       06700       OCUPATI ONAL THERAPY       0       0       0       0       66.00         67.00       06700       OCUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPECH PATHOLOGY       0       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0       72.00         72.00       07200 I IMPL       DEV. CHARGED TO PATI ENTS       0 <td></td> <td>0</td> <td></td> <td></td> <td>0 0</td> <td>0</td> <td></td>		0			0 0	0	
64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       07400       RENAL DI ALYSI S       0       0       0       0       74.00         75.00       07500 ASC (NON-DI STI NCT PART)       0       0       0       0		0			0 0	0	
65.00       06500       RESPI RATORY THERAPY       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       0CCUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       0       74.00         75.00       07500       ASC (NON-DI STI NCT PART)       0 <td< td=""><td></td><td>0</td><td></td><td></td><td>0 0</td><td>0</td><td></td></td<>		0			0 0	0	
66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       07300       REMAL DI ALYSI S       0       0       0       0       73.00         74.00       07500       ASC (NON-DI STI NCT PART)       0       0       0       0       75.00         00TPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0       75.00         91.00       09100       EMERGENCY       0       0       0		0			0 0	0	
67.00       06700       OCCUPATIONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0       0       0       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       07300       RUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       0       74.00         75.00       07500       ASC (NON-DI STI NCT PART)       0       0       0       0       75.00         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0       91.00		0			0 0	0	
68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0       0       0       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       0       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       0       72.00         73.00       07300       RUGS CHARGED TO PATIENTS       0       0       0       0       73.00         74.00       07400       RENAL DIALYSIS       0       0       0       0       74.00         75.00       07500       ASC (NON-DISTINCT PART)       0       0       0       0       75.00         00       09100       EMERGENCY       0       0       0       0       0       91.00		0			0 0	0	
69.00       06900       ELECTROCARDIOLOGY       0<		0			0 0	0	
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         0         70.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0         0         0         0         0         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0         0         0         0         72.00           73.00         07300         DRUGS CHARGED TO PATI ENTS         0         0         0         0         73.00           74.00         07400         RENAL DI ALYSI S         0         0         0         0         74.00           75.00         07500         ASC (NON-DI STI NCT PART)         0         0         0         0         0         75.00           0UTPATI ENT SERVICE COST CENTERS         0         0         0         0         0         0         0         0           91.00         09100         EMERGENCY         0         0         0         0         91.00		0			0 0	0	
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       73.00         74.00       07400       RENAL DI ALYSIS       0       0       0       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0       0       75.00         017400       09100       EMERGENCY       0       0       0       0       0       91.00		0			0 0	-	
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       73.00         74.00       07400       RENAL DIALYSIS       0       0       0       0       74.00         75.00       07500       ASC (NON-DISTINCT PART)       0       0       0       0       75.00         017501       09100       EMERGENCY       0       0       0       0       91.00		0			0 0	0	
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       73.00         74.00       07400       RENAL DI ALYSIS       0       0       0       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0       0       75.00         0UTPATIENT SERVICE COST CENTERS       91.00       0       0       0       0       91.00		0	0		0 0	0	
74. 00         07400         RENAL DI ALYSI S         0         0         0         0         0         74. 00         74. 00         75. 00         00         0         0         0         0         0         0         75. 00         00         0         0         0         0         0         0         75. 00         75. 00         75. 00         75. 00         75. 00         91. 00         0         0         0         0         0         0         91. 00         91. 00         91. 00         0         0         0         0         0         91. 00         91		0	0		0 0	0	
75. 00         07500         ASC (NON-DI STINCT PART)         0         0         0         0         0         75. 00           0UTPATI ENT SERVICE COST CENTERS         91. 00         09100         EMERGENCY         0         0         0         91. 00         91. 00         91. 00         91. 00         0         0         0         91. 00 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td></td></t<>		0	0		0 0	0	
OUTPATI ENT SERVICE COST CENTERS           91.00         09100         EMERGENCY         0         0         0         91.00		0			0 0	-	
91. 00 09100 EMERGENCY 0 0 0 0 91. 00				1	-1 0		
		0	0		0 0	0	91.00
	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
200.00         Total (lines 50 through 199)         0		0	0		0 0	0	

Health Financial Systems	ST. VINCENT FIS	SHERS HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0181	Period: From 07/01/2018 To 06/30/2019		epared: 53 pm
		Titl€	e XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS		-		-	1	
50. 00 05000 OPERATI NG ROOM	0	) C		0 52, 205, 163		
51.00 05100 RECOVERY ROOM	0	) C		0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	)	0 10, 869, 150	0.00000	
53. 00 05300 ANESTHESI OLOGY	0	C	)	0 0	0.00000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C	)	0 11, 418, 464	0.00000	54.00
54.01 03630 ULTRA SOUND	0	C	)	0 2, 884, 444	0.00000	54.01
56. 00 05600 RADI OI SOTOPE	0	C		0 0	0.00000	56.00
56. 01 05601 ONCOLOGY	0	C		0 2, 038, 833	0.00000	56.01
57.00 05700 CT SCAN	0	C		0 6, 003, 674	0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 2, 599, 543	0.000000	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0. 000000	59.00
60. 00 06000 LABORATORY	0	C		0 14, 080, 248	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0.000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	) c		0 0	0.000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	C		0 0	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 1, 883, 345	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 5, 391, 902	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 58, 934	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 729, 818	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 3, 043, 515	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	) c		0 5, 467, 121	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	) c		0 5, 010, 188	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	) c		0 15, 058, 836	0.00000	73.00
74.00 07400 RENAL DI ALYSI S	0			0 0		
75.00 07500 ASC (NON-DI STINCT PART)	0			0 0		
OUTPATIENT SERVICE COST CENTERS	-					
91. 00 09100 EMERGENCY	0	C	)	0 34, 790, 189	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 2, 357, 911		
200.00 Total (lines 50 through 199)	0	C		0 175, 891, 278		200.00
		•				•

