PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT HOSPITAL & HCC (15-0084) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
	• •
Title	
ntre	!
Date	

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	3, 736, 496	-43, 346	0	0	1. 00
2.00	Subprovi der - IPF	0	16, 891	35		0	2. 00
3.00	Subprovi der - I RF	0	-1, 032	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	3, 752, 355	-43, 311	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-MEDICARE.

11/25/2019 6:15 pm Y:\28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

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Health Financial Systems ST. VIN HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	CENT HOSPIT	<u>AL & HCC</u> Provider CC	N: 15-0084	Peri od:	In Lieu	of For Workshe		
THE TIME HOST THE HEALTH SAINE SOME LEAT PREMITTED ATTOM DE		TOVIDET CO	From 07/0	0/2019			pared:	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicai HMO day	d 0° /s Med	ther li cai d lays	
04.00 1.0 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1	1.00	2. 00	3. 00	4. 00	5. 00		0.00	0.4.00
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 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.		6, 154 0		0		104		24. 00 25. 00
				Urban/R				
26.00 Enter your standard geographic classification (not w	age) status	at the bed	innina of t	1. C	1	2. ()()	26. 00
cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassification.	r rural. age) status r "2" for r	at the end ural. If ap	of the cos		1			27. 00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35. 00
				Begi nr		Endi 2. (
36.00 Enter applicable beginning and ending dates of SCH s		cript line	36 for numb	er				36. 00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ls MDH statu	S	0			37. 00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see						37. 01		
instructions) 38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number or enter subsequent dates.								38. 00
				1 (Y/ 2. (
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N		39. 00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October 1. no in column 2, for discharges on or after October 1.	ber 1. Ente	r "Y" for y				N		40.00
Prospective Payment System (PPS)-Capital					V 1.00	XVIII 2. 00	XI X 3. 00	
45.00 Does this facility qualify and receive Capital paymen	nt for disp	roporti onat	e share in	accordance	N	Υ	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through						N	N	46. 00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N N	N N	47. 00 48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes Y							56. OC	
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon' for yes or "N" for no in column 2. If column 2 is "'	r yes or "N th of this	" for no in cost report	column 1. ing period?	If column 1 Enter "Y"				57. 00
"N", complete Wkst. D, Parts III & IV and D-2, Pt. I	l, if appli	cabl e.						F0 00
58.00 If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.		s as	N			58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes	s, complete	Wkst. D-2,	Pt. I.		N			59.00

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Health Financial Systems ST. VING	CENT HOS	SPITAL & HCC		In Lie	u of Form CMS-2	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CCN: 15-0084 Period: From 07/0					
			T		Date/Time Prep 11/25/2019 6:		
			NAHE 413.85	Worksheet A	Pass-Through	то рііі	
			Y/N	Li ne #	Qualification Criterion Code		
			1. 00	2.00	3.00		
60.00 Are you claiming nursing and allied health education			Y			60.00	
any programs that meet the criteria under §413.85? (60.01 If line 60 is yes, complete columns 2 and 3 for each instructions)				23. 00	1	60. 01	
60.02 If line 60 is yes, complete columns 2 and 3 for each instructions)	progran	m. (see		23. 01	1	60. 02	
60.03 If line 60 is yes, complete columns 2 and 3 for each instructions)	. 0	•		23. 02		60. 03	
60.04 If line 60 is yes, complete columns 2 and 3 for each instructions)	progran	m. (see		23. 03	1	60. 04	
	Y/N	IME	Direct GME	I ME	Direct GME		
(4.00 Did besitel mesity FTF elete water 404	1.00	2. 00	3. 00	4. 00	5. 00	(1.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	Y			18.00	18.00	61. 00	
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care						61. 01	
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see							
instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,						61. 02	
and primary care FTEs added under section 5503 of ACA). (see instructions)							
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for						61. 03	
determining compliance with the 75% test. (see instructions)							
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61. 04	
current cost reporting period (see instructions). 51.05 Enter the difference between the baseline primary						61. 0!	
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line							
61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being						61. 0	
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						01.00	
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE		
				FIE Count	Count		
1 10 Of the FTFe in Line (1 OF enecify each new program	CENEDAL	1. 00	2. 00 3650	3. 00	4. 00 10. 28	(1 1	
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			3030	10. 28	10. 20	01.10	
FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE	PEDI ATF	RICS	5250	3. 00	3. 00	61. 20	
residents for each expanded program. (see instructions) Enter in column 1, the program name.							
Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,							
the direct GME FTE unweighted count.					1.00		
ACA Provisions Affecting the Health Resources and Ser				1.6		46.5	
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc		ın this cost	reporting peri	od for which	0.00	62. 00	
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 6 during in this cost reporting period of HRSA THC program. (see instructions)							
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se			cost reporting r	period? Enter	Y	63. 00	
"Y" for yes or "N" for no in column 1. If yes, comple					.	20.00	

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Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMP		CENT HOSPITAL & HCC ATA Provider C		eriod: com 07/01/2018	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre	
			Unweighted		11/25/2019 6: Ratio (col. 1/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Base Ye period that begins on or after			This base year	is your cost r	eporti ng	
64.00 Enter in column 1, if line 63 is in the base year period, the nuresident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in yof (column 1 divided by (column 1	s yes, or your facili mber of unweighted no otations occurring in e number of unweighte our hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	5. 58	46. 85	0. 106428	64. 00
	Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
	1.00	2.00	Si te 3.00	4.00	5. 00	
65.00 Enter in column 1, if line 63 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)	FAMI LY MEDICINE	1350	3. 12	16. 14	0. 161994	
65. 01 65. 02 65. 03	GERIATRIC MEDICINE INTERNAL MEDICINE INTERNAL	1351 1400 2755	0. 31 8. 40 0. 96		0. 173949	65. 02
65. 04	MEDICINE/FAMILY PEDIATRICS	2000	0. 67	10. 67	0. 059083	65. 04
05.01	ji Estiminios	12000	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	00.01
Section 5504 of the ACA Current beginning on or after July 1, 2		n Nonprovider Setting	sEffective fo	or cost reporti	ng peri ods	
66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column	rovider settings. ry care resident 3 the ratio of	5. 66	142. 59	0. 038179	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4.00	5. 00	
67.00 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 your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE - GENERAL	1350	2. 94	17. 24	0. 145689	67.00

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	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION D	ATA Provi der		Period: From 07/01/	/2018	Workshe Part I	et S-2	
					To 06/30/		Date/Ti 11/25/2		
		Program Name	Program Code	Unwei ghted	Unwei gh		Ratio (c	ol. 3/	
				FTEs Nonprovi der	FTEs i Hospit		(col. 3 4)		
				Si te			.,,	,	
67. 01		1.00 INTERNAL MEDICINE -	2.00	3.00	4.00	37. 94	5.0		67. 01
07.01		GENERAL MEDICINE -	1400	4.0	O	37. 94	0.	090007	87.01
67. 02		INTERNAL MEDICINE/FAMILY	1505	1. 3	0	7. 77	0.	143330	67. 02
		MEDICINE -							
67. 03		PEDIATRICS - GENERAL	_ 2000	0. 3	3	13. 67	0.	023571	67. 03
						1.00	2. 00	3.00	
70.00	Inpatient Psychiatric Facility F Is this facility an Inpatient Ps		(LDE) or door it con	tain an IDE cub	nrovi dor?	Y			70.00
70.00	Enter "Y" for yes or "N" for no		(IPF), OF GOES IT COIL	taili ali IPF Suk	provider?	'			70.00
71. 00	If line 70 is yes: Column 1: Did recent cost report filed on or b	the facility have a	an approved GME teach	ing program in	the most	N	N	0	71. 00
	42 CFR 412. 424(d)(1)(iii)(c)) Co								
	program in accordance with 42 CF Column 3: If column 2 is Y, indi								
	(see instructions)	cate which program y	rear began during thi	s cost reportir	ig perrou.				
75 00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re		ty (IDE) or door it	contain on LDE		Y			75. 00
75.00	subprovider? Enter "Y" for yes		ly (TRF), or does it	CONTAIN AN IRF		, ř			/5.00
76. 00	If line 75 is yes: Column 1: Dic					N	N	0	76. 00
	recent cost reporting period enc no. Column 2: Did this facility								
	CFR 412.424 (d)(1)(iii)(D)? Ente	er "Y" for yes or "N"	for no. Column 3: I	f column 2 is Y					
	indicate which program year bega	in during this cost r	reporting period. (se	e instructions)					
	Lang Tarm Care Hearital DDC						1.0	00	
80. 00	Long Term Care Hospital PPS Is this a long term care hospital	al (LTCH)? Enter "Y"	for yes and "N" for	no.			N		80.00
								81.00	
	"Y" for yes and "N" for no. TEFRA Providers							ł	
	Is this a new hospital under 42					no.	N		85.00
86. 00	Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo			r 42 CFR Sectio	n				86. 00
87. 00	Is this hospital an extended neo	pplastic disease care		under section			N		87. 00
	1886(d)(1)(B)(vi)? Enter "Y" for	yes or "N" for no.			V		XL	X	
					1. 00)	2.0	0	
90. 00	Title V and XIX Services Does this facility have title V	and/or XIX inpatient	hospital services?	Enter "Y" for	N		Y		90.00
	yes or "N" for no in the applica	able column.	·						
91. 00	Is this hospital reimbursed for full or in part? Enter "Y" for y				N		Υ		91.00
92.00	Are title XIX NF patients occupy	ving title XVIII SNF	beds (dual certifica				N		92. 00
93 00	instructions) Enter "Y" for yes Does this facility operate an IC			nd XIX? Enter	N		N		93.00
	"Y" for yes or "N" for no in the	e applicable column.							
94. 00	Does title V or XIX reduce capit applicable column.	al cost? Enter "Y" f	or yes, and "N" for	no in the	N		N		94.00
	If line 94 is "Y", enter the red				0.00)	0.0		95.00
96. 00	Does title V or XIX reduce opera applicable column.	iting cost? Enter "Y"	for yes or "N" for	no in the	N		N		96.00
	If line 96 is "Y", enter the red	1 3	1.1		0.00)	0.0		97. 00
98. 00	Does title V or XIX follow Medic stepdown adjustments on Wkst. B,				N		N		98. 00
	column 1 for title V, and in col	umn 2 for title XIX .	· ·						
98. 01	Does title V or XIX follow Medic				N		Y		98. 01
	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 Medic				N		Υ		98. 02
		osts on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 tle 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) N N reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1						98. 03		
	for title V, and in column 2 for title XIX.								
98. 04	Does title V or XIX follow Medic	care (title XVIII) fo			N		N		98. 04
	outpatient services cost? Enter in column 2 for title XIX.	r ror yes or "N" f	or no ra corumn 1 to	ı title v, and					
98. 05	Does title V or XIX follow Medic				N		Υ		98. 05
	Wkst. C, Pt. I, col. 4? Enter "Y column 2 for title XIX.	TOT YES OF N TOP	no in column I for	uite v, and Ir					
	COLUMN 2 TOL LITTE XIX.								

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Health Financial Systems	ST. VINCENT HO	OSPITAL & HCC			In Lie	u of Form CMS	-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provi der CC	N: 15-0084		7/01/2018	Worksheet S- Part I	-2	
	To 06/30/2019							
						11/25/2019 6). 13 piii	
129.00 If this is a Medicare certified I	ung transplant center ent	er the certific	ation date		1. 00	2. 00	129. 00	
column 1 and termination date, if	applicable, in column 2.				17 (0010			
130.00 If this is a Medicare certified podate in column 1 and termination			Titication	08/	17/2010		130. 00	
131.00 If this is a Medicare certified i			erti fi cati d	on			131. 00	
132.00 If this is a Medicare certified i	slet transplant center, er	nter the certifi	cation dat	te			132. 00	
in column 1 and termination date, 133.00 If this is a Medicare certified o	ther transplant center, er	nter the certifi	cation dat	te			133. 00	
in column 1 and termination date, 134.00 If this is an organ procurement o			n column 1	1			134. 00	
and termination date, if applicab								
140.00 Are there any related organization					Υ	15H046	140. 00	
chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th				sts				
1.00	2. (00			3. 00			
If this facility is part of a cha home office and enter the home of				e name and	address	of the		
141.00 Name: ST. VINCENT HEALTH 142.00 Street: 250 WEST 96TH SREET, STE 2	Contractor's Name: WI 15 PO Box:	PS	Contra	actor's Nu	mber: 0810	1	141. 00 142. 00	
143. 00 Ci ty: I NDI ANAPOLI S	State:	N	Zip Co	ode:	4626	0	143. 00	
						1.00	_	
144.00 Are provider based physicians' co	sts included in Worksheet	A?				Υ	144. 00	
					1. 00	2. 00		
145.00 If costs for renal services are c inpatient services only? Enter "Y					Υ		145. 00	
no, does the dialysis facility in	clude Medicare utilizatior							
period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolo		ously filed cost	report?		N		146. 00	
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/		15-2, chapter 4	10, §4020)	lf				
lyes, enter the approval date (min)	day yyyy) TTI COT dillit 2.							
147.00 Was there a change in the statist		1. 00 N	147. 00					
148.00 Was there a change in the order o	f allocation? Enter "Y" fo	or yes or "N" fo	or no.	Fan na		N N	148. 00 149. 00	
149.00 was there a change to the shillpiri	rea cost finding method? E	Part A	Part E		itle V	Title XIX	149.00	
Does this facility contain a prov	ider that qualifies for an	1.00	2.00	ication of	3.00 the Lowe	4.00		
or charges? Enter "Y" for yes or		nent for Part A	and Part		CFR §413	. 13)	155.00	
155.00 Hospi tal 156.00 Subprovi der - IPF		N N	N N		N N	N N	155. 00 156. 00	
157. 00 Subprovi der - I RF 158. 00 SUBPROVI DER		N	N		N	N	157. 00 158. 00	
159. 00 SNF		N	N		N	N	159. 00	
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	N N		N N	N N	160. 00 161. 00	
		_					101100	
Mul ti campus						1.00		
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has or	ne or more campu	uses in dit	fferent CB	SAs?	N	165. 00	
TETTO 1 101 YOS OF W 101 HO.	Name	County	State	Zip Code	CBSA	FTE/Campus		
166.00 If line 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5. 00 0. 0	00 166. 00	
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)								
						1.00		
Health Information Technology (HI								
167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 1					the	Υ	167. 00 0168. 00	
reasonable cost incurred for the	HIT assets (see instructio	ons)						
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	noτ a meaningful user, doe ? Enter "Y" for yes or "N"	es this provider 'for no. (see i	qualify 1 nstruction	ror a hard ns)	shi p		168. 01	
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y") and				nter the	9.9	99169.00	
pridimental ractor. (See Thatfuction	ons <i>j</i>					I	I	

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Health Financial Systems	ST. VINCENT HOSPI	ITAL & HCC	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	Peri od:	Worksheet S-2	!		
			From 07/01/2018		
			To 06/30/2019		pared:
				11/25/2019 6:	15 pm
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				09/30/2018	170. 00
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider have	N	C	171. 00		
section 1876 Medicare cost plans reported of					
"Y" for yes and "N" for no in column 1. If	n				
1876 Medicare days in column 2. (see instru					

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### Provider CRV: 15-0084 Period	Heal th	Financial Systems ST. VINCENT HO	SPLTAL & HCC		In lie	u of Form CMS-	2552-10	
Description Y/N Y/N				F	Period: From 07/01/2018	Worksheet S-2 Part II Date/Time Pre	pared:	
20.00 If line 16 or 17 is yes, were adjustments made to PSAR N N N 20.00			Descri	ption	Y/N		15 pm	
Report data for Other? Describe the other adjustments: Y/N Date Y/N Date								
1.00 Was the cost report prepared only using the provider's N N N 21.00	20. 00						20. 00	
21.00 Was the cost report prepared only using the provider's N N 21.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)								
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions that we there been new capitalized leases entered into during the cost reporting period? If yes, see instructions. 25.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 27.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account? If yes, see instructions and treated as a funded depreciation account? If yes, see instructions. 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If ye	21. 00			2.00			21. 00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions that we there been new capitalized leases entered into during the cost reporting period? If yes, see instructions. 25.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 27.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account? If yes, see instructions and treated as a funded depreciation account? If yes, see instructions. 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If ye						1. 00		
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Provider-Based Physicians 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions. Y/N Date	33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app		g to competiti	ve bidding? If		33. 00	
If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions. Y/N Date		Provi der-Based Physi ci ans						
35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions. Y/N Date	34. 00		rangement with	provi der-base	ed physi ci ans?		34. 00	
Y/N Date 1.00 2.00 Home Office Costs 36.00 Were home office costs claimed on the cost report? 36.00 36.00	35. 00	If line 34 is yes, were there new agreements or amended exi		ts with the pr	rovi der-based		35. 00	
Home Office Costs 36.00 Were home office costs claimed on the cost report? 36.00								
36.00 Were home office costs claimed on the cost report?		Home Office Costs			1.00	2.00		
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00		Were home office costs claimed on the cost report?	repared by the	home office?			36. 00 37. 00	
If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of 38.00	38. 00		fice different	from that of			38. 00	
the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, 39.00	39. 00						39. 00	
	40. 00	If line 36 is yes, did the provider render services to the	home office?	If yes, see			40. 00	
i nstructi ons.		Instructions.						
1.00 2.00			1.	00				
	41. 00	Enter the first name, last name and the title/position	GREGORY KRUPI NSKI				41. 00	
held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report ASCENSION 42.00	42 00	respecti vel y.	ASCENSI ON				42. 00	
preparer.		preparer.			00500000	ov		
43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	43. 00		317-583-3282			SKI @ASCENSI ON.	43. 00	

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Health Financial Systems ST. VIN HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0084

T-	o 06/30/2019	Date/Time Pre 11/25/2019 6:	
		I/P Days / 0/P	15 pili
		Visits / Trips	
Component Worksheet A No. of Beds Bed Days	CAH Hours	Title V	
Li ne Number Available	0,11,11001.0		
1.00 2.00 3.00	4. 00	5. 00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 583 212,665	0.00	0	1. 00
8 exclude Swing Bed, Observation Bed and			
Hospice days)(see instructions for col. 2			
for the portion of LDP room available beds)			
2.00 HMO and other (see instructions)			2. 00
3.00 HMO IPF Subprovider			3. 00
4.00 HMO IRF Subprovider			4. 00
5.00 Hospital Adults & Peds. Swing Bed SNF		0	5. 00
6.00 Hospital Adults & Peds. Swing Bed NF	0.00	0	6.00
7.00 Total Adults and Peds. (exclude observation 583 212, 665	0. 00	0	7. 00
beds) (see instructions)	0.00	0	8. 00
9. 00 CORONARY CARE UNIT 31. 00 0 0	0.00		9.00
9. 01 CARDI OTHORACI C VASCULAR TRANSPL 32. 01 24 8, 760	0.00		9. 00
10. 00 BURN INTENSIVE CARE UNIT 33. 00 0 0	0.00	1	10.00
10. 01 PEDI ATRI C INTENSI VE CARE UNI T 33. 01 15 5, 475	0.00		10.00
11.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0	0.00		11. 00
11. 01 NEONATAL INTENSIVE CARE UNIT 34. 01 90 32, 850	0.00		11. 01
12.00 OTHER SPECIAL CARE (SPECIFY)		_	12.00
13. 00 NURSERY 43. 00		0	13. 00
14.00 Total (see instructions) 768 280,190	0.00	0	14.00
15.00 CAH visits		0	15. 00
16. 00 SUBPROVI DER - I PF 40. 00 57 20, 805		0	16. 00
17. 00 SUBPROVI DER - RF 41. 00 0 3, 060		0	17. 00
18. 00 SUBPROVI DER			18. 00
19.00 SKILLED NURSING FACILITY			19. 00
20.00 NURSING FACILITY			20. 00
21.00 OTHER LONG TERM CARE			21. 00
22.00 HOME HEALTH AGENCY			22. 00
23.00 AMBULATORY SURGICAL CENTER (D. P.) 115.00			23. 00
24. 00 HOSPI CE			24. 00
24. 10 HOSPICE (non-distinct part) 30.00			24. 10
25. 00 CMHC - CMHC			25. 00
26. 00 RURAL HEALTH CLINIC			26. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00		0	
27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days		0	27. 00 28. 00
28.00 Observation Bed Days 29.00 Ambulance Trips		0	29. 00
30.00 Employee discount days (see instruction)			30.00
31.00 Employee discount days (see Histractron)			31.00
32.00 Labor & delivery days (see instructions) 14 5, 110			32.00
32.01 Total ancillary labor & delivery room			32. 00
outpatient days (see instructions)			32.01
33.00 LTCH non-covered days			33. 00
33.01 LTCH site neutral days and discharges			33. 01

11/25/2019 6:15 pm Y:\28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

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Provider CCN: 15-0084

				1	0 06/30/2019	11/25/2019 6:	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	, o p
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	l II ti o xviiii	THE WIN	Patients	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	43, 714	5, 296	119, 778			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	23, 981	44, 529				2. 00
3.00	HMO IPF Subprovider	625	4, 128				3. 00
4.00	HMO IRF Subprovider	130	104				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	43, 714	5, 296	119, 778			7. 00
0.00	beds) (see instructions)	, ,01	007	47 700			0.00
8.00	INTENSIVE CARE UNIT	6, 491	807	17, 782			8. 00
9.00	CORONARY CARE UNIT	0	0	0			9. 00
9. 01	CARDI OTHORACI C VASCULAR TRANSPL	3, 054	0	8, 200			9. 01
10.00	BURN INTENSIVE CARE UNIT	0	0	0 700			10.00
10. 01	PEDIATRIC INTENSIVE CARE UNIT	10	358	2, 702			10. 01
11. 00	SURGICAL INTENSIVE CARE UNIT	0	2 224	20.77			11.00
11. 01	NEONATAL INTENSIVE CARE UNIT	٩	3, 224	28, 663			11. 01 12. 00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY		3, 448	3, 656			13. 00
14. 00	Total (see instructions)	53, 269	13, 133	3, 656 180, 781		4, 097. 11	
15. 00	CAH visits	55, 209	13, 133	180, 781		4,097.11	15. 00
16. 00	SUBPROVI DER - I PF	2, 502	1, 064	15, 796		70. 01	1
17. 00	SUBPROVI DER - I RF	708	1,004	1, 264		7.74	
18. 00	SUBPROVI DER	700	1	1, 204	0.00	7.74	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	48. 36	ł
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			35			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				159. 91	4, 223. 22	27. 00
28.00	Observation Bed Days		0	16, 714			28. 00
29.00	Ambul ance Tri ps	11					29. 00
30.00	Employee discount days (see instruction)			2, 162			30.00
31.00	Employee discount days - IRF			10			31. 00
32.00	Labor & delivery days (see instructions)	O	192	3, 821			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	1	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

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Provider CCN: 15-0084

				To	06/30/2019	Date/Time Prep 11/25/2019 6:	
		Full Time		Di scha	arges	11/23/2017 0.	15 pili
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
1.00		11. 00	12. 00	13.00	14.00	15. 00	1 00
1. 00	Hospi tal Adul ts & Peds. (columns 5, 6, 7 and		(9, 244	1, 241	30, 994	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			3, 886	5, 157		2. 00
3.00	HMO IPF Subprovider			3, 000	719		3. 00
4. 00	HMO IRF Subprovider				, , ,		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				1		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
9. 01	CARDI OTHORACI C VASCULAR TRANSPL						9. 01
10.00	BURN INTENSIVE CARE UNIT						10.00
10. 01	PEDIATRIC INTENSIVE CARE UNIT						10. 01
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
11. 01	NEONATAL INTENSIVE CARE UNIT						11. 01
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00		0.044	4 044	20.004	13.00
14.00	Total (see instructions)	0. 00	(9, 244	1, 241	30, 994	14. 00
15. 00 16. 00	CAH visits SUBPROVIDER - IPF	0. 00	,	302	191	2, 733	15. 00 16. 00
17. 00	SUBPROVIDER - IPF	0.00		50 56	1911	2, 733 109	17. 00
18. 00	SUBPROVI DER	0.00	`	30	'	107	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges						33. 01
55. 51	1 = 1 = 10 mouth at days and an sonar gos	ı		1	1	'	55. 51

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Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0084

					T	o 06/30/2019		
		Wkst. A Line	Amount	Recl assi fi cati	Adjusted	Pai d Hours	11/25/2019 6: Average Hourly	15 pm
		Number	Reported	on of Salaries		Related to	Wage (col. 4 ÷	
				(from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
		1.00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	336, 476, 094	0	336, 476, 094	8, 784, 288. 00	38. 30	1. 00
	instructions)	200.00	000, 1,0,0,1		000, 170, 071			
2. 00	Non-physician anesthetist Part		C	0	0	0. 00	0. 00	2. 00
3.00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	3. 00
4. 00	B Physician-Part A -		526, 429	0	526, 429	2, 933. 00	179. 48	4. 00
	Admi ni strati ve							
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		7, 225, 274 35, 880, 736		.,,	65, 514. 00 329, 265. 00		4. 01 5. 00
	Physician-Part B		00, 000, 700			·		
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		С	0	0	0. 00	0. 00	6. 00
	servi ces		_					
7. 00	Interns & residents (in an approved program)	21. 00	C	9, 990, 526	9, 990, 526	352, 189. 00	28. 37	7. 00
7. 01	Contracted interns and		C	0	0	0. 00	0. 00	7. 01
	residents (in an approved programs)							
8.00	Home office and/or related		3, 902, 893	0	3, 902, 893	375, 333. 00	10. 40	8. 00
9. 00	organization personnel SNF	44. 00	C	o	0	0. 00	0. 00	9. 00
10. 00	Excluded area salaries (see		51, 205, 015	-1, 403, 869	49, 801, 146	1, 075, 504. 00	46. 30	10. 00
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient		5, 461, 676	0	5, 461, 676	68, 071. 00	80. 23	11. 00
12. 00	Care Contract Labor: Top Level		C	o	0	0. 00	0. 00	12. 00
	management and other							
	management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		4, 394, 519	0	4, 394, 519	21, 231. 00	206. 99	13. 00
14. 00	Home office and/or related		C	О	0	0.00	0.00	14. 00
	organization salaries and wage-related costs							
14. 01	Home office salaries		68, 881, 342	0	68, 881, 342	1, 446, 028. 00	47. 63	14. 01
14. 02	Related organization salaries		C	0	0	0.00	0. 00	14. 02
15. 00	Home office: Physician Part A		C	0	0	0. 00	0. 00	15.00
16. 00	- Administrative Home office and Contract		C	o	0	0. 00	0. 00	16. 00
	Physicians Part A - Teaching							
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		61, 399, 172	0	61, 399, 172			17. 00
17.00	instructions)		01, 577, 172		01, 377, 172			17.00
18. 00	Wage-related costs (other)		C	0	0			18. 00
19. 00	(see instructions) Excluded areas		11, 141, 963	0	11, 141, 963			19. 00
20. 00	Non-physician anesthetist Part		11, 141, 903 C	ő	0			20. 00
21. 00	A Non-physician anesthetist Part		r	0	0			21. 00
	В		== 0-:	_				
22. 00	Physician Part A - Administrative		77, 224	0	77, 224			22. 00
22. 01	Physician Part A - Teaching		1, 181, 320	l e				22. 01
23. 00	Physician Part B		5, 885, 287	0	5, 885, 287			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		2, 891, 069	0	2, 891, 069			24. 00 25. 00
	approved program)							
25. 50	Home office wage-related (core)		21, 258, 489	0	21, 258, 489			25. 50
25. 51	Related organization		C	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		C	О	О			25. 52
	- Administrative -							
25. 53	wage-related (core) Home office & Contract		C	О	0			25. 53
	Physicians Part A - Teaching -							
	wage-related (core) OVERHEAD COSTS - DIRECT SALARIE	ES .						
	Employee Benefits Department	4. 00	1, 062, 421					26. 00
	Administrative & General 2019 6:15 pm Y:\28500 - St. Vind	5.00	17, 994, 823				'	27. 00
11//5/	ALLIS D. LO DIII Y. VADDO - ST. VIDO	HOSDITAL (COLD STINKIN.	. wentcare lost				

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Provider CCN: 15-0084

					10	0 06/30/2019	11/25/2019 6:	
		Wkst. A Line	Amount	Reclassi fi cati	Adjusted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		7, 205, 849	0	7, 205, 849	42, 864. 00	168. 11	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	0	0. 00		29. 00
30. 00		7. 00	1, 615, 224	0	1, 615, 224	79, 498. 00	1	30.00
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		31. 00
32. 00	, ,	9. 00		0	0	12. 00		32.00
33. 00	3		9, 311, 173	0	9, 311, 173	358, 602. 00	25. 97	33.00
	(see instructions)							
34. 00		10. 00		0	0	0. 00		34.00
35. 00	`		2, 777, 819	0	2, 777, 819	96, 794. 00	28. 70	35. 00
	instructions)							
36. 00	1	11. 00		0	0	0. 00		36. 00
37. 00	1	12. 00		0	0	0. 00	1	37. 00
38. 00	3	13. 00			10, 151, 735		1	
39. 00	1 1 3	14. 00	4, 499, 163		4, 499, 163		1	
40.00	Pharmacy	15. 00	12, 145, 081	-476, 061	11, 669, 020	272, 154. 00	1	40.00
41. 00	Medical Records & Medical	16. 00	99, 910	0	99, 910	5, 166. 00	19. 34	41.00
	Records Library							
	Soci al Servi ce	17. 00		0	5, 666, 059		1	42.00
43. 00	Other General Service	18. 00	0	0	0	0. 00	0.00	43. 00

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MCRI F32 - 15. 9. 167. 1 17 | Page HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0084 Peri od: Worksheet S-3 From 07/01/2018 To 06/30/2019 Part III Date/Time Prepared: 11/25/2019 6: 15 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number on of Salaries Sal ari es Related to Wage (col. 4 Reported (col . 2 ± col . col . 5) (from Salaries in 3) col. 4 Worksheet A-6) 6.00 1.00 5.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY Net salaries (see 308, 762, 032 -9, 990, 526 298, 771, 506 8, 160, 247. 00 1.00 1.00 36.61 instructions) 2.00 51, 205, 015 1, 075, 504. 00 2.00 Excluded area salaries (see -1, 403, 869 49, 801, 146 46. 30 instructions) 3.00 Subtotal salaries (line 1 257, 557, 017 -8, 586, 657 248, 970, 360 7, 084, 743. 00 35. 14 3.00 minus line 2) 4.00 Subtotal other wages & related 78, 737, 537 78, 737, 537 1, 535, 330. 00 51. 28 4.00 costs (see inst.) Subtotal wage-related costs 5.00 82, 734, 885 Ω 82, 734, 885 0.00 33. 23 5.00 (see inst.) Total (sum of lines 3 thru 5)

-8, 586, 657

-5, 097, 231

410, 442, 782

67, 432, 026

8, 620, 073. 00

1, 981, 240. 00

47 61

34.04

6.00

7.00

419, 029, 439

72, 529, 257

6.00

7.00

Total overhead cost (see

instructions)

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	Fi To	com 07/01/2018 c 06/30/2019	Part IV Date/Time Pre 11/25/2019 6:	
			Amount	
			Reported	
			1. 00	
	PART IV - WAGE RELATED COSTS			
	Part A - Core List			
	RETI REMENT COST			
1.00	401K Employer Contributions		12, 495, 567	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)		5, 408, 903	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		2, 264, 627	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 Administrator)		0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)		26, 164, 785	8. 02
8. 03	Heal th Insurance (Purchased)		0	8. 03
9.00	Prescription Drug Plan		9, 396, 341	9. 00
10.00			1, 025, 488	
11. 00			516, 423	
12.00	Accident Insurance (If employee is owner or beneficiary)		26, 567	
13. 00			1, 970, 466	
14. 00	1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		612, 573	
15.00		5405 407	23, 327	
16. 00		by FASB 106.	0	16. 00
	Non cumulative portion) TAXES			
17 00			21 052 7/0	17.00
17. 00			21, 952, 769	
18.00			0	
19. 00 20. 00				19. 00 20. 00
20.00	State or Federal Unemployment Taxes OTHER		147, 507	20.00
21. 00		1 above (see	341, 152	21. 00
21.00	instructions))	4 above. (See	341, 132	21.00
22. 00			0	22. 00
23. 00			229, 540	
24. 00			82, 576, 035	
27.00	Part B - Other than Core Related Cost		02, 370, 033	27.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25. 00
25.00	Tomak whot keemed doord (dreamin)	ļ	O ₁	25.00

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				11/25/2019 6:	
	Cost Center Description	(Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		5, 461, 676	82, 576, 035	1. 00
2.00	Hospi tal		5, 461, 676	61, 399, 172	2. 00
3.00	Subprovi der - I PF		0	0	3. 00
4.00	Subprovi der - I RF		0	0	4.00
5.00	Subprovi der - (0ther)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF				8. 00
9.00	Hospi tal -Based NF				9. 00
10.00					10.00
11. 00	Hospi tal -Based HHA				11. 00
12.00	Separately Certified ASC		0	0	12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15. 00	Hospital-Based Health Clinic FQHC				15. 00
16.00	Hospi tal -Based-CMHC				16. 00
17. 00			0	0	17. 00
18. 00	Other		0	21, 176, 863	18. 00

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Heal th	Financial Systems ST. VINCENT HOSPIT	TAL & HCC		In Lie	u of Form CMS-2	2552-10
		Provider CC	N: 15-0084	Peri od:	Worksheet S-10	
				From 07/01/2018 To 06/30/2019	Date/Time Prep 11/25/2019 6:	
					1 00	
	Uncompensated and indigent care cost computation				1. 00	
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div Medicaid (see instructions for each line)	vided by lin	ne 202 colum	n 8)	0. 208192	1. 00
2.00	Net revenue from Medicaid				119, 411, 968	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen			ai d?		4. 00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fi	rom Medicai	d		0	5. 00
6. 00	Medi cai d charges				800, 204, 675	
7.00	Medicaid cost (line 1 times line 6)	(I : 7:	6 ! .	2 1 5 : 6	166, 596, 212	
8. 00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	•		nes 2 and 5; IT	47, 184, 244	8. 00
	Children's Health Insurance Program (CHIP) (see instructions for	or each line	e)			
9.00	Net revenue from stand-alone CHIP				0	9.00
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10. 00 11. 00
12. 00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nue line O	f / zero then	0	12. 00
12.00	enter zero)	(TITIE IT IIII)	ilus IIIIe 7,	i C Zei G tileli	U	12.00
	Other state or local government indigent care program (see inst	tructions fo	or each line)		
13. 00	Net revenue from state or local indigent care program (Not incl				0	13.00
14. 00	Charges for patients covered under state or local indigent card 10)	e program (1	Not included	in lines 6 or	0	14. 00
15. 00	State or local indigent care program cost (line 1 times line 14	4)			0	15. 00
16. 00	Difference between net revenue and costs for state or local inc 13; if < zero then enter zero)		program (li	ne 15 minus line	0	16. 00
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/Local indi	gent care program	ıs (see	
	instructions for each line)			,	(
17.00	Private grants, donations, or endowment income restricted to for	undi ng chari	ity care		0	17.00
18. 00	Government grants, appropriations or transfers for support of I				0	18. 00
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent o	care program	s (sum of lines	47, 184, 244	19. 00
			Uni nsured	Insured	Total (col. 1	
		_	pati ents	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	oili+v	116, 686, 1	53 16, 014, 471	132, 700, 624	20. 00
20.00	(see instructions)	JIIILY	110,000,1	10, 014, 471	132, 700, 624	20.00
21. 00	Cost of patients approved for charity care and uninsured discolinstructions)	unts (see	24, 293, 1	16, 014, 471	40, 307, 595	21. 00
22. 00	Payments received from patients for amounts previously written	off as		0 0	0	22. 00
23. 00	charity care Cost of charity care (line 21 minus line 22)		24, 293, 1	24 16, 014, 471	40, 307, 595	23. 00
					1 00	
24. 00	Does the amount on line 20 column 2, include charges for patien	at days boy	ond a Longth	of stay limit	1. 00 N	24. 00
24.00	imposed on patients covered by Medicaid or other indigent care		unu a rengtii	or Stay ITHII t	IN	24.00
25. 00	If line 24 is yes, enter the charges for patient days beyond the	ne indigent	care progra	n's length of	0	25. 00
26. 00	stay limit Total bad debt expense for the entire hospital complex (see in:	structione)			24, 587, 268	26. 00
27. 00	Medicare reimbursable bad debts for the entire hospital complex		ructions)		863, 655	27. 00
27. 01	Medicare allowable bad debts for the entire hospital complex (•			1, 328, 700	
28. 00	Non-Medicare bad debt expense (see instructions)		/		23, 258, 568	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	oense (see i	instructions)	5, 307, 293	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				45, 614, 888	
31. 00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			92, 799, 132	31. 00

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RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C		Provi der C	CN: 15-0084	Peri od:	Worksheet A	
				1	From 07/01/2018 To 06/30/2019	Date/Ti me Pre 11/25/2019 6:	pared: 15 pm
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance	
				+ COI. 2)	ons (see A-o)	(col. 3 +-	
		1.00	2. 00	3.00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS						
1. 00 1. 01	OO100 CAP REL COSTS-BLDG & FIXT OO101 NEW CAP REL COSTS-BLDG-STRESS		13, 705, 555 232, 763			14, 136, 281 232, 763	
1.02	00102 NEW CAP REL COSTS-BLDG-MARTEN H		88, 113	88, 11	3 -84, 925	3, 188	1. 02
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		17, 634, 198	1	8 0	17, 634, 198 0	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 062, 421	61, 461, 144	62, 523, 56	-289, 196	62, 234, 369	4. 00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	17, 994, 823 1, 615, 224	256, 184, 077 26, 138, 225			264, 856, 781 27, 753, 449	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	2, 897, 732	2, 897, 73	2 0	2, 897, 732	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	11, 084, 636 14, 908, 170			11, 084, 636 4, 629, 348	
11. 00	01100 CAFETERI A	0	0)	0 10, 208, 455	10, 208, 455	11. 00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	10, 151, 735 4, 499, 163	4, 127, 047 6, 162, 164			14, 278, 782 8, 342, 888	1
15. 00	01500 PHARMACY	12, 145, 081	89, 360, 904				
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	99, 910 5, 666, 059	291, 791	1		391, 701 6, 850, 188	1
21. 00	02100 &R SERVICES-SALARY & FRINGES A	5, 666, 039	1, 184, 129 0		0 9, 990, 526		
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS A 02300 PARAMED ED PRGM- PHARMACY	20, 396, 443	3, 716, 860			11, 686, 381	
23. 00 23. 01	02301 PARAMED ED PRGM - CPE	378, 275 441, 392	55, 074 30, 788			725, 746 298, 164	
23. 02	02302 PARAMED ED PRGM - RADI OLOGY	195, 433	-6, 455				
23. 03	02303 PARAMED ED PRGM - EMS NPATI ENT ROUTI NE SERVI CE COST CENTERS	702, 922	257, 928	960, 85	0 143, 155	1, 104, 005	23. 03
30.00	03000 ADULTS & PEDIATRICS	74, 479, 672	21, 125, 979				1
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	13, 567, 467 0	5, 032, 909 0	1	6 -2, 029, 166 0 0	16, 571, 210 0	1
32. 01	03201 CARDI OTHORACI C VASCULAR TRANSPL	6, 611, 904	1, 428, 435	8, 040, 33	9 4, 795, 253	12, 835, 592	
33. 00 33. 01	03300 BURN INTENSIVE CARE UNIT 02080 PEDIATRIC INTENSIVE CARE UNIT	4, 236, 064	1, 156, 854	5, 392, 91	0 8 -247, 603	0 5, 145, 315	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0 0	0	34. 00
34. 01 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	21, 294, 837 5, 631, 436	6, 093, 259 763, 187			26, 338, 170 6, 394, 623	
41. 00	04100 SUBPROVI DER - I RF	504, 456	391, 366	895, 82	2 -144	895, 678	41. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 193, 014	363, 584	1, 556, 59	1, 996, 641	3, 553, 239	43. 00
50.00	05000 OPERATING ROOM	24, 061, 037	37, 862, 056			38, 102, 472	
52. 00 54. 00	O5200 DELIVERY ROOM & LABOR ROOM O5400 RADIOLOGY-DIAGNOSTIC	4, 160, 675 4, 977, 358	978, 540 4, 541, 976				
54. 01	05402 AMBULATORY CARDIOVASCULAR SVC	2, 810, 999	1, 220, 128	4, 031, 12	7 463, 110	4, 494, 237	54. 01
54. 02 54. 03	05403 ULTRASOUND 05404 ECHOCARDI OLOGY	1, 091, 291 695, 914	248, 687 708, 483				
54.04	05401 ONCOLOGY	3, 963, 768	5, 891, 704	9, 855, 47	2 -489, 387	9, 366, 085	54. 04
57. 00 58. 00	05700 CT SCAN 05800 MRI	1, 548, 282 914, 072	858, 711 473, 243			1, 769, 412 1, 325, 177	
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 635, 997	12, 001, 203	15, 637, 20	0 -11, 505, 247	4, 131, 953	59. 00
59. 01 60. 00	05901 CARDI AC REHAB 06000 LABORATORY	615, 150 0	198, 514 26, 052, 886			938, 263 26, 032, 569	
65.00	06500 RESPI RATORY THERAPY	7, 410, 238	6, 882, 338	14, 292, 57	6 -1, 713, 555	12, 579, 021	65. 00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	7, 889, 531 1, 072, 029	2, 419, 885 102, 518			10, 280, 004 1, 157, 663	1
68. 00	06800 SPEECH PATHOLOGY	852, 172	325, 549	1, 177, 72	1 -95, 222	1, 082, 499	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 300, 080 1, 505, 015	840, 913 7, 094, 948			2, 467, 903 8, 599, 963	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		0 54, 847, 113	54, 847, 113	71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	56, 982, 525	1	5 0 74, 076, 866	56, 982, 525 74, 076, 866	
74. 00	07400 RENAL DI ALYSI S	0	5, 086, 503	5, 086, 50	3 0	5, 086, 503	74. 00
75. 00	O3330 ENDOSCOPY OUTPATIENT SERVICE COST CENTERS	1, 920, 003	2, 895, 305	4, 815, 30	8 -2, 048, 898	2, 766, 410	75. 00
90. 00	09000 CLI NI C	443, 164	2, 457, 701			5, 389, 677	1
90. 01 91. 00	09001 PARTI AL HOSPI TALI ZATI ON 09100 EMERGENCY	1, 684, 386 13, 337, 823	263, 477 14, 669, 442			1, 947, 863 26, 394, 753	1
91. 01	09101 WOUND CARE 002	595, 019	812, 717			1, 231, 320	1
91. 02 91. 03	09102 WOUND CARE 001 09103 LAFAYETTE RD CLINIC	434, 938	136, 504 222			478, 728 222	
91. 04	09104 ZI ONSVI LLE CLI NI C	310, 997	300, 809	l .		611, 806	91. 04
91. 05 91. 06	09105 BROWNSBURG CLINIC 09106 OP ANTICOAGULATION CLINIC	0 459, 312	129, 363		0 5 -5, 387	0 583, 288	
91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	329, 761	801, 908	1, 131, 66		1, 085, 163	
	04040 FAMILY PRACTICE 2019 6:15 pm Y:\28500 - St. Vincent Hospital	2, 238, 251	1, 833, 070	•			91.08