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-0181         Period: From 0c/30/2019         Worksheet D Part IV Date/Time Proparation           Cost Center Description         Outpatient Ratio of Cost (col. 6 + col.)         Inpatient Program Charges (col. 6 + col.)         Inpatient Program Charges (col. 6 + col.)         Inpatient Program Charges (col. 10)         Mospital         Outpatient Program Charges (col. 10)         Outpatient Program Charges (col. 10)         Dutpatient Program Charges (col. 10)         Outpatient Program Charges (col. 10)         Outpatient Pr	Health Financial Systems	ST. VINCENT FISHE	RS HOSPITAL			In Lie	u of Form CMS-:	2552-10
Cost Center Description         Outpatient Ratio of Cost to Charges (col. 6 + col. 7)         inpatient Program (harges         Inpatient Program (harges         Unpatient Program (harges         Outpatient Program (harges         Outpatient Program (harges         Outpatient Program (harges         Outpatient Program (harges         Outpatient Program (harges           4NCILLARY SERVICE COST CENTERS         0.000000         2,050,057         0         6.113,639         0         50.00           50.00 (RECOVERY ROOM         0.000000         0.000000         0         0         0         50.00           50.00 (RECOVERY ROOM         0.000000         0         0         0         50.00         50.00           52.00 (DELUKENY ROOM & LABOR ROOM         0.000000         0         0         0         51.00           54.00 (D5400 (RADI LOEY-DI AGNOSTI C         0.000000         0         0         20.114         0         54.01           56.00 (D5600 (RADI LOEY-DI AGNOSTI C         0.000000         0         0         20.014         0         56.00           57.00 (D500 (CT SCAN         0.000000         0         0         0         721,789         0         56.00           58.00 (D6400 (AADI LOEY-DI AGNOSTI C         0.000000         0         0         0         0         57.00		RVI CE OTHER PASS			Fro	m 07/01/2018 06/30/2019	Part IV Date/Time Pre 11/22/2019 3:	
Ratio of Cost (col. 6 + col. 7)         Program (harges)         Pr				XVIII				
Image: the second sec	Cost Center Description							
Image: transmission of the standard standar								
P         x col. 10         x col. 12           9.00         10.00         11.00         12.00         13.00           ANCI LLARY SERVICE COST CENTERS         0.000000         0.00         0.00000         0.00000         0.00         0			Charges			Charges		
P. 00         10.00         11.00         12.00         13.00           50.00         05000         OPERATING ROOM         0.000000         2,050.057         0         6,113,639         0         50.00           50.00         051.00         05000         OPERATING ROOM         0.000000         0         0         0         51.00           52.00         05200         DELV LEYR YROM         ALABOR ROOM         0.000000         1889         0         2,306         05.300           54.00         05400         RADIOLOGY PIAGNOSTI C         0.000000         134,718         0         1,434,239         0         54.00           54.01         03630         MLTRA SOUND         0.000000         0         0         0         0         0         0         56.00           56.01         0S600         RADIO ISOTOPE         0.000000         0         0         721,789         56.01         58.00           59.00         05900         CARDIA C CATHETERIZATION         0.000000         13.300         389,358         58.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00					8			
ANCILLARY SERVICE COST CENTERS           50.00         05000 (OPERATING ROOM         0.000000         2,050,057         0         6,113,639         0         50.00           51.00         05100 RECOVERY ROOM         0.000000         0         0         0         0         51.00           52.00         05200 RELIVERY ROOM         0.000000         1,889         0         2,306         0         52.00           53.00         05300 ANESTHESILLOCY         0.000000         0         0         0         0         54.00           54.00         05400 RADI LLOCY-DI AGNOSTI C         0.000000         0         0         0         54.01           56.00         05600 RADI OLSOTOPE         0.000000         0         0         0         0         54.01           56.01         05601 ONCOLGY         0.000000         0         0         72.789         55.00           57.00         05700 CT SCAN         0.000000         13.300         0         398.358         57.00           59.00         05800 MARNETI C RESONANCE I MAGI NG (MRI )         0.000000         0         0         59.00         66000 ADDI AC CATHETERI ZATI ON         0.000000         0         0         59.00         66000 ADDI AC CATHETERI ZATI ON <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
50.         00         05000         0PERATING ROOM         0.000000         2,050,057         0         6,113,639         0         50.00           51.00         05100         RECOVERY ROOM         0.000000         0		9.00	10.00	11.00		12.00	13.00	
51.00       OS100       RECOVERY ROM       0.000000       0       0       0       0       51.00         52.00       OS200       ANESTHESI OLOGY       0.000000       1,889       0       2,306       0       52.00         54.00       OS400       RADI OLOGY-DI AGNOSTI C       0.000000       0       0       0       53.00         54.01       OS400       RADI OLOGY-DI AGNOSTI C       0.000000       0       0       200,141       0       54.01         56.00       OS600       RADI OLOGY-DI AGNOSTI C       0.000000       0       0       200,141       0       54.01         56.01       OS600       RADI OLOGY C       0.000000       0       0       721,789       0       56.00         57.00       OS700 CT SCAN       0.000000       115,600       1.038,325       0       57.00         58.00       OS900 CARDI AC CATHETERI ZATI ON       0.000000       0       0       0       0       59.00         62.00       O6200 LABORATORY       0.000000       0       0       0       62.00       63.00       50.00       60.00       62.00       63.00       60.00       64.00       64.00       64.00       64.00       64.00 <t< td=""><td></td><td></td><td></td><td>r</td><td></td><td></td><td></td><td></td></t<>				r				
52.00         05200         DELIVERY ROOM & LABOR ROOM         0.000000         1,889         0         2,306         0         53.00           53.00         05300         ANESTHESI OLOGY         0.000000         0         0         0         0         53.00           54.01         05400         RADIOLOGY-DI AGNOSTI C         0.000000         0         0         200,141         0         54.01           56.01         05600         RADIOLOGY         0.000000         0         0         0         0         56.01           56.01         05601         0NCOLOGY         0.000000         0         0         721,789         0         56.01           57.00         05700         CT SCAN         0.000000         133,300         0         989,358         0         57.00           58.00         05800         MAGNETIC RESONANCE I MAGING (MRI )         0.000000         13,300         0         98,358         0         58.00           60.00         LABORATORY         0.000000         0         0         0         0         62.00           64.00         06400         INTANY THERAPY         0.000000         0         0         0         62.00           65.00<			2,050,057		0	6, 113, 639		
53.00       65300       ANESTHESI OLOGY       0.000000       0       0       0       53.00         54.00       05400       RADI OLOGY - DI AGNOSTI C       0.000000       134.718       0       1.434.239       0       54.01         56.00       05600       RADI OL SOTOPE       0.000000       0       0       0.00000       0       56.01         57.00       05700       CT SCAN       0.000000       0       0       721.789       0       56.01         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0.000000       13.300       398.358       0       58.00         59.00       05900       CARDI AC CATHETERI ZATI ON       0.000000       0       0       0       0       0       0       0       59.00         06000       LABORATORY       0.000000       0       0       0       0       0       0       0       0       0       0       0       0       0       63.00       66.00       0       64.00       0       64.00       0       64.00       0       64.00       0       64.00       0       64.00       65.00       0       65.00       65.00       65.00       0       65.00       <			-		0	0	0	51.00
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000       134,718       0       1,434,239       0       54.00         54.01       03630       ULTRA SOUND       0.000000       0       0       0       56.00         65.00       RDI OLOGY-DI AGNOSTI C       0.000000       0       0       0       56.00         56.01       05601       NICOLOGY       0.000000       0       0       721,789       0       56.01         57.00       05700       CT SCAN       0.000000       115,600       0       1,038,325       0       58.00         58.00       05900       CARDI AC CATHETERI ZATI ON       0.000000       0       0       0       59.00       60.00       0       0       59.00       60.00       0       0       60.00       60.00       60.00       60.00       0       0       60.00       62.00       60.00       62.00       60.00       62.00       60.00       62.00       60.00       62.00       63.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00 <t< td=""><td></td><td></td><td>1, 889</td><td></td><td>0</td><td>2, 306</td><td>0</td><td>52.00</td></t<>			1, 889		0	2, 306	0	52.00
54.01       03630       ULTRA SOUND       0.000000       0       200,141       0       54.01         56.00       05600       RADIOISTOPE       0.000000       0       0       0       56.00         57.00       05700       CT SCAN       0.000000       115,600       0       1,038,325       0       57.00         58.00       05800       MAGNETIC RESONANCE IMAGING (MRI)       0.000000       13,300       398,358       0       58.00         60.00       05900       CARDIAC CATHETERIZATION       0.000000       0       0       0       59.00         60.00       06000       LABORATORY       0.000000       0       0       0       62.00         60.00       06300       BLOOD STORING, PROCESSING & TRANS.       0.000000       0       0       0       62.00         64.00       06400       INTRAVENOUS THERAPY       0.000000       0       0       0       64.00         650.00       RESPI RATORY THERAPY       0.000000       0       0       0       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00 <td>53. 00 05300 ANESTHESI OLOGY</td> <td>0. 000000</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>53.00</td>	53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	0	53.00
56.00         05600         RADIOISOTOPE         0.000000         0         0         0         56.00           56.01         05601         NCOLOGY         0.000000         0         721,789         0         56.01           57.00         05700         CT SCAN         0.000000         15.600         0         1.038,325         0         57.00           58.00         05800         MAGNETIC RESONANCE I MAGING (MR1)         0.000000         13,300         398,358         0         58.00           59.00         05000         CARDIA C CATHETERI ZATION         0.000000         0 <td< td=""><td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td><td>0. 000000</td><td>134, 718</td><td></td><td>0</td><td>1, 434, 239</td><td>0</td><td>54.00</td></td<>	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	134, 718		0	1, 434, 239	0	54.00
56.01       05601       0NC0LOGY       0.00000       0       0       721,789       0       56.01         57.00       05700       CT SCAN       0.000000       115,600       0       1,038,325       0       58.00         58.00       05900       CARDI AC CATHETERI ZATI ON       0.000000       0       0       0       59.00         60.00       06000       LABORATORY       0.000000       0       0       0       0       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0.000000       0       0       0       62.00         63.00       06400       INTRAVENOUS THERAPY       0.000000       0       0       0       63.00       60.00       64.00       64.00       65.00       64.00       64.00       65.00       66.00       66.00       65.00       66.00       67.00       0       0       66.00       67.00       66.00       67.00       66.00       67.00       66.00       67.00       66.00       67.00       66.00       67.00       66.00       67.00       60.636       68.00       68.00       69.00       71.00       66.00       67.00       60.036       66.00       67.00       60.036       68.00<	54.01 03630 ULTRA SOUND	0. 000000	0		0	200, 141	0	54.01
57.00       05700       CT SCAN       0.000000       115,600       0       1,038,325       0       57.00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0.000000       13,300       0       398,358       0       58.00         59.00       CARDI AC CATHETERI ZATI ON       0.000000       0       0       0       59.00         60.00       LABORATORY       0.000000       0       0       0       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0.000000       0       0       0       62.00         63.00       06400       INTRAVENOUS THERAPY       0.000000       0       0       0       63.00         64.00       06400       INTRAVENOUS THERAPY       0.000000       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0.000000       117,790       0       64.461       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       2,810       0       19,718       0       66.00         67.00       06400       INTRAVENDIAT HERAPY       0.000000       3,076       0       0       67.00       68.00 <td< td=""><td>56. 00 05600 RADI 0I SOTOPE</td><td>0. 000000</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>56.00</td></td<>	56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0	0	0	56.00
58.00       05800       MAGNETIC RESONANCE I MAGI NG (MRI)       0.000000       13,300       0       398,358       0       58.00         59.00       05900       CARDI AC CATHETERI ZATI ON       0.000000       0       0       0       59.00         60.00       LABORATORY       0.000000       863,965       0       2,361,544       0       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0.000000       0       0       0       62.00         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0.000000       0       0       0       63.00         64.00       06400       INTRAVENOUS THERAPY       0.000000       117,790       0       64,461       0       65.00         65.00       06500       RESPI RATORY THERAPY       0.000000       117,790       0       64,461       0       65.00         66.00       OCCUPATI ONAL THERAPY       0.000000       22,810       0       19,718       0       66.00         67.00       06400       PLECT ROCARDI OLOGY       0.000000       160,733       0       861,182       0       69.00         70.00       0700       ELECTROCARDI OLOGY       0.000000       0	56. 01 05601 ONCOLOGY	0. 000000	0		0	721, 789	0	56.01
59.00       05900       CARDI AC CATHETERI ZATI ON       0.000000       0 </td <td>57.00 05700 CT SCAN</td> <td>0. 000000</td> <td>115, 600</td> <td></td> <td>0</td> <td>1, 038, 325</td> <td>0</td> <td>57.00</td>	57.00 05700 CT SCAN	0. 000000	115, 600		0	1, 038, 325	0	57.00
60.00       LABORATORY       0.00000       863,965       0       2,361,544       0       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0.000000       0       0       0       62.00         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0.000000       0       0       0       63.00         64.00       06400       INTRAVENOUS THERAPY       0.000000       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0.000000       117,790       0       64,461       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       98,123       0       19,718       0       66.00         67.00       06700       0 CUPATI ONAL THERAPY       0.000000       3,076       0       66.00       67.00         68.00       06900       ELECTROCARDI OLOGY       0.000000       160,733       0       861,182       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       602,709       642,780	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	13, 300		0	398, 358	0	58.00
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0.000000       0       0       0       0       62.00         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0.000000       0       0       0       63.00         64.00       06400       INTRAVENOUS THERAPY       0.000000       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0.000000       117,790       0       64,461       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       98,123       0       19,718       0       66.00         67.00       0CCUPATI ONAL THERAPY       0.000000       3,076       0       0       67.00       68.00       69.00       69.00       69.00       60,036       0       68.00       69.00       69.00       69.00       69.00       69.00       0       0       0       0       0       70.00       70.00       641.182       0       70.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       72.00       71.00       72.00       71.00       72.00       72.00       72.00       72.00       72.00       72.00	59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	0	59.00
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0.000000       0       0       0       62.00         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0.000000       0       0       0       63.00         64.00       06400       INTRAVENOUS THERAPY       0.000000       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0.000000       117,790       0       64,461       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       98,123       0       19,718       0       66.00         67.00       06400       ELECTROCARDI OLOGY       0.000000       3,076       0       60,636       68.00         69.00       06600       ELECTROCARDI OLOGY       0.000000       3,076       0       69.00       69.00         70.00       07000       ELECTROCARDI OLOGY       0.000000       0       0       0       70.00       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       291,826       0       525,692       0       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       0	60. 00 06000 LABORATORY	0. 000000	863, 965		0	2, 361, 544	0	60.00
64.00       06400       INTRAVENOUS THERAPY       0.000000       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0.000000       117,790       0       64,461       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       98,123       0       19,718       0       66.00         67.00       0CCUPATI ONAL THERAPY       0.000000       22,810       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       3,076       0       60,636       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       160,733       0       861,182       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       291,826       525,692       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       602,709       642,780       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0		0	0	0	62.00
64.00       06400       INTRAVENOUS THERAPY       0.000000       0       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0.000000       117,790       0       64,461       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       98,123       0       19,718       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       22,810       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       3,076       0       60,636       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       160,733       0       861,182       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       291,826       525,692       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       602,709       642,780       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS <t< td=""><td>63.00 06300 BLOOD STORING, PROCESSING &amp; TRANS.</td><td>0. 000000</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>63.00</td></t<>	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	0	63.00
65.00       06500       RESPI RATORY THERAPY       0.000000       117,790       0       64,461       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       98,123       0       19,718       0       66.00         67.00       0CCUPATI ONAL THERAPY       0.000000       22,810       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       3,076       0       68.00       69.00       60,636       68.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       160,733       0       811.182       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       291,826       525,692       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       602,709       642,780       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       0       0       0       73.00         74.00       07400       RENAL DI ALYSI S <t< td=""><td>64.00 06400 INTRAVENOUS THERAPY</td><td>0. 000000</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>64.00</td></t<>	64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0	0	0	64.00
66.00       06600       PHYSI CAL THERAPY       0.000000       98,123       0       19,718       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       22,810       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       3,076       0       60,636       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       160,733       0       861,182       0       99.00         70.00       07000       ELECTROCENCEHALOGRAPHY       0.000000       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       291,826       0       525,692       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       602,709       642,780       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       0       0       0       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       0       0       0       0       74.00         75.00       07500       ASC (NON-DI STI NCT PART)       0.000000	65. 00 06500 RESPI RATORY THERAPY	0, 000000	117, 790		0	64, 461	0	65.00
67.00       06700       0CCUPATIONAL THERAPY       0.000000       22,810       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       3,076       0       60,636       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       160,733       0       861,182       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       0       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.000000       291,826       0       525,692       0       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0.000000       602,709       0       642,780       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       513,732       0       4,523,733       0       73.00         74.00       07500       ASC (NON-DISTINCT PART)       0.000000       0       0       0       0       75.00         017500       ASC (NON-DISTINCT PART)       0.000000       0       0       0       0       75.00       75.00       75.00       75.00	66. 00 06600 PHYSI CAL THERAPY	0, 000000	98, 123		0	19, 718	0	66.00
68.00       06800       SPEECH PATHOLOGY       0.000000       3,076       0       60,636       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       160,733       0       861,182       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       291,826       0       525,692       0       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.000000       602,709       0       642,780       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       513,732       0       4,523,733       0       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       0       0       0       74.00         75.00       07500       ASC (NON-DI STI NCT PART)       0.000000       0       0       0       75.00         01TPATI ENT SERVICE COST CENTERS       91.00       09100       EMERGENCY       0.000000       709,620       3,912,295       0       91.00         92.00 <t< td=""><td>67.00 06700 OCCUPATI ONAL THERAPY</td><td>0, 000000</td><td>22, 810</td><td></td><td>0</td><td></td><td>0</td><td>67.00</td></t<>	67.00 06700 OCCUPATI ONAL THERAPY	0, 000000	22, 810		0		0	67.00
69.00       06900       ELECTROCARDIOLOGY       0.000000       160,733       0       861,182       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       0       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.000000       291,826       0       525,692       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       602,709       0       642,780       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       513,732       0       4,523,733       0       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       0       0       0       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0.000000       0       0       0       0       74.00         91.00       09100       EMERGENCY       0.000000       709,620       0       3,912,295       0       91.00         92.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART)       0.000000       81,422       0       776,198       0       92.00	68.00 06800 SPEECH PATHOLOGY	0, 000000	3, 076		0	60, 636	0	68.00
70. 00         07000         ELECTROENCEPHALOGRAPHY         0. 000000         0	69. 00 06900 ELECTROCARDI OLOGY	0, 000000	160, 733		0	861, 182	0	69.00
71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0.000000         291,826         0         525,692         0         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0.000000         602,709         0         642,780         0         72.00           73.00         07300         DRUGS CHARGED TO PATI ENTS         0.000000         513,732         0         4,523,733         0         73.00           74.00         07400         RENAL DI ALYSI S         0.000000         0         0         0         74.00           75.00         07500         ASC (NON-DI STI NCT PART)         0.000000         0         0         0         0         74.00           0UTPATI ENT SERVICE COST CENTERS         0.000000         0					0	0		1
72.00         07200         IMPL.         DEV.         CHARGED TO PATI ENTS         0.000000         602,709         0         642,780         0         72.00           73.00         07300         DRUGS CHARGED TO PATI ENTS         0.000000         513,732         0         4,523,733         0         73.00           74.00         07400         RENAL DI ALYSI S         0.000000         0         0         0         74.00           75.00         07500         ASC (NON-DI STI NCT PART)         0.000000         0         0         0         75.00           0UTPATI ENT SERVICE COST CENTERS         91.00         09100         EMERGENCY         0.000000         709,620         0         3,912,295         0         91.00           92.00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0.000000         81,422         0         776,198         0         92.00			291, 826		0	525, 692	0	71.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       513,732       0       4,523,733       0       73.00         74.00       07400       RENAL DI ALYSIS       0.000000       0       0       0       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0.000000       0       0       0       0       75.00         0UTPATIENT SERVICE COST CENTERS       0.000000       709,620       0       3,912,295       0       91.00         91.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART)       0.000000       81,422       0       776,198       0       92.00					0		0	72.00
74.00         07400         RENAL DI ALYSI S         0.000000         0         0         0         74.00           75.00         07500         ASC (NON-DI STINCT PART)         0.000000         0         0         0         75.00           0UTPATI ENT SERVICE COST CENTERS         0.000000         709,620         0         3,912,295         0         91.00           92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         0.000000         81,422         0         776,198         0         92.00					0			
75. 00         07500         ASC (NON-DI STINCT PART)         0.000000         0         0         0         0         75. 00           OUTPATI ENT SERVICE COST CENTERS         0.000000         709, 620         0         3, 912, 295         0         91. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         0.000000         81, 422         0         776, 198         0         92. 00					0			
OUTPATI ENT SERVICE COST CENTERS           91. 00         09100         EMERGENCY         0.000000         709, 620         0         3, 912, 295         0         91. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         0.000000         81, 422         0         776, 198         0         92. 00			-		-	-	-	
91.00         09100         EMERGENCY         0.000000         709,620         0         3,912,295         0         91.00           92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         0.000000         81,422         0         776,198         0         92.00					-			1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 000000 81, 422 0 776, 198 0 92. 00		0, 000000	709, 620		0	3, 912, 295	0	91.00
							-	

	ST. VINCENT FIS			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0181	Peri od:	Worksheet D	
				From 07/01/2018 To 06/30/2019		epared:
					11/22/2019 3:	
		Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From Worksheet C.	Services (see inst.)	Reimbursed Services	Reimbursed Services Not	(see inst.)	
	Part I, col. 9	· · ·	Subject To	Subject To		
			Ded. & Coi ns			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 136140			0 0	832, 311	50.00
51.00 05100 RECOVERY ROOM	0. 000000			0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 459008			0 0	1, 058	
53. 00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 210715			0 0	302, 216	
54. 01 03630 ULTRA SOUND	0. 142345			0 0	28, 489	
56. 00 05600 RADI 0I SOTOPE	0.00000			0 0	0	
56. 01 05601 0NC0L0GY	0. 357139 0. 183931			0 0	257, 779	
57.00  05700 CT SCAN 58.00  05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 183931				190, 980 95, 515	
59. 00 05900 CARDIAC CATHETERIZATION	0. 234773			0 0	95, 515	
60. 00 06000 LABORATORY	0. 136504			0 0	322, 360	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			0 0	022,000	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0.00000		)	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 446473	64, 461		0 0	28, 780	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 462066			0 0	9, 111	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 392863			0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 450449			0 0	27, 313	
69. 00 06900 ELECTROCARDI OLOGY	0. 150320			0 0	129, 453	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.00000			0 0	0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 147351			0 0	77, 461	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 310511 0. 321259			0 0 0 4, 311	199, 590 1, 453, 290	
74. 00 07400 RENAL DIALYSIS	0. 000000			0 4, 311	1, 455, 290	
75. 00 07500 ASC (NON-DI STINCT PART)	0. 000000			0 0	0	
OUTPATIENT SERVICE COST CENTERS	0.00000		1	0 0	0	/ 5. 00
91. 00 09100 EMERGENCY	0. 111338	3, 912, 295		0 0	435, 587	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 563767			0 0	437, 595	
200.00 Subtotal (see instructions)		23, 657, 036		0 4, 311	4, 828, 888	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		23, 657, 036	4	0 4, 311	4, 828, 888	202.00

PORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		In Lie Period: From 07/01/2018 To 06/30/2019	Worksheet D Part V Date/Time Pr 11/22/2019 3	repareo 3:53 pn
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				-
ANCI LLARY SERVI CE COST CENTERS	1					
. 00 05000 OPERATING ROOM	0					50.
. 00 05100 RECOVERY ROOM	0					51.
. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.
. 00 05300 ANESTHESI OLOGY	0	0				53.
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.
. 01 03630 ULTRA SOUND	0	0				54.
. 00 05600 RADI OI SOTOPE	0	0				56.
. 01 05601 ONCOLOGY	0	0				56.
. 00 05700 CT SCAN	0	0				57.
. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.
. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.
. 00 06000 LABORATORY	0	0				60.
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.
. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.
. 00 06400 I NTRAVENOUS THERAPY	0	0				64.
. 00 06500 RESPI RATORY THERAPY	0	0				65.
. 00 06600 PHYSI CAL THERAPY	0	0				66.
. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.
. 00 06800 SPEECH PATHOLOGY	0	0				68.
. 00 06900 ELECTROCARDI OLOGY	0	0				69.
. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0				71.
. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS	0	0				72.
. 00 07300 DRUGS CHARGED TO PATIENTS	0	1, 385				73.
. 00 07400 RENAL DI ALYSI S	0	0				74.
. 00 07500 ASC (NON-DI STINCT PART)	0	0				75.
	-					
. 00 09100 EMERGENCY	0					91.
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-				92.
0.00 Subtotal (see instructions)	0	1, 385				200.
1.00 Less PBP Clinic Lab. Services-Program	0					201.
Only Charges						

		ST. VINCENT FIS			In Lie	u of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0181	Peri od:	Worksheet D	
					From 07/01/2018 To 06/30/2019	Part V Date/Time Pre	narod
					10 00/ 30/ 2017	11/22/2019 3:	53 pm
			Titl	e XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	•	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	. ,	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	. Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS			-			
	O OPERATING ROOM	0. 136140		4, 939, 89		0	50.00
51.00 0510	O RECOVERY ROOM	0. 000000	0		0 0	0	51.00
	O DELIVERY ROOM & LABOR ROOM	0. 459008		47, 93	33 0	0	52.00
53.00 0530	0 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	0. 210715	0	902, 65	56 0	0	54.00
54.01 0363	O ULTRA SOUND	0. 142345	0	365, 80	0 0	0	54.01
56.00 0560	0 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
56.01 0560	1 ONCOLOGY	0. 357139	0	235, 63	34 0	0	56.01
57.00 0570	O CT SCAN	0. 183931	0	602, 41	0 0	0	57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0. 239773	0	252, 20	04 0	0	58.00
59.00 0590	O CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00 0600	0 LABORATORY	0. 136504	0	1, 450, 20	60 0	0	60.00
62.00 0620	O WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
63.00 0630	O BLOOD STORING, PROCESSING & TRANS.	0. 000000			0 0	0	63.00
64.00 0640	O I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65.00 0650	0 RESPI RATORY THERAPY	0. 446473	0	164, 65	59 0	0	65.00
66.00 0660	0 PHYSI CAL THERAPY	0. 462066	0	1, 198, 64	19 0	0	66.00
67.00 0670	O OCCUPATI ONAL THERAPY	0. 392863	0	2, 12	29 0	0	67.00
68.00 0680	O SPEECH PATHOLOGY	0. 450449	0	224, 83	35 0	0	68.00
69.00 0690	0 ELECTROCARDI OLOGY	0. 150320	0	305, 60	05 0	0	69.00
70.00 0700	0 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 147351	0	795, 41	15 0	0	71.00
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	0. 310511	0	98, 12	27 0	0	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0. 321259	0	1, 020, 50	6 0	0	73.00
74.00 0740	0 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.00 0750	O ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
OUTP	ATIENT SERVICE COST CENTERS						
	0 EMERGENCY	0. 111338	0	5, 900, 6	78 0	0	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 563767	0	200, 05	50 0	0	92.00
200.00	Subtotal (see instructions)		0	18, 707, 50	07 0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges	1					1
	Net Charges (line 200 - line 201)				07 0		

alth Financial Systems PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		HERS HOSPITAL Provider C	CN: 15-0181	Period: From 07/01/2018 To 06/30/2019	u of Form CMS Worksheet D Part V Date/Time Pr 11/22/2019 3	repared:
		Titl	e XIX	Hospi tal	Cost	_
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				_
ANCI LLARY SERVICE COST CENTERS	(70 510	0				
	672, 518					50.0
1.00 05100 RECOVERY ROOM	0	0				51.0
2. 00 05200 DELIVERY ROOM & LABOR ROOM	22, 002					52.0
3. 00 05300 ANESTHESI OLOGY	0	, s				53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	190, 203					54.0
4. 01 03630 ULTRA SOUND	52,070					54.0
6. 00 05600 RADI OI SOTOPE	0	-				56.
6. 01 05601 0NC0L0GY	84, 154					56.
7. 00 05700 CT SCAN	110, 802					57.0
B. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	60, 472					58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	, o				59.0
	197, 966	0				60.
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0					62.
4. 00 06400 INTRAVENOUS THERAPY	0					64.
5. 00 06500 RESPIRATORY THERAPY	73, 516					65.0
5. 00 06600 PHYSI CAL THERAPY	553, 855					66.
7. 00 06700 OCCUPATI ONAL THERAPY	836					67.
3. 00 06800 SPEECH PATHOLOGY	101, 277					68.
9. 00 06900 ELECTROCARDI OLOGY	45, 939					69.
0. 00 07000 ELECTROENCEPHALOGRAPHY	43, 737					70.
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	117, 205					71.
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	30, 470					72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	327, 866					73.
4. 00 07400 RENAL DIALYSIS	0					74.
5. 00 07500 ASC (NON-DI STINCT PART)	0					75.
OUTPATIENT SERVICE COST CENTERS	0	0	1			- ,
1. 00 09100 EMERGENCY	656, 970	0				91. (
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	112, 782					92. (
00.00 Subtotal (see instructions)	3, 410, 903					200.
01.00 Less PBP Clinic Lab. Services-Program	0					200.0
Only Charges						201.0
D2.00 Net Charges (line 200 - line 201)	3, 410, 903	0				202.