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RECEASSITICATION AND ADJUSTMENTS OF TRIAL BALANCE O	I LAFLINGLS	FI OVI dei C		rom 07/01/2018	WOI KSHEEL A	
				o 06/30/2019	Date/Time Pre	pared·
			'	0 00, 00, 201,	11/25/2019 6:	15 pm
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fied	
·			+ col. 2)	ons (See A-6)	Trial Balance	
			ĺ	, ,	(col. 3 +-	
					col . 4)	
	1.00	2.00	3.00	4. 00	5. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	29, 734	29, 734	-29, 734	0	95. 00
98. 00 09853 GERI ATRI C CLI NI C	o	881	881	0	881	98. 00
98. 01 09851 ELECTROCONVULSI VE THERAPY	o	0	0	0	0	98. 01
98. 02 09852 DI ABETES EDUCATION	296, 482	23, 977	320, 459	0	320, 459	98. 02
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	2, 717, 758	5, 058, 295	7, 776, 053	-1, 436, 357	6, 339, 696	105. 00
106. 00 10600 HEART ACQUI SI TI ON	2, 496, 029	5, 130, 856	7, 626, 885	-1, 336, 222	6, 290, 663	106. 00
112.00 08600 PANCREAS ACQUISITION	o	9, 000	9, 000	0	9, 000	112. 00
113.00 11300 INTEREST EXPENSE		0	0	o	0	113. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	3, 414, 860	9, 171, 503	12, 586, 363	o	12, 586, 363	115. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	302, 050, 122	760, 366, 490	1, 062, 416, 612	0	1, 062, 416, 612	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	1, 023, 889	1, 023, 889	0	1, 023, 889	190. 00
191. 00 19100 RESEARCH	1, 130, 387	603, 268	1, 733, 655	0	1, 733, 655	191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	26, 004, 992	17, 684, 954	43, 689, 946	0	43, 689, 946	192. 00
193. 00 19300 NONPALD WORKERS	o	0	0	0	0	193. 00
193. 01 19304 MARKETI NG	o	350	350	0	350	193. 01
193.02 19305 MISSION SERVICES	512, 922	502, 968	1, 015, 890	0	1, 015, 890	193. 02
193. 03 19306 FOUNDATI ON	782, 101	1, 882, 787			2, 664, 888	193. 03
193. 04 19307 WELLNESS	426, 110	275, 242	701, 352	0	701, 352	193. 04
193. 07 19310 BI LLI NG	o	19, 449, 932	19, 449, 932	0	19, 449, 932	193. 07
193. 09 19312 LI FELI NE	o	2, 372	2, 372	0	2, 372	193. 09
193.10 19313 MARTEN HOUSE	o	0	0	0	0	193. 10
193. 14 19302 VACANT SPACE	o	0	0	0	0	193. 14
193. 16 19316 SETON BOARD	o	0	0	o	0	193. 16
193. 19 19319 SPORTS PERFORMANCE	5, 569, 460	3, 309, 489	8, 878, 949	o	8, 878, 949	193. 19
200.00 TOTAL (SUM OF LINES 118 through 199)	336, 476, 094		1, 141, 577, 835		1, 141, 577, 835	
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 Systems
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 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 15-0084

				To 06/30/2019 Date/Time Pre 11/25/2019 6:	
	Cost Center Description	Adjustments	Net Expenses	1172372017 6.	TO PIII
			For Allocation		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1.00	00100 CAP REL COSTS-BLDG & FLXT	-788, 394	13, 347, 887		1.00
1. 01	00101 NEW CAP REL COSTS-BLDG-STRESS	0	232, 763		1. 01
1.02	00102 NEW CAP REL COSTS-BLDG-MARTEN H	0	3, 188		1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	17, 634, 198		2. 00
3.00	00300 OTHER CAP REL COSTS	150.747	(2.075.(02		3. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	-158, 767 -83, 124, 407	62, 075, 602 181, 732, 374		4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	-564, 266	27, 189, 183		7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0 0	2, 897, 732		8. 00
9.00	00900 HOUSEKEEPI NG	0	11, 084, 636		9. 00
10.00	01000 DI ETARY	-304, 697	4, 324, 651		10.00
11. 00	01100 CAFETERI A	-2, 899, 118	7, 309, 337		11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	-191, 462	14, 087, 320		13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	-265 -22, 004	8, 342, 623 27, 433, 776		14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-22, 004	370, 502		16.00
17. 00	01700 SOCIAL SERVICE	-509, 151	6, 341, 037		17. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES A	0	9, 990, 526		21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS A	-8, 178, 067	3, 508, 314		22. 00
23. 00	02300 PARAMED ED PRGM- PHARMACY	0	725, 746		23. 00
23. 01	02301 PARAMED ED PRGM - CPE	-14, 914	283, 250		23. 01
23. 02	O2302 PARAMED ED PRGM - RADI OLOGY	-51, 476	175, 478		23. 02
23. 03	02303 PARAMED ED PRGM - EMS INPATIENT ROUTINE SERVICE COST CENTERS	-100, 571	1, 003, 434		23. 03
30. 00	03000 ADULTS & PEDI ATRI CS	-25, 146, 886	68, 868, 795		30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	16, 571, 210		31. 00
32.00	03200 CORONARY CARE UNIT	0	0		32. 00
32. 01	03201 CARDI OTHORACI C VASCULAR TRANSPL	-691, 667	12, 143, 925		32. 01
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		33. 00
33. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	-2, 124, 265	3, 021, 050		33. 01
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0 010 750	14 510 410		34. 00
34. 01 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVI DER - PF	-9, 819, 752 -1, 997, 707	16, 518, 418 4, 396, 916		34. 01 40. 00
41. 00	04100 SUBPROVI DER - I RF	-1, 997, 707	895, 678		41.00
43. 00	04300 NURSERY	-1, 190, 844	2, 362, 395		43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-5, 735, 150	32, 367, 322		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-34, 426	4, 611, 869		52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-171, 041	8, 677, 505		54. 00
54. 01 54. 02	05402 AMBULATORY CARDIOVASCULAR SVC 05403 ULTRASOUND	0	4, 494, 237 1, 179, 676		54. 01 54. 02
54. 02	05404 ECHOCARDI OLOGY	-803	1, 174, 076		54. 02
54. 04	05401 ONCOLOGY	-171, 143	9, 194, 942		54. 04
57. 00	05700 CT SCAN	0	1, 769, 412		57. 00
58.00	05800 MRI	0	1, 325, 177		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	4, 131, 953		59. 00
	05901 CARDI AC REHAB	0	938, 263		59. 01
	· ·	0	26, 032, 569 12, 579, 021		60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 -182, 581	10, 097, 423		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	-102, 301	1, 157, 663		67. 00
68. 00	06800 SPEECH PATHOLOGY	408	1, 082, 907		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	2, 467, 903		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	-2, 500, 257	6, 099, 706		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	54, 847, 113		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	56, 982, 525		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	-11, 933, 579	62, 143, 287		73.00
74. 00 75. 00	03330 ENDOSCOPY	0	5, 086, 503 2, 766, 410		74. 00 75. 00
73.00	OUTPATIENT SERVICE COST CENTERS		2,700,410		73.00
90.00	09000 CLINIC	-85, 500	5, 304, 177		90.00
90. 01	09001 PARTIAL HOSPITALIZATION	-11	1, 947, 852		90. 01
91. 00	09100 EMERGENCY	-3, 587, 912	22, 806, 841		91. 00
91. 01	09101 WOUND CARE 002	0	1, 231, 320		91. 01
91. 02	09102 WOUND CARE 001	0	478, 728		91. 02
91. 03 91. 04	O9103 LAFAYETTE RD CLINIC O9104 ZIONSVILLE CLINIC	0	222 611, 806		91. 03 91. 04
91.04	09104 ZTONSVILLE CLINIC		011,800		91.04
	09106 OP ANTI COAGULATION CLINIC	-20, 851	562, 437		91.05
91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	-399, 238	685, 925		91. 07
91. 08	04040 FAMILY PRACTICE	-1, 662, 555	2, 356, 350		91. 08
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT				92. 00

11/25/2019 6:15 pm Y:\28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

MCRI F32 - 15. 9. 167. 1 24 | Page Peri od: Worksheet A From 07/01/2018 To 06/30/2019 Date/Time Prepared:

			10 06/30/2019 Date/IIme P	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0	0		95. 00
98. 00 09853 GERI ATRI C CLI NI C	0	881		98. 00
98. 01 09851 ELECTROCONVULSI VE THERAPY	0	0		98. 01
98. 02 09852 DI ABETES EDUCATION	0	320, 459		98. 02
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	-505, 592	5, 834, 104		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	6, 290, 663		106. 00
112.00 08600 PANCREAS ACQUISITION	0	9, 000		112. 00
113. 00 11300 I NTEREST EXPENSE	0	0		113. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	-16, 558	12, 569, 805		115. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-164, 906, 668	897, 509, 944		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	1, 023, 889		190. 00
191. 00 19100 RESEARCH	0	1, 733, 655		191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	43, 689, 946		192. 00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
193. 01 19304 MARKETI NG	0	350		193. 01
193. 02 19305 MISSION SERVICES	0	1, 015, 890		193. 02
193. 03 19306 FOUNDATI ON	0	2, 664, 888		193. 03
193. 04 19307 WELLNESS	0	701, 352		193. 04
193. 07 19310 BI LLI NG	0	19, 449, 932		193. 07
193. 09 19312 LI FELI NE	0	2, 372		193. 09
193. 10 19313 MARTEN HOUSE	0	0		193. 10
193. 14 19302 VACANT SPACE	0	0		193. 14
193. 16 19316 SETON BOARD	0	0		193. 16
193. 19 19319 SPORTS PERFORMANCE	0	8, 878, 949		193. 19
200.00 TOTAL (SUM OF LINES 118 through 199)	-164, 906, 668	976, 671, 167		200. 00

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HEART ACQUISITION

HEART ACQUISITION

TRANSPL TOTALS

CARDIOTHORACIC VASCULAR

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9.00

RECLASSI FI CATIONS Provider CCN: 15-0084 Peri od: Worksheet A-6 From 07/01/2018 06/30/2019 Date/Time Prepared: 11/25/2019 6: 15 pm Increases Cost Center Sal ary 0ther Line # 2.00 3.00 4.00 5.00 A - Pharmacy 1.00 DRUGS CHARGED TO PATIENTS 73.00 73, 395, 628 1.00 73, 395, 628 **TOTALS** B - Drugs Directly Assigned 1.00 DRUGS CHARGED TO PATIENTS 73.00 681, 238 1.00 2.00 2.00 3.00 3.00 4.00 4.00 5.00 5.00 6.00 6.00 7.00 7.00 8.00 8.00 9.00 9.00 10.00 10.00 11 00 11 00 12.00 12.00 13.00 13.00 14.00 14.00 15.00 15.00 16.00 16.00 17.00 17.00 18.00 18.00 19.00 19.00 681, 238 C - Med Ed Director I&R SERVICES-OTHER PRGM 1.00 22.00 52, 416 1.00 COSTS A Ō 52, 416 D - Nursery 1.00 43. 00 1, 687, 983 NURSERY 308, 658 1.00 1, 687, 983 308, 658 E - Building Rent 1.00 CAP REL COSTS-BLDG & FIXT 1.00 289, 196 1.00 289, 196 F - Rental Beds 1.00 MEDICAL SUPPLIES CHARGED TO 71. 00 1, 921, 651 1.00 PAT 1, 921, 651 G - Marten House 1.00 CAP REL COSTS-BLDG & FIXT 1.00 141, 530 1.00 2.00 2.00 ō 141, 530 H - Resident Salaries 1.00 I&R SERVICES-SALARY & 21.00 9, 990, 526 1.00 FRINGES A Ō 9, 990, 526 - Radiology Paramed 1.00 PARAMED ED PRGM - RADIOLOGY 23.02 37, 976 1.00 Ō 37, 976 J - Pharmacy Paramed 1.00 PARAMED ED PRGM- PHARMACY 23.00 400, 256 1.00 400, 256 Ō K - Pharmacy Year 2 95, 873 1.00 15. 00 11, 986 PHARMACY 1.00 95, 873 11, 986 L - CPE Paramed 1.00 PARAMED ED PRGM - CPE 23. 01 8, 832 1.00 ADMINISTRATIVE & GENERAL 167, 473 15, 375 2.00 5.00 2.00 176, 305 15, 375 M - Organ Acquisition KI DNEY ACQUISITION 105.00 97, 396 1.00 1.00 KIDNEY ACQUISITION 35 424 2.00 105.00 0 2.00 3.00 KIDNEY ACQUISITION 105.00 0 62, 801 3.00 KIDNEY ACQUISITION 4.00 105.00 70, 147 4.00 CARDIOTHORACIC VASCULAR 596, 122 32.01 5.00 5.00 1, 106, 003 TRANSPL HEART ACQUISITION 6.00 106.00 74, 282 0 6.00

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ST. VINCENT HOSPITAL & HCC In Lieu of Form CMS-2552-10 Health Financial Systems RECLASSI FI CATI ONS Provider CCN: 15-0084 Peri od: Worksheet A-6 From 07/01/2018 To 06/30/2019 Date/Time Prepared: 11/25/2019 6: 15 pm Increases Cost Center Sal ary 0ther Li ne # 2.00 3.00 4.00 5.00 N - Dietary 1.00 CAFETERI A 11.00 10, 208, 455 1.00 o 10, 208, 455 O - Medical Supplies MEDICAL SUPPLIES CHARGED TO 52, 925, 462 1.00 71.00 0 1.00 2.00 0.00 2.00 3.00 0.00 0 0 3.00 0 4.00 0.00 4.00 0 5.00 0.00 5.00 6.00 0.00 0 0 0 0 0 0 0 0 0 0 0 6.00 0 0.00 7.00 7.00 8.00 0.00 8.00 9.00 0.00 0 0 0 0 0 9.00 10.00 0.00 10.00 0.00 11.00 11.00

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500.00 Grand Total: Increases

18. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00	TOTALS	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00
1. 00	P - EMS Precepting PARAMED ED PRGM - EMS	23. 03	143, 155		1.00
2. 00 3. 00 4. 00 5. 00 6. 00	PARAMED ED PROM - EMS	23. 03	143, 133		2. 00 3. 00 4. 00 5. 00 6. 00
			143, 155		
	Q - Cardaic Admin				
1.00	ADULTS & PEDIATRICS	30.00	942, 264	891, 819	1. 00
2. 00	CARDIOTHORACIC VASCULAR TRANSPL	32. 01	609, 725	577, 082	2. 00
3.00	OPERATING ROOM	50.00	750, 682	710, 494	3. 00
4. 00	AMBULATORY CARDI OVASCULAR SVC	54. 01	317, 138	300, 160	4. 00
5.00	ECHOCARDI OLOGY	54. 03	97, 844	92, 606	5. 00
6.00	CARDIAC CATHETERIZATION	59.00	1, 229, 683	1, 163, 851	6. 00
7.00	CARDI AC REHAB	59. 01	64, 013	60, 586	7. 00
8.00	ELECTROCARDI OLOGY	69. 00	168, 437	159, 420	8. 00
9. 00	HEART ACQUISITION	106.00	600, 025 4, 779, 811	<u>567, 9</u> 02 4, 523, 920	9. 00
	R - CLINIC		4, 117, 011	4, 323, 720	1
1.00	CLINIC	90.00	2, 034, 617	320, 306	1.00
2.00	CLINIC	90.00	0	133, 889	2. 00
	TOTALS — — — —		2, 034, 617	454, 195	1

22, 143, 188

146, 899, 365

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Provider CCN: 15-0084

					Т	o 06/30/2019	Date/Time Prepared: 11/25/2019 6:15 pm
		Decreases		<u> </u>			1172072017 0. 10 piii
	Cost Center	Li ne #	Salary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
1.00	A - Pharmacy PHARMACY	15. 00	0	73, 395, 628	0		1.00
1.00	TOTALS		 	73, 395, 628			1.00
	B - Drugs Directly Assigned						
1.00	ADULTS & PEDIATRICS	30.00		8, 262			1. 00
2.00	CARDIOTHORACIC VASCULAR	32. 01		510			2. 00
2 00	TRANSPL NEONATAL INTENSIVE CARE UNIT	34. 01		11 041			3 00
3. 00 4. 00	SUBPROVIDER - IRF	41. 00		11, 941 144			3. 00 4. 00
5. 00	OPERATING ROOM	50.00		438, 420			5. 00
6.00	DELIVERY ROOM & LABOR ROOM	52.00		18, 723			6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00		72, 254			7. 00
8.00	AMBULATORY CARDIOVASCULAR	54. 01		6, 577			8. 00
0.00	SVC	54.04		4 057			0.00
9.00	ONCOLOGY	54. 04 58. 00		1, 057 904			9.00
10. 00 11. 00	MRI CARDIAC CATHETERIZATION	59. 00		7, 154			10. 00 11. 00
12. 00	LABORATORY	60.00		20, 317			12. 00
13. 00	RESPIRATORY THERAPY	65.00		2, 576			13. 00
14.00	ELECTROCARDI OLOGY	69.00		947			14. 00
15.00	ENDOSCOPY	75. 00		403			15. 00
16. 00	EMERGENCY	91.00		30, 482			16. 00
17. 00	WOUND CARE 001	91. 02		25, 446			17. 00
18.00	OP ANTI COAGULATION CLINIC	91. 06 95. 00		5, 387 29, 734			18.00
19. 00	AMBULANCE SERVICES	95.00		2 <u>9, 734</u> 681, 238			19. 00
	C - Med Ed Director		<u> </u>	001, 230			
1.00	FAMILY PRACTICE	91.08	52, 416				1. 00
			52, 416				
	D - Nursery						
1.00	ADULTS & PEDIATRICS	30. 00	1, 687, 983	308, 658			1.00
	E Duit Him Don't		1, 687, 983	308, 658			
1. 00	E - Building Rent EMPLOYEE BENEFITS DEPARTMENT	4.00		289, 196	10		1.00
1.00	LINI LOTEL BENEFIT 13 BELAKTIMENT			289, 196			1.00
	F - Rental Beds			===,,	l l		
1.00	CENTRAL SERVICES & SUPPLY	14. 00		<u>1, 921, 6</u> 51			1.00
			0	1, 921, 651			
4 00	G - Marten House	4 00		04.005			1.00
1. 00	NEW CAP REL COSTS-BLDG-MARTEN H	1. 02		84, 925	9		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00		56, 605			2. 00
2.00	Nomination of the second of th			141, 530			2.00
	H - Resident Salaries						
1.00	I&R SERVICES-OTHER PRGM	22. 00	9, 990, 526				1.00
	COSTS A	+	9, 990, 526				
	l - Radiology Paramed		9, 990, 526	0			
1.00	RADI OLOGY-DI AGNOSTI C	54. 00	37, 976				1.00
1.00	TOTAL SECOND PRINCIPLE STATE SECOND S	= = = = = = = = = = = = = = = = = =	$-\frac{37,776}{37,976}$	₀			1.00
	J - Pharmacy Paramed						
1.00	PHARMACY	1500	40 <u>0, 2</u> 56				1.00
			400, 256	0			
4 00	K - Pharmacy Year 2	22 22	95, 873	44 007			1.00
1. 00	PARAMED ED PRGM- PHARMACY		95, 873 95, 873	1 <u>1, 9</u> 86 11, 986			1.00
	L - CPE Paramed		73, 073	11, 700			
1.00	ADMINISTRATIVE & GENERAL	5. 00	8, 832				1. 00
2.00	PARAMED ED PRGM - CPE	23. 01	167, 473	15, 375			2. 00
			176, 305	15, 375			
	M - Organ Acquisition		a 1		T		
1.00	PHARMACY	15. 00	97, 396	0 25 424			1.00
2.00	DI ETARY	10.00	0	35, 424			2.00
3. 00 4. 00	ADMINISTRATIVE & GENERAL HEART ACQUISITION	5. 00 106. 00	70, 147	62, 801 0	1		3. 00 4. 00
4. 00 5. 00	KIDNEY ACQUISITION	105.00	1, 106, 003	596, 122			5. 00
6. 00	PHARMACY	15. 00	74, 282	370, 122 N	0		6. 00
7. 00	DI ETARY	10.00	74, 202	34, 943			7. 00
8.00	ADMINISTRATIVE & GENERAL	5. 00	Ö	72, 998			8. 00
9.00	HEART ACQUISITION	1 <u>06.</u> 00	<u>1, 396, 442</u>	<u>1, 219, 7</u> 83			9. 00
	TOTALS		2, 744, 270	2, 022, 071			

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MCRI F32 - 15. 9. 167. 1 28 | Page Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 ST. VINCENT HOSPITAL & HCC Provider CCN: 15-0084

						11/25/2	.019 6: 15 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other 0.00	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
. 00	N - Dietary DIETARY	10.00		10, 208, 455			1.0
. 00	DIETAKT			10, 208, 455			1.0
	0 - Medical Supplies		<u> </u>	10, 200, 455			
. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	396, 788	0		1.0
. 00	PHARMACY	15. 00	o	190, 502			2. 0
3. 00	ADULTS & PEDIATRICS	30.00	o	1, 417, 799			3. 0
. 00	INTENSIVE CARE UNIT	31.00	o	2, 024, 860			4. 0
. 00	CARDI OTHORACI C VASCULAR	32. 01	ol	709, 394			5. 0
	TRANSPL			•			
5. 00	PEDIATRIC INTENSIVE CARE	33. 01	0	247, 603	0		6. 0
	UNI T						
7. 00	NEONATAL INTENSIVE CARE UNIT	34. 01	0	1, 037, 985			7. 00
3. 00	OPERATING ROOM	50.00	0	24, 829, 800			8. 00
9. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	472, 396			9. 00
0.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	560, 558			10.00
11.00	AMBULATORY CARDI OVASCULAR	54. 01	0	147, 611	0		11. 00
12.00	SVC	E4 00		140 202			12.00
12. 00 13. 00	ULTRASOUND ONCOLOGY	54. 02 54. 04	0	160, 302			12. 00 13. 00
14. 00	CT SCAN	54. 04 57. 00	0	488, 330			13.00
15. 00	MRI	58.00	O O	637, 581 61, 234			15. 00
16. 00	CARDIAC CATHETERIZATION	59.00	0	13, 886, 544	_		16. 00
17. 00	RESPIRATORY THERAPY	65. 00	0	1, 710, 979			17. 00
18. 00	PHYSI CAL THERAPY	66.00	0	29, 412			18. 00
19. 00	OCCUPATI ONAL THERAPY	67. 00	Ö	16, 884			19. 00
20. 00	SPEECH PATHOLOGY	68. 00	o	95, 222			20. 00
21. 00	ENDOSCOPY	75. 00	o	2, 048, 495	_		21. 00
22. 00	EMERGENCY	91.00	O	1, 464, 993			22. 00
23. 00	WOUND CARE 002	91. 01	O	176, 416			23. 00
24. 00	WOUND CARE 001	91. 02	0	67, 268	0		24. 00
25. 00	ST VINCENT OUTPATIENT	91. 07	0	46, 506	0		25. 00
	TREATMENT						
	TOTALS		0	52, 925, 462			
	P - EMS Precepting						
1.00	ADULTS & PEDIATRICS	30.00	1, 351				1. 00
2. 00	INTENSIVE CARE UNIT	31.00	4, 306				2. 00
3.00	OPERATING ROOM	50.00	13, 577				3. 00
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 801				4. 00
5.00	CARDI AC CATHETERI ZATI ON	59. 00 91. 00	5, 083 117, 037				5. 00 6. 00
5. 00	EMERGENCY		143, 155	₀	 		0.00
	Q - Cardaic Admin		143, 133				
1.00	ADMI NI STRATI VE & GENERAL	5. 00	4, 779, 811	4, 523, 920			1. 00
2. 00	A SENERAL	0.00	1, 777, 011	1,020,720			2. 00
3. 00							3. 00
1. 00							4. 00
5. 00							5. 0
. 00							6. 0
7.00							7.00
3. 00							8. 00
. 00							9. 00
			4, 779, 811	4, 523, 920			
	R - CLINIC	1					_
. 00	I &R SERVICES-OTHER PRGM	22. 00	2, 034, 617	320, 306	0		1.00
00	COSTS A I &R SERVICES-OTHER PRGM	22 00		122 000			2.00
2. 00	1	22. 00	U	133, 889	0		2. 00
	TOTALS	+	2, 034, 617	454, 195	 		
500 00	Grand Total: Decreases		22, 143, 188	146, 899, 365			500. 00
ιυυ. UU	lei and Total: Decreases	I	22, 143, 188	140, 899, 365			500.

11/25/2019 6:15 pm Y:\28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

MCRI F32 - 15. 9. 167. 1 29 | Page RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0084 Peri od: Worksheet A-7 From 07/01/2018 Part I Date/Time Prepared: 06/30/2019 11/25/2019 6: 15 pm Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 9, 137, 236 0 11, 233, 128 0 2, 584, 377 2.00 Land Improvements 2, 584, 377 0 2.00 3.00 Buildings and Fixtures 506, 221, 226 44, 952, 542 44, 952, 542 3.00 0 Building Improvements 15, 858, 948 0 4.00 535, 331 4.00 5.00 Fixed Equipment 27, 652, 551 254, 012 0 254, 012 5.00 6.00 12, 791, 474 0 Movable Equipment 277, 272, 379 12, 791, 474 0 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 847, 375, 468 60, 582, 405 60, 582, 405 535, 331 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 847, 375, 468 60, 582, 405 O 60, 582, 405 535, 331 10.00 10.00 Endi ng Bal ance Ful I y Depreci ated

			50p. 00. a toa	
			Assets	
		6. 00	7. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		
1.00	Land	9, 137, 236	0	1.00
2.00	Land Improvements	13, 817, 505	0	2.00
3.00	Buildings and Fixtures	551, 173, 768	0	3.00
4.00	Building Improvements	15, 323, 617	0	4.00
5.00	Fixed Equipment	27, 906, 563	0	5. 00
6.00	Movable Equipment	290, 063, 853	0	6.00
7.00	HIT designated Assets	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	907, 422, 542	0	8.00
9.00	Reconciling Items	0	0	9. 00
10.00	Total (line 8 minus line 9)	907, 422, 542	0	10.00

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	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUMN	I2, LINES 1 ar	nd 2	
1.00	CAP REL COSTS-BLDG & FIXT	0	13, 705, 555		1. 00
1.01	NEW CAP REL COSTS-BLDG-STRESS	0	232, 763		1. 01
1.02	NEW CAP REL COSTS-BLDG-MARTEN H	0	88, 113		1. 02
2.00	CAP REL COSTS-MVBLE EQUIP	0	17, 634, 198		2. 00
3.00	Total (sum of lines 1-2)	0	31, 660, 629		3. 00

15. 00

instructions)

14.00

11/25/2019 6:15 pm Y:\28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

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	n Financial Systems	ST. VINCENT HO				u of Form CMS-2	
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der Co		Peri od: From 07/01/2018	Worksheet A-7 Part III	
					To 06/30/2019		pared:
		COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	ТЭ рііі
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1.00	2. 00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS		1			
1.00	CAP REL COSTS-BLDG & FLXT	604, 282, 604	0			0	
1. 01	NEW CAP REL COSTS-BLDG-STRESS	13, 076, 086	0	1,,		0	1. 01
1. 02 2. 00	NEW CAP REL COSTS-BLDG-MARTEN H CAP REL COSTS-MVBLE EQUIP	290, 063, 852	0	1	0. 000000 2 0. 319657	0	1. 02 2. 00
3.00	Total (sum of lines 1-2)	907, 422, 542	0				3.00
0.00	Total (Sam of Titles 1.2)		TION OF OTHER (F CAPITAL	0.00
	Cost Center Description	Taxes	0ther	Total (sum of	f Depreciation	Lease	
			Capi tal -Relate				
		6. 00	<u>d Costs</u> 7.00	through 7) 8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		7.00	0.00	7.00	10100	
1.00	CAP REL COSTS-BLDG & FLXT	0	0)	0 13, 055, 962	289, 196	1. 00
1.01	NEW CAP REL COSTS-BLDG-STRESS	0	0		0 232, 763	0	1. 01
1.02	NEW CAP REL COSTS-BLDG-MARTEN H	0	0		0 3, 188	0	1. 02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2	0 17, 634, 198		2.00
3.00	Total (sum of lines 1-2)	O	<u> </u>	י <u>ן</u> JMMARY OF CAPI	0 30, 926, 111	289, 196	3. 00
			30	DIVINIART OF CAPT	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate		
					d Costs (see	through 14)	
		11.00	12.00	13.00	instructions) 14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		12.00	13.00	14.00	13.00	
1.00	CAP REL COSTS-BLDG & FLXT	0	2, 729		0 0	13, 347, 887	1. 00
1.01	NEW CAP REL COSTS-BLDG-STRESS	0	0		0 0	232, 763	1. 01
1. 02	NEW CAP REL COSTS-BLDG-MARTEN H	0	0		0 0	3, 188	
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0	0 2, 729	2	0 0	17, 634, 198 31, 218, 036	

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Period: Worksheet A-8
From 07/01/2018
To 06/20/2010 5 ---Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0084

Cost Center Description Basi s/Code (2) Amount						From 07/01/2018 To 06/30/2019	Date/Time Pre	
Cost Center Description Sesis/Code (2) Amount Cost Center Line # Natt. A-7 Ref.					Expense Classification or	n Worksheet A	11/25/2019 6:	15 pm
1.00 Investment Income - CAP REL CASIS-BLICK A FIXT (chapter 2) 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.02 1.00					To/From Which the Amount is	to be Adjusted		
1.00 Investment Income - CAP REL CASIS-BLICK A FIXT (chapter 2) 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.02 1.00								
1.00 Investment Income - CAP REL CASIS-BLICK A FIXT (chapter 2) 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.01 1.00 1.02 1.00								
1.00 Investment income CAP RTI COSTS-BLIG & FIXT COSTS-B		Cost Center Description						
Investment Income - New CaP SRL CORTS-RUBG-STRESS (Chepter COSTS-RUBG-STRESS (Chepter COSTS-RUBG-STRESS (Chepter Chapter 2) ORD Chepter 3) ORD Chepter 4) ORD Ch	1. 00							1. 00
REL COSTS-BLOS-STRESS (Chapter 2)	1 01	1		0	NEW CAP REI	1 01	0	1 01
1.02 Investment Income - NBN CAP ONEW CAP REL 1.02 O 1.02		REL COSTS-BLDG-STRESS (chapter		_				
Chapter 2 0 Chapter 3 0 0 0 0 0 0 0 0 0	1. 02	1 *		0	NEW CAP REL	1. 02	0	1. 02
Investment income - CAP REL OCAP REL COSTS-M9BLE EQUIP 2, 00 0 2, 00					COSTS-BLDG-MARTEN H			
Investment Income - other B	2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
Trade, quantity, and time 0 0.00 0.40 0.00 0.50 0.50 0.00 0.5	3. 00		В	-335, 145	ADMINISTRATIVE & GENERAL	5. 00	O	3. 00
discounts (chapter 8) 0 0 0 0 0 0 0 0 0	4 00			0		0.00	0	4 00
expenses (chapter 8) 6. 08 (extend of provider space by suppliers (chapter 8) 7. 00 Telephone services (pay B 3-39,603 0PERATION OF PLANT 7. 00 0 7. 0		discounts (chapter 8)		-				
Suppliers (chapter 8)	5. 00			0		0.00	0	5. 00
Telephone services (pay stations excluded) (chapter 21) Services Services (chapter 21) Services Serv	6.00			0		0.00	О	6. 00
210 8.00 Television and radio service (chapter 21) 8 -8,464 OPERATION OF PLANT 7.00 0 8.00 0.0	7. 00	Tel ephone servi ces (pay	В	-39, 603	OPERATION OF PLANT	7. 00	О	7. 00
Television and radio service (Chapter 21)								
9.00 Parking I of (chapter 21) B -135, 174 OPERATION OF PLANT 7,00 0,00 9,00 10.00 Provider-based physician adjustment 1.00 Sale of scrap, waste, etc. (chapter 23) 0,00 0,00 11.00 Sale of scrap, waste, etc. (chapter 10) 1.00 1.00 1.00 13.00 Laundry and I I Inen service 0 0,00 0,00 0,13.00 14.00 Cafeter i a-employees and guests 0,00 0,00 0,13.00 14.00 Cafeter i a-employees and guests 0,00 0,00 0,15.00 15.00 Rehatal of quantres to employee and others 0,00 0,00 0,15.00 16.00 Sale of medical and surgical supplies to other than patients 0,00 0,00 0,00 0,15.00 17.00 Sale of medical records and abstracts 0,00 0,00 0,00 0,00 0,00 0,00 18.00 Sale of medical records and abstracts 0,00 0,	8. 00		В	-8, 464	OPERATION OF PLANT	7. 00	O	8. 00
adjustment	9. 00	Parking Lot (chapter 21)	В	•	1	7. 00	0	9. 00
11.00 Sale of scrap, waste, etc. (Chapter 23) Chapter 23. 12.00 Rel ated organization Chapter 10) Chapter 23. 13.00 Laundry and I inen service Chapter 10. 13.00 Laundry and I inen service Chapter 10. 14.00 Cafeteria -employees and guests Chapter 10. 15.00 Rental of quarters to employee and others Chapter 10. 16.00 Sale of medical and surgical supplies to other than patients Chapter 10. 17.00 Sale of medical records and abstracts Chapter 10. 18.00 Sale of medical records and abstracts Chapter 10. 19.00 Sale of medical records and abstracts Chapter 10. 19.00 Sale of medical records and abstracts Chapter 10. 19.00 Value of the chapter 21. 20.00 Vanding machines Chapter 21. 20.00 Vanding machines Chapter 21. 21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments Chapter 14. 24.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14. 24.00 Adjustment for physical threapy costs in excess of limitation (chapter 14. 24.00 Object 11. Chapter 14. 25.00 Utilization review Physical and Chapter 14. 26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT Costs Center Deleted *** 26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT Costs Co	10. 00		A-8-2	-58, 737, 611			0	10. 00
12.00 Related organization Chapter 10) 13.00 Laundry and linen service 0 0.00 0.00 0.13.00 14.00 0.00 0.00 0.13.00 0.00 0.00 0.13.00 0.00 0.00 0.00 0.13.00 0.00	11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
13.00 Laundry and Linem's service 0 0.00 0.00 0.13.00 14.00 Cafeerial-employees and guests 0 0.00 0.00 0.14.00 15.00 Rental of quarters to employee and others 0 0.00 0.00 0.00 16.00 Sale of medical and surgical supplies to other than patients 0 0.00 0.00 0.00 17.00 Sale of flowed and are records and abstracts 0 0.00 0.00 0.00 18.00 Sale of medical records and abstracts 0 0.00 0.00 0.00 19.00 Nursing and allied health education (tuition, fees, books, etc.) 0 0.00 0.00 0.00 19.00 Vending machines 0 0.00 0.00 0.00 10.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 0.00 10.00 0.00 0.00 0	12. 00		A-8-1	-23, 923, 436			0	12. 00
14.00 Cafeteria-employees and guests 0 0.00 0.14.00 0.50 0.00 0.15.00 0.00 0.15.00 0.00 0.15.00 0.00	13. 00	transactions (chapter 10) Laundry and Linen service		0		0.00	0	13. 00
16.00 Sale of medical and surgical supplies to other than patients 0 0.00 0 16.00	14.00	Cafeteria-employees and guests		-	l .	0.00	0	14. 00
Supplies to other than patients Sale of drugs to other than patients Sale of drugs to other than patients O	15. 00			0		0.00	O	15.00
Datients Sale of drugs to other than patients Sale of drugs to other than patients Sale of medical records and abstracts Sale of medical records Sale of medical recor	16. 00			0		0.00	0	16. 00
Datients Sale of medical records and abstracts Sale of medical on (tuition, fees, books, etc.) Sale of medical fees, books, etc. Sale of medical fee		pati ents		_			_	
19.00 Nursing and allied health	17.00			0		0.00	O	17.00
19.00	18. 00			0		0.00	0	18. 00
books, etc.) cooks, etc.) cook	19. 00	Nursing and allied health		0		0.00	0	19. 00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)								
interest, finance or penal ty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 26.01 Depreciation - NEW CAP REL COSTS-BLDG-STRESS 26.02 Depreciation - NEW CAP REL COSTS-BLDG-STRESS 26.02 Depreciation - NEW CAP REL COSTS-BLDG-MARTEN H				_			1	
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 26.01 Depreciation - NEW CAP REL COSTS-BLDG-STRESS 26.02 Depreciation - NEW CAP REL COSTS-BLDG-MARTEN H 27.00 CAP REL COSTS-BLDG-MARTEN H 28.00 O COSTS-BLDG-MARTEN H 29.00 O COSTS-BLDG-MARTEN H 20.00 O COSTS-BLDG-MARTEN H 20.00 O COSTS-BLDG-MARTEN H 20.00 O COSTS-BLDG-MARTEN H	21.00	interest, finance or penalty		0		0.00		21.00
repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14) Adjustment for physical A-8-3 ORESPIRATORY THERAPY 65.00 23.00 A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT COSTS-BLDG & FIXT COSTS-BLDG-STRESS 26.02 Depreciation - NEW CAP REL COSTS-BLDG-STRESS 26.02 Depreciation - NEW CAP REL COSTS-BLDG-MARTEN H ORESPIRATORY THERAPY 65.00 23.00 24.00 24.00 25.00 26.00 COSTS-BLDG & FIXT ONEW CAP REL COSTS-BLDG & FIXT ONEW CAP REL COSTS-BLDG & FIXT ONEW CAP REL COSTS-BLDG-STRESS ONEW CAP REL COSTS-BLDG-MARTEN H	22. 00			0		0.00	0	22. 00
23. 00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 26. 01 Depreciation - NEW CAP REL COSTS-BLDG-STRESS 26. 02 Depreciation - NEW CAP REL COSTS-BLDG-MARTEN H A-8-3 ORESPIRATORY THERAPY 65. 00 23. 00 PHYSICAL THERAPY 65. 00 CAP REL COSTS-BLDG & FIXT ONEW CAP REL COSTS-BLDG & FIXT ONEW CAP REL COSTS-BLDG-STRESS ONEW CAP REL COSTS-BLDG-MARTEN H								
Limitation (chapter 14) Adjustment for physical therapy costs in excess of limitation (chapter 14)	23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 26. 01 Depreciation - NEW CAP REL COSTS-BLDG & FIXT 26. 02 Depreciation - NEW CAP REL COSTS-BLDG & FIXT 26. 02 Depreciation - NEW CAP REL COSTS-BLDG & FIXT 26. 02 Depreciation - NEW CAP REL COSTS-BLDG-STRESS 26. 02 Depreciation - NEW CAP REL COSTS-BLDG-MARTEN H 27. 00 CAP REL COSTS-BLDG & FIXT 28. 01 Depreciation - NEW CAP REL COSTS-BLDG-STRESS 29. 02 COSTS-BLDG-MARTEN H 29. 00 CAP REL COSTS-BLDG-MARTEN H 20. 0		13						
Limitation (chapter 14) Utilization review - Description Depreciation - CAP REL Depreciation - NEW CAP REL COSTS-BLDG-STRESS COSTS-BLDG-MARTEN H Depreciation - NEW CAP REL COSTS-BLDG-MARTEN H Depreciation - NEW CAP REL Depreci	24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26.00 COSTS-BLDG & FIXT 1.00 0 26.00 COSTS-BLDG & FIXT 1.00 0 26.00 COSTS-BLDG-STRESS 1.01 0 0 26.01 COSTS-BLDG-STRESS 0 COSTS-BLDG-STRESS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		limitation (chapter 14)						
26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 26. 01 Depreciation - NEW CAP REL COSTS-BLDG-STRESS 0 NEW CAP REL COSTS-BLDG-STRESS 1.01 0 26. 01 26. 02 Depreciation - NEW CAP REL COSTS-BLDG-STRESS 0 NEW CAP REL COSTS-BLDG-STRESS 1.02 0 26. 02 26. 02 COSTS-BLDG-MARTEN H 1.02 0 26. 02	25. 00			0	*** Cost Center Deleted ***	114. 00		25. 00
COSTS-BLDG & FIXT Depreciation - NEW CAP REL COSTS-BLDG-STRESS COSTS-BLDG-STRESS COSTS-BLDG-STRESS 26. 02 Depreciation - NEW CAP REL COSTS-BLDG-MARTEN H COSTS-BLDG-MARTEN H O NEW CAP REL 1. 01 0 26. 01 COSTS-BLDG-MARTEN H	26 00	(chapter 21)		^	CAD REL COSTS_RIDG & ELVT	1 00		26 00
COSTS-BLDG-STRESS Depreciation - NEW CAP REL COSTS-BLDG-MARTEN H COSTS-BLDG-MARTEN H COSTS-BLDG-MARTEN H COSTS-BLDG-MARTEN H COSTS-BLDG-MARTEN H COSTS-BLDG-MARTEN H 26. 02		COSTS-BLDG & FLXT						
26.02 Depreciation - NEW CAP REL ONEW CAP REL 1.02 0 26.02 COSTS-BLDG-MARTEN H	26. 01					1. 01	0	26. 01
	26. 02					1. 02	0	26. 02
	27. 00	Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP	2. 00	o	27. 00
COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00	28. 00			0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 Physi ci ans' assi stant 0 0. 00 0 29. 00	29. 00	Physicians' assistant		0		0.00	0	29. 00