ST.	VI NCENT	FI SHERS	HOSE	PI TAL	_	

2.00       Injatient days (including sing-bad and observation bed days)       2,008       2,008       2,008       3.00         3.00       Derivate room days (scaluding sing-bed and observation bed days)       15 you have only private room days, only the inpatient days (including private room days) after becember 31 of the cost       0		Financial Systems ST. VINCENT FISHE	RS HOSPITAL	In Lie	u of Form CMS-2	<u>2552-10</u>
To         06/30/2019         Duto The Propured: It is XVIII         Duto The Propured: Propured: Propured: Propured: It is XVIII         Duto The Propured: Propured: It is XVIIII         Duto The Propured: Propured: It is XVIIIII         Duto The Propured: Propured: It is XVIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII						
The XVIII         Hospital         PPS           Dest Center Description         The XVIII         Hospital         PPS           Dest I - ALL PROVIDER COMPGENTS         1.00         1.00           Implition days (including private room days and sing-bod days uncluding needorm)         2.08         2.08           100         Implition days (including private room days, (including private room days)         2.08         2.00           100         Traine XVIII         2.08         2.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>pared.</td></t<>						pared.
Cost Center Description         1.00           PMT1 ENLARY         1.00           PMT1 ENLARY         1.00           Impatternal Asso         1.00           10         Impatternal Asso         2.900           10         Impatternal Asso         2.900           10         Impatternal Asso         0.910           10         Impatternal Asso         0.910           10         For Stars and Asso         0.900           10         Impatternal Asso         0.900           10         Total Impatternal Asso         0.900           10         Impatternal Asso         0.900           10         1000         Impatternal Asso         0.900				10 00/00/2017		
DART I - ALL PROVIDER COMPORENTS         1.00           Institut DAYS         2.900         1.00           Institut DAYS         Institut DAYS         Institut DAYS         2.900         1.00         2.900         1.00         2.900         1.00         2.900         1.00         2.900         1.00         2.900         1.00         2.900         1.00         0.00         2.900         1.00         0.00         2.900         1.00         0.00         2.900         1.00         0.00         2.900         1.00         0.00         1.00         0.00         1.00         0.00         1.00         0.00         1.00 <t< td=""><td></td><td></td><td>Title XVIII</td><td>Hospi tal</td><td>PPS</td><td></td></t<>			Title XVIII	Hospi tal	PPS	
PART 1 - ALL FROMINER COMPONENTS           INPUTTION DATE         2.000         1.00           Inputtion days (including private room days, excluding newborn)         2.000         1.00           Inputtion days (including private room days, excluding sand_bad and deversation bed days).         17 you have only private room days, excluding sand_bad and deversation bed days).         2.000		Cost Center Description			1.00	
IDENTIFY         Description         Description         Description         Description           10         Inpatient days (including private room days, and swing-bed and newborn)         2,008         1.00           10         Inpatient days (including private room days, and abservation bed days).         2,008         2.001           10         Experiment days (including private room days, and abservation bed days).         2,004         2.00           10         Semi-private room days (excluding sing-bed and observation bed days).         2,004         6.00           10         Semi-private room days (including private room days) after December 31 of the cost         0         5.00           10         Total swing-bod MF type inpatient days (including private room days) after December 31 of the cost         0         0           10         Total swing-bod MF type inpatient days (including private room days) after December 31 of the cost         0         0           10         Total swing-bod MF type inpatient days applicable to title XUII only (including private room days)         0         0           10         Total swing-bod MF type inpatient days applicable to title XUII only (including private room days)         0         0           10         Total swing-bod MF type inpatient days applicable to title XUII only (including private room days)         0         0         0           10 <td></td> <td></td> <td></td> <td></td> <td>1.00</td> <td></td>					1.00	
1.00       Inpatient days (including private room days, excluding newborn days)       2,068       1.00         0.01       Inpatient days (including private room days, excluding single-dd and externation bed days)       2,068       1.00         0.00       Inpatient days (including single-dd and externation bed days)       1 you have only private room days)       0.03         0.00       Inpatient days (including private room days) after becember 31 of the cost       0.05         0.00       Total single-bd SW type inpatient days (including private room days) after becember 31 of the cost       0.05         0.00       Total single-bd SW type inpatient days (including private room days) after becember 31 of the cost       0.05         0.01       Total single-bd W type inpatient days (including private room days) after becember 31 of the cost       0.05         0.01       Total single-bd W type inpatient days (including private room days)       10.05       0.00         1.02       Single-bd SW type inpatient days (including private room days)       0.00       10.00       10.00         1.03       Single-bd SW type inpatient days applicable to title XVII only (including private room days)       0.00       10.00         1.04       Single-bd SW type inpatient days applicable to title XVII only (including private room days)       0.00       10.00         1.05       Single-bd SW type inpatient days applicable to title XVII only (including						1
2.00       Inpatient days (including wire year dam observation bed days).       2,008       2,008       2,008       3,00         0.00       brit processing the string.       0,000       3,000 <td>1.00</td> <td></td> <td>ys, excluding newborn)</td> <td></td> <td>2, 908</td> <td>1.00</td>	1.00		ys, excluding newborn)		2, 908	1.00
do not complete this line.       2,299         0 Semi-private room days (sociul and gaving-bed and observation bed days)       10         0 Semi-private room days (sociul and gaving-bed and observation bed days)       10         0 Total swing-bed SWE type inpatient days (including private room days) after December 31 of the cost       0         0 Total swing-bed KE type inpatient days (including private room days) after December 31 of the cost       0         0 Total swing-bed KE type inpatient days (including private room days) after December 31 of the cost       0         0 Total swing-bed KE type inpatient days (including private room days) after December 31 of the cost       0         0 Total swing-bed KE type inpatient days explicable to the Program (excluding swing-bed and the cost reporting period to the cost reporting period to the cost reporting period to the cost reporting period (if calendar year, enter 0 on this line)       0         10.00 Swing-bed KE type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0         10.00 Marter after 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       10         10.00 Marter after after after after after applicable to the Program (excluding swing-bed days)       0       10         10.00 Marter after	2.00				2, 908	2.00
4.00       Seel. private room days (excluding sating-bed and observation bed days)       2264       400         0.10       Total sating-bed Sf type inpatient days (including private room days) through becember 31 of the cost       000         0.10       Total sating-bed Sf type inpatient days (including private room days) after December 31 of the cost       000         0.00       Total sating-bed Sf type inpatient days (including private room days) after December 31 of the cost       000         0.00       Total sating-bed Sf type inpatient days (including private room days) after December 31 of the cost       000         0.00       Stating-bed Sf type inpatient days applicable to the Program (excluding sating-bed and SSB type inpatient days applicable to the Program (excluding sating-bed and SSB type inpatient days applicable to the VSI (including private room days)       000         1.00       Sating-bed SF type inpatient days applicable to the VSI (including private room days)       000       100         1.01       Sating-bed SF type inpatient days applicable to the VSI (including private room days)       001       100         1.02       Sating-bed SF type inpatient days applicable to the Program (excluding sating-bed days)       001       100         1.03       Sating-bed SF type inpatient days applicable to the Program (excluding sating-bed days)       001       100         1.04       Medically necessary private room days, applicable to services af	3.00		ays). If you have only p	rivate room days,	0	3.00
00       Iotal swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period. (I calendar year, enter 0 on this line)       5.00         00       Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period. (I calendar year, enter 0 on this line)       6.00         00       Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period. (I calendar year, enter 0 on this line)       7.00         01       Total swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and swing-bed SWF type inpatient days applicable to the Program (excluding private room days)       0         01.00       Swing-bed SWF type inpatient days applicable to the Program (excluding private room days)       0         12.00       Swing-bed WF type inpatient days applicable to the Program (excluding private room days)       0       13.00         13.00       Swing-bed WF type inpatient days applicable to the Program (excluding swing-bed swiss)       0       14.00         14.00       Medical rate for swing-bed SWF services applicable to services after December 31 of the cost reporting period       0       0         15.00       Total swing-bed SWF services applicab	1 00		dave)		2 260	1 00
reporting period       6.00         Total simplexed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       6.00         100       Swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       7.00         100       Swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       8.00         100       Swing-bed SW type inpatient days applicable to tile XUII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       10.00         100       Swing-bed SW type inpatient days applicable to tiles V or XIX only (including private room days)       0       11.00         100       Swing-bed SW type inpatient days applicable to tiles V or XIX only (including private room days)       0       12.00         11.00       Swing-bed SW type inpatient days applicable to the Program (excluding swing-bed days)       0       13.00         12.00       Swing-bed SW type inpatient days applicable to tiles V or XIX only (including private room days)       0       14.00         13.00       Swing-bed SW type inpatient days applicable to services through December 31 of the cost reporting period (if Calendar year, enter 0 on this line)       0       10.00         10.00       Swing-bed SW type inpatien	5.00			er 31 of the cost		1
In Experting period (if calendar year, enter 0 on this line)       7.00         Total any-bed K Type inpatient days (including private room days) through becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       8.00         10.01       Total inpatient (days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       8.00         10.01       String-bed SW Type inpatient days applicable to the Program (excluding swing-bed and newborn days)       9.00         11.00       String-bed SW Type inpatient days applicable to thits (including private room days)       0.10.00         11.00       String-bed SW Type inpatient days applicable to thits (including private room days)       0.10.00         11.00       String-bed SW Type inpatient days applicable to the Program (excluding private room days)       0.10.00         11.00       String-bed NF type inpatient days applicable to the Program (excluding swing-bed days)       0.10.00         12.00       Metrogen NF type inpatient days applicable to the Program (excluding swing-bed days)       0.10.00         13.00       Metrogen Y take room days applicable to services through December 31 of the cost reporting period (If calendar year, enter 0 on this line)       0.00         14.00       Metrogen Y take room days applicable to services after December 31 of the cost reporting period (If calendar year, enter 0 on this line)       0.00         15.00       Total nursery days (Itit W or XIX o		reporting period	3.			
1.00       Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       7.00         0.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       0         0.00       Swing-bed SWF type inpatient days applicable to title XVII and (ing private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       0         10.00       Swing-bed NF type inpatient days applicable to title XVII and (inding private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       10.00         11.00       Swing-bed NF type inpatient days applicable to title XVII and (inding private room days)       0       12.00         12.00       Swing-bed NF type inpatient days applicable to title XVI and (inding private room days)       0       13.00         13.00       Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)       0       14.00         14.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       17.00         17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       17.00         18.00       Medicare r	6.00		oom days) after December	31 of the cost	0	6.00
reporting period reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days) Swing-bed SWE type inpatient days applicable to title XVIII only (including private room days) Swing-bed SWE type inpatient days applicable to title XVIII only (including private room days) Swing-bed SWE type inpatient days applicable to title XVIII only (including private room days) Swing-bed SWE type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to title V or XIX only (including swing-bed days) (including swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) (including swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) (including swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period (including rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including trate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including trate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including trate for swing-bed NF type services after December 31 of the cost reporting period (line 6 (including trate for swing-bed NF type services after December 31 of the cost reporting period (line 6 (including swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 (including swing-bed cost applicable to NF	7 00		an dava) through Decembe	r 21 of the east		7 00
0.00       Total saving-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days)       0       8.00         0.00       Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)       5.00       10.00         0.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after total days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (is see instructions)       11.00         0.00       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)       13.00         10.00       Medically necessary private room days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line)       14.00         10.00       Medical fast for swing-bed SNF services applicable to services after December 31 of the cost 1       0.00         10.00       Medical fast for swing-bed NF services applicable to services after December 31 of the cost 1       0.00         10.00       Medical fast for swing-bed NF services applicable to services after December 31 of the cost 1       0.00         10.00       Medical fast for swing-bed NF services applicable to services after December 31 of the cost 1       0.00         10.00       Swing-bed cost applicable to NF type services after December 31 o	7.00		bill days) through beceilibe	r 31 OF the cost	0	7.00
reporting period (if calendar year, enter 0 on this line)         9.00           Total inpatient days including private room days applicable to the Program (excluding swing-bed and newtorn days)         9.00           Swing-bed SWF type inpatient days applicable to tille XVIII only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)         0           10.00         Swing-bed SWF type inpatient days applicable to tille XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)         0           12.00         Swing-bed INF type Inpatient days applicable to tille XVI only (including private room days)         0           13.00         Swing-bed INF type Inpatient days applicable to tille XVI only (including private room days)         0           14.00         Medically necessary private room days applicable to the Program (excluding swing-bed days)         0         13.00           15.00         Total interserv days (tille V or XIX only (including private room days)         0         15.00           16.00         Medical rate rof swing-bed SNF services applicable to services through December 31 of the cost reporting period (inc f calendar year, enter 0 on this line)         0         16.00           17.00         Medical rate rof swing-bed SNF services applicable to services through December 31 of the cost reporting period (inc f calendar year, enter 0 on this line)         0         10.00           18.00	8.00		om davs) after December	31 of the cost	0	8.00
newborn days)       newborn days       0         10.00       Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days)       0       0         10.00       Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days)       0       0         10.00       Swing-bed KF type inpatient days applicable to title SV or XIX only (including private room days)       0       0         11.00       Swing-bed KF type inpatient days applicable to title SV or XIX only (including private room days)       0       11.00         12.00       Swing-bed KF type inpatient days applicable to title SV or XIX only (including private room days)       0       12.00         14.00       Medi call y necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Totla nursery days (title V or XIX only)       0       16.00       17.00         16.00       Medi cal rate for swing-bed SWF services applicable to services through December 31 of the cost reporting period (line 6       0.00       18.00         17.00       Medi cal rate for swing-bed WF services applicable to services after December 31 of the cost (line 6       0.00       19.00         10.00       Swing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line 6       0.049,519       21.00         10.00       Swing-			5 /			
10.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (icalendar year, enter 0 on this line)       0       11.00         11.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (ir calendar year, enter 0 on this line)       0       12.00         12.00       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 (ir calendar year, enter 0 on this line)       0       13.00         13.00       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 (ir calendar year, enter 0 on this line)       0       14.00         14.00       Medicat Y necessary private room days applicable to services through December 31 of the cost       0.00       14.00         15.00       SMING Det ADUSISMME       Services applicable to services after December 31 of the cost       0.00       18.00         16.00       Medicat rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       18.00         17.00       Medicat rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       18.00         18.00       Medicat rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       2	9.00		to the Program (excludin	g swing-bed and	538	9.00
through December 31 of the cost reporting period (see instructions)       11.00         Swinp-bed NF type inpatient days applicable to tilt & VII (aluding private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       01.00         100       Swinp-bed NF type inpatient days applicable to tilts V or XIX only (including private room days)       01         1100       Main Jone Mark Stream Stre	10 00		only (including privato	room dave)		10.00
11.00       Swing-bed SN 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)       0       11.00         12.00       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)       0       12.00         13.00       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       0       13.00         14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         16.00       Total nursery days (title V or XIX only)       0       16.00         17.00       Medicater rate for swing-bed SNF services applicable to services through December 31 of the cost       0.00       17.00         18.00       Medicater rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       19.00         19.00       Medicati rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       19.00         10.01       Total general inpatient routine service cost fore brough December 31 of the cost reporting period (line 6 x line 17)       0       20.00         12.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	10.00			i uays)	0	10.00
12.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) (15.00       13.00         13.00       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)       13.00         14.00       Medical reservices (itle V or XIX only)       0         15.00       Nursery days (title V or XIX only)       0         16.00       Medicare rate for swing-bed SF services applicable to services after December 31 of the cost       0.00         17.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         17.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         17.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         17.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6       22.00         17.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6       22.00         17.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6	11.00			room days) after	0	11.00
through December 31 of the cost reporting period       13.00         100       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0         110       Observed State					_	
3.00       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)       13.00         4.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         5.00       Total nursery days (title V or XIX only)       0       16.00         5.01       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost       0.00         17.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         18.00       Medicair rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         19.00       Medicair rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         19.00       Medicair rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         20.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)       0.00         21.00       Total general inpatient routine service cost (see instructions)       6.049,519       21.00         22.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)       0.00       20.00         23.00       Swing-bed cost	12.00		X only (including priva	te room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       14.00         14.00 Medical ly necessary private room days applicable to the Program (excluding swing-bed days)       0         15.00 Nursery days (title V or XIX only)       0         16.00 Nursery days (title V or XIX only)       0         17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00         18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00         10.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         10.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         10.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         10.01 Otal general inpatient routine service cost (see instructions)       6,049,519       21.00         12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period       0       22.00         12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x in 10.0)       21.00       22.00         12.00 Contral report routine service cost net of swing-bed cost reporting period (line 6 x in 10.0)       22.00       20.00         <	13 00		X only (including priva	te room davs)	0	13 00
15.00       Total nursery days (title V or XIX only)       0       15.00         00       Nursery days (title V or XIX only)       0         17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost       0.00         19.00       Medicare fare for swing-bed NF services applicable to services after December 31 of the cost       0.00         19.00       Medicare fare for swing-bed NF services applicable to services after December 31 of the cost       0.00         20.00       Medicare fare for swing-bed NF services through December 31 of the cost       0.00         20.01       Total general inpatient routine service cost (see instructions)       22.00         20.01       Sving-bed cost applicable to SNF type services for December 31 of the cost reporting period (line 6       0.00         21.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8       0.04,09,519         21.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8       0.26,00         20.01       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8       0.26,00         20.01       Swing-bed cost (see instructions)       0.26,00 <td>101.00</td> <td>after December 31 of the cost reporting period (if calendar y</td> <td>year, enter 0 on this li</td> <td>ne)</td> <td></td> <td></td>	101.00	after December 31 of the cost reporting period (if calendar y	year, enter 0 on this li	ne)		
6.00       Nursery days (tile V or XIX only)       0       16.00         SWIM RED ADUSTNENT       10.00         17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost cost cost after a cost for swing-bed NF services applicable to services after December 31 of the cost cost cost cost cost cost cost cost	14.00		ram (excluding swing-bed	days)	-	
SNING BED ADJUSTMENT         Over the provide and the provided of the cost reporting period of the cost reporting period for swing-bed SNF services applicable to services after December 31 of the cost reporting period for the cost applicable to SNF type services after December 31 of the cost reporting period (line for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line for swing-bed cost (see instructions))         Out of the cost reporting period (line for swing-bed cost (line 21 minus line 26)         Out of the cost applicable to NF type services after December 31 of the cost reporting period (line for swing-bed cost (see instructions))         Out of the cost reporting period (line for swing-bed cost (see instructions))         Out of the cost reporting period (line for swing-bed cost (line 21 minus line 26)         Out of the cost for swing-bed cost (line 21 minus line 26)         Out of the cost for swing-bed cost (line 21 minus line 26)         Out of the cost for swing-bed cost (line 22 minus line 33)					-	
17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         10.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6       21.00         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6       23.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8       25.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8       25.00         26.00       Total swing-bed cost (see instructions)       0.049.019         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       0.29.00 </td <td>16.00</td> <td></td> <td></td> <td></td> <td>0</td> <td>16.00</td>	16.00				0	16.00
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29.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.000000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0032.0034.00Average per diem private room cost differential (line 34 x line 31)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)0.36.0036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 049, 51937.0027 minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY0.0038.0078.00Adjusted general inpatient routine service cost per diem (see instructions)2, 080.3038.0039.00Program general inpatient routine service cost (line 9 x line 38)1, 119, 20139.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	28 00		ed and observation bed c	harges)	0	28 00
31.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.00032.0033.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0032.0034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0033.0035.00Average per diem private room cost differential (line 34 x line 31)0.0034.0036.00Private room cost differential adjustment (line 3 x line 35)0.0036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 049, 51937.0027 minus line 36)PART II - HOSPITAL AND SUBPROVIDERS ONLY0.00PART II - HOSPITAL AND SUBPROVIDERS ONLY2, 080.3038.0038.00Adjusted general inpatient routine service cost per diem (see instructions)2, 080.3039.00Program general inpatient routine service cost (line 9 x line 38)1, 119, 20139.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	29.00			nar goo)		1
32.00       Average private room per diem charge (line 29 ÷ line 3)       0.00       32.00         33.00       Average semi - private room per diem charge (line 30 ÷ line 4)       0.00       33.00         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0.00       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 049, 519       37.00         27 minus line 36)       PART 11 - HOSPI TAL AND SUBPROVIDERS ONLY       7.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       2,080.30         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       2,080.30         39.00       Program general inpatient routine service cost (line 9 x line 38)       1,119,201       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
33.00       Average semi-private room per diem charge (line 30 ÷ line 4)       0.00       33.00         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 049, 519       0       36.00         27 minus line 36)       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       0       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       2,080.30       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       1,119,201       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	31.00		÷line 28)			
34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       0.00       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 049, 519       0       36.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       6,049,519       37.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       2,080.30       38.00         38.00       Adjusted general inpatient routine service cost (line 9 x line 38)       2,080.30       38.00         39.00       Program general inpatient routine service cost applicable to the Program (line 14 x line 35)       0       40.00						
35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,049,519       0       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       6,049,519       37.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       2,080.30       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       2,080.30       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       1,119,201       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00			nus line 33)(see instru	ctions)		
37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)       6,049,519       37.00         PART II - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       2,080.30       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       2,080.30       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       1,119,201       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	35.00					
27 minus line 36)         PART II - HOSPITAL AND SUBPROVIDERS ONLY         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS         38.00         Adjusted general inpatient routine service cost per diem (see instructions)       2,080.30         39.00       Program general inpatient routine service cost (line 9 x line 38)       1,119,201         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0	36.00	Private room cost differential adjustment (line 3 x line 35)				1
PART II - HOSPITAL AND SUBPROVIDERS ONLY         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       2,080.30       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       1,119,201       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	37.00		and private room cost d	ifferential (line	6, 049, 519	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS38.00Adjusted general inpatient routine service cost per diem (see instructions)2,080.3039.00Program general inpatient routine service cost (line 9 x line 38)1,119,20140.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0					l	-
38.00Adjusted general inpatient routine service cost per diem (see instructions)2,080.3038.0039.00Program general inpatient routine service cost (line 9 x line 38)1,119,20139.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00			JUSTMENTS			1
39.00Program general inpatient routine service cost (line 9 x line 38)1, 119, 20139.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	38.00				2, 080. 30	38.00
	39.00	Program general inpatient routine service cost (line 9 x line	e 38)			39.00
41.00   IOTAL Program general inpatient routine service cost (line 39 + line 40)   1, 119, 201   41.00		3 31 11 8	, , ,			1
	41.00	liotai Program general inpatient routine service cost (line 39	+ IINE 40)		1, 119, 201	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0181	Peri od:	eu of Form CMS- Worksheet D-1	
					From 07/01/2018 To 06/30/2019		epar
						11/22/2019 3:	
	Cost Center Description	Total	Title Total	Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient Cost				(col. 3 x col.	
				col . 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	0		0.	00 0	) (	42
. 00	INTENSIVE CARE UNIT	0		0.	00 C		5 43
. 00	CORONARY CARE UNI T	0	C	0.	00 C	0 0	4
. 00	BURN INTENSIVE CARE UNIT						45
. 00 . 00	SURGI CAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	C	0.	00 C	C	46
. 00	Cost Center Description						
	·					1.00	
. 00	Program inpatient ancillary service cost (V					1, 103, 281	
. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	<u>s 41 through 48)(s</u>	ee instructio	ons)		2, 222, 482	2 49
00	Pass through costs applicable to Program in	npatient routine s	ervices (from	n Wkst. D, su	m of Parts I and	288, 841	1 50
. 00	Pass through costs applicable to Program in	npatient ancillary	services (fr	om Wkst. D,	sum of Parts II	132, 253	3 5'
. 00	and IV) Total Program excludable cost (sum of lines	s 50 and 51)				421, 094	1 52
. 00	Total Program inpatient operating cost excl		ated, non-phy	sician anest	hetist, and	1, 801, 388	
	medical education costs (line 49 minus line	e 52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					C	5
. 00	Target amount per discharge					0.00	
.00	Target amount (line 54 x line 55)					C	
. 00	Difference between adjusted inpatient opera	ating cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost r	concrting pariod a	nding 1004	undated and a	ampounded by the	0.00	
. 00	market basket	eportring period e	nui ng 1990, t	ipuateu anu c	Silipourided by the	0.00	) <sup>3</sup>
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	) 6
. 00	If line 53/54 is less than the lower of lin					C	) 6'
	which operating costs (line 53) are less thamount (line 56), otherwise enter zero (see		(lines 54 x	60), or 1% o	f the target		
. 00	Relief payment (see instructions)					0	) 63
. 00	Allowable Inpatient cost plus incentive pay	yment (see instruc	tions)			C	6
~~	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	osts through Decem	ber 31 of the	e cost report	ing period (See		) 64
. 00	Medicare swing-bed SNF inpatient routine co	osts after Decembe	r 31 of the o	ost reportin	g period (See	0	65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	tine costs (line 6	4 plus line 6	5)(title XVI	ll only). For	0	66
. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 d	of the cost r	eportina period	0	67
	(line 12 x line 19)	5					
. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	cember 31 of	the cost rep	orting period	C	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	t routine costs (L	ine 67 + line	e 68)			69
. 00	PART III - SKILLED NURSING FACILITY, OTHER			,			
. 00	Skilled nursing facility/other nursing faci	2			)		70
. 00	Adjusted general inpatient routine service		ne 70 ÷ line	2)			7
. 00 . 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		(line 14 v li	ne 35)			72
. 00	Total Program general inpatient routine ser	0	•				74
. 00	Capital-related cost allocated to inpatient				Part II, column		75
00	26, line 45)	ing 2)					_
. 00 . 00	Per diem capital-related costs (line 75 ÷ 1 Program capital-related costs (line 9 x lin	,					70
. 00	Inpatient routine service cost (line 74 mir						78
. 00	Aggregate charges to beneficiaries for exce	ess costs (from pr					79
00	Total Program routine service costs for con	•	st limitatior	n (line 78 mi	nus line 79)		80
00	Inpatient routine service cost per diem lin						8
00 00	Inpatient routine service cost limitation ( Reasonable inpatient routine service costs	• . •					8
. 00	Program inpatient ancillary services (see i	•	/				84
. 00	Utilization review - physician compensation		s)				8
. 00	Total Program inpatient operating costs (su		ough 85)				80
00	PART IV - COMPUTATION OF OBSERVATION BED PA					( )(	
. 00 . 00	Total observation bed days (see instruction Adjusted general inpatient routine cost per		line 2)			639 2, 080. 30	
	The action general inputiont routine cost per	G. ON (1110 Z/ 7	· · · · · · · · · · · · · · · · · · ·			2,000.00	1 00

Health Financial Systems	ST. VINCENT FIS	HERS HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2018	Worksheet D-1	
				Fo 06/30/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 561, 251	6, 049, 519	0. 258079	9 1, 329, 312	343, 068	90.00
91.00 Nursing School cost	0	6, 049, 519	0.00000	1, 329, 312	0	91.00
92.00 Allied health cost	0	6, 049, 519	0.00000	1, 329, 312	0	92.00
93.00 All other Medical Education	0	6, 049, 519	0.00000	1, 329, 312	0	93.00

ST.	VI NCENT	FI SHERS	HOSPI TAL

	Financial Systems         ST. VINCENT FISHERS H           ATION OF INPATIENT OPERATING COST         Pr	IOSPITAL ovider CCN: 15-0181	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2018 To 06/30/2019	Date/Time Pre 11/22/2019 3:	
		Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, e	excluding newborn)		2, 908	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days). do not complete this line.	and newborn days)	ivate room days,	2, 908 0	2.00 3.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation bed of Total swing-bed SNF type inpatient days (including private room of		r 31 of the cost	2, 269 0	
6.00	reporting period Total swing-bed SNF type inpatient days (including private room or reporting period (if calendar year, enter 0 on this line)	days) after December	31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room da reporting period	ays) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room da reporting period (if calendar year, enter 0 on this line)	ays) after December 3	1 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable to the newborn days)	ne Program (excluding	swing-bed and	36	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction	ns)	5 1	0	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only December 31 of the cost reporting period (if calendar year, enter	0 on this line)	5 /	0	
12.00 13.00	Swing-bed NF type inpatient days applicable to titles V or XIX or through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX or	J . J .	3 /	0	
	after December 31 of the cost reporting period (if calendar year, Medically necessary private room days applicable to the Program	enter 0 on this lin	e)	0	
15.00	Total nursery days (title V or XIX only)	<u> </u>		1, 120	15.00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			56	
17.00	Medicare rate for swing-bed SNF services applicable to services reporting period	0			17.00
	Medicare rate for swing-bed SNF services applicable to services a reporting period				18.00
19.00 20.00	Medicaid rate for swing-bed NF services applicable to services th reporting period Medicaid rate for swing-bed NF services applicable to services at	0			19.00 20.00
20.00	reporting period Total general inpatient routine service cost (see instructions)	ter becember 31 01 t	ne cost	6, 049, 519	
21.00	Swing-bed cost applicable to SNF type services through December 3 $5 \times 10^{-10}$ J m $10^{-10}$	31 of the cost report	ing period (line	0, 049, 519	
23.00	Swing-bed cost applicable to SNF type services after December 31 x line 18) $$	of the cost reportin	g period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 3' 7 x line 19)	l of the cost reporti	ng period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 $\alpha$ x line 20)	of the cost reporting	period (line 8	0	25.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (lin PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus line 26)		0 6, 049, 519	
28.00	General inpatient routine service charges (excluding swing-bed and	nd observation bed ch	arges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)		-	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	no 20)		0	30.00
31.00 32.00	General inpatient routine service cost/charge ratio (line 27 ÷ li Average private room per diem charge (line 29 ÷ line 3)	115 20)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minus	line 33)(see instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 3			0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	- · /		0.00	36.00
37.00	General inpatient routine service cost net of swing-bed cost and 27 minus line 36)	private room cost di	fferential (line	6, 049, 519	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IENTS			-
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST			2 000 20	20 00
38.00 39.00	Adjusted general inpatient routine service cost per diem (see ins Program general inpatient routine service cost (line 9 x line 38)	,		2, 080. 30 74, 891	38.00 39.00
40.00	Medically necessary private room cost applicable to the Program			74, 891	
	Total Program general inpatient routine service cost (line 39 + I	• • •		74, 891	

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	ST. VINCENT FIS	Provider C		Period:	worksheet D-1	
					From 07/01/2018 Fo 06/30/2019		epared:
				- XI X		11/22/2019 3:	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
			Inpatient Days	Diem (col. 1 -		(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
2.00	NURSERY (title V & XIX only)	907, 545			4.00		42.0
2.00	Intensive Care Type Inpatient Hospital Units			01010			
3.00	I NTENSI VE CARE UNI T	0	0	0.00			
4.00	CORONARY CARE UNIT	0	0	0.00	0 0	0	1
5.00 6.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0 0	0	45.0
7.00	OTHER SPECIAL CARE (SPECIFY)	0	0	0.00			47.0
	Cost Center Description					1.00	
8.00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)			1.00 1,387,039	48.0
9.00	Total Program inpatient costs (sum of lines			ns)		1, 507, 307	
	PASS THROUGH COST ADJUSTMENTS	~ ~ ~ ~ ~				· · ·	
0.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	0	50.0
1. 00	III) Pass through costs applicable to Program inp	atient ancillar	v services (fr	om Wkst D si	m of Parts II	0	51.0
1.00	and IV)		y services (11	om most. D, St			
2.00	Total Program excludable cost (sum of lines					0	
3.00	Total Program inpatient operating cost exclu		elated, non-phy	sician anesthe	etist, and	0	53. C
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	32)					
4.00	Program di scharges					0	54.
5.00	Target amount per discharge					0.00	
6.00 7.00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	urget amount (1	ino 56 minus l	ino 52)	0	
7.00 B.00	Bonus payment (see instructions)	ing cost and ta	inger anount (i	The so minus i	The 55)		
9.00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, u	pdated and com	pounded by the	0.00	
	market basket					0.00	
0.00 1.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	
1.00	which operating costs (line 53) are less that					0	
	amount (line 56), otherwise enter zero (see				<u>j</u>		
2.00	Relief payment (see instructions)					0	
3.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see Instru	ICTI ONS)			0	63.0
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reportir	ng period (See	0	64. (
	instructions)(title XVIII only)						
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65.0
6.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66. (
	CAH (see instructions)			, .	37		
7.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	f the cost rep	orting period	0	67.0
8.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repor	ting period	0	68.0
0.00	(line 13 x line 20)				ting period		
9.00	Total title V or XIX swing-bed NF inpatient			,		0	69. (
0. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.0
1.00	Adjusted general inpatient routine service c						70.0
2.00	Program routine service cost (line 9 x line			_,			72.0
3.00	Medically necessary private room cost applic			ne 35)			73. (
4.00	Total Program general inpatient routine serv	•	,	arkahaat D. Da	set II oolump		74.0
5.00	Capital-related cost allocated to inpatient 26, line 45)	Service	COSTS (ILON M	υικομέει Β, Ρέ	artir, corumn		75.0
6. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.0
7.00	Program capital-related costs (line 9 x line						77.
8.00 9.00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovidor record	c)			78.
9.00 0.00	Total Program routine service costs for comp				us line 79)		80.
1.00	Inpatient routine service cost per diem limi			()			81.
2.00	Inpatient routine service cost limitation (I		· .				82.
3.00	Reasonable inpatient routine service costs (		is)				83.
4.00 5.00	Program inpatient ancillary services (see in		ns)				84. 85.
5.00 6.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.
	PART IV - COMPUTATION OF OBSERVATION BED PAS					· · · · · · · · · · · · · · · · · · ·	
						(00	
7.00 8.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per					639 2, 080. 30	

Health Financial Systems	ST. VINCENT FIS	HERS HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2018	Worksheet D-1	
				To 06/30/2019		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 561, 251	6, 049, 519	0. 258079	7 1, 329, 312	343, 068	90.00
91.00 Nursing School cost	0	6, 049, 519	0.00000	0 1, 329, 312	0	91.00
92.00 Allied health cost	0	6, 049, 519	0.00000	1, 329, 312	0	92.00
93.00 All other Medical Education	0	6, 049, 519	0.00000	1, 329, 312	0	93.00

Heal th	Fi nanc	i al	Sys	tems	
LNDATL			4 01/		00

Hearth Fina	Incrai Systems ST. VINCENT FISHER	S HUSPITAL		In Lie	U OI FORM CMS-	2552-10
INPATIENT /	ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0181	Peri od:	Worksheet D-3	
				From 07/01/2018	D ( (T) D	
				To 06/30/2019	Date/Time Pre	
					11/22/2019 3:	53 pm
		litl€	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS					
30.00 0300	IO ADULTS & PEDI ATRI CS			1, 438, 136		30.00
31.00 0310	INTENSIVE CARE UNIT			0		31.00
32.00 0320	O CORONARY CARE UNIT			0		32.00
34.00 0340	O SURGICAL INTENSIVE CARE UNIT		1	0		34.00
43.00 0430	0 NURSERY					43.00
ANCI	LLARY SERVICE COST CENTERS					
	O OPERATING ROOM		0. 1361	40 2, 050, 057	279, 095	50.00
51.00 0510	O RECOVERY ROOM		0.0000		0	51.00
	O DELIVERY ROOM & LABOR ROOM		0. 4634		875	52.00
	0 ANESTHESI OLOGY		0.0000		0,0	53.00
	0 RADI OLOGY-DI AGNOSTI C		0. 2107		28, 387	54.00
	0 ULTRA SOUND		0. 1423		20, 307	54.00
	0 RADI OI SOTOPE		0. 0000		0	56.00
	1 ONCOLOGY		0.3600		0	56.00
					Ũ	
	O CT SCAN		0. 1839		21, 262	57.00
	0 MAGNETIC RESONANCE I MAGING (MRI)		0. 2397		3, 189	58.00
	O CARDI AC CATHETERI ZATI ON		0.0000		0	59.00
	O LABORATORY		0. 1365		117, 935	1
	0 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	62.00
	0 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	63.00
	0 INTRAVENOUS THERAPY		0.0000		0	64.00
	0 RESPI RATORY THERAPY		0. 4464	73 117, 790	52, 590	65.00
	0 PHYSI CAL THERAPY		0. 4620	66 98, 123	45, 339	66.00
67.00 0670	O OCCUPATI ONAL THERAPY		0. 3928	53 22, 810	8, 961	67.00
68.00 0680	O SPEECH PATHOLOGY		0. 4504	49 3, 076	1, 386	68.00
69.00 0690	0 ELECTROCARDI OLOGY		0. 1503	20 160, 733	24, 161	69.00
70.00 0700	0 ELECTROENCEPHALOGRAPHY		0.0000		0	70.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1473	51 291, 826	43, 001	71.00
72.00 0720	IMPL. DEV. CHARGED TO PATIENTS		0. 3105		187, 148	72.00
	O DRUGS CHARGED TO PATIENTS		0. 3212		165, 041	73.00
	O RENAL DI ALYSI S		0.0000		0	74.00
	0 ASC (NON-DI STI NCT PART)		0.0000		0	75.00
	ATIENT SERVICE COST CENTERS		0.0000	50 0		/0.00
	0 EMERGENCY		0. 1113	38 709, 620	79,008	91.00
	0 OBSERVATI ON BEDS (NON-DI STINCT PART)		0. 5637		45, 903	
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0. 5057	5, 781, 370	1, 103, 281	1
200.00	Less PBP Clinic Laboratory Services-Program only charges	$(1 i n \circ 61)$		5, 761, 370	1, 103, 201	200.00
201.00	Net charges (line 200 minus line 201)			5, 781, 370		201.00
202.00	liver charges (TTHE 200 IIITHUS TTHE 201)		1	5,761,370		202.00

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LNDATL		NOLL	4 0 1 4		00

Health Financial Systems SI. VINCENT FISHE	RS HUSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15		Peri od:	Worksheet D-3	
			rom 07/01/2018		
			o 06/30/2019	Date/Time Pre	
	T: +1 - VI V	/	lla ani tal	11/22/2019 3: !	53 pm
	Title XIX		Hospi tal	Cost	
Cost Center Description		o of Cost		Inpatient	
	10	Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			643, 626		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
32.00 03200 CORONARY CARE UNI T			0		32.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
43. 00 04300 NURSERY			164, 587		43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM		0.136140	740, 296	100, 784	50.00
51.00 05100 RECOVERY ROOM		0.00000	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.459008	2, 193, 409	1, 006, 792	52.00
53. 00 05300 ANESTHESI OLOGY		0.00000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 210715	19, 393	4, 086	54.00
54.01 03630 ULTRA SOUND		0.142345		1, 407	54.01
56. 00 05600 RADI 0I SOTOPE		0.000000		0	56.00
56. 01 05601 ONCOLOGY		0.357139		0	56.01
57. 00 05700 CT SCAN		0. 183931		7,022	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 239773		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.000000		0	59.00
60. 00 06000 LABORATORY		0. 136504		62, 529	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 000000		02, 529	62.00
				0	63.00
		0.000000		-	
64. 00 06400 I NTRAVENOUS THERAPY		0.000000		0	64.00
65. 00 06500 RESPIRATORY THERAPY		0.446473		18, 910	65.00
66.00 O6600 PHYSI CAL THERAPY		0.462066		7, 223	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0.392863		1, 186	67.00
68.00 O6800 SPEECH PATHOLOGY		0.450449		0	68.00
69.00 06900 ELECTROCARDI OLOGY		0.150320		2, 013	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.147351		33, 718	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 310511		8, 765	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0.321259	334, 103	107, 334	73.00
74. 00 07400 RENAL DI ALYSI S		0.00000	0 0	0	74.00
75.00 07500 ASC (NON-DI STI NCT PART)		0.00000	0 0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY		0. 111338	3 226, 965	25, 270	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.563767	0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			4, 351, 754	1, 387, 039	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			4, 351, 754		202.00
	1				•