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				Provider CCN. 15-0064	From 07/01/2018 To 06/30/2019		pared:
				Expense Classification o	n Worksheet A	11/25/2019 6:	15 pm
			To/	From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
30. 00	Adjustment for occupational	A-8-3	olocc	JPATI ONAL THERAPY	67. 00		30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		OADU	LTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	OSDE	ECH PATHOLOGY	68. 00		31.00
31.00	pathology costs in excess of	A-0-3	USFL	LCII FATIIOLOGI	00.00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33. 00	Mi sc Revenue	В	-958, 931 CAP	REL COSTS-BLDG & FIXT	1.00	9	33.00
33. 01	Mi sc Revenue	В		LOYEE BENEFITS DEPARTMEN			1 00.0.
33. 02 33. 03	Mi sc Revenue Mi sc Revenue	B B		INISTRATIVE & GENERAL RATION OF PLANT	5. 00 7. 00	l e	
33. 04	Mi sc Revenue	В	-304, 697 DI E		10.00	l e	1
33. 05	Mi sc Revenue	В	-2, 899, 118 CAF		11.00		1
33. 06	Mi sc Revenue	В		SING ADMINISTRATION	13. 00	-	
33. 07	Mi sc Revenue	В		TRAL SERVICES & SUPPLY	14. 00		33. 07
33. 08	Mi sc Revenue	В	-22, 004 PHA	RMACY	15. 00	0	33. 08
33. 09	Mi sc Revenue	В		ICAL RECORDS & LIBRARY	16. 00		
33. 10	Mi sc Revenue	В	-281, 551 SOC		17. 00		1 00
33. 11	Mi sc Revenue	В		SERVICES-OTHER PRGM TS A	22. 00	0	33. 11
33. 12	Mi sc Revenue	В	I	AMED ED PRGM - CPE	23. 01	0	33. 12
33. 13	Misc Revenue	В	-51, 285 PAR	AMED ED PRGM - RADIOLOGY	23. 02	0	33. 13
33. 14	Mi sc Revenue	В	I	LTS & PEDIATRICS	30.00		1 00
33. 15	Mi sc Revenue	В		NATAL INTENSIVE CARE UNI		0	1 00
33. 16 33. 17	Mi sc Revenue Mi sc Revenue	B B		PROVIDER - IPF	40. 00 50. 00	0	1 000
33. 17	Mi sc Revenue	В		RATING ROOM IVERY ROOM & LABOR ROOM	52.00		
33. 19	Mi sc Revenue	В	· •	I OLOGY-DI AGNOSTI C	54.00		1
33. 20	Mi sc Revenue	В		OCARDI OLOGY	54. 03		1
33. 21	Mi sc Revenue	В	OONC	OLOGY	54. 04	0	33. 21
33. 22	Misc Revenue	В	-182, 581 PHY	SICAL THERAPY	66.00	0	33. 22
33. 23	Mi sc Revenue	В		ECH PATHOLOGY	68. 00	0	1 000
33. 24	Mi sc Revenue	В		GS CHARGED TO PATIENTS	73.00		1 00
33. 25 33. 26	Mi sc Revenue Mi sc Revenue	B B	-76, 700 CLI	NIC TLAL HOSPITALIZATION	90. 00 90. 01	0	
33. 27	Mi sc Revenue	В	-30, 937 EME		91.00	1	1
33. 28	Mi sc Revenue	В		ANTICOAGULATION CLINIC	91.06		1
33. 29	Mi sc Revenue	В	-16, 558 AMB	JLATORY SURGICAL CENTER	115. 00		1
33. 30	Non-reimbursable items	А	(D.	P.) INISTRATIVE & GENERAL	5. 00	0	33. 30
33. 31	Lobbyi ng dues	Ä		INISTRATIVE & GENERAL	5.00		
33. 32	Provi der tax	A		INISTRATIVE & GENERAL	5. 00		
33. 33	Physician loss funding	A	-15, 576, 823 ADM	INISTRATIVE & GENERAL	5. 00	0	33. 33
33. 34	EMS Training	A		AMED ED PRGM - EMS	23. 03		
33. 35	EMS Income	В		AMED ED PRGM - EMS	23. 03		
33. 36	EMS Income	В	•	AMED ED PRGM - EMS	23. 03		
33. 39 33. 40	Mi dl evel s	A A		LOYEE BENEFITS DEPARTMEN INISTRATIVE & GENERAL	IT 4. 00 5. 00		
33. 41	Mi dl evel s Mi dl evel s	A	· .	SING ADMINISTRATION	13. 00		
33. 41	Mi dl evel s	A	-109, 003 NOK -119, 327 SOC		17. 00		
33. 43	Mi dl evel s	A	-393, 471 I &R	SERVICES-OTHER PRGM	22. 00		1
33. 44	Mi dl evel s	А		TS A LTS & PEDIATRICS	30.00	0	33. 44
33. 45	Mi dl evel s	A		IATRIC INTENSIVE CARE	33. 01	Ö	
22 44	Mi di aval a	_	UNI		T 04.25		22 4.
33. 46	Mi dl evel s	A A	· · · · · · · · · · · · · · · · · · ·	NATAL INTENSIVE CARE UNI DDOVIDED - IDE	T 34. 01 40. 00	0	
33. 47 33. 48	Mi dl evel s Mi dl evel s	A A	-745, 403 SUB -786, 741 OPE	PROVIDER - IPF RATING ROOM	50.00		1
33. 49	Mi dl evel s	A		CTROENCEPHALOGRAPHY	70.00		
33. 50	Mi dl evel s	Ä	-923, 931 EME		91.00		1
33. 51	Mi dl evel s	A		LLY PRACTICE	91. 08	l e	
50.00	TOTAL (sum of lines 1 thru 49)		-164, 906, 668				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

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Health Financial Systems		ST. VINCENT HO	SPITAL & HCC	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 6:	
			Expense Classification or	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1 00	2 00	2 00	4 00	5.00	

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

B. Amount Received - if cost cannot be determined.

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⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 15-0084

Period:
From 07/01/2018
To 06/30/2019
Date/Time Prepared:
11/25/2019 6: 15 pm

				10 06/30/2019	11/25/2019 6:	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	l
	HOME OFFICE COSTS:	IADM NU OTDATIVE & OFNEDAL	lu 0001 0 11 1			
1.00		ADMINISTRATIVE & GENERAL	Home Office - Capital	20, 706, 404	0	
2.00		ADMINISTRATIVE & GENERAL	Home Office - Interest	291, 770	0	2.00
3.00		ADMINISTRATIVE & GENERAL	Home Office - Other	164, 368, 588	215, 395, 943	
3. 01	II	EMPLOYEE BENEFITS DEPARTMENT	SVH Chargebacks	834, 643	834, 643	
3. 02 3. 03		ADMINISTRATIVE & GENERAL	SVH Chargebacks	4, 844, 667	4, 844, 667	3. 02 3. 03
	1	OPERATION OF PLANT	SVH Chargebacks	-90, 221	-90, 221	
3.04	1	NURSI NG ADMI NI STRATI ON	SVH Chargebacks	414, 570	414, 570	
3. 05	1	PHARMACY	SVH Chargebacks	-115, 953	-115, 953	3.05
3.06		PARAMED ED PRGM - RADIOLOGY	SVH Chargebacks	-53, 427	-53, 427	
3. 07		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	SVH Chargebacks SVH Chargebacks	-172, 972	-172, 972	1
3. 08 3. 09			SVH Chargebacks	1, 930, 500 10, 800	1, 930, 500 10, 800	
3. 10			SVH Chargebacks	-806, 878	-806, 878	
3. 10		SUBPROVIDER - IPF	SVH Chargebacks	-480, 900	-480, 900	
3. 11		OPERATING ROOM	SVH Chargebacks	8, 752	8, 752	3. 11
3. 12		RADI OLOGY-DI AGNOSTI C	SVH Chargebacks	-144, 874	-144, 874	
3. 14		AMBULATORY CARDIOVASCULAR SV		-183, 938	-183, 938	
3. 15		ECHOCARDI OLOGY	SVH Chargebacks	-1, 819	-1, 819	1
3. 16		ONCOLOGY	SVH Chargebacks	-376, 230	-376, 230	
3. 17		CARDI AC CATHETERI ZATI ON	SVH Chargebacks	72,000	72, 000	
3. 18	1	CARDI AC REHAB	SVH Chargebacks	30,000	30, 000	1
3. 19	1	RESPI RATORY THERAPY	SVH Chargebacks	-9, 274	-9, 274	
3. 20	1	PHYSI CAL THERAPY	SVH CHARGEBACKS	-177, 020	-177, 020	
3. 21	70.00	ELECTROENCEPHALOGRAPHY	SVH CHARGEBACKS	224, 674	224, 674	
3. 22	1	ENDOSCOPY	SVH CHARGEBACKS	780, 000	780, 000	
3. 23	1	OP ANTICOAGULATION CLINIC	SVH CHARGEBACKS	-34, 896	-34, 896	
3. 24	105.00	KIDNEY ACQUISITION	SVH CHARGEBACKS	6, 240	6, 240	3. 24
3. 25	106.00	HEART ACQUISITION	SVH CHARGEBACKS	662, 420	662, 420	3. 25
3. 26	192. 00	PHYSICIANS PRIVATE OFFICES	SVH CHARGEBACKS	154, 035	154, 035	3. 26
3. 27	193. 02	MISSION SERVICES	SVH CHARGEBACKS	193, 684	193, 684	3. 27
3. 28	193. 19	SPORTS PERFORMANCE	SVH CHARGEBACKS	-113, 978	-113, 978	3. 28
3. 29	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	6, 062, 370	0	3. 29
3.30	5. 00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	43, 375	0	3. 30
3. 31	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEATLH INSURANCE	55, 553, 740	55, 553, 740	3. 31
3. 32	0.00			o	0	3. 32
3. 33	0.00			0	0	3. 33
4.00	0.00			0	0	4. 00
5.00	TOTALS (sum of lines 1-4).			254, 430, 852	278, 354, 288	5. 00
	Transfer column 6, line 5 to					l
	Worksheet A-8, column 2,					l
	line 12.					1

* 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			
Symbol (1)	Name	Percentage of	Name	Percentage of			
<i>Gy</i> (1)	. Tame	Ownershi p	, idamo	Ownershi p			
1. 00	2. 00	3.00	4. 00	5. 00			
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.

6.00	В		0.00 St. Vincent Health	100. 00	6. 00
7.00	В		0. 00 Ascensi on	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	Home Office			100.00
	non-financial) specify:				

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Health Financial Systems	ST. VINCENT HO	SPITAL & HCC		In Lie	eu of Form CMS-	2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	E Provider (CCN: 15-0084	Peri od:	Worksheet A-8	-1
OFFICE COSTS				From 07/01/2018 To 06/30/2019		
			Related Organ	nization(s) and/o	or Home Office	
Symbol (1)	Name	Percentage of	N	lame	Percentage of	
		Ownershi p			Ownershi p	

3.00

4. 00

5. 00

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

1.00

- 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 organi zati on.

2.00

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.

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* 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.

3.32

3.33

4.00

5.00

0

0

0

-23, 923, 436

3. 32 3. 33

4.00

5.00

1103 1101	been posted to norkaneet A,	cordinas i and or 2, the amount arrowable should be mareated in cordinar 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED 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.

i ei iiibui	Schieff under title Aviii.	
6.00	Home Office	6.00
7.00	Home Office	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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Health Financial Systems	ST. VINCENT HOSP	TAL & HCC	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0084	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 07/01/2018 To 06/30/2019	Date/Time Prepared: 11/25/2019 6:15 pm
Related Organization(s) and/or Home Office				
Type of Business				
6, 00				

- (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 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.

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						To 06/30/2019		
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provi der Component	RCE Amount	Physician/Prov ider Component	15 piii
	1. 00	2.00	3.00	4.00	5. 00	6. 00	Hours 7.00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	10, 769			0		1. 00
2.00		ADMINISTRATIVE & GENERAL	729, 893				-	2.00
3. 00 4. 00		NURSING ADMINISTRATION SOCIAL SERVICE	22, 926 108, 273			0	0	3. 00 4. 00
5. 00	•	I &R SERVICES-OTHER PRGM	7, 716, 707				0	5. 00
0.00		COSTS A	1,7,10,707	1,7.10,707				0.00
6.00		PARAMED ED PRGM - RADIOLOGY	191	191		0	0	6. 00
7. 00 8. 00	•	ADULTS & PEDIATRICS CARDIOTHORACIC VASCULAR	23, 615, 169			0	0	7. 00 8. 00
0.00	32.01	TRANSPL	691, 667	691, 667	0			8.00
9. 00	33. 01	PEDIATRIC INTENSIVE CARE UNIT	1, 908, 389	1, 908, 389	0	0	0	9. 00
10.00		NEONATAL INTENSIVE CARE UNIT	8, 624, 881	8, 624, 881	0	0	O	10.00
11.00		SUBPROVI DER - I PF	1, 257, 599			0	0	11.00
12. 00 13. 00		NURSERY OPERATING ROOM	1, 190, 844 4, 947, 400			0	0	12. 00 13. 00
14. 00		RADI OLOGY-DI AGNOSTI C	152, 176				o	14. 00
15. 00		ONCOLOGY	171, 143			O	o	15. 00
16. 00		ELECTROENCEPHALOGRAPHY	2, 396, 095	2, 396, 095	0	0	0	16. 00
17. 00		CLI NI C	8, 800			0	0	17. 00
18. 00 19. 00		EMERGENCY OP ANTICOAGULATION CLINIC	2, 633, 044 8, 366			0	0	18. 00 19. 00
20. 00		ST VINCENT OUTPATIENT TREATMENT	399, 238			Ö	0	20. 00
21.00	91. 08	FAMILY PRACTICE	1, 638, 449	1, 638, 449	0	0	o	21. 00
22. 00	1	KIDNEY ACQUISITION	639, 781	0	639, 781	246, 400		22. 00
23. 00	105.00	KIDNEY ACQUISITION	268, 744		268, 744	197, 500		23. 00
200.00	Wkst. A Line #	Cost Center/Physician	59, 140, 544 Unadj usted RCE		908, 525 Cost of	Provi der	3,631 Physician Cost	200. 00
		I denti fi er	_	Unadjusted RCE Limit	Memberships & Continuing	Component Share of col.	of Malpractice Insurance	
	1. 00	2.00	8.00	9. 00	Education 12.00	12 13. 00	14.00	
1. 00		EMPLOYEE BENEFITS DEPARTMENT	0					1. 00
2.00		ADMINISTRATIVE & GENERAL	0		_	0	0	2. 00
3.00		NURSI NG ADMI NI STRATI ON	0	0	0	0	0	3. 00
4. 00 5. 00	•	SOCIAL SERVICE &R SERVICES-OTHER PRGM	0	0	0	0	0	4. 00 5. 00
5.00	22.00	COSTS A	9					3. 00
6.00		PARAMED ED PRGM - RADIOLOGY	0	0	0	0	0	6. 00
7.00		ADULTS & PEDIATRICS	0	0	0	0	0	7. 00
8. 00	32.01	CARDI OTHORACI C VASCULAR TRANSPL	0	0	U		0	8. 00
9. 00	33. 01	PEDIATRIC INTENSIVE CARE	0	0	0	0	O	9. 00
		UNI T						
10. 00 11. 00		NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	0	0	0	0	10. 00 11. 00
12. 00		NURSERY	0		0		0	12. 00
13. 00		OPERATING ROOM	0	Ö	Ö	O	o	13. 00
14.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	14.00
15.00		ONCOLOGY	0	0	0	0	0	15.00
16. 00 17. 00		ELECTROENCEPHALOGRAPHY CLI NI C	0	0	0	0	0	16. 00 17. 00
18. 00		EMERGENCY			Ö		0	18. 00
19.00		OP ANTICOAGULATION CLINIC	0	0	0	0	0	19. 00
20. 00	91.07	ST VINCENT OUTPATIENT	0	0	0	0	O	20. 00
21. 00	01 09	TREATMENT FAMILY PRACTICE	0	0		0	o	21. 00
22. 00		KIDNEY ACQUISITION	293, 074	14, 654	Ö		Ö	22. 00
23.00	105. 00	KIDNEY ACQUISITION	109, 859			0	0	23. 00
200.00			402, 933			0	0	200. 00
	Wkst. A Line #	Cost Center/Physician I dentifier	Provider Component Share of col.	Adjusted RCE Limit	RCE Di sal I owance	Adjustment		
	1.00	2.00	14 15. 00	16. 00	17. 00	18. 00	-	
1. 00	1 (1(1			10.00	17.00			
1.00	1.00	2.00 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	10, 769		1. 00
2.00	4. 00 5. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL		0	0	729, 893		2. 00
2. 00 3. 00	4. 00 5. 00 13. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL NURSING ADMINISTRATION		0 0 0	0 0	729, 893 22, 926		2. 00 3. 00
2. 00 3. 00 4. 00	4. 00 5. 00 13. 00 17. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL NURSING ADMINISTRATION SOCIAL SERVICE		000000000000000000000000000000000000000	0 0 0	729, 893 22, 926 108, 273		2. 00 3. 00 4. 00
2. 00 3. 00	4. 00 5. 00 13. 00 17. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL NURSING ADMINISTRATION		000000000000000000000000000000000000000	0 0 0	729, 893 22, 926		2. 00 3. 00
2. 00 3. 00 4. 00 5. 00	4. 00 5. 00 13. 00 17. 00 22. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL NURSING ADMINISTRATION SOCIAL SERVICE 1&R SERVICES-OTHER PRGM COSTS A PARAMED ED PRGM - RADIOLOGY		0 0 0 0 0		729, 893 22, 926 108, 273 7, 716, 707		2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	4. 00 5. 00 13. 00 17. 00 22. 00 23. 02 30. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL NURSING ADMINISTRATION SOCIAL SERVICE I&R SERVICES-OTHER PRGM COSTS A	0 0 0 0 0	0 0 0 0	0 0 0	729, 893 22, 926 108, 273 7, 716, 707 191 23, 615, 169		2. 00 3. 00 4. 00 5. 00

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From 07/01/2018 06/30/2019 Date/Time Prepared: 11/25/2019 6: 15 pm Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Li mi t Di sal I owance Share of col. 14 15.00 17. 00 1.00 2.00 16.00 18.00 8.00 32. 01 CARDI OTHORACI C VASCULAR 0 691, 667 8.00 TRANSPL 9.00 33. 01 PEDIATRIC INTENSIVE CARE 0 1, 908, 389 9.00 0 UNI T 34. 01 NEONATAL INTENSIVE CARE UNIT 8, 624, 881 10.00 0 10.00 11.00 40. 00 SUBPROVIDER - IPF 0 0 1, 257, 599 11.00 12.00 43. 00 NURSERY 1, 190, 844 12.00 13.00 50. 00 OPERATING ROOM 0 0 0 4, 947, 400 13.00 54. 00 RADI OLOGY-DI AGNOSTI C 152, 176 0 14.00 0 14.00 0 15.00 54. 04 ONCOLOGY 171, 143 15.00 16.00 70. 00 ELECTROENCEPHALOGRAPHY 0 2, 396, 095 16.00 90. 00 CLI NI C 0 0 17.00 17.00 8,800 2, 633, 044 91. 00 EMERGENCY 18.00 0 0 18.00 19.00 91.06 OP ANTICOAGULATION CLINIC 0 8, 366 19.00 20.00 91. 07 ST VINCENT OUTPATIENT 399, 238 20.00 TREATMENT 91.08 FAMILY PRACTICE 21.00 0 0 1, 638, 449 21.00

0

293, 074

109, 859

402, 933

346, 707

158, 885

505, 592

346, 707

158, 885

58, 737, 611

22.00

23.00

200.00

105.00 KIDNEY ACQUISITION

105.00 KIDNEY ACQUISITION

22.00

23.00

200.00

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Period: Worksheet B From 07/01/2018 Part I Provider CCN: 15-0084

				rom 07/01/2018 o 06/30/2019	Part I Date/Time Pre	
			CAPITAL RE	LATED COSTS	11/25/2019 6:	15 pm
Cost Center Description	Net Expenses	BLDG & FIXT	NEW	NEW	MVBLE EQUIP	
	for Cost Allocation		BLDG-STRESS	BLDG-MARTEN H		
	(from Wkst A					
	col. 7)	1. 00	1. 01	1. 02	2. 00	
GENERAL SERVICE COST CENTERS	<u> </u>		1.01	1.02	2.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-BLDG-STRESS	13, 347, 887 232, 763	13, 347, 887 0	232, 763			1. 00 1. 01
1.02 OO102 NEW CAP REL COSTS-BLDG-STRESS	3, 188	0	232, 763			1. 01
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	17, 634, 198	445 400	0.050		17, 634, 198	2.00
4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT 5.00 OO500 ADMINISTRATIVE & GENERAL	62, 075, 602 181, 732, 374	115, 492 498, 787	2, 058 16, 908		12, 467 1, 139, 455	4. 00 5. 00
7.00 00700 OPERATION OF PLANT	27, 189, 183	2, 332, 537	13, 001	0	483, 851	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING	2, 897, 732 11, 084, 636	3, 797 144, 178	0 2, 359	0	0 2, 097	8. 00 9. 00
10. 00 01000 DI ETARY	4, 324, 651	327, 728	4, 513		17, 063	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINISTRATI ON	7, 309, 337	0 36, 094	0 1, 973	0	1 044 513	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	14, 087, 320 8, 342, 623	413, 725	6, 828		1, 064, 513 991, 386	14.00
15. 00 01500 PHARMACY	27, 433, 776	171, 982	0	0	156, 414	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	370, 502 6, 341, 037	106, 341 22, 275	2, 890 462	0	630 0	16. 00 17. 00
21.00 02100 I &R SERVICES-SALARY & FRINGES A	9, 990, 526	0	0	0	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS A 23.00 02300 PARAMED ED PRGM- PHARMACY	3, 508, 314 725, 746	129, 913 12, 304	0	0	41, 838 0	22. 00 23. 00
23. 01 02301 PARAMED ED PRGM - CPE	283, 250	23, 727	ő	0	0	23. 00
23. 02 02302 PARAMED ED PRGM - RADI OLOGY	175, 478	14, 774	0		0	23. 02
23. 03 02303 PARAMED ED PRGM - EMS I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 003, 434	1, 048	0	0	3, 865	23. 03
30. 00 03000 ADULTS & PEDIATRICS	68, 868, 795	3, 116, 476	0		530, 047	30.00
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	16, 571, 210	454, 435 0	0	0	359, 196 0	31. 00 32. 00
32. 01 03201 CARDI OTHORACI C VASCULAR TRANSPL	12, 143, 925	346, 683	Ö	0	226, 319	32. 01
33. 00 03300 BURN INTENSIVE CARE UNIT 33. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	0 3, 021, 050	0 193, 458	0	0	0 269, 308	33. 00 33. 01
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT	3, 021, 030	173, 436	0	0	204, 308	34. 00
34. 01 02060 NEONATAL INTENSIVE CARE UNIT	16, 518, 418	294, 187	107 544		317, 492	34. 01
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	4, 396, 916 895, 678	41, 976 132, 330	107, 544 0	0	14, 335 602	40. 00 41. 00
43. 00 04300 NURSERY	2, 362, 395	159, 948	0	0	48, 838	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	32, 367, 322	1, 518, 875	0	O	5, 426, 171	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 611, 869	212, 994	0		63, 024	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05402 AMBULATORY CARDI OVASCULAR SVC	8, 677, 505 4, 494, 237	261, 548 123, 003	0	0	855, 948 307, 714	54. 00 54. 01
54. 02 05403 ULTRASOUND	1, 179, 676	20, 355	ő	o o	58, 202	54. 02
54. 03 05404 ECHOCARDI OLOGY	1, 594, 044 9, 194, 942	104 017	0	0	107, 991	
54. 04 05401 0NCOLOGY 57. 00 05700 CT SCAN	1, 769, 412	104, 017 22, 638		0	491, 185 409, 217	54. 04
58. 00 05800 MRI	1, 325, 177	88, 206	0	0	413, 656	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 59. 01 05901 CARDI AC REHAB	4, 131, 953 938, 263	285, 856 0	0	_	1, 226, 553 11, 409	59. 00 59. 01
60. 00 06000 LABORATORY	26, 032, 569	179, 556	Ö	0	24, 159	60. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	12, 579, 021 10, 097, 423	33, 791 109, 910	0 205	0	424, 723 50, 066	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 157, 663	3, 859	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 082, 907	13, 051	0	0	10, 593	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 467, 903 6, 099, 706	8, 051 8, 393	40, 013	0	142, 411 163, 976	69. 00 70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	54, 847, 113	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	56, 982, 525 62, 143, 287	0	0	0	0	72. 00 73. 00
74. 00 07400 RENAL DIALYSIS	5, 086, 503	36, 270	ő	o o	16, 355	74. 00
75. 00 03330 ENDOSCOPY	2, 766, 410	122, 069	0	0	294, 714	75. 00
90. 00 09000 CLINIC	5, 304, 177	O	0	ol	83, 368	90.00
90. 01 09001 PARTIAL HOSPITALIZATION	1, 947, 852	53, 181	34, 009		3, 024	90. 01
91. 00 09100 EMERGENCY 91. 01 09101 WOUND CARE 002	22, 806, 841 1, 231, 320	397, 260 99, 484	0 0	0	603, 129 4, 286	91. 00 91. 01
91. 02 09102 WOUND CARE 001	478, 728	5, 737	Ö	o o	22, 122	91. 02
91. 03 09103 LAFAYETTE RD CLINIC 91. 04 09104 ZIONSVILLE CLINIC	222 611, 806	0	0	0	0 29, 193	91. 03 91. 04
91. 05 09104 210NSVI ELE CETNIC 91. 05 09105 BROWNSBURG CLINIC	011,800	0	0	0	0	91.04
91.06 09106 OP ANTI COAGULATION CLINIC	562, 437	17, 585	0	0	0	91. 06

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Period: Worksheet B
From 07/01/2018 Part I
To 06/30/2019 Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0084

			T	0 06/30/2019	Date/Time Pre 11/25/2019 6:	
			CAPITAL RE	LATED COSTS	1172072017 0.	lo piii
Cost Center Description	Net Expenses	BLDG & FIXT	NEW	NEW	MVBLE EQUIP	
	for Cost		BLDG-STRESS	BLDG-MARTEN H		
	Allocation					
	(from Wkst A					
	col . 7)			4.00		
OA OZ DOAGO CT NAMOCNIT GUITDATI ENT TREATMENT	0	1.00	1. 01	1. 02	2. 00	04.07
91. 07 09107 ST VI NCENT OUTPATIENT TREATMENT	685, 925	0	_		0	91. 07
91. 08 04040 FAMILY PRACTICE	2, 356, 350	0	0	0	12, 389	1
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT						92. 00
OTHER REIMBURSABLE COST CENTERS		(2.7(2			0	05 00
95. 00 09500 AMBULANCE SERVI CES 98. 00 09853 GERI ATRI C CLI NI C	0 881	63, 763	0	0	0	95. 00 98. 00
98. 01 09853 GERTATRIC CLINIC 98. 01 09851 ELECTROCONVULSI VE THERAPY	881	0	0	0	0	98.00
98. 02 09851 ELECTROCONVOLSTVE THERAPY 98. 02 09852 DI ABETES EDUCATION	320, 459	0) 	0	4, 941	98.01
SPECIAL PURPOSE COST CENTERS	320, 439	U		U U	4, 941	90.02
105. 00 10500 KI DNEY ACQUI SI TI ON	5, 834, 104	0	0	٥	18, 397	105 00
106. 00 10600 HEART ACQUISITION	6, 290, 663	0	0	0		106.00
112. 00 08600 PANCREAS ACQUISITION	9,000	0	0	0		112. 00
113. 00 11300 NTEREST EXPENSE	7,000	Ŭ	Ĭ	Ŭ	O	113. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	12, 569, 805	0	0	0	348, 722	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	897, 509, 944	12, 883, 647	232, 763	o	17, 307, 354	
NONREI MBURSABLE COST CENTERS	, , , , , ,	, ,	,	-1	, ,	
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	1, 023, 889	30, 388	0	0	161	190. 00
191. 00 19100 RESEARCH	1, 733, 655	0	0	0	0	191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	43, 689, 946	86, 100	0	0	175, 648	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19304 MARKETI NG	350	0	0	0	0	193. 01
193. 02 19305 MI SSI ON SERVI CES	1, 015, 890	27, 286	0	0	14, 794	
193. 03 19306 FOUNDATI ON	2, 664, 888	0	0	0		193. 03
193. 04 19307 WELLNESS	701, 352	0	0	0		193. 04
193. 07 19310 BI LLI NG	19, 449, 932	0	0	0		193. 07
193. 09 19312 LI FELI NE	2, 372	0	0	0		193. 09
193. 10 19313 MARTEN HOUSE	0	0	0	3, 188		193. 10
193. 14 19302 VACANT SPACE	0	320, 466	0	0		193. 14
193. 16 19316 SETON BOARD	0	0	0	0		193. 16
193. 19 19319 SPORTS PERFORMANCE	8, 878, 949	0	0	0	130, 074	
200.00 Cross Foot Adjustments		_	_	_	_	200.00
201. 00 Negative Cost Centers	07/ /74 4/7	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	976, 671, 167	13, 347, 887	232, 763	3, 188	17, 634, 198	J202. 00

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				1	0 00/30/2019	Date/lime Prep 11/25/2019 6:	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4.00	4A	5. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	, ,					
1.00 1.01 1.02 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 21.00 22.00	00100 CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-BLDG-STRESS 00102 NEW CAP REL COSTS-BLDG-MARTEN H 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	62, 205, 619 2, 480, 264 299, 558 0 0 0 1, 882, 731 834, 410 2, 164, 125 18, 529 1, 050, 822 1, 852, 833	185, 867, 788 30, 318, 130 2, 901, 529 11, 233, 270 4, 673, 955 7, 309, 337 17, 072, 631 10, 588, 972 29, 926, 297 498, 892 7, 414, 596	7, 125, 882 681, 967 2, 640, 234 1, 098, 552 1, 717, 965 4, 012, 700 2, 488, 800 7, 033, 787 117, 258 1, 742, 704 2, 783, 628	37, 444, 012 13, 021 515, 288 1, 163, 773 0 141, 238 1, 479, 157 589, 749 390, 237 80, 438	3, 596, 517 0 0 0 2, 195 2, 362 0 0 0 58	1. 00 1. 01 1. 02 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 16. 00 17. 00 21. 00
23. 00	O2200 1 & R SERVI CES-OTHER PRGM COSTS A O2300 PARAMED ED PRGM- PHARMACY	1, 562, 254 126, 605	5, 242, 319 864, 655	1		0	22. 00 23. 00
23. 00	02301 PARAMED ED PRGM - CPE	52, 439	359, 416			0	23. 00
23. 02	02302 PARAMED ED PRGM - RADIOLOGY	43, 288	233, 540			Ö	23. 02
23. 03	02303 PARAMED ED PRGM - EMS	156, 913	1, 165, 260	273, 879	3, 593	0	23. 03
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	12 (74 50)	0/ 100 024	20, 257, 534	10, 686, 771	1 502 751	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	13, 674, 506 2, 515, 410	86, 189, 824 19, 900, 251			1, 503, 751 237, 530	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
32. 01 33. 00	03201 CARDI OTHORACI C VASCULAR TRANSPL 03300 BURN INTENSI VE CARE UNIT	1, 803, 417	14, 520, 344	3, 412, 818	1, 188, 819	108, 023 0	32. 01 33. 00
33. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	785, 616	4, 269, 432	1, 003, 474	663, 392	54, 641	33. 01
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
34. 01 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	3, 949, 319 1, 044, 400	21, 079, 416 5, 605, 171			131, 848 123, 396	34. 01 40. 00
41. 00	04100 SUBPROVI DER - I RF	93, 556	1, 122, 166				41. 00
43.00	04300 NURSERY	534, 307	3, 105, 488			12, 456	43.00
	ANCILLARY SERVICE COST CENTERS						
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	4, 599, 039 771, 301	43, 911, 407 5, 659, 188			647, 456 54, 224	50. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	916, 053	10, 711, 054			37, 812	54. 00
54. 01	05402 AMBULATORY CARDIOVASCULAR SVC	580, 141	5, 505, 095			46, 301	54. 01
54. 02	05403 ULTRASOUND	202, 390	1, 460, 623	1		0	54. 02
54. 03	05404 ECHOCARDI OLOGY	147, 210	1, 849, 245			0	54. 03
54. 04 57. 00	05401 ONCOLOGY 05700 CT SCAN	735, 116 287, 143	10, 525, 260 2, 488, 410			29, 594 53, 813	54. 04 57. 00
58. 00	05800 MRI	169, 523	1, 996, 562	1			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	901, 441	6, 545, 803	1, 538, 506			
	05901 CARDI AC REHAB	125, 957	1, 075, 629				59. 01
60.00	06000 LABORATORY	1 274 205	26, 236, 284 14, 411, 830			0	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 374, 295 1, 463, 185	11, 720, 789			32, 410	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	198, 817	1, 360, 339			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	158, 043	1, 264, 594	297, 226		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	272, 350	2, 890, 715			4, 139	69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PAT	279, 119	6, 591, 207 54, 847, 113	1		8, 581 0	70. 00 71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	56, 982, 525			0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	62, 143, 287			0	73. 00
74. 00	07400 RENAL DIALYSIS	0	5, 139, 128			15, 475	74. 00
75. 00	03330 ENDOSCOPY OUTPATIENT SERVICE COST CENTERS	356, 082	3, 539, 275	831, 861	418, 591	27, 062	75. 00
90. 00	09000 CLINIC	459, 527	5, 847, 072	1, 374, 278	0	0	90. 00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	312, 385	2, 350, 451			0	90. 01
91. 00	09100 EMERGENCY	2, 451, 914	26, 259, 144			343, 314	91. 00
91. 01	09101 WOUND CARE 002	110, 352	1, 445, 442	1		15, 778	91. 01
91. 02 91. 03	09102 WOUND CARE 001 09103 LAFAYETTE RD CLINIC	80, 663	587, 250 222	1		0	91. 02 91. 03
91. 03	09104 ZI ONSVI LLE CLI NI C	57, 677	698, 676	1		0	91. 03
91. 05	09105 BROWNSBURG CLINIC	0	0	0	0	0	91. 05
91.06	09106 OP ANTI COAGULATI ON CLI NI C	85, 184	665, 206	1		0	91.06
91. 07 91. 08	09107 ST VINCENT OUTPATIENT TREATMENT 04040 FAMILY PRACTICE	61, 157 405, 383	747, 082 2, 774, 122	1	0	0	91. 07 91. 08
	09200 OBSERVATION BEDS (NON-DISTINCT	400, 303	2, 774, 122	1			91.00
	•			•	•	'	

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| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2018 | Part I | To 06/30/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0084

			To	06/30/2019	Date/Time Pre 11/25/2019 6:	
Cost Center Description	EMPLOYEE	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	13 рііі
oost denter beschiptren	BENEFITS	Subtotal	& GENERAL	PLANT	LINEN SERVICE	
	DEPARTMENT		d GENERALE	1 27 11 11	ETHEN SERVICE	
	4. 00	4A	5. 00	7. 00	8. 00	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	63, 763	14, 987	218, 652	0	95.00
98. 00 09853 GERI ATRI C CLI NI C	0	881	207	0	0	98. 00
98. 01 09851 ELECTROCONVULSI VE THERAPY	0	0	0	0	0	98. 01
98. 02 09852 DIABETES EDUCATION	54, 985	380, 385	89, 405	0	0	98. 02
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	329, 987	6, 182, 488	1, 453, 113	0	0	105.00
106.00 10600 HEART ACQUISITION	315, 975	6, 606, 638	1, 552, 804	0	0	106. 00
112.00 08600 PANCREAS ACQUISITION	0	9, 000	2, 115	0	0	112.00
113. 00 11300 I NTEREST EXPENSE						113.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	633, 317	13, 551, 844	3, 185, 185	0	0	115. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	55, 821, 013	890, 331, 066	165, 574, 671	35, 852, 078	3, 596, 517	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	1, 054, 438	247, 832	104, 203		190. 00
191. 00 19100 RESEARCH	209, 640	1, 943, 295	456, 746	0		191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	4, 822, 860	48, 774, 554	11, 463, 825	295, 248		192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193. 01 19304 MARKETI NG	0	350		0		193. 01
193. 02 19305 MI SSI ON SERVI CES	95, 126	1, 153, 096	· ·	93, 566		193. 02
193. 03 19306 FOUNDATI ON	145, 048	2, 812, 555		0		193. 03
193. 04 19307 WELLNESS	79, 026	780, 378	· ·	0		193. 04
193. 07 19310 BI LLI NG	0	19, 449, 932		0		193. 07
193. 09 19312 LI FELI NE	0	5, 920	· ·	0		193. 09
193.10 19313 MARTEN HOUSE	0	3, 188		0		193. 10
193. 14 19302 VACANT SPACE	0	320, 466	75, 321	1, 098, 917		193. 14
193. 16 19316 SETON BOARD	0	0	0	0		193. 16
193. 19 19319 SPORTS PERFORMANCE	1, 032, 906	10, 041, 929	2, 360, 225	0	0	193. 19
200.00 Cross Foot Adjustments		0				200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	62, 205, 619	976, 671, 167	185, 867, 788	37, 444, 012	3, 596, 517	202. 00

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In Lieu of Form CMS-2552-10
Period: Worksheet B
From 07/01/2018 Part I Provider CCN: 15-0084