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0181	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prep 11/22/2019 3:5	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
. 00	DRG Amounts Other than Outlier Payments			0	1.00
. 01	DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1	(see	328, 987	1. 01
. 02	DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	1, 471, 173	1. 02
. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	prior to October	0	1. 03
	1 (see instructions)	0 0			
. 04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	or discharges occurring	on or after	0	1.04
. 00	Outlier payments for discharges. (see instructions)			0	2.00
. 01	Outlier reconciliation amount	:)		0	2.01
. 02 . 00	Outlier payment for discharges for Model 4 BPCI (see instruct Managed Care Simulated Payments	I ONS)		0	2.02 3.00
. 00	Bed days available divided by number of days in the cost repo	rting period (see instru	uctions)	44. 25	4.00
00	Indirect Medical Education Adjustment			0.00	F 00
. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.00
. 00	FTE count for allopathic and osteopathic programs that meet t	he criteria for an add-o	on to the cap for	0.00	6.00
. 00	new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified	under 42 CFR \$412 105(f)	$(1)(i_{V})(B)(1)$	0.00	7.00
. 01	ACA § 5503 reduction amount to the IME cap as specified under			0.00	
00	cost report straddles July 1, 2011 then see instructions.	+b:		0.00	0.00
. 00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.			0.00	8.00
	1998), and 67 FR 50069 (August 1, 2002).				
. 01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
. 02	The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teachi	ng hospital	0.00	8. 02
. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin	ac (9, 9, 01, and 9, 02)	(500	0.00	9.00
. 00	instructions)	es (o, o, or and o, oz)	(see	0.00	9.00
0.00	FTE count for allopathic and osteopathic programs in the curr	ent year from your reco	rds		10.00
	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00	11.00 12.00
3.00	Total allowable FTE count for the prior year.			0.00	
4.00	Total allowable FTE count for the penultimate year if that ye	ar ended on or after Se	otember 30, 1997,	0.00	14.00
5.00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15.00
	Adjustment for residents in initial years of the program				16.00
	Adjustment for residents displaced by program or hospital clo	sure			17.00
	Adjusted rolling average FTE count				18.00
	Current year resident to bed ratio (line 18 divided by line 4	).		0.00000	
	Prior year resident to bed ratio (see instructions)			0.000000 0.000000	
	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)				21.00 22.00
	IME payment adjustment - Managed Care (see instructions)				22.00
	Indirect Medical Education Adjustment for the Add-on for § 42				
3.00	Number of additional allopathic and osteopathic IME FTE resid $(f)(1)(iv)(C)$ .	ent cap slots under 42 (	CFR 412.105	0.00	23.00
4.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
5.00	If the amount on line 24 is greater than -O-, then enter the	lower of line 23 or line	e 24 (see	0.00	25.00
6. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
7.00	IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions)			0	28.00
	IME add-on adjustment amount - Managed Care (see instructions	)		0	28.01
	Total IME payment ( sum of lines 22 and 28)			0	
9. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	29.01
0.00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instru	ctions)	0.44	30. 00
	Percentage of Medicaid patient days (see instructions)	arient days (see institut			30.00
2.00	Sum of Lines 30 and 31				32.00
	Allowable disproportionate share percentage (see instructions	)		2. 93	
	Disproportionate share adjustment (see instructions)			13, 186	

	Financial Systems ST. VINCENT FISH ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0181	Period: From 07/01/2018	eu of Form CMS-2 Worksheet E Part A	
			To 06/30/2019	Date/Time Prep	
		Title XVIII	Hospi tal	11/22/2019 3:5 PPS	ss pill
		·	Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment		4 7/4 /05 1/4	0 070 070 447	25.0
	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000029582	8, 272, 872, 447 0. 000066841	35. 0 35. 0
	Hospital uncompensated care payment (If line 34 is zero, ent	ter zero on this line) (se			
J. 02	instructions)		200, 173	332, 770	55.0
5. 03	Pro rata share of the hospital uncompensated care payment an	nount (see instructions)	50, 455	413, 591	35.
	Total uncompensated care (sum of columns 1 and 2 on line 35.		464, 046	L	36.
	Additional payment for high percentage of ESRD beneficiary d	lischarges (lines 40 throu			
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding	g discharges for MS-DRGs	0		40.
	652, 682, 683, 684 and 685 (see instructions)		Before 1/1	On/After 1/1	
			1,00	1.01	
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41. (
	instructions)	•			
1. 01	Total ESRD Medicare covered and paid discharges excluding MS	S-DRGs 652, 682, 683, 684	0	0	41.
	an 685. (see instructions)				
2.00 3.00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Modicaro ESPD inpationt days excluding MS DPCs (652)	3 3 .	0.00		42. 43.
J. UU	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6 instructions)	002, 003, 004 all 085. (See	0		43.
4. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0.00000		44.
-	days)				
5.00	Average weekly cost for dialysis treatments (see instruction		0.00	0.00	
o. 00	Total additional payment (line 45 times line 44 times line 4	11.01)	0		46.
. 00	Subtotal (see instructions)		2, 277, 392		47.
3.00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural nospitals	0		48.
				Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instruction	is)		2, 277, 392	49.
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I a			146, 499	
	Exception payment for inpatient program capital (Wkst. L, Pt			0	51.
2.00	Direct graduate medical education payment (from Wkst. E-4, I			0	52.
2. 00 8. 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment			0	52. 53.
2.00 3.00 4.00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0 0 0	52. 53. 54.
2. 00 3. 00 4. 00 4. 01	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment	ine 49 see instructions).		0	52. 53. 54. 54.
2. 00 3. 00 4. 00 4. 01 5. 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies	<pre>ine 49 see instructions). 69)</pre>		0 0 0	52. 53. 54. 54. 55.
. 00 . 00 . 00 . 01 . 00 . 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	ine 49 see instructions). 69) tructions)	hrough 35).	0 0 0 0	52. 53. 54. 54. 55. 56.
. 00 . 00 . 01 . 01 . 00 . 00 . 00 . 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt.	ine 49 see instructions). 69) rructions) III, column 9, lines 30 t	hrough 35).	0 0 0 0 0 0 0 0	52. 53. 54. 55. 55. 56. 57. 58.
. 00 . 00 . 00 . 01 . 00 . 00 . 00 . 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	ine 49 see instructions). 69) rructions) III, column 9, lines 30 t	hrough 35).	0 0 0 0 0 0	52. 53. 54. 55. 55. 55. 57. 58. 59.
2. 00 3. 00 4. 00 5. 00 5. 00 5. 00 5. 00 6. 00 6. 00 6. 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments	ine 49 see instructions). 69) tructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 0 0 0 0 0 0 2, 423, 891 0	52. 53. 54. 55. 55. 55. 57. 58. 59. 60.
. 00 . 00 . 01 . 01 . 00 . 00 . 00 . 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu	ine 49 see instructions). 69) tructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 0 0 0 0 2, 423, 891 0 2, 423, 891	52. 53. 54. 55. 55. 55. 57. 58. 59. 60. 61.
. 00 . 00 . 00 . 01 . 00 . 00 . 00 . 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries	ine 49 see instructions). 69) tructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 0 0 0 0 2, 423, 891 0 2, 423, 891 251, 568	52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62.
. 00 . 00 . 01 . 00 . 00 . 00 . 00 . 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries	ine 49 see instructions). 69) tructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 0 0 0 0 2, 423, 891 0 2, 423, 891 251, 568 0	52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63.
2. 00 3. 00 4. 00 4. 01 5. 00 5. 00 7. 00 7. 00 8. 00 9.	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	ine 49 see instructions). 69) tructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 0 0 0 0 2, 423, 891 251, 568 0 7, 229	52. 53. 54. 55. 55. 57. 58. 59. 60. 61. 62. 63. 64.
. 00 . 00 . 01 . 00 . 00 . 00 . 00 . 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries	ine 49 see instructions). 69) fructions) III, column 9, lines 30 t IV, col. 11 line 200) us line 60)	hrough 35).	0 0 0 0 0 2, 423, 891 0 2, 423, 891 251, 568 0	52 53 54 55 55 55 56 57 58 59 60 61 62 63 64 63
. 00 . 00 . 01 . 00 . 00 . 00 . 00 . 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	ine 49 see instructions). 69) fructions) III, column 9, lines 30 t IV, col. 11 line 200) us line 60)	hrough 35).	0 0 0 0 0 2, 423, 891 0 2, 423, 891 251, 568 0 7, 229 4, 699	522 533 544 555 566 577 588 579 600 611 62 633 644 655 665
2. 00 3. 00 4. 01 5. 00 5. 00 7. 00 3. 00 7. 00 3. 00 7. 00 3. 00 5.	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	ine 49 see instructions). 69) tructions) III, column 9, lines 30 t IV, col. 11 line 200) us line 60) structions) - applicable to MS-DRGs (s	ee instructions)	0 0 0 0 0 2, 423, 891 0 2, 423, 891 251, 568 0 7, 229 4, 699 6, 304 2, 177, 022 0	52 53 54 55 55 56 57 58 59 60 61 62 63 64 65 66 67 68
. 00 . 00 . 00 . 01 . 00 . 00 . 00 . 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)	ine 49 see instructions). 69) tructions) III, column 9, lines 30 t IV, col. 11 line 200) us line 60) structions) - applicable to MS-DRGs (s	ee instructions)	0 0 0 0 0 2, 423, 891 251, 568 0 2, 423, 891 251, 568 0 7, 229 4, 699 6, 304 2, 177, 022 0 0 0	52 53 54 55 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69
	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ine 49 see instructions). 69) fructions) III, column 9, lines 30 t IV, col. 11 line 200) us line 60) structions) c applicable to MS-DRGs (s . (For SCH see instruction	ee instructions) s)	$\begin{array}{c} 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 2, 423, 891\\ 251, 568\\ 0\\ 2, 423, 891\\ 251, 568\\ 0\\ 7, 229\\ 4, 699\\ 6, 304\\ 2, 177, 022\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	52 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70.
	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	ine 49 see instructions). 69) fructions) III, column 9, lines 30 t IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (s (For SCH see instruction stration) adjustment (see	ee instructions) s)	0 0 0 0 0 2, 423, 891 0 2, 423, 891 251, 568 0 7, 229 4, 699 6, 304 2, 177, 022 0 0 0 0 0 0 0	52. 53. 54. 55. 55. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70.
	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (\$410A Demons Demonstration payment adjustment amount before sequestration	ine 49 see instructions). 69) fructions) III, column 9, lines 30 t IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (s (For SCH see instruction stration) adjustment (see	ee instructions) s)	0 0 0 0 0 2, 423, 891 0 2, 423, 891 251, 568 0 7, 229 4, 699 6, 304 2, 177, 022 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52 53 54. 55. 56. 57. 58. 57. 58. 57. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70. 70.
2. 00           3. 00           4. 01           5. 00           5. 00           6. 01           6. 00           7. 00           7. 00           8. 00           9. 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	ine 49 see instructions). 69) fructions) III, column 9, lines 30 t IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (s 0. (For SCH see instruction stration) adjustment (see	ee instructions) s)	0 0 0 0 0 2, 423, 891 0 2, 423, 891 251, 568 0 7, 229 4, 699 6, 304 2, 177, 022 0 0 0 0 0 0 0	52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70. 70. 70.
	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (\$410A Demons Demonstration payment adjustment amount before sequestration	ine 49 see instructions). 69) fructions) III, column 9, lines 30 t IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (s 0. (For SCH see instruction stration) adjustment (see	ee instructions) s)	0 0 0 0 0 2, 423, 891 0 2, 423, 891 251, 568 0 7, 229 4, 699 6, 304 2, 177, 022 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52. 53. 54. 55. 55. 57. 58. 59. 60. 61. 62. 63. 64. 65. 64. 67. 68. 67. 70. 70. 70. 70. 70.
2. 00           3. 00           4. 01           5. 00           5. 00           5. 00           6. 00           7. 00           8. 00           9. 00           9. 00           9. 00           9. 00           9. 00           9. 00           9. 00           9. 00           9. 00           9. 00           9. 00           9. 00           9. 00           9. 00           9. 00           9. 00           9. 88           9. 89	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	ine 49 see instructions). 69) fructions) III, column 9, lines 30 t IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (s 0. (For SCH see instruction stration) adjustment (see	ee instructions) s)	0 0 0 0 0 2, 423, 891 251, 568 0 7, 229 4, 699 6, 304 2, 177, 022 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70. 70. 70. 70. 70. 70.
2. 00 3. 00 4. 01 5. 00 7. 00 7. 00 9. 00 9. 00 1. 00 1. 00 1. 00 1. 00 3. 00 4. 00 5. 00 5. 00 5. 00 5. 00 5. 00 0. 00 1.	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	ine 49 see instructions). 69) fructions) III, column 9, lines 30 t IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (s 0. (For SCH see instruction stration) adjustment (see	ee instructions) s)	$\begin{array}{c} 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 2, 423, 891\\ 251, 568\\ 0\\ 7, 229\\ 4, 699\\ 6, 304\\ 2, 177, 022\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	$\begin{array}{c} 52.\\ 53.\\ 54.\\ 55.\\ 55.\\ 55.\\ 55.\\ 58.\\ 60.\\ 61.\\ 62.\\ 63.\\ 64.\\ 65.\\ 66.\\ 66.\\ 67.\\ 70.\\ 70.\\ 70.\\ 70.\\ 70.\\ 70.\\ 70.\\ 7$
2. 00 3. 00 4. 01 5. 00 5. 00 7. 00 3. 00 9. 00 1. 00 1. 00 2. 00 3. 00 4. 01 5. 00 5.	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	ine 49 see instructions). 69) fructions) III, column 9, lines 30 t IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (s 0. (For SCH see instruction stration) adjustment (see	ee instructions) s)	$\begin{array}{c} 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 2, 423, 891\\ 251, 568\\ 0\\ 2, 423, 891\\ 251, 568\\ 0\\ 7, 229\\ 4, 699\\ 6, 304\\ 2, 177, 022\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	$\begin{array}{c} 52.\\ 53.\\ 54.\\ 55.\\ 56.\\ 56.\\ 57.\\ 58.\\ 59.\\ 60.\\ 61.\\ 62.\\ 63.\\ 66.\\ 67.\\ 68.\\ 66.\\ 67.\\ 70.\\ 70.\\ 70.\\ 70.\\ 70.\\ 70.\\ 70.\\ 7$

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## ST VINCENT FISHERS HOSPITAL

Health Financial Systems ST. VINCENT FISHEF	RS HOSPITAL		In Lie	eu of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0181	Peri od:	Worksheet E	
			From 07/01/2018		
			To 06/30/2019		
	T: +1 -		lla aut dal	11/22/2019 3:	53 pm
	Intre	XVIII	Hospi tal	PPS	
		FFY	<u>(уууу)</u>	Amount	
70.96 Low volume adjustment for federal fiscal year (vvvv) (Enter ju			0	1.00	70.04
	n corumn o		0	0	70.96
the corresponding federal year for the period prior to 10/1) 70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		0	0	70.97
the corresponding federal year for the period ending on or af			0	0	10. 71
70.98 Low Volume Payment-3				0	70.98
70.99  HAC adjustment amount (see instructions)				0	1
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 6	69 & 70)			2, 172, 483	1
71.01 Sequestration adjustment (see instructions)	o, a ,o)			43, 450	
71.02 Demonstration payment adjustment amount after sequestration				0	1
72.00 Interim payments				2, 120, 693	
73.00 Tentative settlement (for contractor use only)				0	
74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02	2 72 and			8, 340	
73)	2, 72, 414			0,010	/ 1. 00
75.00 Protested amounts (nonallowable cost report items) in accorda	nce with			37, 662	75.00
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum (	of 2.03			0	90.00
plus 2.04 (see instructions)					
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operating outlier reconciliation adjustment amount (see instru	uctions)			0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instruc	tions)			0	93.00
94.00 The rate used to calculate the time value of money (see instru	uctions)			0.00	94.00
95.00 Time value of money for operating expenses (see instructions)				0	95.00
96.00 Time value of money for capital related expenses (see instruct	tions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount				1	
100.00 HSP bonus amount (see instructions)			0	0	100.00
HVBP Adjustment for HSP Bonus Payment					-
101.00 HVBP adjustment factor (see instructions)			0.000000000		
102.00 HVBP adjustment amount for HSP bonus payment (see instructions	s)		0	0	102.00
HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	100.00
103.00 HRR adjustment factor (see instructions)	<b>`</b>		0.0000		103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)			0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstr					000 00
200.00 Is this the first year of the current 5-year demonstration per	riod under t	ne zist			200.00
Century Cures Act? Enter "Y" for yes or "N" for no.					-
Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	o 40)				201.00
201. 00 Medicare inpatient service costs (from west. D-1, Pt. 11, 1110 202. 00 Medicare discharges (see instructions)	e 49)				201.00
203.00 Case-mix adjustment factor (see instructions)					202.00
Computation of Demonstration Target Amount Limitation (N/A in	first year	of the currer	nt 5-year demonst	tration	203.00
period)	TTTSt year	of the curren	rt 5-year demons		
204.00 Medicare target amount					204.00
					205.00
205 UDUCase_mix adjusted target amount (line 203 times line 204)					206.00
205.00 Case-mix adjusted target amount (line 203 times line 204) 206.00 Medicare inpatient routine cost can (line 202 times line 205)					200.00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)					007 00
206.00 <u>Medicare inpatient routine cost cap (line 202 times line 205)</u> Adjustment to Medicare Part A Inpatient Reimbursement	ructions)				1207 00
206.00 <u>Medicare inpatient routine cost cap (line 202 times line 205)</u> Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see insti					207.00
<ul> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>207.00 Program reimbursement under the §410A Demonstration (see instraction 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,</li> </ul>					208.00
<ul> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>207.00 Program reimbursement under the §410A Demonstration (see instructed 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions)</li> </ul>					208. 00 209. 00
<ul> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>207.00 Program reimbursement under the §410A Demonstration (see instructed 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>210.00 Reserved for future use</li> </ul>					208.00 209.00 210.00
<ul> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>207.00 Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>210.00 Reserved for future use</li> <li>211.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>					208. 00 209. 00
<ul> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>207.00 Program reimbursement under the §410A Demonstration (see instractions)</li> <li>208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>210.00 Reserved for future use</li> <li>211.00 Total adjustment to Medicare IPPS payments (see instructions)</li> <li>Comparision of PPS versus Cost Reimbursement</li> </ul>	line 59)				208. 00 209. 00 210. 00 211. 00
<ul> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>207.00 Program reimbursement under the §410A Demonstration (see instructions)</li> <li>208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>210.00 Reserved for future use</li> <li>211.00 Total adjustment to Medicare IPPS payments (see instructions)</li> <li>Comparision of PPS versus Cost Reimbursement</li> <li>212.00 Total adjustment to Medicare Part A IPPS payments (from line 200)</li> </ul>	line 59)				208.00 209.00 210.00 211.00 212.00
<ul> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>207.00 Program reimbursement under the §410A Demonstration (see instractions)</li> <li>208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>210.00 Reserved for future use</li> <li>211.00 Total adjustment to Medicare IPPS payments (see instructions)</li> <li>Comparision of PPS versus Cost Reimbursement</li> </ul>	line 59) 211)	nbursement)			208. 00 209. 00 210. 00 211. 00

DW VC	Financial Systems DLUME CALCULATION EXHIBIT 4		ST. VINCENT FIS	Provider C		eri od:	u of Form CMS-2 Worksheet E	
						rom 07/01/2018 0 06/30/2019	Date/Time Pre	par
				Ti tl c	e XVIII	Hospi tal	11/22/2019 3: PPS	53
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
00	DRG amounts other than outlier	0	1.00	2.00	3.00 C	4.00	5.00 0	1
01	payments DRG amounts other than outlier	1. 01	328, 987	0	328, 987		328, 987	1
)2	payments for discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 471, 173	0		1, 471, 173	1, 471, 173	
3	1 DRG for Federal specific operating payment for Model 4 BPCL occurring prior to	1. 03	0	0	с		0	
)4	October 1 DRG for Federal specific operating payment for Model 4 BPCL occurring on or after	1. 04	0	0		0	0	
0	October 1 Outlier payments for discharges (see instructions)	2.00	0	0	C	0	0	
)1	Outlier payments for	2.02	0	0	c	о	0	:
0	discharges for Model 4 BPCI Operating outlier reconciliation	2. 01	о	0	с	0	0	
0	Managed care simulated payments	3.00	0	0	С	0	0	
	Indirect Medical Education Adju							
0	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0.000000	0.000000		
0	IME payment adjustment (see instructions)	22.00	0	0	C	0	0	
1	IME payment adjustment for managed care (see instructions)	22.01	0	0	C	0	0	
~	Indirect Medical Education Adju					0.000000		
0	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0.000000	0. 000000		
0	IME adjustment (see instructions)	28.00	0	0	C	0	0	
1	IME payment adjustment add on for managed care (see	28.01	0	0	C	0	0	
0	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0	c	0	0	
1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	С	0	0	
00	Disproportionate Share Adjustme Allowable disproportionate	ent 33.00	0. 0293	0. 0293	0. 0293	0. 0293		1 1
00	share percentage (see instructions)	55.00	0. 0293	0. 0295	0.0293	0. 0293		
00	Disproportionate share adjustment (see instructions)	34.00	13, 186	0	2, 410	10, 776	13, 186	1
01	Uncompensated care payments	36.00	464,046		50, 454	413, 589	464, 043	1
00	Additional payment for high per Total ESRD additional payment	centage of ESI 46.00	v beneficiary 0	di scharges 0	C	0	0	1
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments	47.00 48.00	2, 277, 392 0	0	381, 851 C	1, 895, 541 0	2, 277, 392 0	
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)			-	201 051	1 005 544		
00	Total payment for inpatient operating costs (see instructions)	49.00	2, 277, 392	0	381, 851	1, 895, 541	2, 277, 392	
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	146, 499	0	173, 298	-26, 799	146, 499	1
00	Special add-on payments for new technologies	54.00	0	0	С	0	0	1
01 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	с	0	0	1

Heal th	Financial Systems	S	T. VINCENT FIS	HERS HOSPI TAL		In Lie	u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 07/01/2018 To 06/30/2019	Date/Time Pre 11/22/2019 3:	pared:
				Title	XVIII	Hospi tal	PPS	-
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.00
19 00	SUBTOTAL			0	555, 14	9 1, 868, 742	2, 423, 891	19 00
17100		W/S L, line	(Amounts from L)			1,000,712	21 1201071	
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	146, 499	0				20.00
	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	•
21.00	Capital DRG outlier payments	2.00	0	0		o o	0	21.00
	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0 0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.00
24.00	Al lowable di sproporti onate share percentage (see i nstructi ons)	10.00	0. 0000	0. 0000	0.000	0 0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	146, 499	0	173, 29	8 –26, 799	146, 499	26.00
		W/S E, Part A						
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 23357 129, 66		129, 667	27.00 28.00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. OC
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Υ					100. 00

SPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC	CN: 15-0181	Period:	Worksheet E	
					From 07/01/2018 To 06/30/2019	Date/Time Prep 11/22/2019 3:	pared
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
00	DRG amounts other than outlier payments	1.00					1.
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	328, 987	328, 98	7	328, 987	1.
)2	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1, 471, 173		1, 471, 173	1, 471, 173	1.
)3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.
)4	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.
00	Outlier payments for discharges (see instructions)	2.00	0		0 0	0	2.
D1	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2.
00	Operating outlier reconciliation	2.01	0		0 0	0	
00	Managed care simulated payments	3.00	0		0 0	0	4.
	Indirect Medical Education Adjustment						
00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0.00000		5.
00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6.
)1	IME payment adjustment for managed care (see instructions)	22.01	0		0 0	0	6.
	Indirect Medical Education Adjustment for the						
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0.00000		7.
00	IME adjustment (see instructions)	28.00	0		0 0	0	8.
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	
00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9.
	Disproportionate Share Adjustment	1			-		
00	Allowable disproportionate share percentage	33.00	0. 0293	0. 029	3 0. 0293		10.
00	(see instructions) Disproportionate share adjustment (see instructions)	34.00	13, 186	2, 41	0 10, 776	13, 186	11.
01	Uncompensated care payments	36.00	464, 046	50, 45	413, 591	464, 046	11.
01	Additional payment for high percentage of ESR			00, 10	110,071	101, 010	
00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.
00	Subtotal (see instructions)	47.00	2, 277, 392	381, 85	2 1, 895, 540	2, 277, 392	13.
	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0		0 0	0	
00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	2, 277, 392	381, 85	2 1, 895, 540	2, 277, 392	15.
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	146, 499	173, 29	-26, 799	146, 499	16.
00 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0		0 0	0	17. 17.
02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	
00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.
	SUBTOTAL			555, 15	1, 868, 741	2, 423, 891	10

Health Financial Systems HOSPITAL ACQUIRED CONDITI	ON (HAC) REDUCTION CALCULA	ST. VINCENT FIS TION EXHIBIT 5	Provider CC		Period: From 07/01/2018 To 06/30/2019		t 5 pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other	than outlier	1.00	146, 499	173, 29	-26, 799	146, 499	20.00
20.01 Model 4 BPCI Capita	al DRG other than outlier	1.01	0		0 0	0	20.01
21.00 Capital DRG outlie	r payments	2.00	0		0 0	0	21.00
21.01 Model 4 BPCI Capita	al DRG outlier payments	2.01	0		0 0	0	21.01
22.00 Indirect medical en instructions)	ducation percentage (see	5.00	0.0000	0.000	0. 0000		22.00
23.00 Indirect medical en instructions)	ducation adjustment (see	6.00	0		0 0	0	23.00
	rtionate share percentage	10.00	0.0000	0.000	0.0000		24.00
	hare adjustment (see	11.00	0		0 0	0	25.00
	capital payments (see	12.00	146, 499	173, 29	-26, 799	146, 499	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00 Low volume adjustme	ent prior to October 1	70.96	0		0	0	28.00
29.00 Low volume adjustm	ent on or after October 1	70.97	0		0	0	29.00
30.00 HVBP payment adjus	tment (see instructions)	70. 93	-2, 185	6, 03	-8, 222	-2, 185	30.00
30.01 HVBP payment adjust payment (see instru	tment for HSP bonus uctions)	70. 90	0		0 0	0	30. 01
31.00 HRR adjustment (se	e instructions)	70.94	-2, 354		0 -2,354	-2, 354	31.00
31.01 HRR adjustment for instructions)	HSP bonus payment (see	70. 91	0		0 0	0	31.01
· · · · · · · · · · · · · · · · · · ·						(Amt. to Wkst.	
						E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Prog instructions)	<b>,</b>	70. 99			0 0	0	
100.00 Transfer HAC Reduction Wkst. E, Pt. A.	tion Program adjustment to		N				100.00

	LATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0181 Period: From 07/01/2018 To 06/30/2019	Date/Time Pre 11/22/2019 3:	
	Title XVIII Hospital	PPS	
		1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES	4 005	1 00
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)	1, 385 4, 828, 888	1.00 2.00
3.00	OPPS payments	4, 020, 000	
4.00	Outlier payment (see instructions)	35, 539	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	
6.00	Line 2 times line 5	0	6.00
7.00 8.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)	0.00	7.00 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1, 385	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
12.00	Reasonable charges Ancillary service charges	1 211	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	4, 511	12.00
14.00		-	14.00
	Customary charges		
15.00			15.00
16.00		0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17 00
18.00		4, 311	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	2, 926	19.00
~~ ~~	instructions)		
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00		1, 385	21.00
	Interns and residents (see instructions)	0	
23.00	15 5 1 K	0	23.00
24.00		4, 067, 080	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00		742, 750	
27.00	<b>o i i j</b>	3, 325, 715	
~~ ~~	instructions)		
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
30.00		3, 325, 715	
31.00			31.00
32.00		3, 320, 826	32.00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	0	
33.00 34.00		0 41, 805	
35.00		27, 173	
36.00		24, 774	
27 00		3, 347, 999	37.00
37.00		-361	
38.00		0	39.00
38. 00 39. 00			
38. 00 39. 00 39. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
38. 00 39. 00	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration	0	39.50
38. 00 39. 00 39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration		39. 50 39. 97
38. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)	0 0 3, 348, 360	39.50 39.97 39.98 39.99 40.00
<ol> <li>38. 00</li> <li>39. 00</li> <li>39. 50</li> <li>39. 97</li> <li>39. 98</li> <li>39. 99</li> <li>40. 00</li> <li>40. 01</li> </ol>	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions)	0 0 3, 348, 360 66, 967	39.50 39.97 39.98 39.99 40.00 40.01
38.00 39.00 39.50 39.97 39.98 39.99 40.00 40.01 40.02	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	0 0 3, 348, 360 66, 967 0	39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02
<ol> <li>38. 00</li> <li>39. 00</li> <li>39. 50</li> <li>39. 97</li> <li>39. 98</li> <li>39. 99</li> <li>40. 00</li> <li>40. 01</li> </ol>	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments	0 0 3, 348, 360 66, 967	39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02
38. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions)	0 0 3, 348, 360 66, 967 0 3, 253, 740	39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00
38. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0 0 3, 348, 360 66, 967 0 3, 253, 740 0	39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00
38. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0 0 3, 348, 360 66, 967 0 3, 253, 740 0 27, 653	39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00
38. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00 44. 00	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR	0 3, 348, 360 66, 967 0 3, 253, 740 0 27, 653 0	39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00 44. 00
38. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00 44. 00	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	0 0 3, 348, 360 66, 967 0 3, 253, 740 0 27, 653 0	39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00
38. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00 44. 00	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money	0 0 3, 348, 360 66, 967 0 3, 253, 740 0 27, 653 0 27, 653 0 0 0 0 0.00	39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00 44. 00 90. 00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 07/01/2018 To 06/30/2019		pared:
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2, 120, 6	93	3, 253, 740	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.00
3.00	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)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02 3.03				0	0	3. 02 3. 03
3.03				0	0	3.03
3.05				0	0	3.05
	Provider to Program	11		-	-	
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3.94 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.99
5. 77	3. 50-3. 98)			0	Ŭ	0.7
4.00	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, 120, 6	93	3, 253, 740	4.00
	TO BE COMPLETED BY CONTRACTOR	11				
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program			_		_
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.51 5.52
5.52 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.92
	5. 50-5. 98)			Ĭ		
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		8, 3		27, 653	6.01
6.02 7.00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		2, 129, 0	0	0 3, 281, 393	6.02 7.00
7.00	Total wearcare program frability (see fistructions)		2, 129, 0	Contractor Number	NPR Date (Mo/Day/Yr)	7.00
		C	)	1.00	2.00	
8.00	Name of Contractor					8.0