					To 06/30/2019	Date/Time Pre	pared:
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	11/25/2019 6: CENTRAL SERVI CES & SUPPLY	15 pm
		9. 00	10. 00	11. 00	13.00	14. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01 1. 02 2. 00 4. 00 5. 00 7. 00 8. 00	00100 OAN REL COSTS-BLDG A TIAN 00101 NEW CAP REL COSTS-BLDG-STRESS 00102 NEW CAP REL COSTS-BLDG-MARTEN H 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						1. 01 1. 02 2. 00 4. 00 5. 00 7. 00 8. 00
9.00	00900 HOUSEKEEPI NG	14, 388, 792	7 200 000				9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	453, 609	7, 389, 889 0	9, 027, 302			10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	55, 051	Ö	349, 356	1		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	576, 537	0	188, 783		15, 324, 444	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	229, 869 152, 104	0	326, 927 6, 206		316, 264 229	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	31, 353	O	186, 793		4, 243	17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES A	0	0	423, 070		0	21. 00
22. 00 23. 00	02200 I &R SERVI CES-OTHER PRGM COSTS A 02300 PARAMED ED PRGM- PHARMACY	173, 639 16, 446	0	232, 375 23, 342		15, 906 0	22. 00 23. 00
23. 01	02301 PARAMED ED PRGM - CPE	31, 713	0	15, 121		0	23. 00
23. 02	02302 PARAMED ED PRGM - RADIOLOGY	19, 746	0	6, 938		0	23. 02
23. 03	02303 PARAMED ED PRGM - EMS INPATIENT ROUTINE SERVICE COST CENTERS	1, 401	0	28, 559	9 0	109	23. 03
30. 00	03000 ADULTS & PEDIATRICS	4, 165, 431	5, 289, 810	2, 266, 847	7, 976, 157	702, 605	30. 00
31. 00	03100 INTENSIVE CARE UNIT	607, 391	100, 535	446, 610	2, 112, 378	0	31. 00
32. 00 32. 01	03200 CORONARY CARE UNIT 03201 CARDI OTHORACI C VASCULAR TRANSPL	0 463, 371	0 251, 290	299, 247	0 7 1, 268, 649	0 542	32. 00 32. 01
33. 00	03300 BURN INTENSIVE CARE UNIT	103, 371	251, 270	277, 247	0	0	33. 00
33. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	258, 573	28, 858	98, 401	342, 071	16, 645	33. 01
34. 00 34. 01	03400 SURGICAL INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	0 393, 205	0	514, 407	0 7 2, 237, 037	0 30, 754	34. 00 34. 01
40. 00	04000 SUBPROVI DER - I PF	427, 179	903, 843	174, 931	1 1	3, 780	40. 00
41.00	04100 SUBPROVI DER - I RF	176, 870	0	19, 334		4, 767	41. 00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	213, 783	0	78, 473	3 250, 758	27, 570	43. 00
50. 00	05000 OPERATING ROOM	2, 030, 104	29, 068	825, 007	2, 372, 351	213, 440	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	284, 684	0	144, 283	516, 334	47	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	349, 580	706	189, 031		345, 566	54.00
54. 01 54. 02	05402 AMBULATORY CARDI OVASCULAR SVC 05403 ULTRASOUND	164, 404 27, 207	0	107, 944 26, 986		49, 346 0	54. 01 54. 02
54. 03	05404 ECHOCARDI OLOGY	0	Ö	23, 907		78, 771	54. 03
54. 04	05401 ONCOLOGY	139, 028	0	124, 247		17, 690	54. 04
57. 00 58. 00	05700 CT SCAN 05800 MRI	30, 257 117, 895	0	49, 572 29, 028	l l	1, 957 46, 907	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	382, 070	0	140, 008		40, 707	59. 00
59. 01	05901 CARDI AC REHAB	O	0	26, 866		1, 331	
60.00	06000 LABORATORY	239, 992	0	2/4 01		9, 165	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	45, 164 147, 611	0	264, 917 285, 527		0 23, 362	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	5, 158	0	34, 576		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	17, 444	0	27, 770		7, 095	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	10, 761 149, 275	0	51, 952 55, 791		64, 398 39, 571	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	o	(0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	12, 399, 191	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0 48, 478	0	(0 155, 420	73. 00 74. 00
75. 00	03330 ENDOSCOPY	163, 156	0	60, 548	199, 553	155, 420	75. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01	09000 CLINIC 09001 PARTIAL HOSPITALIZATION	188, 421	0	19, 373 69, 053		7, 300 1, 481	90. 00 90. 01
91.00	09100 EMERGENCY	530, 971	37, 555	446, 271	1	11, 836	91.00
91. 01	09101 WOUND CARE 002	132, 968	0	24, 261	64, 025	0	91. 01
91. 02	09102 WOUND CARE 001 09103 LAFAYETTE RD CLINIC	7, 668	0	13, 648		0	91. 02 91. 03
91. 03 91. 04	09103 LAFAYETTE RD CLINIC		0	(4, 628	91. 03 91. 04
91. 05	09105 BROWNSBURG CLINIC		ō	(0	91. 05
91.06	09106 OP ANTI COAGULATION CLINIC	23, 504	O	(34, 284	543	91.06
91. 07 91. 08	09107 ST VINCENT OUTPATIENT TREATMENT 04040 FAMILY PRACTICE		0	(52, 036 59, 555	0 2, 425	91. 07 91. 08
	09200 OBSERVATI ON BEDS (NON-DI STI NCT			·		_, .20	92. 00

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COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0084 Peri od: Worksheet B From 07/01/2018 Part I 06/30/2019 Date/Time Prepared: 11/25/2019 6:15 pm Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL ADMI NI STRATI ON SERVICES & **SUPPLY** 9.00 10.00 11.00 13.00 14.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 85, 225 0 0 95.00 98. 00 09853 GERIATRIC CLINIC 0 0 98.00 0 98. 01 09851 ELECTROCONVULSIVE THERAPY 0 0 0 0 0 98. 01 09852 DIABETES EDUCATION 98.02 0 0 10, 254 103 98.02 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 0 0 30, 838 62, 926 316 105. 00 0 85, 918 311 106.00 0 40, 227 112.00 08600 PANCREAS ACQUISITION 0 0 0 112.00 113. 00 11300 | INTEREST EXPENSE 113. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 646, 425 115. 00 120, 831 SUBTOTALS (SUM OF LINES 1 through 117) 13, 7<u>68, 296</u> 20, 880, 068 6, 641, 665 8, 928, 436 15, 252, 039 118. 00 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 40, 616 0 190. 00 0 191.00 191. 00 19100 RESEARCH 0 28, 264 192.00 19200 PHYSICIANS PRIVATE OFFICES 115,080 0 C 701, 110 50, 146 192. 00 193. 00 19300 NONPALD WORKERS 0 193.00 0 193. 01 19304 MARKETI NG 0 193. 01 0 0 193. 02 19305 MISSION SERVICES 66 193. 02 18, 659 36, 470 0 193. 03 19306 FOUNDATI ON 22, 972 0 193. 03 193. 04 19307 WELLNESS 28, 971 49, 798 488 193. 04 0 193. 07 19310 BI LLI NG 0 193. 07 0 0 0 0 0 193.09 193. 09 19312 LI FELI NE 0 C 0 0 193. 10 19313 MARTEN HOUSE 0 C 0 0 0 193. 10 193. 14 19302 VACANT SPACE 0 193. 14 428, 330 0 193. 16 19316 SETON BOARD 748, 224 0 0 0 193, 16 0 193. 19 19319 SPORTS PERFORMANCE 0 0 21, 705 193. 19 200.00 Cross Foot Adjustments 200. 00

14, 388, 792

7, 389, 889

0 201. 00

15, 324, 444 202. 00

21, 630, 976

9, 027, 302

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

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Provider CCN: 15-0084

				T		Date/Time Pre 11/25/2019 6: RESIDENTS	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES A	SERVICES-OTHER PRGM COSTS A	
		15. 00	LI BRARY 16. 00	17. 00	21. 00	22. 00	
	GENERAL SERVICE COST CENTERS	10.00	10.00	17.00	21.00	22.00	
1. 00 1. 01 1. 02 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00	00100 CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-BLDG-STRESS 00102 NEW CAP REL COSTS-BLDG-MARTEN H 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION						1. 00 1. 01 1. 02 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00
14. 00 15. 00 16. 00 17. 00 21. 00 22. 00 23. 00 23. 01 23. 02 23. 03	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I &R SERVICES-SALARY & FRINGES A 02200 I &R SERVICES-OTHER PRGM COSTS A 02300 PARAMED ED PRGM - PHARMACY 02301 PARAMED ED PRGM - CPE 02302 PARAMED ED PRGM - RADIOLOGY 02303 PARAMED ED PRGM - EMS INPATIENT ROUTINE SERVICE COST CENTERS	38, 425, 255 0 0 0 45, 387 0 0	1, 164, 926 0 0 0 0 0 0 0	1	15, 050, 057	7, 387, 310	14. 00 15. 00 16. 00 17. 00 21. 00 22. 00 23. 00 23. 01 23. 02 23. 03
30.00	03000 ADULTS & PEDIATRICS	103, 019	149, 719			2, 663, 673	
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	89, 877 0	6, 456 0	721, 853 0	905, 829 0	444, 626 0	31. 00 32. 00
32. 01	03201 CARDI OTHORACI C VASCULAR TRANSPL	37, 821	7, 890	1, 311	99, 724	48, 950	32. 01
33. 00 33. 01	03300 BURN INTENSIVE CARE UNIT 02080 PEDIATRIC INTENSIVE CARE UNIT	2, 343	0 1, 194	0 381, 464	0 83, 104	0 40, 791	33. 00 33. 01
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
34. 01 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	9, 298	3, 255 10, 635			57, 108 110, 137	
41. 00	04100 SUBPROVI DER – I RF	371	0,033		0	0	1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 706	10, 852	431, 714	141, 276	69, 345	43. 00
50. 00	05000 OPERATI NG ROOM	234, 839	109, 947	75, 594	2, 434, 935	1, 195, 186	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 331	4, 574			244, 748	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05402 AMBULATORY CARDI OVASCULAR SVC	27, 413 249, 353	293, 251 0			216, 194 36, 712	
54. 02	05403 ULTRASOUND	31	43, 675	_		4, 079	
54. 03	05404 ECHOCARDI OLOGY	0	5, 359	1	116, 345	57, 108	
54. 04 57. 00	O5401 ONCOLOGY O5700 CT SCAN	22, 235 12, 260	57, 822 0	1	457, 070 16, 621	224, 352 8 158	54. 04 57. 00
58. 00	05800 MRI	4, 052	4	Ö	16, 621		58. 00
59. 00 59. 01	O5900 CARDI AC CATHETERI ZATI ON O5901 CARDI AC REHAB	50, 336	27, 961 932	1	,	61, 187	
60.00	06000 LABORATORY	1, 747	42, 907		16, 621 232, 690	8, 158 114, 216	
65. 00	06500 RESPI RATORY THERAPY	3, 323, 773	3, 015	0		89, 741	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	4, 019	19, 653 0	0	99, 724 0	48, 950 0	
68. 00	06800 SPEECH PATHOLOGY	o o	Ö	ő	Ö	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	186, 745	7, 575	1	257, 621	126, 453	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PAT	1, 549	13, 801 0	0	166, 207 0	81, 583 0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	O	0	0	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	29, 791, 014 26, 253	0	0	0 166, 207	0 81, 583	
75. 00		13, 471	5, 5 9 5	61, 174		97, 899	
00.00	OUTPATIENT SERVICE COST CENTERS	150 212	0	202 (00	440 440	21/ 104	00.00
90.00	09000 CLINIC 09001 PARTIAL HOSPITALIZATION	150, 212 0	4, 396	393, 698 0	440, 449 0	216, 194 0	90. 00 90. 01
	09100 EMERGENCY	11, 904	249, 874			354, 885	
91. 01 91. 02	09101 WOUND CARE 002 09102 WOUND CARE 001	1, 209 3, 441	3, 810 0	0	166, 207 0	81, 583 0	
91. 03	09103 LAFAYETTE RD CLINIC	O	0	Ö	o	0	91. 03
91.04	09104 ZI ONSVI LLE CLINI C	142	28, 609	0	0	0	91. 04 91. 05
91.05	O9105 BROWNSBURG CLINIC O9106 OP ANTICOAGULATION CLINIC	982	5, 271	0		0	91.05
91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	0	0	0	0		91. 07
91. 08	04040 FAMI LY PRACTI CE	206	0	18, 352	698, 070	342, 647	91.08

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				To	06/30/2019	Date/Time Pre 11/25/2019 6:	
					INTERNS &		T DIII
					THIERIO U	RESTRENTS	
Cost Center [Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	
	70001 1 p 21 011		RECORDS &	0001712 021171 02	Y & FRINGES A		
			LI BRARY				
		15. 00	16. 00	17. 00	21.00	22. 00	
92. 00 09200 OBSERVATI ON E	BEDS (NON-DISTINCT						92.00
OTHER REI MBURSABLE	COST CENTERS						1
95. 00 09500 AMBULANCE SER	RVICES	28	1, 021	0	0	0	95. 00
98. 00 09853 GERIATRIC CLI	NI C	0	0	0	o	0	98. 00
98. 01 09851 ELECTROCONVUI	_SI VE_THERAPY	0	0	0	o	0	98. 01
98. 02 09852 DI ABETES EDUC	CATION	O	724	0	o	0	98. 02
SPECIAL PURPOSE CO	ST CENTERS						1
105.00 10500 KI DNEY ACQUIS	SITION	60	0	0	58, 173	28, 554	105. 00
106.00 10600 HEART ACQUI SI	TION	26	0	0	58, 173	28, 554	106. 00
112.00 08600 PANCREAS ACQL	JISITION	0	0	0	0	0	112. 00
113.00 11300 INTEREST EXPE	ENSE						113. 00
115.00 11500 AMBULATORY SU	JRGI CAL CENTER (D. P.)	312, 895	32, 570	0	8, 310	4, 079	115. 00
118.00 SUBTOTALS (SU	JM OF LINES 1 through 117)	34, 726, 348	1, 152, 347	9, 396, 766	14, 659, 470	7, 195, 591	118. 00
NONREI MBURSABLE CO							
190. 00 19000 GIFT FLOWER	COFFEE SHOP & CAN	0	0	0	0		190. 00
191. 00 19100 RESEARCH		0	0	0	257, 621	126, 453	191. 00
192. 00 19200 PHYSI CLANS PF	RIVATE OFFICES	3, 676, 642	0	100, 500	0	0	192. 00
193. 00 19300 NONPALD WORKE	ERS	0	0	0	0	0	193. 00
193. 01 19304 MARKETI NG		0	0	0	0	0	193. 01
193. 02 19305 MI SSI ON SERVI	CES	0	0	0	0		193. 02
193. 03 19306 FOUNDATI ON		0	0	0	0		193. 03
193. 04 19307 WELLNESS		439	0	0	0		193. 04
193. 07 19310 BI LLI NG		0	0	0	0		193. 07
193. 09 19312 LI FELI NE		0	0	0	0		193. 09
193. 10 19313 MARTEN HOUSE		0	0	0	0		193. 10
193. 14 19302 VACANT SPACE		0	0	0	0		193. 14
193.16 19316 SETON BOARD		0	0	0	0	0	193. 16
193. 19 19319 SPORTS PERFOR	RMANCE	21, 826	12, 579	0	132, 966	65, 266	193. 19
200.00 Cross Foot Ad	djustments				0	0	200. 00
201.00 Negative Cost	Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum li	nes 118 through 201)	38, 425, 255	1, 164, 926	9, 497, 266	15, 050, 057	7, 387, 310	202. 00

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COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0084 Peri od: Worksheet B From 07/01/2018 Part I To 06/30/2019 Date/Time Prepared:

					To	06/30/2019	Date/Time Prep 11/25/2019 6:	
		Cost Center Description	PARAMED ED PRGM- PHARMACY	PARAMED ED PRGM - CPE	PARAMED ED PRGM -	PARAMED ED PRGM - EMS	Subtotal	10 piii
			23. 00	23. 01	RADI OLOGY 23. 02	23. 03	24.00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02	1	NEW CAP REL COSTS-BLDG-STRESS NEW CAP REL COSTS-BLDG-MARTEN H						1. 01 1. 02
2.00	1	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	1	ADMINISTRATIVE & GENERAL						5. 00
7.00	1	OPERATION OF PLANT						7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10. 00	1	DI ETARY						10.00
11. 00	1	CAFETERI A						11. 00
13. 00 14. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY						13. 00 14. 00
15. 00	1	PHARMACY						15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY						16. 00
17. 00	1	SOCIAL SERVICE						17. 00
21. 00 22. 00		&R SERVICES-SALARY & FRINGES A &R SERVICES-OTHER PRGM COSTS A						21. 00 22. 00
23. 00	1	PARAMED ED PRGM- PHARMACY	1, 149, 863					23. 00
23. 01	1	PARAMED ED PRGM - CPE		572, 089				23. 01
23. 02		PARAMED ED PRGM - RADIOLOGY			365, 776	4 470 004		23. 02
23. 03		PARAMED ED PRGM - EMS LENT ROUTINE SERVICE COST CENTERS				1, 472, 801		23. 03
30.00		ADULTS & PEDIATRICS	0	280, 793	0	0	150, 087, 272	30. 00
31. 00		INTENSIVE CARE UNIT	0	137, 892	0	o	31, 946, 837	31. 00
32. 00 32. 01		CORONARY CARE UNIT CARDIOTHORACIC VASCULAR TRANSPL	0	0 18, 875	0	0	0 21, 727, 674	32. 00 32. 01
33. 00	1	BURN INTENSIVE CARE UNIT	0	10, 6/5	0	ol Ol	21, 727, 674	33. 00
33. 01	1	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	o	7, 244, 383	
34. 00	1	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34. 01 40. 00	1	NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	30, 887 83, 909	0	0	32, 096, 155 10, 505, 876	34. 01 40. 00
41.00	1	SUBPROVIDER - I RF	0	7, 893		0	2, 141, 890	
43.00	04300	NURSERY	0	0	0	o	5, 621, 806	
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	l ol	1 272	O	ol	40,400,022	E0 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	0	1, 373 0		ol ol	69, 609, 922 9, 790, 329	50. 00 52. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	0	0		o	16, 403, 423	
54. 01	1	AMBULATORY CARDIOVASCULAR SVC	0	0	0	0	8, 244, 583	
54. 02 54. 03	1	ULTRASOUND ECHOCARDI OLOGY	0	0	54, 941 0	0	2, 038, 953 2, 565, 376	
54. 04	1	ONCOLOGY	O	0	Ö	o	14, 725, 212	
57. 00	1	CT SCAN	0	0	92, 809	0	3, 416, 353	
58. 00 59. 00	05800	MRI CARDI AC CATHETERI ZATI ON	0	0	29, 305 0	0 0	3, 042, 559 10, 172, 187	
59. 01	1	CARDI AC REHAB	0	0	0	o	1, 422, 237	
60.00	06000	LABORATORY	0	0	0	О	33, 659, 217	
65. 00	1	RESPI RATORY THERAPY	0	0	0	0	21, 824, 453	
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY		0	0	0	15, 515, 574 1, 733, 037	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	O	0	0	Ö	1, 658, 884	
69. 00	1	ELECTROCARDI OLOGY	0	0	0	O	4, 307, 391	
70. 00 71. 00	1	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	9, 039, 722 67, 738, 214	70. 00 71. 00
71.00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	ol	82, 774, 718	
73. 00		DRUGS CHARGED TO PATIENTS	1, 149, 863	0	0	ō	107, 690, 136	
74.00		RENAL DIALYSIS	0	0		0	6, 964, 804	
75. 00		ENDOSCOPY TIENT SERVICE COST CENTERS	0	0	0	0	5, 617, 634	75. 00
90.00		CLI NI C	0	0	0	0	8, 501, 061	90. 00
90. 01	1	PARTI AL HOSPI TALI ZATI ON	0	0	-	0	3, 649, 656	
91. 00 91. 01	1	EMERGENCY WOUND CARE 002	0	10, 467 0	0	1, 472, 801 0	42, 540, 885 2, 616, 156	
91. 01	1	WOUND CARE 001		0	o	o	833, 155	
91. 03	09103	LAFAYETTE RD CLINIC	0	0	0	o	274	91. 03
91. 04	1	ZIONSVILLE CLINIC	0	0	0	0	896, 270	
91. 05 91. 06		BROWNSBURG CLINIC OP ANTICOAGULATION CLINIC		0	0	0	946, 440	91. 05 91. 06
91. 07	09107	ST VINCENT OUTPATIENT TREATMENT	0	o	O	ō	974, 710	91. 07
		FAMILY PRACTICE	0	0	0	0	4, 547, 398	
92. 00	109200	OBSERVATION BEDS (NON-DISTINCT	1	ı		ı		92. 00

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COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0084 Peri od: Worksheet B From 07/01/2018 Part I 06/30/2019 Date/Time Prepared: 11/25/2019 6:15 pm Cost Center Description PARAMED ED PARAMED ED PARAMED ED PARAMED ED Subtotal PRGM- PHARMACY PRGM -PRGM - EMS PRGM - CPE RADI OLOGY 23.00 23. 01 23. 03 24.00 23.02 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0 0 383, 676 95.00 98. 00 09853 GERIATRIC CLINIC 0 0 0 98.00 1,088 0 0 98. 01 09851 ELECTROCONVULSI VE THERAPY 0 0 98. 01 0 09852 DIABETES EDUCATION 0 98.02 0 0 0 480, 871 98.02 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 7, 816, 468 105. 00 0 0 0 0 0 0 0 8, 372, 651 106. 00 0 112.00 08600 PANCREAS ACQUISITION 0 0 0 11, 115 112. 00 113. 00 11300 INTEREST EXPENSE 113.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 17, 862, 139 115. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 149, 863 572, 089 365, 776 1, 472, 801 861, 760, 824 118. 00 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 1, 447, 089 190. 00 2, 812, 379 191. 00 191. 00 19100 RESEARCH 000000000000000 0 0 0 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 65, 177, 105 192. 00 193. 00 19300 NONPALD WORKERS 0 0 193. 00 0 193. 01 19304 MARKETI NG 0 0 0 432 193. 01 1, 572, 877 193. 02 193. 02 19305 MISSION SERVICES 0 0 193. 03 19306 FOUNDATI ON 0 0 3, 496, 581 193. 03 193. 04 19307 WELLNESS 0 1, 043, 492 193. 04 0 0 0 193. 07 19310 BI LLI NG 24, 021, 386 193. 07 0 0 0 7, 311 193. 09 193. 09 19312 LI FELI NE 0 193. 10 19313 MARTEN HOUSE 0 0 3, 937 193. 10 0

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1, 149, 863

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365, 776

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1, 472, 801

0

C

572,089

1, 923, 034 193. 14

12, 656, 496 193. 19

976, 671, 167 202. 00

748, 224 193. 16

0 200.00

0 201. 00

193. 14 19302 VACANT SPACE

193. 19 19319 SPORTS PERFORMANCE

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

193. 16 19316 SETON BOARD

200.00

201.00

202.00

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COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0084 Period: Worksheet B From 07/01/2018 Part I To 06/30/2019 Date/Time Prepared:

				To 06/30/2019 Date/Time Pre	
	Cost Center Description	Intern &	Total	11/23/2019 0.	15 piii
		Residents Cost & Post			
		Stepdown			
		Adj ustments	27.00		
	GENERAL SERVICE COST CENTERS	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT				1. 00
1. 01 1. 02	00101 NEW CAP REL COSTS BLDG-STRESS				1. 01 1. 02
2.00	00102 NEW CAP REL COSTS-BLDG-MARTEN H 00200 CAP REL COSTS-MVBLE EQUI P				2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE				7. 00 8. 00
9. 00	00900 HOUSEKEEPING				9. 00
10. 00	01000 DI ETARY				10. 00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON				11. 00
	01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00	01500 PHARMACY				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY				16.00
17. 00 21. 00	01700 SOCIAL SERVICE 02100 L&R SERVICES-SALARY & FRINGES A				17. 00 21. 00
22. 00					22. 00
23. 00	02300 PARAMED ED PRGM- PHARMACY				23. 00
23. 01 23. 02	02301 PARAMED ED PRGM - CPE 02302 PARAMED ED PRGM - RADI OLOGY				23. 01
23. 02	02303 PARAMED ED PRGM - RADIOLOGY				23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS				1
30.00		-8, 090, 335	141, 996, 937	•	30.00
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	-1, 350, 455 0	30, 596, 382 0		31.00
32. 01	03201 CARDI OTHORACI C VASCULAR TRANSPL	-148, 674	21, 579, 000		32. 01
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		33. 00
33. 01 34. 00	02080 PEDIATRIC INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	-123, 895	7, 120, 488		33. 01 34. 00
34. 00	02060 NEONATAL INTENSIVE CARE UNIT	-173, 453	31, 922, 702		34. 00
40. 00	04000 SUBPROVI DER - I PF	-334, 517	10, 171, 359		40. 00
41. 00 43. 00	04100 SUBPROVI DER - I RF	210 621	2, 141, 890		41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	-210, 621	5, 411, 185		43.00
50.00	05000 OPERATING ROOM	-3, 630, 121	65, 979, 801		50. 00
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM	-743, 369	9, 046, 960		52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C 05402 AMBULATORY CARDI OVASCULAR SVC	-656, 643 -111, 505	15, 746, 780 8, 133, 078	l .	54. 00 54. 01
54. 02	05403 ULTRASOUND	-12, 389	2, 026, 564	l .	54. 02
54. 03	05404 ECHOCARDI OLOGY	-173, 453	2, 391, 923		54. 03
54. 04 57. 00	05401 0NCOLOGY	-681, 422 -24, 779	14, 043, 790 3, 391, 574	l .	54. 04 57. 00
	05800 MRI	-24, 779	3, 017, 780		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	-185, 842	9, 986, 345		59. 00
59. 01 60. 00	05901 CARDI AC REHAB	-24, 779 -346, 906	1, 397, 458 33, 312, 311	·	59. 01
65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	-272, 569	21, 551, 884	l .	60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	-148, 674	15, 366, 900		66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	1, 733, 037	·	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	-384, 074	1, 658, 884 3, 923, 317	·	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	-247, 790	8, 791, 932		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	67, 738, 214	·	71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	82, 774, 718 107, 690, 136		72. 00 73. 00
74. 00	1	-247, 790	6, 717, 014		74. 00
75. 00	03330 ENDOSCOPY	-297, 348	5, 320, 286		75. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	-656, 643	7, 844, 418		90.00
90.00	09000 CETNIC 09001 PARTI AL HOSPI TALI ZATI ON	-656, 643	7, 844, 418 3, 649, 656		90.00
91. 00	09100 EMERGENCY	-1, 077, 886	41, 462, 999		91. 00
91. 01	09101 WOUND CARE 002	-247, 790	2, 368, 366	l .	91. 01
91. 02 91. 03	09102 WOUND CARE 001 09103 LAFAYETTE RD CLINIC	0	833, 155 274		91. 02
91. 04	09104 ZI ONSVI LLE CLI NI C	0	896, 270		91. 03
91. 05	09105 BROWNSBURG CLINIC	0	0		91. 05
91. 06 91. 07	09106 OP ANTICOAGULATION CLINIC 09107 ST VINCENT OUTPATIENT TREATMENT	0	946, 440 974, 710		91. 06 91. 07
	04040 FAMILY PRACTICE	-1, 040, 717	3, 506, 681	l .	91.07
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COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0084 Peri od: Worksheet B From 07/01/2018 To 06/30/2019 Part I Date/Time Prepared: 11/25/2019 6: 15 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 383, 676 95.00 0 98. 00 | 09853 | GERIATRIC CLINIC 0 1, 088 98.00 98. 01 09851 ELECTROCONVULSIVE THERAPY 0 98. 01 09852 DIABETES EDUCATION 480, 871 98.02 98.02 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION -86, 727 7, 729, 741 105.00 106. 00 10600 HEART ACQUISITION -86, 727 8, 285, 924 106. 00 112.00 08600 PANCREAS ACQUISITION 11, 115 112. 00 0 113. 00 11300 INTEREST EXPENSE 113. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) -12, 389 17, 849, 750 115. 00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 -21, 855, 061 839, 905, 763 118.00 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 1, 447, 089 190.00 191. 00 19100 RESEARCH -384, 074 2, 428, 305 191. 00 192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 65, 177, 105 192. 00 193. 00 19300 NONPALD WORKERS 193. 00 Ω 193. 01 19304 MARKETI NG 0 432 193. 01 193. 02 19305 MISSION SERVICES 1, 572, 877 193. 02 0000000 193. 03 19306 FOUNDATION 193. 04 19307 WELLNESS 3, 496, 581 193. 03 1,043,492 193.04 193. 07 19310 BI LLI NG 24, 021, 386 193. 07 193. 09 19312 LI FELI NE 7, 311 193. 09 193. 10 19313 MARTEN HOUSE 3, 937 193. 10 193. 14 19302 VACANT SPACE 1, 923, 034 193. 14 193. 16 19316 SETON BOARD 748, 224 193. 16 193. 19 19319 SPORTS PERFORMANCE -198, 232 193. 19 12, 458, 264 Cross Foot Adjustments 200.00 0 200.00 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118 through 201) -22, 437, 367 954, 233, 800 202. 00

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				Ť	o 06/30/2019		
			CAPITAL RELATED COSTS			11/25/2019 6:	15 piii
			BUBB & FLVT	1	l vew	10/01/5 50/11/5	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	NEW BLDG-STRESS	NEW BLDG-MARTEN H	MVBLE EQUIP	
		Capi tal		DEDG STRESS	DEDG WIAKTEN II		
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1. 00	1. 01	1. 02	2. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-BLDG-STRESS						1. 01
1. 02	00102 NEW CAP REL COSTS-BLDG-MARTEN H						1. 02
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT	401, 003	115, 492	2, 058	0	12, 467	2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	22, 074, 119	498, 787			1, 139, 455	5. 00
7.00	00700 OPERATION OF PLANT	61, 727	2, 332, 537			483, 851	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	3, 797		-	0	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	144, 178 327, 728			2, 097 17, 063	9. 00 10. 00
11. 00	01100 CAFETERI A		327, 728	4, 513		17,003	1
13.00	01300 NURSI NG ADMI NI STRATI ON	8, 098	36, 094		0	1, 064, 513	
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 921, 651	413, 725			991, 386	
15. 00 16. 00	O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY	803, 767	171, 982 106, 341			156, 414 630	1
17. 00	01700 SOCIAL SERVICE	0	22, 275			0	1
21. 00	02100 I&R SERVICES-SALARY & FRINGES A	0	0	C		0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS A	150	129, 913		0	41, 838	1
23. 00 23. 01	O2300 PARAMED ED PRGM- PHARMACY O2301 PARAMED ED PRGM - CPE	0	12, 304 23, 727		0	0	23. 00 23. 01
23. 01	02302 PARAMED ED PRGM - RADI OLOGY		14, 774			0	23. 01
23. 03	02303 PARAMED ED PRGM - EMS	100, 420	1, 048		0	3, 865	23. 03
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	000 040	0.447.477			500.047	
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 INTENSI VE CARE UNI T	233, 019 9, 450	3, 116, 476 454, 435			530, 047 359, 196	ł
32. 00	03200 CORONARY CARE UNIT	0	0	Ö		0	32. 00
32. 01	03201 CARDI OTHORACI C VASCULAR TRANSPL	0	346, 683	C	-	226, 319	
33. 00	03300 BURN INTENSIVE CARE UNIT	0	102 450	0	0	0	33. 00 33. 01
33. 01 34. 00	02080 PEDIATRIC INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	2, 148	193, 458 0	1 0	0	269, 308 0	34. 00
34. 01	02060 NEONATAL INTENSIVE CARE UNIT	27, 159	294, 187	C	0	317, 492	ı
40.00	04000 SUBPROVI DER - I PF	0	41, 976			14, 335	1
41. 00 43. 00	04100 SUBPROVI DER - RF 04300 NURSERY	0 0	132, 330 159, 948			602 48, 838	
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	137, 740		0	40, 030	43.00
50.00	05000 OPERATING ROOM	827, 376	1, 518, 875			5, 426, 171	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	39, 797	212, 994			63, 024	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05402 AMBULATORY CARDI OVASCULAR SVC	491, 150 444, 671	261, 548 123, 003			855, 948 307, 714	
54. 02	05403 ULTRASOUND	4, 243	20, 355	1	0	58, 202	1
54. 03	05404 ECHOCARDI OLOGY	99, 028	0	C	-	107, 991	1
54. 04	05401 ONCOLOGY	2, 260, 848	104, 017		0	491, 185	
	05700 CT SCAN 05800 MRI	52, 156	22, 638 88, 206		0	409, 217 413, 656	
59. 00	05900 CARDI AC CATHETERI ZATI ON	294, 094	285, 856		0	1, 226, 553	1
59. 01	05901 CARDI AC REHAB	104, 299	0	C	0	11, 409	1
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0 177, 084	179, 556 33, 791	0	0	24, 159 424, 723	60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 323, 834	109, 910	l ~	١		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	3, 859			0	ı
68. 00	06800 SPEECH PATHOLOGY	112, 929	13, 051	C	0	10, 593	1
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	99, 028 142, 454	8, 051 8, 393	0 40, 013	0	142, 411 163, 976	1
	07100 MEDICAL SUPPLIES CHARGED TO PAT	142, 454	0, 393	40,013	0	103, 970	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	Ö	0	C	0	0	ı
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	
74.00	07400 RENAL DI ALYSI S	7, 425	36, 270			16, 355	1
75. 00	03330 ENDOSCOPY OUTPATIENT SERVICE COST CENTERS	l O	122, 069		0	294, 714	75. 00
90.00	09000 CLI NI C	2, 107, 293	0	C		83, 368	90.00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	10, 875	53, 181				90. 01
91. 00 91. 01	O9100 EMERGENCY O9101 WOUND CARE OO2	95, 490 76, 000	397, 260 99, 484		-	603, 129	91.00
91.01	09101 WOUND CARE 002	78,000	5, 737		ol	22, 122	
91. 03	09103 LAFAYETTE RD CLINIC	0	0	0	o	0	91. 03
91. 04	09104 ZIONSVILLE CLINIC	237, 366	0	0	0		91.04
	O9105 BROWNSBURG CLINIC O9106 OP ANTICOAGULATION CLINIC	41, 531	0 17, 585		0	0	
	09107 ST VINCENT OUTPATIENT TREATMENT	140, 827	17, 333	0	0		91.00
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Period: Worksheet B From 07/01/2018 Part II Provider CCN: 15-0084

				06/30/2019	Date/Time Pre 11/25/2019 6:	
			CAPLTAL RE	LATED COSTS	11/25/2019 6.	13 pili
Cost Center Description	Directly	BLDG & FIXT	NEW	NEW	MVBLE EQUIP	
	Assigned New		BLDG-STRESS	BLDG-MARTEN H		
	Capi tal					
	Related Costs					
	0	1. 00	1. 01	1. 02	2. 00	
91. 08 04040 FAMILY PRACTICE	346, 352	0	0	0	12, 389	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT						92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	63, 763	0	0	0	1 ,0.00
98. 00 09853 GERI ATRI C CLI NI C	0	0	0	0	0	
98. 01 09851 ELECTROCONVULSI VE THERAPY	0	0	0	0	0	1
98. 02 09852 DI ABETES EDUCATION	0	0	0	0	4, 941	98. 02
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	437, 847	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	194, 395	0	0	0		106. 00
112.00 08600 PANCREAS ACQUISITION	0	0	0	0	0	112. 00
113.00 11300 INTEREST EXPENSE						113. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	348, 722	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	35, 811, 103	12, 883, 647	232, 763	0	17, 307, 354	118. 00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	63, 643	30, 388	0	0		190. 00
191. 00 19100 RESEARCH	107, 642	0	0	0		191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	2, 127, 035	86, 100	0	0	175, 648	
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193. 01 19304 MARKETI NG	0	0	0	0		193. 01
193. 02 19305 MI SSI ON SERVI CES	2, 916	27, 286	0	0		193. 02
193. 03 19306 FOUNDATI ON	85, 835	0	0	0		193. 03
193. 04 19307 WELLNESS	0	0	0	0		193. 04
193. 07 19310 BI LLI NG	0	0	0	0		193. 07
193. 09 19312 LI FELI NE	0	0	0	0		193. 09
193. 10 19313 MARTEN HOUSE	0	0	0	3, 188		193. 10
193. 14 19302 VACANT SPACE	0	320, 466	0	0		193. 14
193.16 19316 SETON BOARD	0	0	0	0		193. 16
193. 19 19319 SPORTS PERFORMANCE	1, 366, 378	0	0	0	130, 074	1
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	39, 564, 552	13, 347, 887	232, 763	3, 188	17, 634, 198	202. 00

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ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0084 Peri od: Worksheet B From 07/01/2018 Part II To 06/30/2019 Date/Time Prepared:

				1	0 06/30/2019	Date/lime Prep 11/25/2019 6:	
	Cost Center Description	Subtotal	EMPLOYEE	ADMI NI STRATI VE		LAUNDRY &	•
			BENEFITS DEPARTMENT	& GENERAL	PLANT	LINEN SERVICE	
		2A	4. 00	5.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02	00101 NEW CAP REL COSTS-BLDG-STRESS 00102 NEW CAP REL COSTS-BLDG-MARTEN H						1. 01 1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	531, 020	531, 020				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	23, 729, 269	21, 170				5. 00
7. 00 8. 00	00700 OPERATION OF PLANT	2, 891, 116	2, 557			02.262	7.00
9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	3, 797 148, 634	0	1	· ·	92, 262 0	8. 00 9. 00
10.00	01000 DI ETARY	349, 304	0				10.00
11. 00	01100 CAFETERI A	0	0	219, 521	0	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 110, 678	16, 070			0	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	3, 333, 590 1, 132, 163	7, 122 18, 472			56 61	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	109, 861	15, 472	1		0	16. 00
17. 00	01700 SOCIAL SERVICE	22, 737	8, 969			o	17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES A	0	15, 815			0	21. 00
22. 00 23. 00	02200 1 &R SERVICES-OTHER PRGM COSTS A 02300 PARAMED ED PRGM- PHARMACY	171, 901	13, 335		· ·	1 0	22. 00 23. 00
23. 00	02301 PARAMED ED PRGM - CPE	12, 304 23, 727	1, 081 448	1			23. 00
23. 02	02302 PARAMED ED PRGM - RADIOLOGY	14, 774	369			Ö	23. 02
23. 03	02303 PARAMED ED PRGM - EMS	105, 333	1, 339	34, 996	365	0	23. 03
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 070 542	11/ 700	2 500 704	1 005 740	20 577	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 879, 542 823, 081	116, 780 21, 470	1		38, 577 6, 093	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	023,001	21, 470	0	0	0, 0, 3	32. 00
32. 01	03201 CARDI OTHORACI C VASCULAR TRANSPL	573, 002	15, 393	436, 089	120, 781	2, 771	32. 01
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
33. 01 34. 00	02080 PEDIATRIC INTENSIVE CARE UNIT	464, 914	6, 706		67, 399		33. 01
34. 00	03400 SURGICAL INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	638, 838	33, 710	0 633, 078	102, 492	0 3, 382	34. 00 34. 01
40. 00	04000 SUBPROVI DER - I PF	163, 855	8, 915		· ·	3, 166	40. 00
41. 00	04100 SUBPROVI DER - I RF	132, 932	799			586	41. 00
43. 00	04300 NURSERY	208, 786	4, 561	93, 267	55, 724	320	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	7, 772, 422	39, 255	1, 318, 791	529, 161	16, 609	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	315, 815	6, 583				52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 608, 646	7, 819		· ·	970	54.00
54. 01	05402 AMBULATORY CARDIOVASCULAR SVC	875, 388	4, 952	1		1, 188	54. 01
54. 02 54. 03	05403 ULTRASOUND 05404 ECHOCARDI OLOGY	82, 800 207, 019	1, 728			0	54. 02 54. 03
54. 04	05401 ONCOLOGY	2, 856, 050	1, 257 6, 275	316, 105			54. 04
57. 00	05700 CT SCAN	431, 855	2, 451			1, 380	57. 00
58. 00	05800 MRI	554, 018	1, 447				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 806, 503	7, 694				
60.00	05901 CARDI AC REHAB 06000 LABORATORY	115, 708 203, 715	1, 075 0			1	59. 01 60. 00
65. 00	06500 RESPIRATORY THERAPY	635, 598	11, 730			0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 484, 015	12, 489		38, 476		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	3, 859	1, 697				67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	136, 573 249, 490	1, 349 2, 325			0	68. 00 69. 00
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	354, 836	2, 382			1	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	2, 332			0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1, 711, 356		0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1, 866, 349		0	73.00
74. 00 75. 00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	60, 050 416, 783	3, 039	154, 343 106, 295	· ·	1	74. 00 75. 00
73.00	OUTPATIENT SERVICE COST CENTERS	410, 703	3, 037	100, 273	42, 320	074	73.00
90. 00	09000 CLI NI C	2, 190, 661	3, 922		0	0	90. 00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	101, 089	2, 666	1	49, 113	0 007	90. 01
91. 00 91. 01	09100 EMERGENCY 09101 WOUND CARE 002	1, 095, 879 179, 770	20, 929 942			8, 807 405	91. 00 91. 01
91.01	09101 WOUND CARE 002	27, 859	689				91.01
91. 03	09103 LAFAYETTE RD CLINIC	0	0	1	0	ő	91. 03
91. 04	09104 ZIONSVILLE CLINIC	266, 559	492	20, 983	0	0	91. 04
	09105 BROWNSBURG CLINIC	0	0	0	0	0	91.05
91. 06 91. 07	09106 OP ANTI COAGULATION CLINIC 09107 ST VINCENT OUTPATIENT TREATMENT	59, 116 140, 827	727 522			0	91. 06 91. 07
	04040 FAMILY PRACTICE	358, 741	3, 460			Ö	91. 08
	09200 OBSERVATION BEDS (NON-DISTINCT	O					92.00

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Period: Worksheet B
From 07/01/2018 Part II
To 06/30/2019 Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0084

				T	06/30/2019	Date/Time Pre 11/25/2019 6:	
C	ost Center Description	Subtotal	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	13 pili
C	ost center bescription	Subtotal	BENEFITS	& GENERAL	PLANT	LINEN SERVICE	
			DEPARTMENT	& OLIVEIVAL	I LAWI	LINEN SERVICE	
		2A	4.00	5. 00	7. 00	8. 00	
OTHER R	EIMBURSABLE COST CENTERS						
95. 00 09500 Al	MBULANCE SERVICES	63, 763	0	1, 915	22, 215	0	95. 00
98. 00 09853 GI	ERIATRIC CLINIC	0	0	26	0	0	98. 00
98. 01 09851 EI	LECTROCONVULSI VE THERAPY	0	0	0	O	0	98. 01
98. 02 09852 D	I ABETES EDUCATION	4, 941	469	11, 424	0	0	98. 02
	PURPOSE COST CENTERS						
	IDNEY ACQUISITION	456, 244	2, 817	185, 679	0	0	105. 00
106. 00 10600 HI	EART ACQUISITION	194, 395	2, 697	198, 417	0	0	106. 00
112. 00 08600 PA	ANCREAS ACQUISITION	0	0	270	0	0	112. 00
113.00 11300 11	NTEREST EXPENSE						113. 00
115. 00 11500 AI	MBULATORY SURGICAL CENTER (D.P.)	348, 722	5, 406	407, 003	0	0	115. 00
118. 00 SI	UBTOTALS (SUM OF LINES 1 through 117)	66, 234, 867	476, 524	21, 157, 386	3, 642, 481	92, 262	118. 00
	IBURSABLE COST CENTERS						
	IFT FLOWER COFFEE SHOP & CAN	94, 192	0	31, 668	10, 587	0	190. 00
191. 00 19100 RI	ESEARCH	107, 642	1, 789	58, 363	0	0	191. 00
	HYSICIANS PRIVATE OFFICES	2, 388, 783	41, 166	1, 464, 846	29, 996		192. 00
	ONPALD WORKERS	0	0	0	0		193. 00
193. 01 19304 M	1	0	0	11	0		193. 01
	ISSION SERVICES	44, 996	812		9, 506		193. 02
193. 03 19306 F		88, 454	1, 238	84, 469	0		193. 03
193. 04 19307 WI		0	675		0		193. 04
193. 07 19310 B		0	0	584, 140	0		193. 07
193. 09 19312 LI		3, 548	0	178	0		193. 09
193. 10 19313 M		3, 188	0	96	0		193. 10
193. 14 19302 V		320, 466	0	9, 625	111, 647		193. 14
193. 16 19316 SI		0	0	0	0		193. 16
	PORTS PERFORMANCE	1, 496, 452	8, 816	301, 589	0		193. 19
	ross Foot Adjustments	0					200. 00
	egative Cost Centers	0	0	0	0		201. 00
202. 00 TO	OTAL (sum lines 118 through 201)	70, 782, 588	531, 020	23, 750, 439	3, 804, 217	92, 262	202. 00

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Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0084

				o 06/30/2019	Date/Time Pre	
Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	11/25/2019 6: CENTRAL SERVICES &	15 pm
					SUPPLY	
GENERAL SERVICE COST CENTERS	9. 00	10. 00	11. 00	13. 00	14. 00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 NEW CAP REL COSTS-BLDG-STRESS						1. 01
1.02 O0102 NEW CAP REL COSTS-BLDG-MARTEN H						1. 02
2. 00 00200 CAP REL COSTS - MVBLE EQUI P						2.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.00 O0500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7.00 OO700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG	538, 355					9. 00
10. 00 01000 DI ETARY	16, 972	624, 885				10.00
11. 00 01100 CAFETERI A	0	0	219, 521			11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	2, 060 21, 571	0	8, 49 <i>6</i> 4, 591		3, 835, 228	13. 00 14. 00
15. 00 01500 PHARMACY	8, 601	o	7, 950	I I	79, 152	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	5, 691	О	151	0	57	16. 00
17. 00 01700 SOCIAL SERVICE	1, 173	0	4, 542		1, 062	17. 00
21. 00 02100 1 &R SERVICES-SALARY & FRINGES A	0	0	10, 288	I I	0	21.00
22.00 02200 L&R SERVICES-OTHER PRGM COSTS A 23.00 02300 PARAMED ED PRGM- PHARMACY	6, 497 615	O O	5, 651 568	I I	3, 981 0	22. 00 23. 00
23. 01 02301 PARAMED ED PRGM - CPE	1, 187	0	368		0	23. 00
23. 02 02302 PARAMED ED PRGM - RADI OLOGY	739	O	169		0	23. 02
23. 03 O2303 PARAMED ED PRGM - EMS	52	0	694	0	27	23. 03
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	155.04/	447.204	FF 10	(12.72/	175 040	20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 NTENSI VE CARE UNI T	155, 846 22, 725	447, 304 8, 501	55, 124 10, 861		175, 842 0	30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT	22, 725	0, 301	10, 001		0	32. 00
32. 01 03201 CARDI OTHORACI C VASCULAR TRANSPL	17, 337	21, 249	7, 277	97, 616	136	32. 01
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	C	0	0	33. 00
33. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	9, 674	2, 440	2, 393	26, 321	4, 166	33. 01
34.00 03400 SURGI CAL INTENSIVE CARE UNIT 34.01 02060 NEONATAL INTENSIVE CARE UNIT	14 712	0	12 500	0 172 120	7 (07	34. 00 34. 01
40. 00 04000 SUBPROVI DER - I PF	14, 712 15, 983	76, 428	12, 509 4, 254		7, 697 946	40.00
41. 00 04100 SUBPROVI DER - RF	6, 618	70, 420	470		1, 193	41. 00
43. 00 04300 NURSERY	7, 999	0	1, 908		6, 900	43. 00
ANCILLARY SERVICE COST CENTERS	T					
50. 00 05000 OPERATING ROOM	75, 956	2, 458 0	20, 062		53, 418	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 651 13, 080	60	3, 509 4, 597		12 86, 485	52. 00 54. 00
54. 01 05402 AMBULATORY CARDI OVASCULAR SVC	6, 151	0	2, 625		12, 350	54. 01
54. 02 05403 ULTRASOUND	1, 018	О	656	0	0	54. 02
54. 03 05404 ECHOCARDI OLOGY	0	0	581		19, 714	54. 03
54. 04 05401 0NCOLOGY	5, 202	0	3, 021		4, 427	54. 04
57. 00 05700 CT SCAN 58. 00 05800 MRI	1, 132 4, 411	0	1, 205 70 <i>6</i>	I I	490 11, 739	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	14, 295	0	3, 405		0	59. 00
59. 01 05901 CARDI AC REHAB	0	0	653		333	
60. 00 06000 LABORATORY	8, 979	0	(-	2, 294	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 690	0	6, 442		0 E 047	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	5, 523 193	0	6, 943 841		5, 847 0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	653	0	675		1, 776	68. 00
69. 00 06900 ELECTROCARDI OLOGY	403	0	1, 263	0	16, 117	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	5, 585	0	1, 357		9, 904	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	(0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	O	(3, 103, 120 0	72. 00 73. 00
74. 00 07400 RENAL DIALYSIS	1, 814	0	(38, 897	74.00
75. 00 03330 ENDOSCOPY	6, 104	O	1, 472	15, 355	0	75. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	471		1, 827	90.00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON 91. 00 09100 EMERGENCY	7, 050 19, 866	0 3, 176	1, 679 10, 852	I I	371 2, 962	90. 01 91. 00
91. 01 09101 WOUND CARE 002	4, 975	3, 170	590		2, 902	91.00
91. 02 09102 WOUND CARE 001	287	o	332		0	91. 02
91.03 09103 LAFAYETTE RD CLINIC	0	О	C		0	91. 03
91. 04 09104 ZI ONSVI LLE CLINI C	0	O	(0	1, 158	91.04
91. 05 09105 BROWNSBURG CLINIC 91. 06 09106 OP ANTI COAGULATION CLINIC	0 879	0	(0 0 2,638	0 136	91. 05 91. 06
91. 06 09106 OF ANTI-COAGULATION CLINIC 91. 07 09107 ST VINCENT OUTPATIENT TREATMENT	879	0	(136 0	91.06
91. 08 04040 FAMILY PRACTICE	Ö	ő	C		607	91. 08
92.00 09200 OBSERVATION BEDS (NON-DISTINCT						92. 00

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ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0084 Peri od: Worksheet B From 07/01/2018 Part II 06/30/2019 Date/Time Prepared: 11/25/2019 6:15 pm Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL ADMI NI STRATI ON SERVICES & **SUPPLY** 9.00 10.00 11.00 13.00 14.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 3, 189 0 0 95.00 98. 00 09853 GERIATRIC CLINIC 0 0 98.00 0 0 0 98. 01 09851 ELECTROCONVULSIVE THERAPY 0 0 0 98. 01 09852 DIABETES EDUCATION 98.02 0 0 249 26 98.02 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 79 105. 00 0 0 750 4, 842 0 978 78 106. 00 0 6, 611 112.00 08600 PANCREAS ACQUISITION 0 0 0 112.00 113. 00 11300 INTEREST EXPENSE 113. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 2, 938 161, 782 115. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 515, 138 561, 616 217, 116 1, 606, 616 3, 817, 108 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 1, 520 0 190. 00 0 191.00 191. 00 19100 RESEARCH 0 687 53, 947 192.00 19200 PHYSICIANS PRIVATE OFFICES 12, 550 192. 00 4, 306 0 C 193. 00 19300 NONPALD WORKERS 0 193.00 0 193. 01 19304 MARKETI NG 0 0 193. 01 0 0 193. 02 19305 MISSION SERVICES 16 193. 02 0 454 1, 365 0 193. 03 19306 FOUNDATI ON 0 559 0 193. 03 193. 04 19307 WELLNESS 0 705 122 193. 04 0 3, 832 193. 07 19310 BI LLI NG 0 0 193. 07 0 0 0 193. 09 19312 LI FELI NE 0 193. 09 0 0 0 193. 10 19313 MARTEN HOUSE 0 0 0 0 0 193. 10 193. 14 19302 VACANT SPACE 0 193. 14 16,026 0 193. 16 19316 SETON BOARD 63, 269 0 0 193, 16 0 193. 19 19319 SPORTS PERFORMANCE

0

538, 355

624, 885

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

0

1, 664, 395

219, 521

5, 432 193. 19

3, 835, 228 202. 00

200. 00 0 201. 00

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MCRI F32 - 15. 9. 167. 1 59 | Page Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0084 Peri od: Worksheet B From 07/01/2018 Part II To 06/30/2019 Date/Ti me Prepared:

					00/00/201/	11/25/2019 6:	
					INTERNS &	RESI DENTS	
	Coot Conton Decemintion	DUADMACY	MEDLOAL	COCLAL CEDVICE	CEDVI CEC CALAD	CEDVI CEC OTHER	
	Cost Center Description	PHARMACY	MEDICAL RECORDS &	SUCTAL SERVICE	Y & FRINGES A	SERVICES-OTHER PRGM COSTS A	
			LI BRARY		T W THINGES A	TROM GOOTS A	
		15.00	16. 00	17. 00	21. 00	22. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-BLDG-STRESS						1.01
1. 02 2. 00	00102 NEW CAP REL COSTS-BLDG-MARTEN H 00200 CAP REL COSTS-MVBLE EQUIP						1. 02 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
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	01100 CAFETERI A						11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	2 205 002					14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 205, 092	170, 548				15. 00 16. 00
17. 00	01700 SOCIAL SERVICE		170, 548				17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES A	0	0	272, 190	381, 795		21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS A	2, 605	0	Ö	001,770	406, 674	22. 00
23. 00	02300 PARAMED ED PRGM- PHARMACY	0	0	Ö		,	23. 00
23. 01	02301 PARAMED ED PRGM - CPE	0	0	0			23. 01
23. 02	02302 PARAMED ED PRGM - RADI OLOGY	0	0	0			23. 02
23. 03	02303 PARAMED ED PRGM - EMS	0	0	0			23. 03
	INPATIENT ROUTINE SERVICE COST CENTERS			1		Г	
30.00	03000 ADULTS & PEDIATRICS	5, 912	21, 919	1			30.00
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	5, 158	945	20, 689 0			31. 00 32. 00
32. 00	03201 CARDI OTHORACI C VASCULAR TRANSPL	2, 170	1, 155				32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	2,170	1, 155	0			33.00
33. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	134	175	1			33. 01
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0			34. 00
34.01	02060 NEONATAL INTENSIVE CARE UNIT	534	477	43, 832			34. 01
40.00	04000 SUBPROVI DER - I PF	0	1, 557	0			40. 00
41. 00	04100 SUBPROVI DER - I RF	21	0	0			41.00
43. 00	04300 NURSERY	98	1, 589	12, 373			43. 00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	12 477	14 004	2 147			 EO OO
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	13, 477 363	16, 096 670				50. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 573	42, 931	7,077			54.00
54. 01	05402 AMBULATORY CARDI OVASCULAR SVC	14, 309	0	Ö			54. 01
54. 02	05403 ULTRASOUND	2	6, 394	0			54. 02
54.03	05404 ECHOCARDI OLOGY	0	785	0			54. 03
54.04	05401 ONCOLOGY	1, 276	8, 465	0			54. 04
57. 00	05700 CT SCAN	704	0				57. 00
58. 00	05800 MRI	233	1	0			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 889	4, 094				59.00
59. 01 60. 00	O5901 CARDI AC REHAB O6000 LABORATORY	100	137 6, 282				59. 01 60. 00
65. 00	06500 RESPIRATORY THERAPY	190, 739	0, 202 441				65.00
66. 00	06600 PHYSI CAL THERAPY	231	2, 877	0			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	_, 0	Ö			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0			68. 00
69.00	06900 ELECTROCARDI OLOGY	10, 717	1, 109	0			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	89	2, 020	0			70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0			71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 709, 604	0	0			73.00
74. 00 75. 00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	1, 507	819	1, 753			74. 00 75. 00
75.00	OUTPATIENT SERVICE COST CENTERS	113	019	1, 700			75.00
90. 00	09000 CLINIC	8, 620	0	11, 284			90.00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0,020	644				90. 01
91. 00	09100 EMERGENCY	683	36, 582				91.00
91. 01	09101 WOUND CARE 002	69	558				91. 01
91. 02	09102 WOUND CARE 001	197	0	0			91. 02
91. 03	09103 LAFAYETTE RD CLINIC	0	0	0			91. 03
91.04	09104 ZI ONSVI LLE CLI NI C	8	4, 188	0			91.04
91. 05	09105 BROWNSBURG CLINIC	0	0	0			91.05
91. 06 91. 07	09106 OP ANTI COAGULATION CLINIC 09107 ST VINCENT OUTPATIENT TREATMENT	56	772				91. 06 91. 07
	04040 FAMILY PRACTICE	12	0	526			91.07
	2019 6:15 pm Y:\28500 - St. Vincent Hospital	<u>'</u>		<u>'</u>		<u> </u>	, , , , , , ,

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Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0084

			Т	o 06/30/2019	Date/Time Pro	
				INTERNS &	RESI DENTS	To pili
				1111211110 4	11201321110	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	2
		RECORDS &		Y & FRINGES A	PRGM COSTS A	
		LI BRARY				
	15. 00	16. 00	17. 00	21. 00	22.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT						92. 00
OTHER REIMBURSABLE COST CENTERS				ı		
95. 00 09500 AMBULANCE SERVICES	2	150	0			95. 00
98. 00 09853 GERI ATRI C CLI NI C	0	0	0			98. 00
98. 01 09851 ELECTROCONVULSI VE THERAPY	0	0	0			98. 01
98. 02 09852 DI ABETES EDUCATION	0	106	0			98. 02
SPECIAL PURPOSE COST CENTERS			T _		Г	4
105. 00 10500 KI DNEY ACQUI SI TI ON	3	0	0			105. 00
106. 00 10600 HEART ACQUISITION	1	0	0			106. 00
112.00 08600 PANCREAS ACQUISITION	0	0	0			112.00
113. 00 11300 INTEREST EXPENSE	17.05/	4 7/0				113. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	17, 956 1, 992, 825	4, 768 168, 706		0	,	115. 00 118. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	1, 992, 825	108, 700	269, 316	0		7118.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN		0	0			190. 00
191. 0019100 RESEARCH		0				191. 00
192.0019200 PHYSICIANS PRIVATE OFFICES	210, 989	0	2, 880			192. 00
193. 00 19300 NONPALD WORKERS	210, 707	0	2,000			193. 00
193. 01 19304 MARKETI NG		0	0			193. 01
193. 02 19305 MI SSI ON SERVI CES		0	0			193. 02
193. 03 19306 FOUNDATION	o	0	Ö			193. 03
193. 04 19307 WELLNESS	25	0	0			193. 04
193. 07 19310 BI LLI NG	O	0	0			193. 07
193. 09 19312 LI FELI NE	O	0	0			193. 09
193.10 19313 MARTEN HOUSE	0	0	0			193. 10
193. 14 19302 VACANT SPACE	0	0	0			193. 14
193. 16 19316 SETON BOARD	0	0	0			193. 16
193. 19 19319 SPORTS PERFORMANCE	1, 253	1, 842	0			193. 19
200.00 Cross Foot Adjustments				381, 795		200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 205, 092	170, 548	272, 196	381, 795	406, 674	202. 00

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Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0084

					To 06/30/2019		
	Cost Center Description	PARAMED ED PRGM- PHARMACY	PARAMED ED PRGM - CPE	PARAMED ED PRGM -	PARAMED ED PRGM - EMS	11/25/2019 6: Subtotal	15 pili
		23. 00	23. 01	23. 02	23. 03	24. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-BLDG-STRESS						1. 00 1. 01
1.01	00102 NEW CAP REL COSTS-BLDG-MARTEN H						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9. 00	00900 HOUSEKEEPING						8. 00 9. 00
10. 00	1 1						10.00
11. 00							11. 00
13. 00							13.00
14.00	1 1						14. 00
15. 00 16. 00	1 1						15. 00 16. 00
17. 00	1 1					•	17. 00
21.00	02100 I &R SERVICES-SALARY & FRINGES A						21. 00
22. 00	1 1						22. 00
23. 00 23. 01	1 1	44, 823	44 700				23. 00 23. 01
23. 01	1 1		44, 790	28, 212	,		23. 01
23. 03	1 1			20, 212	142, 806		23. 03
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	1					9, 254, 596	
31. 00 32. 00	1					1, 838, 045 0	31. 00 32. 00
32. 00	1					1, 295, 014	
33. 00						0	33. 00
33. 01						724, 881	33. 01
34.00	1					0	34.00
34. 01 40. 00	1 1					1, 663, 390 587, 502	34. 01 40. 00
41.00	1 1					227, 819	
43. 00	1 1					412, 820	1
	ANCILLARY SERVICE COST CENTERS				1		
50. 00 52. 00	1 1					10, 042, 412 631, 969	
54.00	1 1					2, 193, 531	
54. 01	1 1					1, 147, 845	
54. 02	1 1					143, 557	54. 02
54. 03						284, 894	
54. 04 57. 00	1 1					3, 260, 702 521, 838	
58. 00	1 1					663, 820	•
59.00	05900 CARDI AC CATHETERI ZATI ON					2, 156, 757	59. 00
	1 1					153, 279	
60. 00 65. 00	1 1					1, 071, 880	•
66.00	1					1, 291, 242 1, 909, 242	
67. 00	1					48, 790	
68. 00	1					183, 553	
69. 00	1					371, 152	
70. 00 71. 00	1 1					613, 257 1, 647, 223	70. 00 71. 00
71.00	1 · · · · · · · · · · · · · · · · · · ·					4, 814, 476	1
73. 00	1 · · · · · · · · · · · · · · · · · · ·					3, 575, 953	
74.00	1 1					269, 644	•
75. 00						595, 615	75. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC					2, 396, 428	90. 00
90. 01	1 · · · · · · · · · · · · · · · · · · ·					233, 203	
91. 00	09100 EMERGENCY					2, 330, 419	91. 00
91. 01	1 1					270, 305	
91. 02 91. 03	1 1					53, 882 7	91. 02 91. 03
91. 03	1 1					293, 388	
						0	91. 05
91. 06	1 1					90, 429	
	1 · · · · · · · · · · · · · · · · · · ·					167, 790	
	04040 FAMILY PRACTICE 09200 OBSERVATION BEDS (NON-DISTINCT					451, 243	91. 08 92. 00
, 2. 00	11.221,0002	ı	'	ı	1	1	, , , , , , , , , , , , , , , , , , , ,

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MCRI F32 - 15. 9. 167. 1 62 | Page Health Financial Systems In Lieu of Form CMS-2552-10 ST. VINCENT HOSPITAL & HCC ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0084 Peri od: Worksheet B From 07/01/2018 Part II 06/30/2019 Date/Time Prepared: 11/25/2019 6:15 pm Cost Center Description PARAMED ED PARAMED ED PARAMED ED PARAMED ED Subtotal PRGM- PHARMACY PRGM -PRGM - EMS PRGM - CPE RADI OLOGY 23.00 23. 01 23. 03 24.00 23. 02 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 91, 234 95.00 98. 00 09853 GERIATRIC CLINIC 98.00 26 98. 01 09851 ELECTROCONVULSI VE THERAPY 0 98. 01 09852 DIABETES EDUCATION 98.02 17, 215 98.02 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 650, 414 105. 00 403, 177 106. 00 112.00 08600 PANCREAS ACQUISITION 270 112. 00 113. 00 11300 INTEREST EXPENSE 113. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 948, 575 115. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 61, 994, 703 118. 00 0 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 137, 967 190. 00 191. 00 19100 RESEARCH 168, 481 191. 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 4, 209, 463 192. 00 193. 00 19300 NONPALD WORKERS 0 193. 00 193. 01 19304 MARKETI NG 11 193. 01 193. 02 19305 MI SSI ON SERVI CES 91, 780 193. 02 193. 03 19306 FOUNDATI ON 174, 720 193. 03 193. 04 19307 WELLNESS 28, 796 193. 04 193. 07 19310 BI LLI NG 584, 140 193. 07 3, 726 193. 09 193. 09 19312 LI FELI NE 193. 10 19313 MARTEN HOUSE 3, 284 193. 10 193. 14 19302 VACANT SPACE 457, 764 193. 14 193. 16 19316 SETON BOARD 63, 269 193. 16 193. 19 19319 SPORTS PERFORMANCE 1, 815, 384 193. 19 200.00 Cross Foot Adjustments 44, 823 44, 790 28, 212 142, 806 1, 049, 100 200. 00 0 201.00 201.00 Negative Cost Centers

44, 823

44, 790

28, 212

142, 806

70, 782, 588 202. 00

TOTAL (sum lines 118 through 201)

202.00

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ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0084 Period: Worksheet B From 07/01/2018 Part II

Control Center Description					To 06/30/2019 Date/Time Pre	
September Sept		Cost Center Description		Total		15 pili
Adjustments			& Post			
1.00 001000/CAP REF COSTS-RUE OF A FIXT 1.00		JOSUSTAL OSTALOS AGOST OFFITS		26.00		
1.01 1.00	1. 00		1			1.00
2.00	1.01	00101 NEW CAP REL COSTS-BLDG-STRESS				1. 01
4.00		· ·				
0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.00000000		l l				
8.00 00800 LANDROY & LINEN SERVICE 9.00 00900 LANDROY & LINEN SERVICE 9.00 00900 LINENS RET PINN 6.00 10000 CENTRAL SERVICE 9.00 10000 CENTRAL SERVICE 8.00 110.00		1				1
0.000 0.0000 0.0000 0.00000 0.00000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000		1	1			1
11.00 01300 CAFETERIA 11.00 13.00	9.00	00900 HOUSEKEEPI NG				9. 00
13.00 13.00 NIRSH ING ADM INSTRATION						
15.00						
16. 00 1600 MEDICAL, RECORDS & LIBRARY						
17. 00 1700 SOZIAL SERVICE						1
22.00						1
23.00						1
23.01 03201 PARAMED ED PREM - CPE 23.01 23.02 23.03 PARAMED ED PREM - PABRIOLOGY 23.03 23.03 PARAMED ED PREM - EMB 23.03 23.03 PARAMED ED PREM - EMB 23.00 23.00 23.00 23.00 PARAMED ED PREM - EMB 23.00						
23.03 02300 PARAMED ED PRIGN = LINS	23. 01	02301 PARAMED ED PRGM - CPE				23. 01
INPATI ENT ROUTINE SERVICE COST CENTERS 0 9,254,596 30,00 310,00 310,00 03100 ADULTS & PEDIATRICS 0 9,254,596 31,00 32,00 322,00 322,00 322,00 03200 CRONARY CARE UNIT 0 1,98,014 32,01 32,00 330						1
33.00 03100 INTENSIVE CARE UNIT 0 0 0 02.00 032.01 03201 CARDI OTHORACIC VASCULAR TRANSPL 0 1, 295.014 32.01 03201 CARDI OTHORACIC VASCULAR TRANSPL 0 1, 295.014 32.01 033.01 03300 03300 03800 SURIN INTENSIVE CARE UNIT 0 0 0 33.00 03300 03300 03800 SURIS CLAI INTENSIVE CARE UNIT 0 0 0 0 34.00 034.01 02060 NEGNITAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0	23.03					23.03
32.00 03200 COROMARY CARE UNIT 0 0 1.295,014 33.00 33.		· ·	1	· · · · · · · · · · · · · · · · · · ·		1
22 01 03201 CARDI OTHORACIC VASCULAR TRANSPL 0 1, 295, 014 32, 01 33, 00 330 0300 SURN INTERSIVE CARE UNIT 0 0 0 33, 00 33, 01 34, 01 02060 NEGNITAL INTERSIVE CARE UNIT 0 0 0 0 34, 01 34, 00 340 00 02060 NEGNITAL INTERSIVE CARE UNIT 0 1, 663, 390 34, 01 02060 NEGNITAL INTERSIVE CARE UNIT 0 1, 663, 390 34, 01 02060 NEGNITAL INTERSIVE CARE UNIT 0 1, 663, 390 34, 01 04, 00 04000 SUBPROVI DER - IPF 0 0, 587, 502 40, 00 04, 00 04100 SUBPROVI DER - IPF 0 0, 227, 819 41, 00 04100 SUBPROVI DER - IPF 0 0, 227, 819 41, 00 04100 SUBPROVI DER - IPF 0 0, 227, 819 41, 00 04100 SUBPROVI DER - IPF 0 0, 227, 819 41, 00 04100 SUBPROVI DER - IPF 0 0, 227, 819 41, 00 04100 SUBPROVI DER - IPF 0 0, 227, 819 41, 00 04100 SUBPROVI DER - IPF 0 0, 247, 819 41, 00 04100 SUBPROVI DER - IPF 0 0, 247, 819 41, 00 04100 SUBPROVI DER - IPF 0 0, 247, 819 41, 00 04100 SUBPROVI DER - IPF 0 0, 247, 819 41, 00 04100 SUBPROVI DER - IPF 0 0, 247, 819 41, 00 04100 SUBPROVI DER - IPF 0 0, 249, 819 41, 00 0, 00, 00 0, 00, 00 0, 00, 00		1	1	1		1
33. 01 20080 PEDIATRIC INTENSIVE CARE UNIT 0 724, 881 33. 01 34. 00	32. 01	03201 CARDI OTHORACI C VASCULAR TRANSPL	0	1, 295, 014		32. 01
34.00 03400 SURGI CAL INTERSI VE CARE UNIT 0 1		1	-			1
40.00 04000 SUBPROVI DER - 1 PF 0 587, 502 41.00 410 41.00 410.00 410.00 410.00 54070 41.00 410.00		1	1	724, 881		
41. 00 04100 SUBPROVIDER - I RF 0 227, 819 0 412, 820 43. 00 43. 00 44. 0		1	-			
ABOOD AURSERY		1	1			1
50.00 05000 05000 05000 05000 05000 05000 0500 05000		04300 NURSERY				1
52.00 05.200 DELIVERY ROOM & LABOR ROOM 0 6.31, 969 52.00	50.00			10 042 412		50.00
54. 01 05402 AMBULATORY CARDI OVASCULAR SVC 0 1,147,845 54. 01			1			
54. 02 05403 LITERASQUIND 0 143,557 54,02 54. 03 05404 ECHOCARDI OLOGY 0 284,894 54,03 57. 00 05700 CT SCAN 0 3,260,702 54,04 57. 00 05700 CT SCAN 0 521,838 57,00 58. 00 05800 MBI 0 663,820 58,00 59. 01 05901 CARDIAC CATHETERI ZATION 0 2,156,757 59,00 59. 01 05901 CARDIAC CATHETERI ZATION 0 1,071,880 66,00 60. 00 06000 LABORATORY 0 1,071,880 66,00 65. 00 06500 RESPI RATORY THERAPY 0 1,291,242 65,00 66. 00 06600 PHYSICAL THERAPY 0 1,909,242 65,00 67. 00 06700 OCCUPATI ONAL THERAPY 0 1,909,242 65,00 68. 00 06800 SPEECH PATHOLOGY 0 183,553 68,00 69. 00 06900 ELECTROCARDI OLOGY 0 183,553 68,00 71. 00 071,00 07000 ELECTROCARDI OLOGY 0 1613,257 70,00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 1,647,223 71,00 71. 00 07200 IMPL DEV. CHARGED TO PATIENTS			-			
54. 03 05404 [ECHOCARDI OLOGY 0 284, 894 54, 03 034, 0540 05401 [ONCOLOGY 54, 04 55, 00 05700 CT SCAN 0 3, 260, 702 55, 00 55, 00 05800 MRI 0 663, 820 58, 00 58, 00 58, 00 59, 00 60, 00						1
57. 00 05700 CT SCAN 0 521,838 57. 00 58. 00 05800 MRI 0 0 663,820 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 2,156,757 59. 00 59. 01 05901 CARDI AC REHAB 0 153,279 59. 01 60. 00 60.00 LABORATORY 0 1,071,880 60. 00 60.00 CABORATORY 0 1,291,242 65. 00 66. 00 66.00 RESPI RATORY THERAPY 0 1,991,242 66. 00 66. 00 66.00 RESPI RATORY THERAPY 0 1,999,242 66. 00 66. 00 66.00 SPECH PATHOLOGY 0 48,790 67. 00 67. 00 60.00			-	284, 894		54. 03
58 00 05800 MRI 0 663,820 58,00 59,00 05900 CARDI AC CATHETERI ZATI ON 0 2,156,757 59,00 59,01 05901 CARDI AC REHAB 0 153,279 59,01 60,00 06000 LABORATORY 0 1,071,880 60,00 65,00 06500 RESPIR RATORY THERAPY 0 1,291,242 66,00 66,00 06400 PHYSI CAL THERAPY 0 1,909,242 66,00 67,00 06700 OCCUPATI OUAL THERAPY 0 48,790 67,00 68,00 08600 SPECH PATHOLOGY 0 183,553 68,00 69,00 06900 ELECTROCARDI OLOGY 0 371,152 69,00 70,00 07000 ELECTROCARDI OLOGY 0 371,152 69,00 71,00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 1,647,223 71,00 71,00 07200 IIMPL DEV. CHARGED TO PATI ENTS 0 4,814,476 72,00 73,00 07300 DRUGS CHARGED TO PATI ENTS 0 269,644 74,00 75,00 0330 REN			1 -1			1
59 01 05901 CARDI AC REHAB 0 153, 279 59, 01 60. 00 06000 LABORATORY 0 1, 071, 880 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 1, 291, 242 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 1, 909, 242 66. 00 67. 00 06700 OCUPATI ONAL THERAPY 0 48, 790 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 183, 553 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 371, 152 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 371, 152 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 0 1, 647, 223 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 4, 814, 476 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 3, 755, 953 73. 00 75. 00 03330 ENDOSCOPY 0 595, 615 75. 00 90. 01 O9900 PARTI AL HOSPI TALI ZATI ON 0 23			-1			
60. 00 6000 LABORATORY 0 1,071,880 60.00 65. 00 06500 RESPI RATORY THERAPY 0 1,291,242 66.00 66. 00 06600 PHYSI CAL THERAPY 0 1,991,242 66.00 67. 00 6600 OCCUPATI ONAL THERAPY 0 48,790 67.00 68. 00 06800 SPEECH PATHOLOGY 0 183,553 68.00 69. 00 06900 ELECTROCARDI OLOGY 0 371,152 69.00 70. 00 07000 ELECTROCARDI OLOGY 0 371,152 69.00 71. 00 07000 ELECTROENCEPHAL OGRAPHY 0 613,257 70.00 71. 00 07000 MEDI CAL SUPPLIES CHARGED TO PAT 0 1,647,223 71.00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 4,814,476 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 3,575,953 73.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 269,644 74.00 75. 00 03330 ENDOSCOPY 0 595,615 75.00 0017PATIENT SERVICE COST CENTERS 90. 00 90000 CLIN C 90. 01 09000 PARTI AL HOSPI TALI ZATI ON 0 233,203 90.01 91. 00 09000 EMERGENCY 0 2,330,419 91.00 91. 01 09101 WOUND CARE 002 0 2,330,419 91.00 91. 02 09102 WOUND CARE 002 0 2,330,419 91.00 91. 01 09101 WOUND CARE 002 0 7.005 91.01 91. 02 09102 WOUND CARE 001 0 53,882 91.02 91. 03 09103 LAFAYETTE RD CLINIC 0 7.005 91.01 91. 04 09104 ZIONSVILLE CLINIC 0 7.005 91.04 91. 05 09105 BROWNSBURG CLINIC 0 991.05 91. 06 09106 DP ANTI OLORHITICS CLINIC 0 90104 ZIONSVILLE CLINIC 0 91.07 91. 07 09107 ST VINCENT OUTPATIENT TREATMENT 0 167,790 91.07 91. 08 04040 FAMILY PRACTICE 0 91.07		1	1			
65. 00 06500 RESPIRATORY THERAPY 0 1,291,242 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 1,909,242 66. 00 67. 00 06700 0CUPATIONAL THERAPY 0 1,909,242 66. 00 67. 00 06700 0CUPATIONAL THERAPY 0 183,553 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 371, 152 69. 00 06900 ELECTROCARDI OLOGY 0 613,257 77. 00 07000 ELECTROCARDI OLOGY 0 613,257 77. 00 07000 ELECTROCARDI OLOGY 0 613,257 77. 00 07000 ELECTROCARDI OLOGY 0 613,257 77. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 0 1,647,223 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 4,814,476 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 3,575,953 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 3,575,953 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 269,644 74. 00 74. 00 75. 00 07300 DRUGS CHARGED TO PATI ENTS 0 595,615 75. 00 07000 ELECTROCARDI OLOGY 0 233,203 90. 00 90.			-			
67. 00 06700 0CCUPATI ONAL THERAPY 0 48,790 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 183,553 68. 00 70. 00 07000 07000 07000 ELECTROCARDI OLOGY 0 613,257 70. 00 71. 00 07000 MEDI CAL SUPPLI ES CHARGED TO PAT 0 1,647,223 71. 00 72. 00 07200 1 MPL. DEV. CHARGED TO PATI ENTS 0 4,814,476 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 3,575,953 73. 00 74. 00 07400 RENAL DIALYSIS 0 269,644 74. 00 75. 00 07300 DRUGS CHARGED TO PATI ENTS 0 595,615 75. 00 000 07400 RENAL DIALYSIS 0 269,644 74. 00 75. 00 00 07400 RENAL DIALYSIS 0 269,644 74. 00 76. 00 07400 RENAL DIALYSIS 0 279,615 75. 00 00 07500 RENGERORY 0 279,305 91. 00 00 07500 RENGERORY 0 0 293,388 91. 00 00 07500 RENGERORY 0 0 293,388 91. 00 00 07500 RENGERORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65. 00	06500 RESPIRATORY THERAPY	0	1, 291, 242		65. 00
68. 00		· ·	0			
70.00 07000 ELECTROENCEPHALOGRAPHY 0 613, 257 70.00 71.00 70.00 MEDI CAL SUPPLI ES CHARGED TO PAT 0 1, 647, 223 71.00 72.00 72.00 MPL. DEV. CHARGED TO PATI ENTS 0 4, 814, 476 72.00 73.00 73.00 DRUGS CHARGED TO PATI ENTS 0 3, 575, 953 73.00 73.00 74.00 RENAL DI ALYSI S 0 269, 644 74.00 75.00 03330 ENDOSCOPY 0 595, 615 75.00 001794TI ENT SERVICE COST CENTERS		1	o			
71. 00			-			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 4,814,476 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 3,575,953 73. 00 74. 00 07400 RENAL DIALYSIS 0 269,644 74. 00 75. 00 03330 ENDOSCOPY 0 595,615 75. 00 0UTPATIENT SERVICE COST CENTERS 0 2,396,428 90. 00 90. 01 09000 CLI NI C 0 233,203 90. 01 91. 00 09100 PARTI AL HOSPI TALI ZATI ON 0 233,203 90. 01 91. 01 09101 WOUND CARE 002 0 270,305 91. 01 91. 02 09102 WOUND CARE 001 0 53,882 91. 02 91. 03 09103 LAFAYETTE RD CLINIC 0 7 91. 03 91. 04 09104 ZI ONSVI LLE CLINIC 0 293,388 91. 04 91. 05 09105 BROWNSBURG CLINIC 0 0 91. 05 91. 06 09106 OP ANTI COAGULATI ON CLINIC 0 90,429 91. 06 91. 07 09107 ST VI NCENT OUTPATIENT TREATMENT 0 167,790 91. 08			-			
74. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 814, 476		72. 00
75. 00 03330 ENDOSCOPY 0 595, 615 75. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 2, 396, 428 90. 01 90. 01 09001 PARTIAL HOSPITALIZATION 0 233, 203 90. 01 91. 00 09100 EMERGENCY 0 2, 330, 419 91. 00 91. 01 09101 WOUND CARE 002 0 270, 305 91. 01 91. 02 09102 WOUND CARE 001 0 53, 882 91. 02 91. 03 09103 LAFAYETTE RD CLINIC 0 7 91. 04 09104 ZI ONSVILLE CLINIC 0 293, 388 91. 04 91. 05 09105 BROWNSBURG CLINIC 0 293, 388 91. 04 91. 06 09106 OP ANTI COAGULATION CLINIC 0 90, 429 91. 07 09107 ST VI NCENT OUTPATIENT TREATMENT 0 167, 790 91. 08 04040 FAMILY PRACTICE 91. 08			-			
90. 00 09000 CLINIC 0 2,396,428 90. 00 90. 01 9001 PARTI AL HOSPITALIZATION 0 233, 203 90. 01 91. 00 91. 00 91. 00 91. 01 91. 01 91. 01 91. 01 91. 01 91. 02 91. 02 91. 02 91. 02 91. 03 91. 04 91. 05 91. 04 91. 05 91. 05 91. 06 91. 06 91. 06 91. 07 91. 08 04040 FAMILY PRACTICE 0 451, 243 91. 08		1	1			1
90. 01 09001 PARTI AL HOSPITALI ZATI ON 0 233, 203 90. 01 91. 00 91. 00 91. 00 91. 01 09101 WOUND CARE 002 0 270, 305 91. 01 91. 02 91. 02 91. 03 09103 LAFAYETTE RD CLINI C 0 7 91. 03 91. 04 91. 04 21 ONSVI LLE CLINI C 0 293, 388 91. 05 91. 06 91. 06 91. 06 09105 BROWNSBURG CLINI C 0 0 0 91. 05 91. 06 91. 07 91. 08 04040 FAMILY PRACTICE 0 451, 243 91. 08 91.	00.00			0.007.400		
91. 00 09100 09100 09100 09101 09101 09101 09101 09101 09101 09101 09101 09101 09101 09101 09101 09102 09102 09102 09102 09103 09103 09104 09104 09104 09104 09104 09104 09104 09104 09104 09104 09105			1			1
91. 02 09102 WOUND CARE 001 0 53, 882 91. 02 91. 03 09103 LAFAYETTE RD CLINIC 0 7 91. 03 91. 04 09104 ZI ONSVI LLE CLINIC 0 293, 388 91. 04 91. 05 09105 BROWNSBURG CLINIC 0 0 0 0 91. 05 91. 06 09106 OP ANTI COAGULATION CLINIC 0 90, 429 91. 06 91. 07 91. 07 91. 08 04040 FAMILY PRACTICE 0 451, 243 91. 08	91. 00	09100 EMERGENCY	1	2, 330, 419		91. 00
91. 03 09103 LAFAYETTE RD CLINIC 0 7 91. 03 91. 04 09104 ZI ONSVI LLE CLINIC 0 293, 388 91. 04 91. 05 09105 BROWNSBURG CLINIC 0 0 0 0 91. 05 91. 06 09106 0P ANTI COAGULATION CLINIC 0 90, 429 91. 06 91. 07 09107 ST VI NCENT OUTPATIENT TREATMENT 0 167, 790 91. 07 91. 08 04040 FAMILY PRACTICE 0 451, 243 91. 08			0			
91. 05 09105 BROWNSBURG CLINIC 0 0 0 91. 05 91. 06 91. 06 91. 06 91. 07 09107 ST VINCENT OUTPATIENT TREATMENT 0 167, 790 91. 08 04040 FAMILY PRACTICE 0 451, 243 91. 08				7		
91. 06 09106 OP ANTI COAGULATI ON CLINIC 0 90, 429 91. 06 91. 07 09107 ST VI NCENT OUTPATIENT TREATMENT 0 167, 790 91. 08 04040 FAMILY PRACTICE 0 451, 243 91. 08			0			1
91. 07 09107 ST VINCENT OUTPATIENT TREATMENT 0 167, 790 91. 07 91. 08 04040 FAMILY PRACTICE 0 451, 243 91. 08				-1		1
	91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	O	167, 790		91. 07
			1 -1	<u> </u>	Papart\ 20100620\ UES E: Lac\ 20500 10 magg	J 91. 08