Heal th	Health Financial Systems ST. VINCENT FISHERS HOSPITAL In Lieu						
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0181 Period: From 07/01/2018 To 06/30/2019						
	Ti tle XVIII Hospi tal						
				1.00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		1.00				
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8			2.00			
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00		
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00		
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	ine 20			6.00		
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168 $$	ertified HIT technology	Wkst. S-2, Pt. I		7.00		
8.00	Calculation of the HIT incentive payment (see instructions)				8.00		
9.00	Sequestration adjustment amount (see instructions)				9.00		
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		· · · · · · · · · · · · · · · · · · ·				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00		
31.00	Other Adjustment (specify)				31.00		
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)		32.00		

	Financial Systems ST. VINCENT FI ATION OF REIMBURSEMENT SETTLEMENT	SHERS HOSPI TAL Provi der CCN: 15-0181	Peri od:	u of Form CMS-2 Worksheet E-3	
ALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0181	From 07/01/2018 To 06/30/2019	Part VII Date/Time Pre	pared
		Title XIX	Hospi tal	11/22/2019 3: Cost	53 pr
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH	I SERVICES FOR TITLES V OR X	I X SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		1, 507, 307		1.
00	Medical and other services			3, 410, 903	2.
00	Organ acquisition (certified transplant centers only)		0		3.
00	Subtotal (sum of lines 1, 2 and 3)		1, 507, 307	3, 410, 903	4.
00	Inpatient primary payer payments		0	0	5.
00 00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		1, 507, 307	0 3, 410, 903	6. 7.
00	COMPUTATION OF LESSER OF COST OR CHARGES		1, 307, 307	3,410,903	· /
	Reasonabl e Charges				
00	Routine service charges		643, 626		8.
00	Ancillary service charges		4, 351, 754	18, 707, 507	9
. 00	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		4, 995, 380	18, 707, 507	12
	CUSTOMARY CHARGES				
. 00	Amount actually collected from patients liable for payment	t for services on a charge	0	0	13
~ ~	basi s				
. 00	Amounts that would have been realized from patients liable	n 0	0	14	
. 00	a charge basis had such payment been made in accordance wi Ratio of line 13 to line 14 (not to exceed 1.000000)	th 42 CFR §413.13(e)	0. 000000	0,000000	15
	Total customary charges (see instructions)		4, 995, 380	18, 707, 507	
	Excess of customary charges over reasonable cost (complete	only if line 16 exceeds	3, 488, 073	15, 296, 604	
. 00	line 4) (see instructions)	in grant and the to exceeds	3, 400, 073	13, 270, 004	''
. 00	Excess of reasonable cost over customary charges (complete	e only if line 4 exceeds lin	e 0	0	18
	16) (see instructions)	5			
. 00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see i		0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or li		1, 507, 307	3, 410, 903	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only	/ be completed for PPS provi		-	
	Other than outlier payments		0	0	22
	Outlier payments		0	0	23
	Program capital payments Capital exception payments (see instructions)		0		24
	Routine and Ancillary service other pass through costs		0	0	26
	Subtotal (sum of lines 22 through 26)		0	0	20
	Customary charges (title V or XIX PPS covered services onl	v)	0	0	28
	Titles V or XIX (sum of lines 21 and 27)	<i></i>	1, 507, 307	3, 410, 903	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 ar	nd 6)	1, 507, 307	3, 410, 903	31
. 00	Deducti bl es		0	0	32
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35
		2 and 33)	1, 507, 307	3, 410, 903	
	, , , , ,		1 507 207	2 410 003	37
	Subtotal (line 36 ± line 37)	1)	1, 507, 307	3, 410, 903	
	Direct graduate medical education payments (from Wkst. E-4 Total amount payable to the provider (sum of lines 38 and	-	1, 507, 307	3, 410, 903	39 40
		57)	1, 507, 307	3, 410, 903	
	Balance due provider/program (line 40 minus line 41)		1, 307, 307	3, 410, 903	41
. 00 . 00	Protested amounts (nonallowable cost report items) in acco	ordance with CMS Pub 15-2	0	0	
		. aaoo wi tii owo i ub i 0-2,	0	0	1 10

	Financial Systems ST. VINCENT FISH E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: rom 07/01/2018	Worksheet G	
ly)	ype accounting records, comprete the General Fund corumn		T	0 06/30/2019	Date/Time Pre 11/22/2019 3:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	1, 296	C	0	0	1
00	Temporary investments	0	C	0	0	2
00	Notes receivable	0	C	0	0	3
00	Accounts receivable	21, 035, 945	C	0	0	4
00	Other receivable	10 710 552		0	0	5
00 00	Allowances for uncollectible notes and accounts receivable Inventory	-10, 718, 553 1, 106, 430		0	0	
00	Prepaid expenses	1, 100, 430		0	0	8
00	Other current assets	3, 361, 589	C	0	0	Ģ
. 00	Due from other funds	0	C	0	0	10
. 00	Total current assets (sum of lines 1-10)	14, 786, 707	C	0	0	11
~ ~	FIXED ASSETS	10.071.000				
. 00 . 00	Land Land improvements	10, 871, 320		-	0	12
	Accumulated depreciation	22, 176 -8, 194		0	0	14
	Bui I di ngs	43, 929, 675		0	0	15
. 00	Accumulated depreciation	-9, 200, 960	C C	0	0	16
. 00	Leasehold improvements	853, 803	c	0	0	17
. 00	Accumulated depreciation	-851, 133	C	0	0	18
	Fixed equipment	3, 273, 895	C	0	0	19
. 00	Accumulated depreciation	-2, 270, 191	C	0	0	20
	Automobiles and trucks	0	C	0	0	21
	Accumulated depreciation Major movable equipment	0 19, 836, 885		0	0	22
	Accumulated depreciation	-14, 230, 234		0	0	24
	Mi nor equipment depreciable	14, 230, 234		0	0	25
	Accumul ated depreciation	0		0	0	26
	HIT designated Assets	0	C	0	0	27
. 00	Accumulated depreciation	0	C	0	0	28
	Mi nor equipment-nondepreciable	0	C	0	0	29
. 00	Total fixed assets (sum of lines 12-29)	52, 227, 042	C	0	0	30
00	OTHER ASSETS Investments	E 02E	C	0	0	1 24
. 00 . 00	Deposits on Leases	5, 825 0		0	0	31
. 00	Due from owners/officers	0		0	0	33
. 00	Other assets	231, 942		0	0	34
. 00	Total other assets (sum of lines 31-34)	237, 767	C	0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	67, 251, 516	C	0	0	36
	CURRENT LI ABI LI TI ES					
	Accounts payable	1, 815, 151	C		0	37
. 00	Salaries, wages, and fees payable	857, 920	0		0	38
. 00 . 00	Payroll taxes payable Notes and Loans payable (short term)	0		0	0	39
	Deferred income	0		0	0	40
. 00	Accel erated payments	0	, C	Ŭ	0	42
. 00	Due to other funds	0	c	0	0	
. 00	Other current liabilities	7, 348, 149	C	0	0	44
. 00	Total current liabilities (sum of lines 37 thru 44)	10, 021, 220	C	0	0	45
~ ~	LONG TERM LIABILITIES					
. 00	Mortgage payable	0	0	0	0	
. 00 . 00	Notes payable Unsecured Loans	0		0	0	47
. 00	Other long term liabilities	0		0	0	40
. 00	Total long term liabilities (sum of lines 46 thru 49)	0		0	0	50
	Total liabilities (sum of lines 45 and 50)	10, 021, 220	C	0	0	51
	CAPI TAL ACCOUNTS					
. 00	General fund balance	57, 230, 296				52
. 00	Specific purpose fund		C	_		53
. 00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
. 00 . 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56 57
. 00	Plant fund balance - reserve for plant improvement,				0	58
. 00	replacement, and expansion				0	
. 00	Total fund balances (sum of lines 52 thru 58)	57, 230, 296	c	0	0	59
. 00						

	In Lieu of Form CMS-255	52-10
	od: 07/01/2018 06/30/2019 Uate/Time Prepar 11/22/2019 3:53	
Special Purpose	se Fund Endowment Fund	
3.00	4.00 5.00	1 00
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 0. \ 00\\ 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ \end{array}$
Fund		
8.00		1.00
0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
000	11 1 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1:	0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
	0 0	0 1 1 1 1 1 1 1

	Heal th	Fi nanci al	Systems
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ST. VINCENT FISHERS HOSPITAL

<u>Heal th</u>	Financial Systems ST. VINCENT FISHERS	HOSPI TAL		In Lie	u of Form CMS-2	<u>2552-10</u>
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	rovider CCN		Period: From 07/01/2018 To 06/30/2019	Worksheet G-2 Parts I & II Date/Time Pre 11/22/2019 3:	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		12, 243, 57	8	12, 243, 578	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER				_	4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE		10 040 57	0	10 040 570	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		12, 243, 57	8	12, 243, 578	10.00
11.00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT			0	0	11.00
12.00	CORONARY CARE UNIT			0	0	12.00
12.00	BURN INTENSIVE CARE UNIT			0	0	12.00
13.00	SURGICAL INTENSIVE CARE UNIT			0	0	
14.00	OTHER SPECIAL CARE (SPECIFY)			0	0	15.00
16.00	Total intensive care type inpatient hospital services (sum of li	nos		0	0	
10.00	11-15)	lies		0	0	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		12, 243, 57	8	12, 243, 578	17.00
18.00	Ancillary services		28, 771, 42		138, 743, 178	
19.00	Outpatient services		2, 464, 81		37, 148, 100	1
20.00	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС			0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst.	43, 479, 82	2 144, 655, 034	188, 134, 856	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			51, 253, 794		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00 38.00	DEDUCT (SPECIFY)			0		37.00 38.00
38.00				0		38.00
39.00 40.00				0		40.00
40.00				0		40.00
41.00	Total deductions (sum of lines 37-41)			й 		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(	transfer		51, 253, 794		42.00
-5.00	to Wkst. G-3, line 4)			51, 255, 774		+3.00
		I		1	I	I

Health Financial Systems

Heal th	Financial Systems ST. VINCENT FISHE	RS HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATEN	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0181 Period:		Worksheet G-3		
			From 07/01/2018		
			To 06/30/2019		
				11/22/2019 3:	53 pm
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			188, 134, 856	1.00
2.00	Less contractual allowances and discounts on patients' accoun	ts		114, 741, 488	2.00
3.00	Net patient revenues (line 1 minus line 2)			73, 393, 368	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		51, 253, 794	4.00
5.00	Net income from service to patients (line 3 minus line 4)			22, 139, 574	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			122, 891	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			-110	
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			708, 172	
23.00	Governmental appropriations			000, 172	23.00
23.00	OTHER (SPECIFY)			0	23.00
24.00	OTHER MISCELLANEOUS INCOME				24.00
24.01	EHR/HIT INCENTIVE REVENUE			-1, 091	
24.03	OTHER (SPECIFY)			0	24.03
24.04	MEDICAL STAFF DUES REVENUE			200	
24.05	UNCLAIMED PROPERTY EXEMPTIONS			4, 811	
24.06	LATE PENALTY FEES			1, 133	
	OTHER MISC REVENUE			780	
	Total other income (sum of lines 6-24)			837, 276	
26.00	Total (line 5 plus line 25)			22, 976, 850	
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			22, 976, 850	29.00

Health Financial Systems CALCULATION OF CAPITAL PAYMENT ST. VINCENT FISHERS HOSPITAL In Lieu of Form CMS-2552-10 
 Period:
 Worksheet L

 From 07/01/2018
 Parts I-III

 To 06/30/2019
 Date/Time Prepared: 11/22/2019 3:53 pm

 Hospital
 PPS
 Provider CCN: 15-0181 Title XVIII

		Title XVIII	Hospi tal	PPS	
			-	1.00	
	PART I - FULLY PROSPECTIVE METHOD		I		
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			146, 499	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1.01
2.00	Capital DRG outlier payments			0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2.01
3.00	Total inpatient days divided by number of days in the cost repo	orting period (see inst	ructions)	7.95 0.00	3.00 4.00
4.00 5.00	Number of interns & residents (see instructions) Indirect medical education percentage (see instructions)			0.00	4. 00 5. 00
5.00 6.00		sum of Lipos 1 and 1 01	columns 1 and	0.00	6.00
5.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)		0	0.00	
7.00	Percentage of SSI recipient patient days to Medicare Part A pat	tient days (Worksheet F	nart A line	0.00	7.00
7.00	30) (see instructions)	trent days (norksheet E		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instruct	tions)		0, 00	8.00
9.00	Sum of lines 7 and 8			0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)			0.00	10.00
	Disproportionate share adjustment (see instructions)			0	11.00
12.00	Total prospective capital payments (see instructions)			146, 499	12.00
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			Ő	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			Ő	3.00
4.00	Capital cost payment factor (see instructions)			0	4.00
5.00			0	5.00	
				-	
				1.00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS		1	0	1 00
1.00 2.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances	(coo instructions)		0	1.00 2.00
2.00	Net program inpatient capital costs (line 1 minus line 2)	s (see fistfuctions)		0	2.00
3.00 4.00	Applicable exception percentage (see instructions)			0.00	4.00
4.00 5.00	Capital cost for comparison to payments (line 3 x line 4)			0.00	4. 00 5. 00
5.00 6.00	Percentage adjustment for extraordinary circumstances (see inst	tructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary of		lino (	0.00	7.00
7.00 B.00	Capital minimum payment level (line 5 plus line 7)	circuiistances (irrie z x	TTHE 0)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applica	able)		0	9.00
10.00	Current year comparison of capital minimum payment level to cap		less line 9)	0	10.00
		bi tui puymonto (i ino o			11.00
	Carryover of accumulated capital minimum payment level over cap	oital payment (from pri	or year	0	11.00
11.00	Carryover of accumulated capital minimum payment level over cap Worksheet L, Part III, line 14)		5	0	
11. 00 12. 00	Carryover of accumulated capital minimum payment level over cap Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital paym	nents (line 10 plus lin	e 11)	-	12.00
11.00 12.00 13.00	Carryover of accumulated capital minimum payment level over cap Worksheet L, Part III, line 14)	ments (line 10 plus line the amount on this line	e 11) )	0	12.00 13.00
11. 00 12. 00 13. 00 14. 00	Carryover of accumulated capital minimum payment level over cap Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital paym Current year exception payment (if line 12 is positive, enter t Carryover of accumulated capital minimum payment level over cap	nents (line 10 plus lin the amount on this line bital payment for the fi	e 11) )	0	12. 00 13. 00 14. 00
11.00 12.00 13.00 14.00 15.00	Carryover of accumulated capital minimum payment level over cap Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital paym Current year exception payment (if line 12 is positive, enter to Carryover of accumulated capital minimum payment level over cap (if line 12 is negative, enter the amount on this line)	nents (line 10 plus lin the amount on this line bital payment for the fi	e 11) )	0 0 0	12.00 13.00 14.00