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Health Financial Systems	ST. VINCENT HOS	SPITAL & HCC		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO	CN: 15-0084	Period: From 07/01/2018 To 06/30/2019	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
as as leaded appendix on pens (non proteins	25. 00	26. 00			
92. 00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT	0				92. 00
OTHER REIMBURSABLE COST CENTERS		04.004	ı		05.00
95. 00 09500 AMBULANCE SERVI CES	0	91, 234	•		95. 00 98. 00
98. 00 09853 GERI ATRI C CLI NI C 98. 01 09851 ELECTROCONVULSI VE THERAPY	0	26 0	•		98.00
98. 01 09851 ELECTROCONVOLSTVE THERAPY 98. 02 09852 DI ABETES EDUCATION	0	17, 215	I		98.01
SPECIAL PURPOSE COST CENTERS	l d	17, 213			96. 02
105. 00 10500 KI DNEY ACQUISITION		650, 414			105. 00
106. 00 10600 HEART ACQUISITION		403, 177			106.00
112. 00 08600 PANCREAS ACQUISITION		270			112.00
113. 00 11300 NTEREST EXPENSE		210			113.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	948, 575			115. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		61, 994, 703			118.00
NONREI MBURSABLE COST CENTERS	-1	21,111,110			
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	137, 967			190. 00
191. 00 19100 RESEARCH	o	168, 481			191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	o	4, 209, 463			192. 00
193. 00 19300 NONPALD WORKERS	o	0			193. 00
193. 01 19304 MARKETI NG	0	11			193. 01
193. 02 19305 MI SSI ON SERVI CES	O	91, 780			193. 02
193. 03 19306 FOUNDATI ON	0	174, 720			193. 03
193. 04 19307 WELLNESS	0	28, 796			193. 04
193. 07 19310 BI LLI NG	0	584, 140			193. 07
193. 09 19312 LI FELI NE	0	3, 726			193. 09
193.10 19313 MARTEN HOUSE	0	3, 284			193. 10
193. 14 19302 VACANT SPACE	0	457, 764			193. 14
193. 16 19316 SETON BOARD	0	63, 269			193. 16
193. 19 19319 SPORTS PERFORMANCE	0	1, 815, 384	•		193. 19
200.00 Cross Foot Adjustments	0	1, 049, 100	i		200. 00
201.00 Negative Cost Centers	0	0			201. 00
202.00 TOTAL (sum lines 118 through 201)	0	70, 782, 588			202.00

11/25/2019 6:15 pm Y:\28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

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Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0084 Peri od: Worksheet B-1 From 07/01/2018 | Worksneet B-1 | From 07/01/2018 | To 06/30/2019 | Date/Time Prepared:

				Ť	o 06/30/2019	Date/Time Pre 11/25/2019 6:	
		CAPITAL RELATED COSTS			1117 207 2017 01	р	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	NEW BLDG-STRESS (SQUARE FEET)	NEW BLDG-MARTEN H (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.00	1. 01	1. 02	2. 00	4. 00	
4 00	GENERAL SERVI CE COST CENTERS	1 00/ 570		1			4 00
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-BLDG-STRESS	1, 286, 573 0	57, 916				1. 00 1. 01
1. 02	00102 NEW CAP REL COSTS-BLDG-MARTEN H	0	0	149, 190			1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP				17, 634, 198		2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	11, 132 48, 077	512 4, 207	0		335, 413, 673	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	224, 828	3, 235		1, 139, 455 483, 851	13, 373, 653 1, 615, 224	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	366	0	1		0	8. 00
9.00	00900 HOUSEKEEPI NG	13, 897	587	0	=, 0,,,	0	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	31, 589	1, 123		17, 063	0	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	3, 479	491		-	10, 151, 735	
14. 00	01400 CENTRAL SERVICES & SUPPLY	39, 878	1, 699	C	,	4, 499, 163	
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	16, 577 10, 250	0 719		156, 414 630	11, 669, 020 99, 910	
17. 00	01700 SOCIAL SERVICE	2, 147	115	•		5, 666, 059	
21. 00	02100 I&R SERVICES-SALARY & FRINGES A	0	0	C	0	9, 990, 526	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS A	12, 522	0	C	41, 838	8, 423, 716	
23. 00 23. 01	02300 PARAMED ED PRGM - PHARMACY 02301 PARAMED ED PRGM - CPE	1, 186 2, 287	0		0	682, 658 282, 751	
23. 02	02302 PARAMED ED PRGM - RADIOLOGY	1, 424	0	C	-	233, 409	
23. 03	02303 PARAMED ED PRGM - EMS	101	0	С	3, 865	846, 077	23. 03
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	300, 390	0	C	530, 047	73, 732, 602	30.00
31. 00	03100 NTENSI VE CARE UNI T	43, 802	0			13, 563, 161	
32. 00	03200 CORONARY CARE UNIT	0	0	C	-	0	32. 00
32. 01 33. 00	03201 CARDI OTHORACI C VASCULAR TRANSPL 03300 BURN I NTENSI VE CARE UNI T	33, 416	0	C	,	9, 724, 074	32. 01 33. 00
33. 00	02080 PEDIATRIC INTENSIVE CARE UNIT	18, 647	0		-	4, 236, 064	
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	C	0	0	34. 00
34. 01	02060 NEONATAL INTENSIVE CARE UNIT	28, 356	0	C		21, 294, 837	
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	4, 046 12, 755	26, 759 0	1	,	5, 631, 436 504, 456	
43. 00	04300 NURSERY	15, 417	0	C		2, 880, 997	
F0 00	ANCILLARY SERVICE COST CENTERS	14/ 404		1	5 407 474	04 700 440	F0 00
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	146, 401 20, 530	0	0		24, 798, 142 4, 158, 874	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	25, 210	0	C		4, 939, 382	
54. 01	05402 AMBULATORY CARDIOVASCULAR SVC	11, 856	0	C	307, 714	3, 128, 137	
54. 02 54. 03	05403 ULTRASOUND 05404 ECHOCARDI OLOGY	1, 962 0	0		58, 202 107, 991	1, 091, 291 793, 758	
	05401 ONCOLOGY	10, 026	0	ď	491, 185	3, 963, 768	
	05700 CT SCAN	2, 182	0	C	409, 217	1, 548, 282	
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	8, 502 27, 553	0		413, 656 1, 226, 553	914, 072 4, 860, 597	
59. 01	05901 CARDI AC REHAB	0	0		11, 409	679, 163	
60.00	06000 LABORATORY	17, 307	0	C	24, 159	0	
65. 00	06500 RESPIRATORY THERAPY	3, 257	0	C	424, 723	7, 410, 238	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	10, 594 372	51 0	0	50, 066 0	7, 889, 531 1, 072, 029	
68. 00		1, 258	0	C	10, 593	852, 172	
69. 00	06900 ELECTROCARDI OLOGY	776	0	C	142, 411	1, 468, 517	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PAT	809	9, 956	0	163, 976	1, 505, 015 0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	
74.00	07400 RENAL DI ALYSI S	3, 496	0	C		1 020 003	
75.00	03330 ENDOSCOPY OUTPATI ENT SERVI CE COST CENTERS	11, 766	0	C	294, 714	1, 920, 003	75. 00
90.00	09000 CLI NI C	0	0		83, 368	2, 477, 781	90. 00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	5, 126	8, 462	1	-,	1, 684, 386	
91.00	09100 EMERGENCY 09101 WOUND CARE 002	38, 291 9, 589) 0 0	C		13, 220, 786 595, 019	
	09102 WOUND CARE 001	553	Ö	ď	22, 122	434, 938	
	09103 LAFAYETTE RD CLINIC	0	0	0	0	0	
	09104 ZI ONSVI LLE CLI NI C 09105 BROWNSBURG CLI NI C	0	0		29, 193 0	310, 997 0	91.04
	09106 OP ANTICOAGULATION CLINIC	1, 695	0		o	459, 312	
11 /05 /	2010 6:15 pm V:\28500 - St Vincent Hospital	(0(+b C+)) 200	Madiaara Caat	. Danast\ 20100/	20\UEC ELLee\20	F00 10	·

11/25/2019 6:15 pm Y:\28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

MCRI F32 - 15. 9. 167. 1 66 | Page COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0084 Peri od: Worksheet B-1 From 07/01/2018 06/30/2019 Date/Time Prepared: 11/25/2019 6: 15 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Cost Center Description NEW NEW (SQUARE FEET) **BLDG-STRESS** BLDG-MARTEN H (DOLLAR VALUE) **BENEFITS** (SQUARE FEET) (SQUARE FEET) DEPARTMENT (GROSS SALARI ES) 1.00 1. 01 1. 02 2. 00 4.00 91. 07 | 09107 ST VINCENT OUTPATIENT TREATMENT 0 329, 761 91. 07 0 91. 08 | 04040 FAMILY PRACTICE 0 0 2, 185, 835 12, 389 91.08 C 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 6, 146 n O 0 0 09853 GERIATRIC CLINIC 0 98.00 0 0 0 98.00 98. 01 09851 ELECTROCONVULSI VE THERAPY 0 0 0 0 98.01 09852 DIABETES EDUCATION 296, 482 98.02 0 0 0 4, 941 98.02 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 18, 397 1, 779, 298 105. 00 106.00 10600 HEART ACQUISITION 0 0 1, 703, 747 106. 00 0 112.00 08600 PANCREAS ACQUISITION 0 0 112.00 0 0 113.00 11300 INTEREST EXPENSE 113.00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 348, 722 3, 414, 860 115. 00 SUBTOTALS (SUM OF LINES 1 through 117) 57, 916 300, 987, 701 118. 00 118.00 1, 241, 826 0 17, 307, 354 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 2,929 0 161 0 190 00 191. 00 19100 RESEARCH 0 1, 130, 387 191. 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 8, 299 0 0 175, 648 26, 004, 992 192. 00 193. 00 19300 NONPALD WORKERS 0 0 193, 00 0 193. 01 19304 MARKETI NG 0 0 193. 01 193. 02 19305 MISSION SERVICES 14, 794 512, 922 193. 02 2,630 193. 03 19306 FOUNDATI ON 2, 619 782, 101 193. 03 193. 04 19307 WELLNESS 193. 07 19310 BI LLI NG 0 0 0 426, 110 193. 04 0 C 0 0 193. 07 193. 09 19312 LI FELI NE 0 193. 09 0 3, 548 193. 10 19313 MARTEN HOUSE 0 0 149, 190 0 193. 10 193. 14 19302 VACANT SPACE 0 193. 14 30,889 C 0 193. 16 19316 SETON BOARD 0 193. 16 0 193. 19 19319 SPORTS PERFORMANCE 0 130, 074 5, 569, 460 193. 19 200 00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 62, 205, 619 202. 00 Cost to be allocated (per Wkst. B, 13, 347, 887 232, 763 3, 188 17, 634, 198 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 4. 018976 0.021369 1.000000 0. 185459 203. 00 10. 374761 531, 020 204. 00 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001583 205.00 H) 206.00 NAHE adjustment amount to be allocated 206.00

207. 00

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(per Wkst. B-2)

Parts III and IV)

NAHE unit cost multiplier (Wkst. D,

207.00

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ST. VINCENT HOSPITAL & HCC

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0084

Period:
From 07/01/2018
To 06/30/2019

Date/Time Prepared:
11/25/2019 6: 15 pm

Cost Center Description

Reconciliation ADMINISTRATIVE
& GENERAL
PLANT
PLANT
COUNTY COST)
(COUNTS FEET)
(COUNTS FEET)

				o 06/30/2019	Date/Time Prep 11/25/2019 6:	
Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	15 рііі
	5A	5. 00	7. 00	LAUNDRY) 8. 00	9. 00	
GENERAL SERVICE COST CENTERS 1. 00						1. 00 1. 01 1. 02
2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01100 DIETARY 11. 00 01100 CAFETERIA	-185, 867, 788 0 0 0 0	790, 803, 379 30, 318, 130 2, 901, 529 11, 233, 270 4, 673, 955 7, 309, 337	1, 052, 498 366 14, 484	2, 586, 775 0 0	1, 037, 648 32, 712 0	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00
13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 21.00 02100 I &R SERVI CES-SALARY & FRI NGES A	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17, 072, 631 10, 588, 972 29, 926, 297 498, 892 7, 414, 596 11, 843, 359	3, 970 41, 577 16, 577 10, 969 2, 261	0 1, 579 1, 699 0	3, 970 41, 577 16, 577 10, 969 2, 261	13. 00 14. 00 15. 00 16. 00 17. 00 21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS A 23. 00 02300 PARAMED ED PRGM - PHARMACY 23. 01 02301 PARAMED ED PRGM - CPE 23. 02 02302 PARAMED ED PRGM - RADI OLOGY 23. 03 02303 PARAMED ED PRGM - EMS I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0 0	5, 242, 319 864, 655 359, 416 233, 540 1, 165, 260	12, 522 1, 186 2, 287 1, 424	42 0 0 0	12, 522 1, 186 2, 287 1, 424 101	22. 00 23. 00 23. 01 23. 02 23. 03
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	0 0	86, 189, 824 19, 900, 251 0	300, 390 43, 802	170, 842	300, 390 43, 802 0	30. 00 31. 00 32. 00
32. 01 03201 CARDI OTHORACI C VASCULAR TRANSPL 33. 00 03300 BURN INTENSI VE CARE UNI T 33. 01 02080 PEDI ATRI C INTENSI VE CARE UNI T	0 0	14, 520, 344 0 4, 269, 432	33, 416 0	77, 695 0	33, 416 0 18, 647	32. 01 33. 00 33. 01
34.00 03400 SURGI CAL INTENSIVE CARE UNIT 34.01 02060 NEONATAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVI DER - I PF 41.00 04100 SUBPROVI DER - I RF	0 0 0	0 21, 079, 416 5, 605, 171 1, 122, 166	30, 806 12, 755	94, 831 88, 752 16, 436		34. 00 34. 01 40. 00 41. 00
43. 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS	0	3, 105, 488				43. 00
50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05402 AMBULATORY CARDI OVASCULAR SVC 05403 ULTRASOUND 05404 ECHOCARDI OLOGY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	43, 911, 407 5, 659, 188 10, 711, 054 5, 505, 095 1, 460, 623 1, 849, 245	25, 210 11, 856 1, 962	39, 000 27, 196 33, 302 0	146, 401 20, 530 25, 210 11, 856 1, 962	50. 00 52. 00 54. 00 54. 01 54. 02 54. 03
54. 03 05404 CHOCKNOT CEOUT 54. 04 05401 0NCOLOGY 57. 00 05700 CT SCAN 58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON 59. 01 05901 CARDI AC REHAB	0 0 0	10, 525, 260 2, 488, 410 1, 996, 562 6, 545, 803 1, 075, 629	10, 026 2, 182 8, 502 27, 553	21, 285 38, 705 16, 033 42, 547	10, 026 2, 182 8, 502 27, 553 0	54. 04 57. 00 58. 00
60. 00 06000 LABORATORY 065. 00 06500 RESPI RATORY THERAPY 066. 00 06600 PHYSI CAL THERAPY 067. 00 06700 OCCUPATI ONAL THERAPY 068. 00 06800 SPEECH PATHOLOGY	0 0 0 0	26, 236, 284 14, 411, 830 11, 720, 789 1, 360, 339 1, 264, 594	17, 307 3, 257 10, 645 372 1, 258	0 23, 311 0 0	17, 307 3, 257 10, 645 372 1, 258	60. 00 65. 00 66. 00 67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S	0 0 0 0 0 0	2, 890, 715 6, 591, 207 54, 847, 113 56, 982, 525 62, 143, 287 5, 139, 128	10, 765 C C	6, 172 0 0 0	776 10, 765 0 0 0 3, 496	69. 00 70. 00 71. 00 72. 00 73. 00 74. 00
75. 00 03330 ENDOSCOPY OUTPATIENT SERVICE COST CENTERS	0	3, 539, 275	11, 766	19, 464	11, 766	75. 00
90. 00 09000 CLINI C 90. 01 09001 PARTI AL HOSPI TALI ZATI ON 91. 00 09100 EMERGENCY 91. 01 09101 WOUND CARE 002 91. 02 09102 WOUND CARE 001 91. 03 09103 LAFAYETTE RD CLINI C	0 0 0 0	5, 847, 072 2, 350, 451 26, 259, 144 1, 445, 442 587, 250 222	13, 588 38, 291 9, 589 553 C	0 246, 927 11, 348 0	0 13, 588 38, 291 9, 589 553 0	90. 00 90. 01 91. 00 91. 01 91. 02 91. 03
91.04 09104 ZIONSVILLE CLINIC 91.05 09105 BROWNSBURG CLINIC 91.06 09106 OP ANTICOAGULATION CLINIC 91.07 09107 ST VINCENT OUTPATIENT TREATMENT 91.08 04040 FAMILY PRACTICE 92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0 0 0 0 0 0	698, 676 0 665, 206 747, 082 2, 774, 122	1, 695 0	0 0 0 0	0 0 1, 695 0 0	91. 04 91. 05 91. 06 91. 07 91. 08 92. 00
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Heal th F	inancial Systems	ST. VINCENT HOSPITAL & HCC In Lieu o			u of Form CMS-2	2552-10	
	OCATION - STATISTICAL BASIS		Provi der Co	CN: 15-0084 F	Peri od:	Worksheet B-1	
					rom 07/01/2018	5	
					o 06/30/2019	Date/Time Pre 11/25/2019 6:	
	Cost Center Description	Reconciliation/	NDMI NII STDATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	13 pili
	cost center bescription	Reconciliation	& GENERAL	PLANT	LINEN SERVICE	(SQUARE FEET)	
			(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF	(SQUARE LELT)	
			(110001111	(SQO/IKE TEET)	LAUNDRY)		
		5A	5. 00	7. 00	8. 00	9. 00	
0	THER REIMBURSABLE COST CENTERS						
	9500 AMBULANCE SERVICES	0	63, 763	6, 146	0	6, 146	95. 00
	9853 GERIATRIC CLINIC	o	881			0	98. 00
	9851 ELECTROCONVULSI VE THERAPY	0	0		0	0	98. 01
	9852 DI ABETES EDUCATION	o	380, 385		0	0	98. 02
	PECIAL PURPOSE COST CENTERS	-					
	0500 KIDNEY ACQUISITION	0	6, 182, 488	(0	0	105. 00
	0600 HEART ACQUISITION	o	6, 606, 638	1	0		106. 00
	8600 PANCREAS ACQUISITION	o	9, 000	1	0		112. 00
	1300 INTEREST EXPENSE		.,				113. 00
	1500 AMBULATORY SURGICAL CENTER (D. P.)	0	13, 551, 844		0	0	115. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-185, 867, 788	704, 463, 278	l .	2, 586, 775	992, 901	
	ONREI MBURSABLE COST CENTERS	,,,	,	., .,			
	9000 GIFT FLOWER COFFEE SHOP & CAN	0	1, 054, 438	2, 929	0	2, 929	190. 00
	9100 RESEARCH	0	1, 943, 295			-	191. 00
	9200 PHYSICIANS PRIVATE OFFICES	o	48, 774, 554		0		192. 00
	9300 NONPALD WORKERS	0	0	. (0	0	193. 00
193. 01 1	9304 MARKETI NG	0	350		0	0	193. 01
193. 02 1	9305 MISSION SERVICES	0	1, 153, 096	2, 630	0	2, 630	193. 02
	9306 FOUNDATION	0	2, 812, 555				193. 03
193. 04 1	9307 WELLNESS	0	780, 378	1	0	0	193. 04
193. 07 1	9310 BI LLI NG	0	19, 449, 932		0	0	193. 07
	9312 LI FELI NE	o	5, 920	1	0	0	193. 09
	9313 MARTEN HOUSE	0	3, 188	1	0	0	193. 10
	9302 VACANT SPACE	o	320, 466	1	0	30, 889	193. 14
	9316 SETON BOARD	o	0	(0		193. 16
	9319 SPORTS PERFORMANCE	0	10, 041, 929		0		193. 19
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,		185, 867, 788	37, 444, 012	3, 596, 517	14, 388, 792	202. 00
	Part I)				7, 2, 2, 2, 1	,,	
203. 00	Unit cost multiplier (Wkst. B, Part I)		0. 235037	35. 576326	1. 390348	13. 866737	203. 00
204.00	Cost to be allocated (per Wkst. B,		23, 750, 439	3, 804, 217	92, 262	538, 355	
	Part II)				•		
205.00	Unit cost multiplier (Wkst. B, Part		0. 030033	3. 614465	0. 035667	0. 518822	205. 00
	11)						
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)						

11/25/2019 6:15 pm Y:\28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

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COST ALLOCATION - STATISTICAL BASIS	31. VINCENT 1103	Provider C	CN: 15-0084 Pe	eri od:	Worksheet B-1	2332-10
		From 07/0		com 07/01/2018 0 06/30/2019	9 Date/Time Prepared:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	11/25/2019 6: PHARMACY	15 pm
cost center bescription	(MEALS SERVED)	(HOURS)	ADMI NI STRATI ON	SERVICES &	(COSTED	
			(DI DECT NECINO	SUPPLY	REQUIS.)	
			(DIRECT NRSING HRS)	(COSTED REQUIS.)		
	10.00	11.00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS-BLDG & FLXT	<u> </u>					1. 00
1.01 00100 CAP REL COSTS-BLDG & FTXT						1. 00
1.02 00102 NEW CAP REL COSTS-BLDG-MARTEN H						1. 02
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY	387, 448					10.00
11. 00 01100 CAFETERI A	0	7, 514, 866				11. 00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY	0	290, 825 157, 154		70, 426, 045		13. 00 14. 00
15. 00 01500 PHARMACY		272, 154		1, 453, 446	48, 712, 888	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	O	5, 166	1	1, 052	0	16. 00
17. 00 01700 SOCIAL SERVICE 21. 00 02100 &R SERVICES-SALARY & FRINGES A	0	155, 498 352, 189		19, 500	0	17. 00 21. 00
22. 00 02200 1 &R SERVICES-SALARY & FRINGES A		193, 443	1	73, 101	57, 538	
23.00 02300 PARAMED ED PRGM- PHARMACY	0	19, 431	0	0	0	23. 00
23. 01 02301 PARAMED ED PRGM - CPE 23. 02 02302 PARAMED ED PRGM - RADIOLOGY	0	12, 588	1	0	0	23. 01 23. 02
23. 02 02302 PARAMED ED PRGM - RADIOLOGY 23. 03 02303 PARAMED ED PRGM - EMS		5, 776 23, 774		502	0	23. 02
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 NTENSI VE CARE UNI T	277, 342 5, 271	1, 887, 056 371, 785		3, 228, 941	130, 600 113, 940	30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT	5, 2/1	371, 763		0	113, 940	32.00
32. 01 03201 CARDI OTHORACI C VASCULAR TRANSPL	13, 175	249, 111	189, 312	2, 491	47, 947	32. 01
33. 00 03300 BURN INTENSIVE CARE UNIT 33. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	0 1, 513	0 81, 915	0	0 76, 497	2 070	33. 00 33. 01
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT	1, 513	01, 913	51, 045 0	70, 497	2, 970 0	34. 00
34.01 02060 NEONATAL INTENSIVE CARE UNIT	0	428, 223		141, 334	11, 787	34. 01
40. 00 04000 SUBPROVI DER - PF	47, 388 0	145, 623		17, 370	0	40. 00 41. 00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY		16, 095 65, 326		21, 906 126, 701	470 2, 163	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 524	686, 785 120, 110		980, 900 218	297, 712 8, 026	50. 00 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	37	157, 361			· ·	54. 00
54. 01 05402 AMBULATORY CARDI OVASCULAR SVC	0	89, 859		226, 777	316, 112	54. 01
54. 02 05403 ULTRASOUND 54. 03 05404 ECHOCARDI OLOGY	0	22, 465 19, 902	1	0 362, 008	39 0	54. 02 54. 03
54. 04 05401 ONCOLOGY		103, 431	44, 379	81, 297	28, 188	
57.00 05700 CT SCAN	0	41, 267	0	8, 992	15, 543	57. 00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	24, 165 116, 551		215, 567	5, 137 63, 812	58. 00 59. 00
59. 01 05901 CARDI AC REHAB		22, 365		6, 119	03, 812	59. 01
60. 00 06000 LABORATORY	0	0	0	42, 121	2, 215	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	220, 533 237, 690	1	0 107, 362	4, 213, 649 5, 095	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o o	28, 783		0	0,075	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	23, 117	1	32, 605	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	43, 248 46, 444	1	295, 951 181, 857	236, 743 1, 964	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	O	10, 111	0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	56, 982, 525	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	0	0	0	714, 260	37, 766, 995 33, 282	73. 00 74. 00
75. 00 03330 ENDOSCOPY	O	50, 404	29, 778	0	17, 077	75.00
OUTPATIENT SERVICE COST CENTERS	1	4, 407	7 000	00 550	100 100	
90. 00 09000 CLI NI C 90. 01 09001 PARTI AL HOSPI TALI ZATI ON	0	16, 127 57, 484		33, 550 6, 806	190, 429 0	90. 00 90. 01
91. 00 09100 EMERGENCY	1, 969	371, 503		54, 396	15, 091	91. 00
91. 01 09101 WOUND CARE 002	0	20, 196		O	1, 533	91. 01
91. 02 09102 WOUND CARE 001 91. 03 09103 LAFAYETTE RD CLINIC	0	11, 361 0	9, 468	0	4, 362 0	91. 02 91. 03
91. 04 09104 ZI ONSVI LLE CLINIC		0	o o	21, 271	180	91.03
91. 05 09105 BROWNSBURG CLINIC	0	0	0	0	0	91.05
91.06 09106 OP ANTICOAGULATION CLINIC 91.07 09107 ST VINCENT OUTPATIENT TREATMENT	0	0	5, 116 7, 765	2, 497 0	1, 245 0	91. 06 91. 07
91. 08 04040 FAMILY PRACTICE		0	8, 887	11, 146	261	
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Health Finar	iciai Systems	ST. VINCENT HOSE	TIAL & HCC		In Lie	u of form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		eri od:	Worksheet B-1	
					rom 07/01/2018	Date/Time Pre	narod:
				To	06/30/2019	11/25/2019 6:	
	Cost Center Description	DIETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	15 piii
	oost denter bescription	(MEALS SERVED)		ADMI NI STRATI ON	SERVICES &	(COSTED	
		((1.001.0)		SUPPLY	REQUIS.)	
				(DIRECT NRSING	(COSTED	REGOT 5.)	
				HRS)	REQUIS.)		
		10.00	11. 00	13. 00	14. 00	15. 00	
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT	10100	111.00	101.00	11100	101 00	92. 00
	REIMBURSABLE COST CENTERS			I			
	AMBULANCE SERVICES	0	0	0	O	36	95. 00
	GERIATRIC CLINIC		0	- 1	2	0	1
	ELECTROCONVULSI VE THERAPY		0	_	o o	0	
4	DI ABETES EDUCATION		8, 536	-	474	0	98. 02
	AL PURPOSE COST CENTERS	<u> </u>	0, 550	0	7/7		70.02
	KIDNEY ACQUISITION	0	25, 671	9, 390	1, 454	76	105. 00
	HEART ACQUISITION		33, 487	· ·	1, 434		106. 00
	PANCREAS ACQUISITION		33, 467 0		1, 430		112. 00
		U	Ü	٥	Ч	Ü	l
	INTEREST EXPENSE		400 507		0 070 750	20/ //7	113.00
	AMBULATORY SURGICAL CENTER (D. P.)	0	100, 587		2, 970, 758	396, 667	•
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	348, 219	7, 432, 564	3, 115, 793	70, 093, 292	44, 023, 669	118.00
	IMBURSABLE COST CENTERS				_1		
	GIFT FLOWER COFFEE SHOP & CAN	0	0		0		190. 00
191. 00 19100		0	23, 529		0		191. 00
	PHYSICIANS PRIVATE OFFICES	0	0	104, 622	230, 456	4, 660, 992	
4	NONPALD WORKERS	0	0	0	0		193. 00
193. 01 19304		0	0	0	0		193. 01
193. 02 19305	MISSION SERVICES	0	15, 533	0	302	0	193. 02
193. 03 19306	FOUNDATI ON	0	19, 123	0	0	0	193. 03
193. 04 19307	WELLNESS	0	24, 117	7, 431	2, 244	557	193. 04
193. 07 19310	BILLING	0	0	0	0	0	193. 07
193. 09 19312	LIFELINE	0	0	0	0	0	193. 09
193. 10 19313	MARTEN HOUSE	0	0	0	o	0	193. 10
	VACANT SPACE	o	0	0	o	0	193. 14
193. 16 19316	SETON BOARD	39, 229	0	0	ol	0	193. 16
	SPORTS PERFORMANCE		0	0	99, 751	27, 670	193. 19
200. 00	Cross Foot Adjustments				·		200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	7, 389, 889	9, 027, 302	21, 630, 976	15, 324, 444	38, 425, 255	202.00
	Part I)	.,,	.,,		,	, .=-, =	
203. 00	Unit cost multiplier (Wkst. B, Part I)	19. 073241	1. 201259	6. 701366	0. 217596	0. 788811	203. 00
204. 00	Cost to be allocated (per Wkst. B,	624, 885	219, 521		3, 835, 228	2, 205, 092	ı
	Part II)	32.,300	2.,,021	1, 55., 676	3, 555, 226	2,200,072	
205.00	Unit cost multiplier (Wkst. B, Part	1. 612823	0. 029212	0. 515636	0. 054458	0. 045267	205 00
		012020	5. 02/212	3.010000	5. 55 1 150	5. 5 15207	
206. 00	NAHE adjustment amount to be allocated						206. 00
230.00	(per Wkst. B-2)						_ 50. 55
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
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COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0084 Peri od: Worksheet B-1 From 07/01/2018 To 06/30/2019 Date/Time Prepared: 11/25/2019 6:15 pm INTERNS & RESIDENTS SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER Cost Center Description MEDI CAL PARAMED ED PRGM- PHARMACY RECORDS & Y & FRINGES A PRGM COSTS A LI BRARY (ASSI GNED (TIME SPENT) (ASSI GNED (ASSI GNED (TIME SPENT) TIME) TIME) TIME) 16.00 17. 00 21.00 22.00 23. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FIXT 1 00 1.01 00101 NEW CAP REL COSTS-BLDG-STRESS 1.01 1.02 00102 NEW CAP REL COSTS-BLDG-MARTEN H 1.02 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16, 00 16,00 262, 352 17 00 01700 SOCIAL SERVICE 21, 735 17 00 02100 I &R SERVICES-SALARY & FRINGES A 1,811 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS A 0 C 1,811 22.00 02300 PARAMED ED PRGM- PHARMACY 23.00 0 100 23.00 C 02301 PARAMED ED PRGM - CPE 23.01 0 C 23.01 02302 PARAMED ED PRGM - RADIOLOGY 0 23.02 23.02 02303 PARAMED ED PRGM - EMS 23.03 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 33, 718 5, 549 653 653 0 30.00 03100 INTENSIVE CARE UNIT 31.00 1, 454 1,652 109 109 31.00 32.00 03200 CORONARY CARE UNIT C 0 0 32.00 03201 CARDI OTHORACI C VASCULAR TRANSPL 32.01 1,777 12 12 0 32.01 03300 BURN INTENSIVE CARE UNIT 33.00 C 0 33.00 33. 01 02080 PEDIATRIC INTENSIVE CARE UNIT 269 873 10 10 0 33.01 03400 SURGICAL INTENSIVE CARE UNIT 34 00 0 Λ 0 0 34 00 34.01 02060 NEONATAL INTENSIVE CARE UNIT 733 3,500 14 14 0 34.01 04000 SUBPROVI DER - I PF 40.00 40.00 2, 395 27 27 0 04100 SUBPROVI DER - I RF 41.00 0 41.00 C 04300 NURSERY 988 0 43.00 2, 444 17 17 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 24, 761 173 293 293 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 1 030 725 60 60 0 52 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 66,043 C 53 53 0 54.00 54.01 05402 AMBULATORY CARDIOVASCULAR SVC 0 q 0 54.01 54.02 05403 ULTRASOUND 9,836 0 0 54.02 05404 ECHOCARDI OLOGY 54 03 1 207 Ω 54 03 14 14 0 54.04 05401 ONCOLOGY 13,022 0 55 55 0 54.04 57.00 05700 CT SCAN 0 2 57.00 0 05800 MRI 2 58.00 0 2 0 58.00 05900 CARDIAC CATHETERIZATION 6, 297 59 00 Ω 15 15 0 59 00 59.01 05901 CARDI AC REHAB 210 0 2 0 59.01 06000 LABORATORY 28 28 60.00 9,663 60.00 06500 RESPIRATORY THERAPY 22 65.00 679 0 22 0 65.00 06600 PHYSI CAL THERAPY 66.00 4.426 12 12 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 C 06800 SPEECH PATHOLOGY 0 68.00 0 0 0 68.00 06900 ELECTROCARDI OLOGY 69 00 1.706 Ω 31 31 69 00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 3, 108 20 20 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 71.00 71.00 0 0 0 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 0 0 0 07300 DRUGS CHARGED TO PATIENTS Ω 100 73.00 0 Ω 73.00 74.00 07400 RENAL DIALYSIS C 20 20 0 74.00 03330 ENDOSCOPY 75.00 1, 260 140 24 0 75.00 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 901 53 53 0 09001 PARTIAL HOSPITALIZATION 990 0 90.01 90.01 91.00 09100 EMERGENCY 56, 274 6, 959 87 87 O 91.00 09101 WOUND CARE 002 91.01 91.01 858 C 20 20 0 91.02 09102 WOUND CARE 001 0 C 0 0 0 91.02 91.03 09103 LAFAYETTE RD CLINIC 0 0 0 0 91.03 09104 ZIONSVILLE CLINIC 0 0 91.04 91.04 C 0 91.05 91.05 09105 BROWNSBURG CLINIC 0 0 C 0

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91.06 09106 OP ANTI COAGULATION CLINIC

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0 91.06 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0084 Peri od: Worksheet B-1 From 07/01/2018 То 06/30/2019 Date/Time Prepared: 11/25/2019 6: 15 pm INTERNS & RESIDENTS SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER Cost Center Description MEDI CAL PARAMED ED PRGM- PHARMACY RECORDS & Y & FRINGES A PRGM COSTS A LI BRARY (TIME SPENT) (ASSI GNED (ASSI GNED (ASSI GNED (TIME SPENT) TIME) TIME) TIME) 16. 00 17. 00 21.00 22. 00 23. 00 91. 07 | 09107 ST VINCENT OUTPATIENT TREATMENT 0 91.07 0 C 0 91. 08 | 04040 FAMILY PRACTICE 0 84 91. 08 84 42 0 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 230 n O n 0 09853 GERIATRIC CLINIC 0 98.00 0 0 0 0 98.00 98. 01 09851 ELECTROCONVULSI VE THERAPY 0 0 0 0 0 98.01 09852 DIABETES EDUCATION 98.02 0 0 0 98.02 163 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 7 0 106.00 0 112.00 08600 PANCREAS ACQUISITION 0 ol 0 112.00 0 113.00 11300 INTEREST EXPENSE 113.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 7, 335 0 115.00 SUBTOTALS (SUM OF LINES 1 through 117) 259, 519 100 118.00 118.00 21,505 1,764 1,764 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN C 0 0 190, 00 191. 00 19100 RESEARCH 31 31 0 191.00 0000000000 192.00 19200 PHYSICIANS PRIVATE OFFICES 230 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 193. 00 0 C 193. 01 19304 MARKETI NG 0 0 193. 01 Ω 193. 02 19305 MISSION SERVICES 0 0 0 193. 02 0 0 0 193. 03 19306 FOUNDATI ON 0 193. 03 0 193. 04 19307 WELLNESS 193. 07 19310 BI LLI NG 0 193. 04 0 0 C 0 0 193. 07 193. 09 19312 LI FELI NE 0 193. 09 0 0 193. 10 19313 MARTEN HOUSE 0 0 0 193. 10 193. 14 19302 VACANT SPACE 0 0 0 193. 14 C 193. 16 19316 SETON BOARD 0 0 193. 16 193. 19 19319 SPORTS PERFORMANCE 2,833 16 16 0 193. 19 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 201. 00 202.00 9, 497, 266 15, 050, 057 1, 149, 863 202. 00 Cost to be allocated (per Wkst. B, 1, 164, 926 7, 387, 310 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 4. 440317 436. 957258 8, 310. 357261 4, 079. 133076 11, 498. 630000 203. 00 44, 823 204. 00 204.00 Cost to be allocated (per Wkst. B, 170, 548 272, 196 381, 795 406, 674 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.650073 12. 523395 210.819989 224. 557703 448. 230000 205. 00 H) 206.00 NAHE adjustment amount to be allocated 0 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00

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Parts III and IV)

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COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0084

Cost Center Description					Т	o 06/30/2019 Date/Time Pro 11/25/2019 6:	
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Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0084

Cost Center Description					Τ̈́	o 06/30/2019	Date/Time Prepared: 11/25/2019 6:15 pm
PRGM - CPE (ASSIGNED TIME)		Cost Center Description	PARAMED ED	PARAMED ED	PARAMED ED		11/23/2019 0. 13 piii
TIME CHARGES TIME CALARGES TIME CALARGES		·	PRGM - CPE	PRGM -	PRGM - EMS		
STHER REIMBURSABLE COST CENTERS 0			,		,		
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115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 83,350 176,813,027 100 118.00 118	112.00 08600	PANCREAS ACQUISITION	0	0	C)	112. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 83,350 176,813,027 100 10	113.00 11300	INTEREST EXPENSE					113. 00
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204.00 Cost to be allocated (per Wkst. B, 44,790 28,212 142,806 204.00	204. 00	Cost to be allocated (per Wkst. B,					204. 00
Part II)	2011.00	,,,	, , , , ,	20/212	1.2,000		25 55
205.00 Unit cost multiplier (Wkst. B, Part 0.537373 0.000160 1,428.060000 205.00	205. 00		0. 537373	0. 000160	1, 428. 060000		205. 00
[11]			2. 22. 37.0	2. 223.00	,		=====
206.00 NAHE adjustment amount to be allocated 0 0 0 206.00	206. 00		0	0	c)	206. 00
(per Wkst. B-2)							
207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 0.000000 0.000000 207.00	207. 00		0. 000000	0. 000000	0. 000000)	207. 00
Parts III and IV)		Parts III and IV)					

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COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od: From 07/01/2018	Worksheet C Part I	
					To 06/30/2019	Date/Time Pre	
			Title	e XVIII	Hospi tal	11/25/2019 6: PPS	15 pm
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B, Part I, col.	Adj .		Di sal I owance		
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	141, 996, 937		141, 996, 93			
	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	30, 596, 382		30, 596, 38	2 0	30, 596, 382 0	
	03201 CARDI OTHORACI C VASCULAR TRANSPL	21, 579, 000		21, 579, 00		21, 579, 000	
	03300 BURN INTENSIVE CARE UNIT	0			0 0	0	33. 00
	02080 PEDIATRIC INTENSIVE CARE UNIT	7, 120, 488		7, 120, 48	8 0	7, 120, 488	
	03400 SURGICAL INTENSIVE CARE UNIT	0			0	0	34. 00
	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	31, 922, 702 10, 171, 359		31, 922, 70		31, 922, 702	
	04100 SUBPROVIDER - I RF	2, 141, 890		10, 171, 35 2, 141, 89		10, 171, 359 2, 141, 890	
	04300 NURSERY	5, 411, 185		5, 411, 18			
	ANCILLARY SERVICE COST CENTERS					·	
	05000 OPERATING ROOM	65, 979, 801		65, 979, 80			1
	05200 DELIVERY ROOM & LABOR ROOM	9, 046, 960		9, 046, 96			
	05400 RADI OLOGY-DI AGNOSTI C 05402 AMBULATORY CARDI OVASCULAR SVC	15, 746, 780 8, 133, 078		15, 746, 78 8, 133, 07		15, 746, 780 8, 133, 078	
	05403 ULTRASOUND	2, 026, 564		2, 026, 56		2, 026, 564	
	05404 ECHOCARDI OLOGY	2, 391, 923		2, 391, 92		2, 391, 923	
	05401 ONCOLOGY	14, 043, 790		14, 043, 79	0 0	14, 043, 790	
	05700 CT SCAN	3, 391, 574		3, 391, 57		3, 391, 574	
	05800 MRI	3, 017, 780		3, 017, 78		3, 017, 780	1
	05900 CARDI AC CATHETERI ZATI ON 05901 CARDI AC REHAB	9, 986, 345 1, 397, 458		9, 986, 34 1, 397, 45		9, 986, 345 1, 397, 458	
	06000 LABORATORY	33, 312, 311		33, 312, 31			
	06500 RESPIRATORY THERAPY	21, 551, 884	0	1		21, 551, 884	
	06600 PHYSI CAL THERAPY	15, 366, 900	0	15, 366, 90	0	15, 366, 900	
	06700 OCCUPATI ONAL THERAPY	1, 733, 037	0	1, 733, 03		1, 733, 037	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 658, 884 3, 923, 317	0	1, 658, 88 3, 923, 31		1, 658, 884 3, 923, 317	
	07000 ELECTROENCEPHALOGRAPHY	8, 791, 932		8, 791, 93		8, 791, 932	
	07100 MEDICAL SUPPLIES CHARGED TO PAT	67, 738, 214		67, 738, 21			
	07200 IMPL. DEV. CHARGED TO PATIENTS	82, 774, 718		82, 774, 71		82, 774, 718	
	07300 DRUGS CHARGED TO PATIENTS	107, 690, 136		107, 690, 13			
	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	6, 717, 014 5, 320, 286		6, 717, 01 5, 320, 28		6, 717, 014 5, 320, 286	
	OUTPATIENT SERVICE COST CENTERS	5, 320, 280		5, 320, 20	0	5, 320, 200	75.00
	09000 CLI NI C	7, 844, 418		7, 844, 41	8 0	7, 844, 418	90.00
	09001 PARTIAL HOSPITALIZATION	3, 649, 656		3, 649, 65			
	09100 EMERGENCY	41, 462, 999		41, 462, 99		41, 462, 999	1
	09101 WOUND CARE 002 09102 WOUND CARE 001	2, 368, 366 833, 155		2, 368, 36 833, 15			
	09103 LAFAYETTE RD CLINIC	274		27	-	,	91.02
	09104 ZI ONSVI LLE CLINI C	896, 270		896, 27		896, 270	
	09105 BROWNSBURG CLINIC	0			0 0	0	1
	09106 OP ANTICOAGULATION CLINIC	946, 440		946, 44		946, 440	1
	09107 ST VINCENT OUTPATIENT TREATMENT	974, 710		974, 71		974, 710	1
	04040 FAMILY PRACTICE 09200 OBSERVATION BEDS (NON-DISTINCT	3, 506, 681 17, 388, 076		3, 506, 68 17, 388, 07		3, 506, 681 17, 388, 076	
	OTHER REIMBURSABLE COST CENTERS	17, 300, 070		17, 300, 07	O _I	17, 300, 070	72.00
	09500 AMBULANCE SERVICES	383, 676		383, 67	6 0	383, 676	95. 00
	09853 GERIATRIC CLINIC	1, 088		1, 08			
	09851 ELECTROCONVULSI VE THERAPY	0		400.07	0		
	09852 DIABETES EDUCATION SPECIAL PURPOSE COST CENTERS	480, 871		480, 87	1 0	480, 871	98. 02
	10500 KIDNEY ACQUISITION	7, 729, 741		7, 729, 74	1	7, 729, 741	105. 00
	10600 HEART ACQUI SI TI ON	8, 285, 924		8, 285, 92		8, 285, 924	
112. 00	08600 PANCREAS ACQUISITION	11, 115		11, 11		11, 115	112. 00
	11300 INTEREST EXPENSE	47.040.75		47.000 ==		47 040 7	113.00
115. 00 200. 00	11500 AMBULATORY SURGICAL CENTER (D.P.) Subtotal (see instructions)	17, 849, 750 857, 293, 839	0	17, 849, 75 857, 293, 83	0 9 0	17, 849, 750 857, 293, 839	
200.00	Less Observation Beds	17, 388, 076	U	17, 388, 07		17, 388, 076	
202.00	· ·	839, 905, 763	0	1			
				•			-

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COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0084 Peri od: Worksheet C From 07/01/2018 Part I Date/Time Prepared: 06/30/2019 11/25/2019 6:15 pm Title XVIII Hospi tal PPS Charges TEFRA Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other I npati ent + col. 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 375, 273, 060 375, 273, 060 30.00 30.00 03100 INTENSIVE CARE UNIT 31.00 115, 607, 556 115, 607, 556 31.00 03200 CORONARY CARE UNIT 32.00 32.00 32. 01 03201 CARDI OTHORACI C VASCULAR TRANSPL 59, 552, 818 59, 552, 818 32. 01 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 33. 01 02080 PEDIATRIC INTENSIVE CARE UNIT 26, 988, 055 26, 988, 055 33.01 34 00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 02060 NEONATAL INTENSIVE CARE UNIT 212, 842, 609 212, 842, 609 34.01 34.01 04000 SUBPROVIDER - IPF 40.00 39, 478, 521 39, 478, 521 40.00 41.00 04100 SUBPROVIDER - IRF 2, 404, 704 2, 404, 704 41.00 43.00 04300 NURSERY 18, 090, 202 18, 090, 202 43.00 ANCILLARY SERVICE COST CENTERS 405, 224, 667 0.000000 50.00 05000 OPERATING ROOM 298, 648, 951 703, 873, 618 0.093738 50.00 05200 DELIVERY ROOM & LABOR ROOM 63, 600, 891 2, 399, 796 66, 000, 687 0.137074 0.000000 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 23, 861, 044 67, 376, 403 91, 237, 447 0.172591 0.000000 54.00 05402 AMBULATORY CARDIOVASCULAR SVC 12, 228, 947 34, 930, 415 47, 159, 362 0.172459 0.000000 54.01 54 01 54.02 05403 ULTRASOUND 15, 091, 938 11, 462, 527 26, 554, 465 0.076317 0.000000 54.02 05404 ECHOCARDI OLOGY 945, 127 30, 354, 442 31, 299, 569 0.076420 0.000000 54.03 54.03 05401 ONCOLOGY 5, 059, 464 81, 933, 408 86, 992, 872 0. 161436 0.000000 54.04 54.04 44, 857, 088 21, 527, 206 57.00 05700 CT SCAN 23, 329, 882 0.075608 0.000000 57.00 58.00 05800 MRI 5, 303, 323 8,860,703 14, 164, 026 0.213059 0.000000 58.00 05900 CARDIAC CATHETERIZATION 205, 724, 757 59.00 85, 896, 176 119, 828, 581 0.048542 0.000000 59.00 05901 CARDI AC REHAB 59 01 928.873 2, 826, 329 3, 755, 202 0. 372139 0.000000 59 01 06000 LABORATORY 273, 907, 910 60.00 103, 977, 794 377, 885, 704 0.088154 0.000000 60.00 06500 RESPIRATORY THERAPY 76, 730, 584 3, 388, 037 80, 118, 621 0. 269000 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 17, 815, 512 20, 060, 311 37, 875, 823 0.405718 0.000000 66.00 06700 OCCUPATIONAL THERAPY 8, 590, 888 357, 069 8, 947, 957 0.193680 0.000000 67.00 67.00 2, 255, 688 68.00 06800 SPEECH PATHOLOGY 4, 210, 360 6, 466, 048 0. 256553 0.000000 68.00 06900 ELECTROCARDI OLOGY 29, 257, 088 69.00 19, 105, 483 10, 151, 605 0.134098 0.000000 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 3 538 682 17, 403, 947 20, 942, 629 0.419810 0.000000 70 00 07100 MEDICAL SUPPLIES CHARGED TO PAT 73, 778, 699 172, 421, 436 0. 392864 0.000000 71.00 98, 642, 737 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 117, 713, 865 52, 979, 054 170, 692, 919 0.484934 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 343, 297, 746 86, 648, 755 429, 946, 501 0. 250473 0.000000 73.00 74 00 07400 RENAL DIALYSIS 17, 940, 586 2, 416, 918 20, 357, 504 0. 329953 0.000000 74 00 03330 ENDOSCOPY 75.00 16, 138, 415 34, 585, 785 50, 724, 200 0.104887 0.000000 75.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 9,733 11, 970, 292 11, 980, 025 0.654791 0.000000 90.00 09001 PARTIAL HOSPITALIZATION 90.01 0. 237318 53.871 15, 324, 907 15, 378, 778 0.000000 90 01 91.00 09100 EMERGENCY 72, 212, 450 151, 500, 914 223, 713, 364 0.185340 0.000000 91.00 91.01 09101 WOUND CARE 002 672, 549 16, 310, 474 16, 983, 023 0.139455 0.000000 91.01 09102 WOUND CARE 001 0.342389 0.000000 91.02 91.02 2, 230, 770 202, 589 2, 433, 359 09103 LAFAYETTE RD CLINIC 91.03 0.000000 0.000000 91.03 91.04 09104 ZIONSVILLE CLINIC 17, 319 2, 843, 801 2, 861, 120 0.313258 0.000000 91.04 91. 05 09105 BROWNSBURG CLINIC 0.000000 0.000000 91.05 09106 OP ANTI COAGULATION CLINIC 3, 217, 714 0.293375 0.000000 91.06 91.06 8.329 3, 226, 043 09107 ST VINCENT OUTPATIENT TREATMENT 91.07 14, 518 3, 771, 105 3, 785, 623 0.257477 0.000000 91.07 04040 FAMILY PRACTICE 0.000000 0.000000 91.08 91.08 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 13, 595, 264 31, 965, 108 45, 560, 372 0.381649 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 0.000000 95.00 0 0 98.00 09853 GERIATRIC CLINIC 0 0 0 0.000000 0.000000 98.00 09851 ELECTROCONVULSI VE THERAPY 98. 01 10, 148 0.000000 0.000000 98.01 10, 148 0 98.02 09852 DIABETES EDUCATION 0.000000 0.000000 98.02 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 6, 320, 819 766, 826 7, 087, 645 105.00 106.00 10600 HEART ACQUISITION 7, 717, 668 47, 686 7, 765, 354 106, 00 112.00 08600 PANCREAS ACQUISITION 112.00 C 113.00 11300 INTEREST EXPENSE 113.00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116, 012, 009 116, 012, 009 115. 00 200.00 Subtotal (see instructions) 2, 590, 401, 387 1, 443, 888, 524 4, 034, 289, 911 200. 00 201.00 Less Observation Beds 201.00 2, 590, 401, 387 1, 443, 888, 524 4, 034, 289, 911 202.00 Total (see instructions) 202.00

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Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0084 Peri od: Worksheet C From 07/01/2018 Part I To 06/30/2019 Date/Ti me Prepared:

			10 00/30/2019	11/25/2019 6: 15 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
I NDATI ENT DOUTI NE CEDVI CE COCT CENTEDO	11.00			
30.00 O3000 ADULTS & PEDIATRICS				30.00
31. 00 03100 NTENSI VE CARE UNI T				31. 00
32. 00 03200 CORONARY CARE UNIT				32.00
32. 01 03201 CARDI OTHORACI C VASCULAR TRANSPL				32. 01
33. 00 03300 BURN INTENSIVE CARE UNIT				33.00
33. 01 02080 PEDI ATRI C INTENSI VE CARE UNI T				33. 01
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT				34. 00
34. 01 02060 NEONATAL INTENSIVE CARE UNIT				34. 01
40. 00 04000 SUBPROVI DER - 1 PF				40.00
41. 00 04100 SUBPROVI DER - 1 RF				41.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 093738			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 137074			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 172591			54.00
54. 01 05402 AMBULATORY CARDIOVASCULAR SVC	0. 172459			54. 01
54. 02 05403 ULTRASOUND	0. 076317			54. 02
54. 03 05404 ECHOCARDI OLOGY	0. 076420			54. 03
54. 04 05401 ONCOLOGY	0. 161436			54. 04
57. 00 05700 CT SCAN	0. 075608			57. 00
58. 00 05800 MRI	0. 213059			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 048542			59. 00
59. 01 05901 CARDI AC REHAB	0. 372139			59. 01
60. 00 06000 LABORATORY	0. 088154			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 269000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 405718			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 193680			67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0. 256553			68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 134098 0. 419810			69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 392864			71. 00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATENTS	0. 484934			71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 250473			73. 00
74. 00 07400 RENAL DIALYSIS	0. 329953			74. 00
75. 00 03330 ENDOSCOPY	0. 104887			75. 00
OUTPATIENT SERVICE COST CENTERS	0. 10 1007			75. 55
90. 00 09000 CLI NI C	0. 654791			90.00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	0. 237318			90. 01
91. 00 09100 EMERGENCY	0. 185340			91.00
91. 01 09101 WOUND CARE 002	0. 139455			91. 01
91.02 09102 WOUND CARE 001	0. 342389			91. 02
91.03 09103 LAFAYETTE RD CLINIC	0. 000000			91. 03
91. 04 09104 ZI ONSVI LLE CLI NI C	0. 313258			91.04
91. 05 09105 BROWNSBURG CLINIC	0. 000000			91. 05
91.06 09106 OP ANTICOAGULATION CLINIC	0. 293375			91.06
91.07 09107 ST VINCENT OUTPATIENT TREATMENT	0. 257477			91. 07
91. 08 04040 FAMILY PRACTICE	0. 000000			91. 08
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT	0. 381649			92. 00
OTHER REIMBURSABLE COST CENTERS	0.00000			05
95. 00 09500 AMBULANCE SERVI CES	0. 000000			95. 00
98. 00 09853 GERI ATRI C CLI NI C	0. 000000			98. 00
98. 01 09851 ELECTROCONVULSI VE THERAPY	0.000000			98. 01
98. 02 09852 DI ABETES EDUCATION SPECIAL PURPOSE COST CENTERS	0. 000000			98. 02
				105.00
105.00 10500 KI DNEY ACQUI SI TI ON				105.00
106. 00 10600 HEART ACQUISITION				106.00
112.00 08600 PANCREAS ACQUISITION				112. 00 113. 00
113.00 11300 INTEREST EXPENSE 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				200.00
202.00 Total (see instructions)				202. 00
(222 : 1100: 400: 010)	1			1232. 00

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	Thancial Systems	31. VINCENT HO				u or Form CM3-2	2332-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0084	Period: From 07/01/2018	Worksheet C Part I	
				-	To 06/30/2019	Date/Time Pre	pared:
						11/25/2019 6:	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS	1			_		
	03000 ADULTS & PEDIATRICS	150, 087, 272	l e	150, 087, 27		150, 087, 272	
	03100 INTENSIVE CARE UNIT	31, 946, 837	1	31, 946, 83		31, 946, 837	
	03200 CORONARY CARE UNIT	C	I I	1	0	0	32. 00
	03201 CARDI OTHORACI C VASCULAR TRANSPL	21, 727, 674	•	21, 727, 67	4 0	21, 727, 674	
	03300 BURN INTENSIVE CARE UNIT	7 044 000)	7 044 00	0	0	33. 00
	02080 PEDIATRIC INTENSIVE CARE UNIT	7, 244, 383	8	7, 244, 38	3 0	7, 244, 383	
	03400 SURGI CAL I NTENSI VE CARE UNI T	00 00/ 155)	00.00/.45	0	0	34.00
	02060 NEONATAL INTENSIVE CARE UNIT	32, 096, 155	l .	32, 096, 15		32, 096, 155	
	04000 SUBPROVI DER – I PF	10, 505, 876		10, 505, 87		10, 505, 876	
	04100 SUBPROVI DER – I RF	2, 141, 890	l .	2, 141, 89		2, 141, 890	1
	04300 NURSERY	5, 621, 806)	5, 621, 80	6 0	5, 621, 806	43. 00
	NCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	69, 609, 922	,	69, 609, 92	2 0	40,400,022	50.00
	05200 DELIVERY ROOM & LABOR ROOM	9, 790, 329		9, 790, 32		69, 609, 922 9, 790, 329	
	05400 RADI OLOGY-DI AGNOSTI C	16, 403, 423	l control of the cont	16, 403, 42			
1			1			16, 403, 423	1
	05402 AMBULATORY CARDIOVASCULAR SVC	8, 244, 583 2, 038, 953		8, 244, 58		8, 244, 583	1
	05404 ECHOCARDI OLOGY	2, 565, 376	l .	2, 038, 95		2, 038, 953	1
	05401 ONCOLOGY		1	2, 565, 37		2, 565, 376	
		14, 725, 212	1	14, 725, 21		14, 725, 212	
	05700 CT SCAN	3, 416, 353	l .	3, 416, 35		3, 416, 353	1
	05800 MRI	3, 042, 559 10, 172, 187		3, 042, 55		3, 042, 559 10, 172, 187	
	05900 CARDI AC DELIAR		1	10, 172, 18			
	05901 CARDI AC REHAB 06000 LABORATORY	1, 422, 237 33, 659, 217		1, 422, 23		1, 422, 237	1
	06500 RESPI RATORY THERAPY		l e	33, 659, 21		33, 659, 217 21, 824, 453	
1	06600 PHYSI CAL THERAPY	21, 824, 453 15, 515, 574				15, 515, 574	
	06700 OCCUPATI ONAL THERAPY	1, 733, 037				1, 733, 037	
	06800 SPEECH PATHOLOGY	1, 658, 884	I .	1, 753, 03		1, 753, 037	
	06900 ELECTROCARDI OLOGY	4, 307, 391		4, 307, 39		4, 307, 391	
	07000 ELECTROENCEPHALOGRAPHY	9, 039, 722		9, 039, 72		9, 039, 722	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PAT	67, 738, 214		67, 738, 21		67, 738, 214	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	82, 774, 718		82, 774, 71		82, 774, 718	
	07300 DRUGS CHARGED TO PATIENTS	107, 690, 136		107, 690, 13		107, 690, 136	
1	07400 RENAL DIALYSIS	6, 964, 804	l .	6, 964, 80		6, 964, 804	1
	33330 ENDOSCOPY	5, 617, 634	l .	5, 617, 63		5, 617, 634	1
	OUTPATIENT SERVICE COST CENTERS	0,017,001		0,017,00	<u> </u>	0,017,001	70.00
	09000 CLI NI C	8, 501, 061		8, 501, 06	1 0	8, 501, 061	90.00
	09001 PARTIAL HOSPITALIZATION	3, 649, 656		3, 649, 65		3, 649, 656	1
	09100 EMERGENCY	42, 540, 885		42, 540, 88		42, 540, 885	1
	09101 WOUND CARE 002	2, 616, 156	1	2, 616, 15			1
	09102 WOUND CARE 001	833, 155	1	833, 15		833, 155	1
	09103 LAFAYETTE RD CLINIC	274	1	27		274	1
91.04 0	09104 ZIONSVILLE CLINIC	896, 270		896, 27		896, 270	
91.05 0	09105 BROWNSBURG CLINIC	C		1	0	0	91. 05
91.06 0	09106 OP ANTICOAGULATION CLINIC	946, 440		946, 44	0	946, 440	91.06
91. 07 0	09107 ST VINCENT OUTPATIENT TREATMENT	974, 710		974, 71	0	974, 710	91. 07
	04040 FAMILY PRACTICE	4, 547, 398		4, 547, 39		4, 547, 398	
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT	17, 388, 076		17, 388, 07		17, 388, 076	
0	THER REIMBURSABLE COST CENTERS		•				1
95. 00 0	9500 AMBULANCE SERVICES	383, 676)	383, 67	6 0	383, 676	95. 00
98. 00 0	19853 GERIATRIC CLINIC	1, 088	3	1, 08	8 0	1, 088	98. 00
98. 01 0	9851 ELECTROCONVULSI VE THERAPY	C			0	0	98. 01
98. 02 0	09852 DIABETES EDUCATION	480, 871		480, 87	1 0	480, 871	98. 02
S	PECIAL PURPOSE COST CENTERS						
105.001	0500 KIDNEY ACQUISITION	7, 816, 468	<u> </u>	7, 816, 46	8	7, 816, 468	105. 00
	0600 HEART ACQUISITION	8, 372, 651		8, 372, 65	1	8, 372, 651	
112. 00 0	08600 PANCREAS ACQUISITION	11, 115	<u> </u>	11, 11	5	11, 115	112. 00
113. 00 1	1300 I NTEREST EXPENSE						113. 00
	1500 AMBULATORY SURGICAL CENTER (D. P.)	17, 862, 139		17, 862, 13		17, 862, 139	
200.00	Subtotal (see instructions)	879, 148, 900	l .			879, 148, 900	
201. 00	Less Observation Beds	17, 388, 076	l .	17, 388, 07		17, 388, 076	
202.00	Total (see instructions)	861, 760, 824	· o	861, 760, 82	4 0	861, 760, 824	202. 00

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COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0084 Peri od: Worksheet C From 07/01/2018 Part I Date/Time Prepared: 06/30/2019 11/25/2019 6:15 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 375, 273, 060 375, 273, 060 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 115, 607, 556 115, 607, 556 31.00 03200 CORONARY CARE UNIT 32.00 32.00 32. 01 03201 CARDI OTHORACI C VASCULAR TRANSPL 59, 552, 818 59, 552, 818 32. 01 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 33. 01 02080 PEDIATRIC INTENSIVE CARE UNIT 26, 988, 055 26, 988, 055 33.01 34 00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 02060 NEONATAL INTENSIVE CARE UNIT 212, 842, 609 212, 842, 609 34.01 34.01 04000 SUBPROVIDER - IPF 40.00 39, 478, 521 39, 478, 521 40.00 41.00 04100 SUBPROVIDER - IRF 2, 404, 704 2, 404, 704 41.00 43.00 04300 NURSERY 18, 090, 202 18, 090, 202 43.00 ANCILLARY SERVICE COST CENTERS 405, 224, 667 0. 098895 0.000000 50.00 05000 OPERATING ROOM 298, 648, 951 703, 873, 618 50.00 05200 DELIVERY ROOM & LABOR ROOM 63, 600, 891 2, 399, 796 66, 000, 687 0.148337 0.000000 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 23, 861, 044 67, 376, 403 91, 237, 447 0. 179788 0.000000 54.00 05402 AMBULATORY CARDIOVASCULAR SVC 12, 228, 947 34, 930, 415 47, 159, 362 0.174824 0.000000 54.01 54 01 54.02 05403 ULTRASOUND 15, 091, 938 11, 462, 527 26, 554, 465 0.076784 0.000000 54.02 05404 ECHOCARDI OLOGY 945, 127 30, 354, 442 31, 299, 569 0.081962 0.000000 54.03 54.03 05401 ONCOLOGY 5, 059, 464 81, 933, 408 86, 992, 872 0.169269 0.000000 54.04 54.04 44, 857, 088 57.00 05700 CT SCAN 21, 527, 206 23, 329, 882 0.076161 0.000000 57.00 58.00 05800 MRI 5, 303, 323 8,860,703 14, 164, 026 0.214809 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 85, 896, 176 119, 828, 581 205, 724, 757 0.049446 0.000000 59.00 05901 CARDI AC REHAB 59 01 928.873 2, 826, 329 3, 755, 202 0. 378738 0.000000 59 01 273, 907, 910 60.00 06000 LABORATORY 103, 977, 794 377, 885, 704 0.089072 0.000000 60.00 06500 RESPIRATORY THERAPY 76, 730, 584 3, 388, 037 80, 118, 621 0. 272402 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 17, 815, 512 20, 060, 311 37, 875, 823 0.409643 0.000000 66.00 06700 OCCUPATIONAL THERAPY 8, 590, 888 357, 069 8, 947, 957 0.193680 0.000000 67.00 67.00 2, 255, 688 68.00 06800 SPEECH PATHOLOGY 4, 210, 360 6, 466, 048 0. 256553 0.000000 68.00 06900 ELECTROCARDI OLOGY 29, 257, 088 69.00 19, 105, 483 10, 151, 605 0.147226 0.000000 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 3 538 682 17, 403, 947 20, 942, 629 0 431642 0.000000 70 00 07100 MEDICAL SUPPLIES CHARGED TO PAT 73, 778, 699 172, 421, 436 0.000000 71.00 98, 642, 737 0.392864 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 117, 713, 865 52, 979, 054 170, 692, 919 0.484934 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 343, 297, 746 86, 648, 755 429, 946, 501 0.250473 0.000000 73.00 07400 RENAL DIALYSIS 17, 940, 586 2, 416, 918 20, 357, 504 0.000000 74 00 0.342125 74 00 03330 ENDOSCOPY 16, 138, 415 75.00 34, 585, 785 50, 724, 200 0.110749 0.000000 75.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 9,733 11, 970, 292 11, 980, 025 0.709603 0.000000 90.00 90.01 09001 PARTIAL HOSPITALIZATION 53.871 15, 324, 907 15, 378, 778 0.237318 0.000000 90 01 91.00 09100 EMERGENCY 72, 212, 450 151, 500, 914 223, 713, 364 0. 190158 0.000000 91.00 91.01 09101 WOUND CARE 002 672, 549 16, 310, 474 16, 983, 023 0. 154045 0.000000 91.01 09102 WOUND CARE 001 2, 230, 770 0.342389 91.02 91.02 202, 589 2, 433, 359 0.000000 09103 LAFAYETTE RD CLINIC 91.03 0.000000 0.000000 91.03 91.04 09104 ZIONSVILLE CLINIC 17, 319 2, 843, 801 2, 861, 120 0.313258 0.000000 91.04 91. 05 09105 BROWNSBURG CLINIC 0.000000 0.000000 91.05 09106 OP ANTICOAGULATION CLINIC 0.293375 0.000000 91.06 91.06 8.329 3, 217, 714 3, 226, 043 09107 ST VINCENT OUTPATIENT TREATMENT 91.07 14, 518 3, 771, 105 3, 785, 623 0.257477 0.000000 91.07 04040 FAMILY PRACTICE 0.000000 0.000000 91.08 91.08 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 13, 595, 264 31, 965, 108 45, 560, 372 0.381649 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 0.000000 95.00 0 0 98.00 09853 GERIATRIC CLINIC 0 0 0 0.000000 0.000000 98.00 09851 ELECTROCONVULSI VE THERAPY 10, 148 98.01 0.000000 0.000000 98.01 10, 148 0 98.02 09852 DIABETES EDUCATION 0.000000 0.000000 98.02 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 6, 320, 819 766, 826 7, 087, 645 105.00 106.00 10600 HEART ACQUISITION 7, 717, 668 47, 686 7, 765, 354 106, 00 112.00 08600 PANCREAS ACQUISITION 112.00 C 113.00 11300 INTEREST EXPENSE 113.00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116, 012, 009 116, 012, 009 115. 00 Subtotal (see instructions) 2, 590, 401, 387 1, 443, 888, 524 4, 034, 289, 911 200.00 200. 00 201.00 Less Observation Beds 201.00 2, 590, 401, 387 1, 443, 888, 524 4, 034, 289, 911

11/25/2019 6:15 pm Y:\28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

202.00

Total (see instructions)

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202.00

In Lieu of Form CMS-2552-10 Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0084 Peri od: Worksheet C From 07/01/2018 Part I 06/30/2019 Date/Time Prepared: 11/25/2019 6:15 pm Title XIX Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 32. 00 |03200 | CORONARY CARE UNIT 32.00 32. 01 03201 CARDI OTHORACI C VASCULAR TRANSPL 32.01 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 33. 01 02080 PEDIATRIC INTENSIVE CARE UNIT 33. 01 03400 SURGICAL INTENSIVE CARE UNIT 34.00 34 00 34. 01 02060 NEONATAL INTENSIVE CARE UNIT 34.01 40.00 04000 SUBPROVI DER - I PF 40.00 04100 SUBPROVI DER - I RF 41.00 41 00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 000000 50.00 52.00 | 05200 | DELIVERY ROOM & LABOR ROOM 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 54.01 05402 AMBULATORY CARDIOVASCULAR SVC 0.000000 54.01 54. 02 05403 ULTRASOUND 0.000000 54.02 05404 ECHOCARDI OLOGY 0.000000 54.03 54 03 54.04 05401 ONCOLOGY 0.000000 54.04 05700 CT SCAN 57.00 0.000000 57.00 05800 MRI 0.000000 58.00 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 59.00 59.01 05901 CARDI AC REHAB 0.000000 59.01 06000 LABORATORY 60.00 0. 000000 60.00 06500 RESPIRATORY THERAPY 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 71.00 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 74.00 03330 ENDOSCOPY 75.00 0.000000 75.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 09001 PARTIAL HOSPITALIZATION 90. 01 0.000000 90.01 91. 00 09100 EMERGENCY 0.000000 91.00 09101 WOUND CARE 002 91.01 0.000000 91.01 91. 02 09102 WOUND CARE 001 0.000000 91.02 91.03 09103 LAFAYETTE RD CLINIC 0.000000 91.03 09104 ZIONSVILLE CLINIC 91 04 0.000000 91 04 91.05 09105 BROWNSBURG CLINIC 0.000000 91.05 91.06 09106 OP ANTICOAGULATION CLINIC 0.000000 91.06 91.07 09107 ST VINCENT OUTPATIENT TREATMENT 0. 000000 91.07 91.08 04040 FAMILY PRACTICE 0.000000 91.08 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 09853 GERIATRIC CLINIC 95.00 95.00 0.000000 98.00 0.000000 98 00 98. 01 09851 ELECTROCONVULSI VE THERAPY 0.000000 98.01 98 02 09852 DIABETES EDUCATION 0.000000 98.02 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 105 00 106.00 10600 HEART ACQUISITION 106.00 112.00 08600 PANCREAS ACQUISITION 112.00 113.00 11300 INTEREST EXPENSE 113.00

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115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

200.00

201.00

202.00

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115. 00

200.00

201.00

202.00

Health Financial Systems	ST. VINCENT HOS	SPITAL & HCC		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	AL COSTS	Provi der C		Peri od: From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 6:	epared: 15 pm
			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 Cos			
	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	9, 254, 596	0	9, 254, 59	96 136, 492	67. 80	30.00
31.00 INTENSIVE CARE UNIT	1, 838, 045		1, 838, 0	45 17, 782	103. 37	31.00
32. 00 CORONARY CARE UNIT	0			0 0	0.00	32.00
32. 01 CARDI OTHORACI C VASCULAR TRANSPL	1, 295, 014		1, 295, 0°	14 8, 200	157. 93	32. 01
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33. 00
33. 01 PEDIATRIC INTENSIVE CARE UNIT	724, 881		724, 88	31 2, 702	268. 28	33. 01
34. 00 SURGICAL INTENSIVE CARE UNIT	o			0 0	0.00	34.00
34. 01 NEONATAL INTENSIVE CARE UNIT	1, 663, 390		1, 663, 39	90 28, 663	58. 03	34. 01
40. 00 SUBPROVI DER - I PF	587, 502	0				40.00
41. 00 SUBPROVI DER - I RF	227, 819	0	227, 8		180. 24	41.00
43. 00 NURSERY	412, 820		412, 82			
200.00 Total (lines 30 through 199)	16, 004, 067		16, 004, 0			200.00
Cost Center Description	Inpatient	Inpatient	.,,			
	Program days	Program				
		Capital Cost				
		(col . 5 x col .				
		6)				
	6.00	7. 00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	43, 714	2, 963, 809				30.00
31. 00 INTENSIVE CARE UNIT	6, 491	670, 975	;			31.00
32. 00 CORONARY CARE UNIT	o	0)			32.00
32. 01 CARDI OTHORACI C VASCULAR TRANSPL	3, 054	482, 318				32. 01
33. 00 BURN INTENSIVE CARE UNIT		. 0				33.00
33. 01 PEDIATRIC INTENSIVE CARE UNIT	10	2, 683				33. 01
34. 00 SURGICAL INTENSIVE CARE UNIT		_,,	1			34.00
34. 01 NEONATAL INTENSIVE CARE UNIT	0	0				34. 01
40. 00 SUBPROVI DER - I PF	2, 502	93, 049				40.00
41. 00 SUBPROVI DER - I RF	708	127, 610				41.00
43. 00 NURSERY	0	.27,010	1			43.00
200.00 Total (lines 30 through 199)	56, 479	4, 340, 444	1			200. 00
, , , , , , , , , , , , , , , , , , , ,	1 1		1			

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APPOR	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co		Peri od: From 07/01/2018 To 06/30/2019	Worksheet D Part II Date/Time Prepared:	
			T: 11	V0.41.1		11/25/2019 6:	15 pm
		0 111		XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	2.00	2.00	4.00	F 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
50. 00	05000 OPERATING ROOM	10, 042, 412	703, 873, 618	0. 01426	7 132, 683, 081	1, 892, 990	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	631, 969					52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 193, 531	91, 237, 447			186, 148	54.00
54. 00	05402 AMBULATORY CARDIOVASCULAR SVC	1, 147, 845		•		1	
54. 01	05403 ULTRASOUND	143, 557	26, 554, 465				54. 01
54. 02	05404 ECHOCARDI OLOGY	284, 894		l .		515	54. 02
54. 03	05401 ONCOLOGY					•	54. 03
		3, 260, 702					
57. 00	05700 CT SCAN	521, 838				93, 423	57. 00
58. 00	05800 MRI	663, 820					
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 156, 757					59. 00
59. 01	05901 CARDI AC REHAB	153, 279				15, 281	59. 01
60.00	06000 LABORATORY	1, 071, 880				256, 717	60.00
65. 00	06500 RESPI RATORY THERAPY	1, 291, 242				l	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 909, 242					66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	48, 790					67. 00
68. 00	06800 SPEECH PATHOLOGY	183, 553					68. 00
69. 00	06900 ELECTROCARDI OLOGY	371, 152	29, 257, 088	0. 01268	7, 800, 713	98, 960	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	613, 257	20, 942, 629	0. 02928	1, 429, 099	41, 848	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1, 647, 223	172, 421, 436	0.00955	33, 116, 585	316, 363	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 814, 476	170, 692, 919	0. 02820	15 44, 088, 641	1, 243, 520	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 575, 953	429, 946, 501	0. 00831	7 68, 866, 223	572, 760	73. 00
74.00	07400 RENAL DIALYSIS	269, 644	20, 357, 504	0. 01324	7, 816, 593	103, 531	74. 00
75.00	03330 ENDOSCOPY	595, 615	50, 724, 200	0. 01174	6, 535, 666	76, 742	75. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	2, 396, 428	11, 980, 025	0. 20003	5 0	0	90.00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	233, 203	15, 378, 778	0. 01516	3, 682	56	90. 01
91.00	09100 EMERGENCY	2, 330, 419	223, 713, 364	0. 01041	7 24, 303, 897	253, 174	91.00
91. 01	09101 WOUND CARE 002	270, 305	16, 983, 023	0. 01591	6 160, 887	2, 561	91. 01
91. 02	09102 WOUND CARE 001	53, 882	2, 433, 359	0. 02214	1, 038, 201	22, 989	91. 02
91. 03	09103 LAFAYETTE RD CLINIC	7	0	0.00000	0	0	91. 03
91. 04	09104 ZI ONSVI LLE CLI NI C	293, 388	2, 861, 120			0	91. 04
91. 05	09105 BROWNSBURG CLINIC	0	0	0. 00000		0	91. 05
91.06	09106 OP ANTI COAGULATION CLINIC	90, 429	3, 226, 043			16	91. 06
91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	167, 790				0	91. 07
91. 08	04040 FAMILY PRACTICE	451, 243				Ö	91. 08
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	1, 133, 268	l .			1	92. 00
50	OTHER REIMBURSABLE COST CENTERS	.,, 200	,,0,2		.,	, 0,,,	
95. 00	09500 AMBULANCE SERVICES						95. 00
98. 00	09853 GERIATRIC CLINIC	26	0	0. 00000	00 0	0	98. 00
98. 01	09851 ELECTROCONVULSI VE THERAPY	0	l			Ō	98. 01
98. 02	09852 DI ABETES EDUCATION	17, 215		0.00000		0	98. 02
200.0			3, 053, 187, 378		511, 737, 739	6, 580, 375	200. 00

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02060 NEONATAL INTENSIVE CARE UNIT

Total (lines 30 through 199)

40. 00 04000 SUBPROVIDER - IPF

41. 00 | 04100 | SUBPROVI DER - I RF

43. 00 | 04300 NURSERY

34. 01

200.00

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Provider CCN: 15-0084 Peri od: Worksheet D From 07/01/2018 Part IV To 06/30/2019 Date/Ti me Prepared: THROUGH COSTS

					00,00,20.,	11/25/2019 6:	15 pm
			Ti tl e	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C	(0	1, 373	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C	(0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C	(0	188, 721	54.00
54.01	05402 AMBULATORY CARDIOVASCULAR SVC	0	l c	(0	0	54. 01
54.02	05403 ULTRASOUND	0	l c	(0	54, 941	54. 02
54.03	05404 ECHOCARDI OLOGY	0	l c	(0	0	54. 03
54.04	05401 ONCOLOGY	0	l c	(0	0	54. 04
57.00	05700 CT SCAN	0	l c	(0	92, 809	57.00
58.00	05800 MRI	0	l c		o	29, 305	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	l c		o	0	59. 00
59. 01	05901 CARDI AC REHAB	0	l c		o o	0	59. 01
60.00	06000 LABORATORY	0	l c		o	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	l c		o	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0			0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0			0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0			0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	l c		0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	l c		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	l c		0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0				1, 149, 863	73. 00
74. 00	07400 RENAL DIALYSIS	0			0	0	74. 00
75. 00	03330 ENDOSCOPY	0				Ö	
70.00	OUTPATIENT SERVICE COST CENTERS				,, ,		70.00
90.00	09000 CLI NI C	0	C	(0	0	90. 00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0				0	90. 01
91. 00	09100 EMERGENCY	0				1, 483, 268	91.00
91. 01	09101 WOUND CARE 002	0				0	91. 01
91. 02	09102 WOUND CARE 001					ĺ	91. 02
91. 03	09103 LAFAYETTE RD CLINIC					Ö	91. 03
91. 04	09104 ZI ONSVI LLE CLI NI C					0	91. 04
91. 05	09105 BROWNSBURG CLINIC					Ö	91. 05
91. 06	09106 OP ANTI COAGULATION CLINIC					Ö	91.06
91. 07	09107 ST VINCENT OUTPATIENT TREATMENT					0	91.00
91. 07	04040 FAMILY PRACTICE					0	91.07
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT					34, 376	92.00
92.00	OTHER REIMBURSABLE COST CENTERS				<u>/ </u>	34, 370	72.00
95. 00	09500 AMBULANCE SERVICES						95. 00
98. 00	09853 GERIATRIC CLINIC		C			0	
98. 00	09851 ELECTROCONVULSI VE THERAPY						98. 00
98. 02	09852 DI ABETES EDUCATION						98. 02
200.00	1 1						
200.00	Tiotai (Titles 50 tillough 199)	ı	1	l l	ار	3, 034, 030	₁ 200.00

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From 07/01/2018 Part IV THROUGH COSTS 06/30/2019 Date/Time Prepared: 11/25/2019 6:15 pm Title XVIII Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols Outpati ent Education Cost Cost (sum of 1, 2, 3, and Part I, col. (col. 5 ÷ col 4) col s. 2, 3, 8) 7) and 4) 4.00 5.00 7.00 8.00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 703, 873, 618 0.000002 50.00 1, 373 1, 373 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 66, 000, 687 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 91, 237, 447 54.00 00000000000000000000 188, 721 188, 721 0.002068 54.00 05402 AMBULATORY CARDIOVASCULAR SVC 47, 159, 362 0.000000 54.01 54.01 26, 554, 465 05403 ULTRASOUND 54.02 54, 941 54, 941 0.002069 54.02 54.03 05404 ECHOCARDI OLOGY 31, 299, 569 0.000000 54.03 54.04 05401 ONCOLOGY 86, 992, 872 0.000000 54.04 44, 857, 088 05700 CT SCAN 92.809 92.809 0.002069 57 00 57 00 05800 MRI 58.00 29, 305 29, 305 14, 164, 026 0.002069 58.00 59.00 05900 CARDIAC CATHETERIZATION 205, 724, 757 0.000000 59.00 05901 CARDI AC REHAB 59.01 0 3, 755, 202 0.000000 59.01 377, 885, 704 06000 LABORATORY 0 0 000000 60 00 60 00 65.00 06500 RESPIRATORY THERAPY 0 80, 118, 621 0.000000 65.00 06600 PHYSI CAL THERAPY 37, 875, 823 66.00 0.000000 66.00 8, 947, 957 06700 OCCUPATIONAL THERAPY 0 67 00 0.000000 67 00 68.00 06800 SPEECH PATHOLOGY 6, 466, 048 0.000000 68.00

06900 ELECTROCARDI OLOGY 29, 257, 088 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 20, 942, 629 0.000000 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PAT 172, 421, 436 0.000000 71 00 Ω 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 170, 692, 919 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 149, 863 1, 149, 863 429, 946, 501 0.002674 73.00 0 74.00 07400 RENAL DIALYSIS 20, 357, 504 0.000000 74.00 03330 ENDOSCOPY 0 50, 724, 200 0.00000075.00 75.00 OUTPATIENT SERVICE COST CENTERS 0 11, 980, 025 0.000000 90.00 09000 CLI NI C 90.00 15, 378, 778 09001 PARTIAL HOSPITALIZATION 0.000000 90.01 00000000 0 90.01 223, 713, 364 09100 EMERGENCY 1, 483, 268 1, 483, 268 0.006630 91.00 91.00 09101 WOUND CARE 002 16, 983, 023 0.000000 91.01 91.01 09102 WOUND CARE 001 91.02 0 2, 433, 359 0.000000 91.02 09103 LAFAYETTE RD CLINIC 0 0.000000 91.03 0 91.03 09104 ZIONSVILLE CLINIC 0 91.04 C 2, 861, 120 0.000000 91 04 09105 BROWNSBURG CLINIC 0.000000 91.05 91.05 91.06 09106 OP ANTICOAGULATION CLINIC 0 3, 226, 043 0.000000 91.06 09107 ST VINCENT OUTPATIENT TREATMENT 3, 785, 623 0 0.000000 91.07 91.07 C 0 91.08 04040 FAMILY PRACTICE 0 0.000000 91.08 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 34, 376 34, 376 45, 560, 372 0.000755 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 98.00 09853 GERIATRIC CLINIC 0 0.000000 98.00 98. 01 09851 ELECTROCONVULSI VE THERAPY 0 0 10, 148 0.000000 98.01 Ω 0 98. 02 09852 DI ABETES EDUCATION 0.000000 98.02 0 200.00 Total (lines 50 through 199) 3, 034, 656 3, 034, 656 3, 053, 187, 378 200. 00

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TTIKOOC	30010			Т	o 06/30/2019	Date/Time Pre 11/25/2019 6:	
			Title	XVIII	Hospi tal	PPS	15 piii
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS			,	T		
50. 00	05000 OPERATI NG ROOM	0. 000002	132, 683, 081			127	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	181, 326	•	,	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 002068	7, 742, 637			53, 290	
54. 01	05402 AMBULATORY CARDI OVASCULAR SVC	0. 000000	5, 076, 553		4, 343, 852	0	54. 01
54. 02	05403 ULTRASOUND	0. 002069	5, 953, 904			6, 939	
54. 03	05404 ECHOCARDI OLOGY	0. 000000	56, 592		10, 721, 178	0	
54. 04	05401 ONCOLOGY	0. 000000	1, 743, 653			0	
57. 00	05700 CT SCAN	0. 002069	8, 030, 882			12, 103	
58. 00	05800 MRI	0. 002069	1, 496, 923			4, 296	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	27, 151, 563	0	49, 420, 769	0	59. 00
59. 01	05901 CARDI AC REHAB	0. 000000	374, 361	0	1, 289, 510	0	59. 01
60.00	06000 LABORATORY	0. 000000	90, 488, 952	0	21, 715, 146	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	20, 254, 219	0	1, 071, 014	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	6, 269, 738	0	199, 091	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	2, 510, 344	0	79, 831	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	1, 629, 638	0	569, 140	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	7, 800, 713	0	3, 090, 986	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 429, 099	0	2, 030, 043	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000	33, 116, 585	0	17, 784, 006	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	44, 088, 641	0	19, 324, 461	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 002674	68, 866, 223	184, 148	30, 465, 257	81, 464	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	7, 816, 593	0	1, 045, 439	0	74.00
75.00	03330 ENDOSCOPY	0. 000000	6, 535, 666	0	8, 920, 341	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0	0	399, 136	0	90. 00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0. 000000	3, 682	0	17, 430	0	90. 01
91.00	09100 EMERGENCY	0. 006630	24, 303, 897	161, 135	22, 191, 275	147, 128	91.00
91. 01	09101 WOUND CARE 002	0. 000000	160, 887	0	7, 910, 199	0	91. 01
91. 02	09102 WOUND CARE 001	0. 000000	1, 038, 201	0	96, 626	0	91. 02
91. 03	09103 LAFAYETTE RD CLINIC	0. 000000	0	0	0	0	91. 03
91. 04	09104 ZI ONSVI LLE CLI NI C	0. 000000	0	0	111, 075	0	91. 04
91. 05	09105 BROWNSBURG CLINIC	0. 000000	0	0	0	0	91. 05
91. 06	09106 OP ANTICOAGULATION CLINIC	0. 000000	580	0	1, 330, 431	0	91. 06
91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	0. 000000	0	0	1, 514, 582	0	91. 07
91. 08	04040 FAMILY PRACTICE	0. 000000	0	0	0	0	91. 08
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 000755	4, 932, 606	3, 724	7, 151, 145	5, 399	92.00
	OTHER REIMBURSABLE COST CENTERS	· ·					
95.00	09500 AMBULANCE SERVICES						95. 00
98.00	09853 GERIATRIC CLINIC	0. 000000	0	0	0	0	98. 00
98. 01	09851 ELECTROCONVULSI VE THERAPY	0. 000000	0	0	0	0	98. 01
98. 02	09852 DI ABETES EDUCATION	0. 000000	0	0	0	0	98. 02
200.00	Total (lines 50 through 199)		511, 737, 739	397, 316	338, 895, 014	310, 746	200. 00

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Health Fin	ancial Systems	SI. VINCENI HO	SPLIAL & HCC		In Lie	u of Form CMS-:	2552-10
APPORTI ONM	IENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Period: From 07/01/2018 To 06/30/2019	Worksheet D Part V Date/Time Pre 11/25/2019 6:	
			Ti tl e	e XVIII	Hospi tal	PPS	то ріп
				Charges	noopi tui	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not	(,,	
		Part I, col. 9	· /	Subject To	Subject To		
				Ded. & Coins.	-		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
ANCI	LLARY SERVICE COST CENTERS			•			
	OO OPERATING ROOM	0. 093738	63, 577, 488		0 0	5, 959, 627	50.00
52. 00 0520	OO DELIVERY ROOM & LABOR ROOM	0. 137074	12, 057	1	0 0	1, 653	52. 00
	00 RADI OLOGY-DI AGNOSTI C	0. 172591			0 0	4, 447, 482	54.00
	02 AMBULATORY CARDIOVASCULAR SVC	0. 172459			0	749, 136	54. 01
	03 ULTRASOUND	0. 076317			o o	255, 967	54. 02
	04 ECHOCARDI OLOGY	0. 076420			o o	819, 312	54. 03
	01 ONCOLOGY	0. 161436		1	0 0	4, 110, 841	54. 04
	OO CT SCAN	0. 075608		1	0 0	442, 290	1
	DO MRI	0. 213059		1	0 0		58.00
	00 CARDI AC CATHETERI ZATI ON			1	0 0	442, 440	59.00
		0. 048542			0 0	2, 398, 983	59.00
	01 CARDI AC REHAB	0. 372139			-	479, 877	
	00 LABORATORY	0. 088154				1, 914, 277	60.00
	00 RESPI RATORY THERAPY	0. 269000		1	0	288, 103	65. 00
	00 PHYSI CAL THERAPY	0. 405718		1	0	80, 775	66. 00
	00 OCCUPATI ONAL THERAPY	0. 193680		1	0	15, 462	67. 00
	00 SPEECH PATHOLOGY	0. 256553		1	0	146, 015	68. 00
	00 ELECTROCARDI OLOGY	0. 134098		1	0	414, 495	
	00 ELECTROENCEPHALOGRAPHY	0. 419810			0	852, 232	70. 00
	00 MEDICAL SUPPLIES CHARGED TO PAT	0. 392864			0	6, 986, 696	
72. 00 0720	00 IMPL. DEV. CHARGED TO PATIENTS	0. 484934			0	9, 371, 088	72. 00
73. 00 0730	DO DRUGS CHARGED TO PATIENTS	0. 250473	30, 465, 257	8, 32	6 85, 746	7, 630, 724	73. 00
74. 00 0740	OO RENAL DIALYSIS	0. 329953	1, 045, 439	1	0	344, 946	74. 00
75. 00 0333	30 ENDOSCOPY	0. 104887	8, 920, 341		0	935, 628	75. 00
OUTF	PATIENT SERVICE COST CENTERS						
	DO CLI NI C	0. 654791	399, 136		0 0	261, 351	90. 00
90. 01 0900	01 PARTIAL HOSPITALIZATION	0. 237318	17, 430)	0	4, 136	90. 01
	DO EMERGENCY	0. 185340	22, 191, 275		0 896	4, 112, 931	91.00
91. 01 0910	01 WOUND CARE 002	0. 139455	7, 910, 199		0 0	1, 103, 117	91. 01
	02 WOUND CARE 001	0. 342389	96, 626	,	0 0	33, 084	91. 02
91. 03 0910	03 LAFAYETTE RD CLINIC	0. 000000			0 0	0	91. 03
	04 ZIONSVILLE CLINIC	0. 313258			0	34, 795	91. 04
- 1	05 BROWNSBURG CLINIC	0. 000000		1	o o	0	91. 05
	06 OP ANTICOAGULATION CLINIC	0. 293375		1	o o	390, 315	
	07 ST VINCENT OUTPATIENT TREATMENT	0. 257477			o o	389, 970	
	40 FAMILY PRACTICE	0. 000000		1	o o		91. 08
	OO OBSERVATION BEDS (NON-DISTINCT	0. 381649		1	0 0		92.00
	ER REIMBURSABLE COST CENTERS	0. 301047	7, 131, 143	1	0 0	2, 127, 221	72.00
	00 AMBULANCE SERVICES	0. 000000			ol		95. 00
	53 GERIATRIC CLINIC	0. 000000		1	o o	0	1
	51 ELECTROCONVULSI VE THERAPY	0. 000000			0 0	0	98. 01
	52 DI ABETES EDUCATION	0. 000000				0	98. 02
200. 00		0.000000	338, 895, 014	19, 84	5 04 442	58, 146, 975	
	Subtotal (see instructions)		330, 893, 014	19, 84	5 86, 642	00, 140, 9/5	
201. 00	Less PBP Clinic Lab. Services-Program				<u>ا</u> 0		201. 00
202 00	Only Charges (Line 200 Line 201)		220 005 014	10.04	5 04 442	EO 144 075	202 00
202. 00	Net Charges (line 200 - line 201)	1	338, 895, 014	19, 84	5 86, 642	58, 146, 975	J2U2. UU

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0084 Peri od: Worksheet D From 07/01/2018 Part V 06/30/2019 Date/Time Prepared: 11/25/2019 6:15 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05402 AMBULATORY CARDI OVASCULAR SVC 54.01 0 54.01 54. 02 05403 ULTRASOUND 0 54.02 54.03 05404 ECHOCARDI OLOGY 0 54.03 05401 ONCOLOGY 0 54.04 54.04 57. 00 05700 CT SCAN 0 57.00 05800 MRI 0 58.00 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 0 59 00 59.01 05901 CARDI AC REHAB 0 59.01 60.00 06000 LABORATORY 1,015 0 60.00 0 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 2,085 21, 477 73.00 07400 RENAL DIALYSIS 74.00 74 00 03330 ENDOSCOPY 75.00 75.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 09001 PARTI AL HOSPI TALI ZATI ON 0 90. 01 r 90.01 09100 EMERGENCY 91.00 91.00 000000000 166 09101 WOUND CARE 002 91.01 0 91.01 09102 WOUND CARE 001 91.02 91.02 0 91.03 09103 LAFAYETTE RD CLINIC 0 91.03 09104 ZIONSVILLE CLINIC 91. 04 0 91.04 09105 BROWNSBURG CLINIC 91.05 0 91.05 09106 OP ANTICOAGULATION CLINIC 91.06 0 91.06 91.07 09107 ST VINCENT OUTPATIENT TREATMENT 0 91.07 91.08 04040 FAMILY PRACTICE 0 91.08 0 09200 OBSERVATION BEDS (NON-DISTINCT 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 09853 GERIATRIC CLINIC 0 98.00 98.00 0 09851 ELECTROCONVULSIVE THERAPY 98.01 98.01 0 0 98. 02 | 09852 | DI ABETES EDUCATION 98.02 200.00 Subtotal (see instructions) 3, 100 21,643 200.00 Less PBP Clinic Lab. Services-Program 201.00 201 00 Only Charges

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202.00

Net Charges (line 200 - line 201)

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3, 100

21, 643

202.00

Heal th	Financial Systems	ST. VINCENT HO	ISPLTAL & HCC		In lie	eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT		Provi der C	CN: 15-0084	Peri od:	Worksheet D	2002 10
7 0	TO STATE OF THE PROPERTY OF TH	7.E 000.0		10 0001	From 07/01/2018	Part II	
			Component	CCN: 15-S084	To 06/30/2019	Date/Time Pre 11/25/2019 6:	
			Title	· XVIII	Subprovi der - PPS		то ріп
					IPF		
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	2.00	2.00	4.00	F 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
50. 00	05000 OPERATING ROOM	10, 042, 412	703, 873, 618	0. 01426	811, 860	11, 583	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	631, 969				11, 363	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 193, 531		l .		574	
54. 00	05400 RADI OLOGY - DI AGNOSTI C 05402 AMBULATORY CARDI OVASCULAR SVC	1, 147, 845				403	
54. 01	05402 AMBOLATORY CARDIOVASCULAR SVC	143, 557	26, 554, 465	l .		9	
54. 02	05404 ECHOCARDI OLOGY	284, 894		l .		0	
54. 04	05401 ONCOLOGY	3, 260, 702		l .		556	
57. 00	05700 CT SCAN	521, 838		l .		485	
58. 00	05800 MRI						
59. 00		663, 820				0	
59. 00 59. 01	05900 CARDI AC CATHETERI ZATI ON	2, 156, 757					
	05901 CARDI AC REHAB	153, 279					
60.00	06000 LABORATORY	1, 071, 880				1, 120	
65.00	06500 RESPIRATORY THERAPY	1, 291, 242		1		78	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 909, 242		•		2, 009	1
67.00	06700 OCCUPATIONAL THERAPY	48, 790		1		63	
68.00	06800 SPEECH PATHOLOGY	183, 553				75	
69.00	06900 ELECTROCARDI OLOGY	371, 152		l .		276	
70.00	07000 ELECTROENCEPHALOGRAPHY	613, 257		l .		162	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1, 647, 223				545	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 814, 476				40	
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 575, 953				3, 622	
74. 00 75. 00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	269, 644				340	
75.00	OUTPATIENT SERVICE COST CENTERS	595, 615	50, 724, 200	0.01172	12 0	0	75.00
90. 00	09000 CLINIC	2, 396, 428	11, 980, 025	0. 20003	9, 733	1, 947	90.00
90. 00	09001 PARTI AL HOSPI TALI ZATI ON	2, 340, 428				298	
91. 00	09100 EMERGENCY	2, 330, 419				2, 755	1
91.00	09101 WOUND CARE 002	270, 305		l .		2,755	1
91. 01	09102 WOUND CARE 002	53, 882				0	91.01
91. 02	09103 LAFAYETTE RD CLINIC	33,002	2,433,339	1		0	
91. 03	09103 LAPATETTE RD CLINIC	293, 388	~	1			91.03
91. 04	09105 BROWNSBURG CLINIC	273, 300	2,001,120	0. 00000		0	
91.05	09106 OP ANTI COAGULATION CLINIC	90, 429	3, 226, 043			0	
91. 00	09107 ST VINCENT OUTPATIENT TREATMENT	167, 790				0	91.00
91. 07	04040 FAMILY PRACTICE	451, 243				0	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT	451, 243	ł	l .		0	
72.00	OTHER REIMBURSABLE COST CENTERS		45, 500, 572	0.00000	,o 33, 1 63	<u> </u>	72.00
95. 00	09500 AMBULANCE SERVICES			1			95. 00
98. 00	09853 GERIATRIC CLINIC	26	0	0. 00000	00	0	
98. 01	09851 ELECTROCONVULSI VE THERAPY	0		•		0	
98. 02	09852 DI ABETES EDUCATI ON	17, 215				0	
200.00			3, 053, 187, 378		2, 240, 540		200.00
	(, .,,, 0,0	1			

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		Titl∈	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	C	0)	0	1, 373	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	0) (0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0) (0	188, 721	54.00
54. 01 05402 AMBULATORY CARDIOVASCULAR SVC	() 0) (0	0	54. 01
54. 02 05403 ULTRASOUND	0	0) (0	54, 941	54. 02
54. 03 05404 ECHOCARDI OLOGY	C	0) (0	0	54. 03
54. 04 05401 ONCOLOGY		0) (0	0	54. 04
57. 00 05700 CT SCAN	C	0		0	92, 809	57. 00
58. 00 05800 MRI		0		0	29, 305	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON				0	0	59. 00
59. 01 05901 CARDI AC REHAB				0	0	59. 01
60. 00 06000 LABORATORY				0	0	60.00
65. 00 06500 RESPIRATORY THERAPY				0	0	65.00
66. 00 06600 PHYSI CAL THERAPY				0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY				0	0	67.00
68. 00 06800 SPEECH PATHOLOGY				0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY				0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY					0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS					0	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS					_	72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S					1, 149, 863 0	74.00
75. 00 03330 ENDOSCOPY		1		,	0	75. 00
OUTPATIENT SERVICE COST CENTERS		,,	'1) 0	0	75.00
90. 00 09000 CLINIC) (0	0	90.00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON		1	1	-	0	90. 01
91. 00 09100 EMERGENCY					1, 483, 268	91.00
91. 01 09101 WOUND CARE 002				o o	0	91. 01
91. 02 09102 WOUND CARE 001				0	0	91. 02
91. 03 09103 LAFAYETTE RD CLINIC				0	0	91. 03
91. 04 09104 ZI ONSVI LLE CLI NI C	d			0	0	91. 04
91. 05 09105 BROWNSBURG CLINIC		0) (0	0	91. 05
91.06 09106 OP ANTICOAGULATION CLINIC		0) (0	0	91.06
91.07 09107 ST VINCENT OUTPATIENT TREATMENT	C	0) (0	0	91. 07
91. 08 04040 FAMILY PRACTICE		0) (0	0	91. 08
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT					0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
98. 00 09853 GERI ATRI C CLI NI C	C	0	0	0	0	98. 00
98. 01 09851 ELECTROCONVULSI VE THERAPY	(C	0) (0	0	98. 01
98. 02 09852 DI ABETES EDUCATION	C	0) (0	0	98. 02
200.00 Total (lines 50 through 199)	C)) (0	3, 000, 280	200. 00

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Heal th	Financial Systems	ST. VINCENT HO	NOT B LATIGN		Inlie	u of Form CMS-2	2552_10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CN: 15-0084	Peri od:	Worksheet D	2332 10
	GH COSTS	WIGE OTHER TAG	J TTOVI dei 0		From 07/01/2018	Part IV	
11111001	311 00010		Component	CCN: 15-S084	To 06/30/2019	Date/Time Pre	
						11/25/2019 6:	15 pm
			Ti tl e	XVIII	Subprovi der -	PPS	
		1 11 011	T	T	I PF	D 11 C 0 1	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3, and 4)	8)	7)	
		4.00	5.00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00	05000 OPERATI NG ROOM	0	1, 373	1, 37	3 703, 873, 618	0. 000002	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1,375	1	0 66, 000, 687	0. 000002	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	188, 721	1		0.002068	1
54. 00	05402 AMBULATORY CARDIOVASCULAR SVC		100, 721	1	0 47, 159, 362	0.002008	
54. 01	05403 ULTRASOUND		54, 941			0.00000	
54. 02	05404 ECHOCARDI OLOGY		34, 941	1	0 31, 299, 569	0.002009	
54. 04	05401 ONCOLOGY	0		1	0 86, 992, 872	0.000000	1
57. 00	05700 CT SCAN		92, 809			0.00000	
58. 00	05800 MRI		29, 305			0.002069	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	27, 303	1	0 205, 724, 757	0.002007	
59. 01	05901 CARDI AC REHAB	0			0 3, 755, 202	0.000000	
60.00	06000 LABORATORY	0			0 377, 885, 704	0.000000	
65. 00	06500 RESPIRATORY THERAPY				0 80, 118, 621	0.000000	
66. 00	06600 PHYSI CAL THERAPY				0 37, 875, 823	0.000000	1
67. 00	06700 OCCUPATI ONAL THERAPY				0 8, 947, 957	0.000000	1
68. 00	06800 SPEECH PATHOLOGY				0 6, 466, 048	0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY			1	0 29, 257, 088	0.000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY				0 20, 942, 629	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT			1	0 172, 421, 436	0.000000	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS			l .	0 172, 421, 430	0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS		1, 149, 863	1		0. 002674	
74. 00	07400 RENAL DIALYSIS		1, 149, 803	1	0 20, 357, 504	0.002074	
75. 00	03330 ENDOSCOPY				0 50, 724, 200	0.000000	
73.00	OUTPATIENT SERVICE COST CENTERS			1	0 30, 724, 200	0.000000	73.00
90. 00	09000 CLINIC	0	О		0 11, 980, 025	0. 000000	90.00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0			0 15, 378, 778	0. 000000	
91. 00	09100 EMERGENCY	0	1, 483, 268			0. 006630	
91. 01	09101 WOUND CARE 002	0	1, 403, 200	1	0 16, 983, 023	0. 000000	
91. 02	09102 WOUND CARE 001	0			0 2, 433, 359	0. 000000	1
91. 03	09103 LAFAYETTE RD CLINIC	0		1	0 2, 100, 007	0. 000000	
91. 04	09104 ZI ONSVI LLE CLI NI C	0		1	0 2, 861, 120	0. 000000	
91. 05	09105 BROWNSBURG CLINIC	0			0 2,001,120	0. 000000	
91. 06	09106 OP ANTI COAGULATI ON CLINI C	0			0 3, 226, 043	0. 000000	
91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	0		1	0 3, 785, 623	0. 000000	
91. 08	04040 FAMILY PRACTICE	0			0 3, 703, 023	0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	0	-	1	0 45, 560, 372	0. 000000	
,2.00	OTHER REIMBURSABLE COST CENTERS	·		1	5, 10, 500, 572	0.000000	1 /2.00
95. 00	09500 AMBULANCE SERVICES			1			95. 00
98. 00	09853 GERI ATRI C CLI NI C	0			o	0. 000000	1
98. 01	09851 ELECTROCONVULSI VE THERAPY	1 0			0 10, 148	0. 000000	
98. 02	09852 DI ABETES EDUCATION	0		1	0 0	0. 000000	
200.00	l i	Ō	3, 000, 280	3, 000, 28	0 3, 053, 187, 378		200. 00
		•	•	•		•	

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Hoal th	Financial Systems	ST. VINCENT HOSE	DITAL & UCC		Inlio	u of Form CMS-2	2552 10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CN: 15-0084	Peri od:	Worksheet D	2332-10
	SH COSTS	KVI CE OTTEK TASS	Trovider 6	CIV. 15 0004	From 07/01/2018	Part IV	
	66616		Component	CCN: 15-S084	To 06/30/2019	Date/Time Pre 11/25/2019 6:	pared: 15 pm
			Titl∈	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
	T	9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0. 000002	811, 860		2 0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	1	0 0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 002068	23, 891	•	19 0	0	54. 00
54. 01	05402 AMBULATORY CARDIOVASCULAR SVC	0. 000000	16, 569	•	0	0	54. 01
54. 02	05403 ULTRASOUND	0. 002069	1, 701		4 0	0	54. 02
54. 03	05404 ECHOCARDI OLOGY	0. 000000	0)	0	0	54. 03
54.04	05401 ONCOLOGY	0. 000000	14, 824	•	0	0	54. 04
57. 00	05700 CT SCAN	0. 002069	41, 650		86 0	0	57. 00
58. 00	05800 MRI	0. 002069	1, 900)	4 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0)	0	0	59. 00
59. 01	05901 CARDI AC REHAB	0. 000000	0)	0	0	59. 01
60.00	06000 LABORATORY	0. 000000	394, 675	5	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	4, 824		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	39, 861		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	11, 482	2	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	2, 652	2	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	21, 742	2	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	5, 542	2	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000	57, 004		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 430		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 002674	435, 458	1, 16	1, 656	4	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	25, 657	'	0	0	74.00
75.00	03330 ENDOSCOPY	0. 000000	0		0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	9, 733	3	0 0	0	90. 00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0. 000000	19, 655	5	0 518	0	90. 01
91.00	09100 EMERGENCY	0. 006630	264, 445	1, 75	53 0	0	91.00
91. 01	09101 WOUND CARE 002	0. 000000	0		0	0	91. 01
91. 02	09102 WOUND CARE 001	0. 000000	0		0	0	91. 02
91.03	09103 LAFAYETTE RD CLINIC	0. 000000	0		0	0	91. 03
91.04	09104 ZIONSVILLE CLINIC	0. 000000	0		0	0	91. 04
91.05	09105 BROWNSBURG CLINIC	0. 000000	0		0	0	91. 05
91.06	09106 OP ANTICOAGULATION CLINIC	0. 000000	0		0	0	91. 06
91.07	09107 ST VINCENT OUTPATIENT TREATMENT	0. 000000	0		0 0	0	91. 07
91.08	04040 FAMILY PRACTICE	0. 000000	0		0 0	0	91. 08
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000	33, 985	i	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	<u>.</u>					1
95.00	09500 AMBULANCE SERVICES						95. 00
98.00	09853 GERIATRIC CLINIC	0. 000000	0		0 0	0	98. 00
98. 01	09851 ELECTROCONVULSI VE THERAPY	0. 000000	0)	0 0	0	98. 01
98. 02	09852 DI ABETES EDUCATION	0. 000000	0)	0	0	98. 02
200.00	Total (lines 50 through 199)		2, 240, 540	3, 06	2, 174	4	200. 00

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	WIGGINE GGG	Component		From 07/01/2018 To 06/30/2019	Part V Date/Time Pre 11/25/2019 6:	
		Title	· XVIII	Subprovi der – I PF	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
ANOLLI ADV. CEDVI OF COCT. OFNITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.002720	1 0	1	0 0	0	50.00
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 093738 0. 137074	0	1	0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 137074			0 0	0	1
54. 00 05400 RADI OLOGT - DI AGNOSTI C 54. 01 05402 AMBULATORY CARDI OVASCULAR SVC	0. 172391			0 0	0	1
54. 01 05402 AMBULATORY CARDIOVASCULAR SVC	0. 172439		1	0 0	0	1
54. 03 05404 ECHOCARDI OLOGY	0. 076317			0 0	0	54. 02
54. 03 05404 ECHOCARDI OLOGY 54. 04 05401 0NCOLOGY	0. 076420			0 0	0	54. 03
57. 00 05700 CT SCAN	0. 075608			0 0	0	1
58. 00 05800 MRI	0. 073008		1	0 0	0	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 048542			0 0	0	59.00
59. 01 05901 CARDI AC CATHETERI ZATTON	0. 372139		1	0 0	0	1
60. 00 06000 LABORATORY	0. 088154		•	0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 269000			0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 405718			0 0	0	1
67. 00 06700 OCCUPATI ONAL THERAPY	0. 193680			0 0	0	1
68. 00 06800 SPEECH PATHOLOGY	0. 256553		l .	0 0	0	1
69. 00 06900 ELECTROCARDI OLOGY	0. 134098			0 0	0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 419810			0 0	0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 392864			0 0	0	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 392884		•	0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 250473	1, 656		0 750	415	1
74. 00 07400 RENAL DI ALYSI S	0. 329953	1,030		0 750	0	1
75. 00 03330 ENDOSCOPY	0. 104887			0 0	0	1
OUTPATIENT SERVICE COST CENTERS	0. 104007		l	o _l o		75.00
90. 00 09000 CLI NI C	0. 654791	0		0 0	0	90.00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	0. 237318	518		o o	123	
91. 00 09100 EMERGENCY	0. 185340	0	•	0 0	0	1
91. 01 09101 WOUND CARE 002	0. 139455	ĺ	•	0 0	0	1 .
91. 02 09102 WOUND CARE 001	0. 342389	ĺ		0 0	Ö	
91. 03 09103 LAFAYETTE RD CLINIC	0. 000000	0		0 0	0	1
91. 04 09104 ZI ONSVI LLE CLI NI C	0. 313258	0		0 0	0	1
91. 05 09105 BROWNSBURG CLINIC	0. 000000	Ö	1	0	0	91. 05
91.06 09106 OP ANTICOAGULATION CLINIC	0. 293375	l o	1	0	0	1
91. 07 09107 ST VINCENT OUTPATIENT TREATMENT	0. 257477	l o	1	0	0	1
91.08 04040 FAMILY PRACTICE	0. 000000	0		0	0	91. 08
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 381649	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS				-		
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95. 00
98.00 09853 GERIATRIC CLINIC	0. 000000	0		0 0	0	98. 00
98. 01 09851 ELECTROCONVULSI VE THERAPY	0. 000000	0		0	0	98. 01
98.02 09852 DIABETES EDUCATION	0. 000000	0		0 0	0	98. 02
200.00 Subtotal (see instructions)		2, 174		0 750	538	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	1	2, 174	l	0 750	538	202. 00

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98. 01

98.02

200.00

201.00

202.00

04040 FAMILY PRACTICE

09500 AMBULANCE SERVICES

09852 DIABETES EDUCATION

Only Charges

09853 GERIATRIC CLINIC

09200 OBSERVATION BEDS (NON-DISTINCT

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

OTHER REIMBURSABLE COST CENTERS

09851 ELECTROCONVULSIVE THERAPY

11/25/2019 6:15 pm Y:\28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

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Heal th	Financial Systems	ST. VINCENT HO	SPLTAL & HCC		In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0084	Peri od:	Worksheet D	
					From 07/01/2018		
			Component	CCN: 15-T084	To 06/30/2019	Date/Time Pre 11/25/2019 6:	pared:
			Ti tl e	xVIII	Subprovi der -	PPS	15 piii
			11 11	, , , , , , , , , , , , , , , , , , , ,	IRF	113	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)			1.00		
	ANGLI LADV CEDVICE COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	10, 042, 412	703, 873, 618	0. 01426	69, 458	991	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	631, 969		1		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 193, 531		1		420	
54. 00	05402 AMBULATORY CARDI OVASCULAR SVC	1, 147, 845		1		96	
54. 02	05403 ULTRASOUND	143, 557		1		56	
54. 03	05404 ECHOCARDI OLOGY	284, 894		1		103	
54. 04	05401 ONCOLOGY	3, 260, 702				0	
57. 00	05700 CT SCAN	521, 838		1		138	
58. 00	05800 MRI	663, 820		1		134	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 156, 757	205, 724, 757	0. 01048	17, 356	182	59. 00
59. 01	05901 CARDI AC REHAB	153, 279	3, 755, 202	0. 04081	18 0	0	59. 01
60.00	06000 LABORATORY	1, 071, 880	377, 885, 704	0. 00283	379, 884	1, 078	60.00
65.00	06500 RESPI RATORY THERAPY	1, 291, 242		1		79	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 909, 242				18, 354	
67. 00	06700 OCCUPATI ONAL THERAPY	48, 790		1		1, 977	67. 00
68. 00	06800 SPEECH PATHOLOGY	183, 553		1		3, 474	1
69. 00	06900 ELECTROCARDI OLOGY	371, 152		1		0	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PAT	613, 257				27 697	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 647, 223 4, 814, 476		1		57	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 575, 953		1		1, 416	
74. 00	07400 RENAL DIALYSIS	269, 644		1		1	
75. 00	03330 ENDOSCOPY	595, 615				96	
70.00	OUTPATIENT SERVICE COST CENTERS	3707010	00//2//200	0.01.7	.2 0,1,7	,,,	70.00
90.00	09000 CLI NI C	2, 396, 428	11, 980, 025	0. 20003	35 0	0	90.00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	233, 203	15, 378, 778	0. 01516	64 0	0	90. 01
91.00	09100 EMERGENCY	2, 330, 419	223, 713, 364	0. 01041	17 0	0	91. 00
91. 01	09101 WOUND CARE 002	270, 305	16, 983, 023	0. 01591	16 0	0	91. 01
91. 02	09102 WOUND CARE 001	53, 882	2, 433, 359			l	
91. 03	09103 LAFAYETTE RD CLINIC	7	0	1 0.0000		l e	
91. 04	09104 ZI ONSVI LLE CLI NI C	293, 388	2, 861, 120			1	91. 04
91. 05	09105 BROWNSBURG CLINIC	0	0	0.00000		1	
91.06	09106 OP ANTI COAGULATI ON CLINI C	90, 429				0	
91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	167, 790				0	
91. 08 92. 00	04040 FAMILY PRACTICE 09200 OBSERVATION BEDS (NON-DISTINCT	451, 243 0		7 0.0000			
92.00	OTHER REIMBURSABLE COST CENTERS	0	45, 560, 372	0.00000	0 0	0	92.00
95. 00	09500 AMBULANCE SERVICES	T		I			95. 00
98. 00	09853 GERIATRI C CLINI C	26	0	0. 00000	00 0	0	
98. 01	09851 ELECTROCONVULSI VE THERAPY	0	ł	1		l	
98. 02	09852 DI ABETES EDUCATI ON	17, 215		1		0	
200.00			3, 053, 187, 378		1, 729, 345	30, 651	200. 00
		•		-	•	-	-

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		Ti tl e	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Non Physician	Nursi na School	Nursi na School	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	(0	1, 373	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM) () (0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C) () (0	188, 721	54.00
54. 01 05402 AMBULATORY CARDIOVASCULAR SVC) (0	0	54. 01
54. 02 05403 ULTRASOUND	(0	54, 941	54. 02
54. 03 05404 ECHOCARDI OLOGY	(0	0	54. 03
54. 04 05401 ONCOLOGY	(0	0	54. 04
57. 00 05700 CT SCAN	(0	92, 809	57. 00
58. 00 05800 MRI	(0	29, 305	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	(0	0	59. 00
59. 01 05901 CARDI AC REHAB	(0	0	59. 01
60. 00 06000 LABORATORY	(0	0	60.00
65. 00 06500 RESPIRATORY THERAPY				0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY				0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY				0	0	67.00
68. 00 06800 SPEECH PATHOLOGY				0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY				0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY				0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT				0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS				0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS				0	1, 149, 863	73.00
74.00 07400 RENAL DIALYSIS				0	0	74.00
75. 00 03330 ENDOSCOPY	(0	0	75. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C) (0	0	90. 00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON) () (0	_	
91. 00 09100 EMERGENCY) () (0	1, 483, 268	91.00
91. 01 09101 WOUND CARE 002) () (0	0	91. 01
91. 02 09102 WOUND CARE 001) () (0	0	91. 02
91.03 09103 LAFAYETTE RD CLINIC	() (0	0	91. 03
91. 04 09104 ZI ONSVI LLE CLI NI C) () (0	0	91. 04
91. 05 09105 BROWNSBURG CLINIC	() (0	0	91. 05
91.06 O9106 OP ANTICOAGULATION CLINIC	(0	0	91. 06
91. 07 09107 ST VINCENT OUTPATIENT TREATMENT	(0	0	91. 07
91.08 04040 FAMILY PRACTICE	(0	0	91. 08
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	((ס	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
98. 00 09853 GERIATRIC CLINIC	() () (0	0	98. 00
98. 01 09851 ELECTROCONVULSI VE THERAPY) () (0	0	98. 01
98. 02 09852 DIABETES EDUCATION) () (0	0	98. 02
200.00 Total (lines 50 through 199)) () (0	3, 000, 280	200. 00

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llool +h	Financial Cystems	CT VINCENT HO	CDITAL ® UCC		ما ا ما	u of Form CMC	2552 10
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	ST. VINCENT HOS		°N: 15_0084	Peri od:	u of Form CMS-2 Worksheet D	2332-10
	SH COSTS	WICE OTHER PASS	FIOVIDE C		From 07/01/2018	Part IV	
THROOK			Component		To 06/30/2019	Date/Time Pre 11/25/2019 6:	
			Title	XVIII	Subprovi der - PPS		
	Cost Center Description	All Other	Total Cost	Total	IRF Total Charges	Dotin of Cont	
	cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost	•	Cost (sum of		(col. 5 ÷ col.	
		Laucati on cost	4)	col s. 2, 3,	8)	7)	
			'/	and 4)	0)	, ,	
		4.00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	1, 373	1, 37	3 703, 873, 618	0.000002	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	0		0 66, 000, 687	0.000000	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	188, 721	188, 72	1 91, 237, 447	0. 002068	54.00
54. 01	05402 AMBULATORY CARDIOVASCULAR SVC	0	0		0 47, 159, 362	0.000000	54. 01
54. 02	05403 ULTRASOUND	0	54, 941	54, 94	1 26, 554, 465	0. 002069	54. 02
54. 03	05404 ECHOCARDI OLOGY	o	0		0 31, 299, 569	0.000000	54. 03
54.04	05401 ONCOLOGY	0	0		0 86, 992, 872	0.000000	54. 04
57.00	05700 CT SCAN	0	92, 809	92, 80	9 44, 857, 088	0. 002069	57.00
58.00	05800 MRI	0	29, 305	29, 30	14, 164, 026	0. 002069	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 205, 724, 757	0.000000	59. 00
59. 01	05901 CARDI AC REHAB	0	0		0 3, 755, 202	0.000000	59. 01
60.00	06000 LABORATORY	o	0		0 377, 885, 704	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 80, 118, 621	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 37, 875, 823	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 8, 947, 957	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 6, 466, 048	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 29, 257, 088	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 20, 942, 629	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		0 172, 421, 436	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 170, 692, 919	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 149, 863	1, 149, 86	3 429, 946, 501	0. 002674	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 20, 357, 504	0.000000	74.00
75.00	03330 ENDOSCOPY	0	0		0 50, 724, 200	0. 000000	75. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 11, 980, 025	0. 000000	90. 00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0	0		0 15, 378, 778	0. 000000	90. 01
91.00	09100 EMERGENCY	0	1, 483, 268	1, 483, 26	8 223, 713, 364	0. 006630	91. 00
91. 01	09101 WOUND CARE 002	0	0		0 16, 983, 023	0. 000000	91. 01
91. 02	09102 WOUND CARE 001	0	0		0 2, 433, 359	0. 000000	91. 02
91. 03	09103 LAFAYETTE RD CLINIC	0	0		0	0. 000000	91. 03
91. 04	09104 ZI ONSVI LLE CLI NI C	0	0		0 2, 861, 120	0. 000000	91. 04
91. 05	09105 BROWNSBURG CLINIC	0	0		0	0. 000000	91. 05
91. 06	09106 OP ANTI COAGULATION CLINIC	0	0		0 3, 226, 043	0. 000000	91. 06
91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	0	0		0 3, 785, 623	0. 000000	91. 07
91. 08	04040 FAMILY PRACTICE	0	0		0	0. 000000	91. 08
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0		0 45, 560, 372	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
98. 00	09853 GERIATRIC CLINIC	0	0	•	0	0. 000000	
98. 01	09851 ELECTROCONVULSI VE THERAPY	0	0	1	0 10, 148	0. 000000	
98. 02	09852 DI ABETES EDUCATION	0	0		0	0. 000000	
200.00	Total (lines 50 through 199)	0	3, 000, 280	3, 000, 28	3, 053, 187, 378		200. 00

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Hoal th	Financial Systems	ST. VINCENT HOSE	DITAL & HCC		In lie	eu of Form CMS-:	2552_10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provi der CCN: 15-0084		Peri od:	Worksheet D	
	SH COSTS			CCN: 15-T084	From 07/01/2018 To 06/30/2019	Part IV Date/Time Pre 11/25/2019 6:	
			Ti tl e	· XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col . 12)	
	ANOLILIADY CERVICE COCT CENTERS	9. 00	10. 00	11.00	12. 00	13. 00	
FO 00	ANCILLARY SERVICE COST CENTERS	0.000000	(0.450	1			FO 00
50.00	05000 OPERATING ROOM	0. 000002	69, 458		0 0	1	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 002068	17, 450		36 0	0	
54. 01	05402 AMBULATORY CARDI OVASCULAR SVC	0.000000	3, 924		0 0	0	
54. 02	05403 ULTRASOUND	0. 002069	10, 446	•	22 0	0	54. 02
54. 03	05404 ECHOCARDI OLOGY	0. 000000	11, 352	1	0 0	0	
54. 04	05401 ONCOLOGY	0. 000000	0		0 0	0	
57. 00	05700 CT SCAN	0. 002069	11, 900		25 0	0	
58. 00	05800 MRI	0. 002069	2, 850	1	6 0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	17, 356		0	0	59. 00
59. 01	05901 CARDI AC REHAB	0. 000000	0		0	0	
60.00	06000 LABORATORY	0. 000000	379, 884		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	4, 884		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	364, 115		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	362, 561		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	122, 385		0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	914		0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000	73, 011		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 038		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 002674	170, 274	4	55 0	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	96, 346		0	0	74.00
75.00	03330 ENDOSCOPY	0. 000000	8, 197		0 0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0. 000000	O		0 0	0	90. 00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0. 000000	0		0	0	90. 01
91.00	09100 EMERGENCY	0. 006630	0		0 0	0	91.00
91.01	09101 WOUND CARE 002	0. 000000	0		0 0	0	91. 01
91. 02	09102 WOUND CARE 001	0. 000000	0		0 0	0	91. 02
91.03	09103 LAFAYETTE RD CLINIC	0. 000000	0		0 0	0	91. 03
91.04	09104 ZI ONSVI LLE CLI NI C	0. 000000	0		0 0	0	91. 04
91.05	09105 BROWNSBURG CLINIC	0. 000000	0		0 0	0	91. 05
91.06	09106 OP ANTICOAGULATION CLINIC	0. 000000	O		0 0	0	91.06
91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	0. 000000	O		0 0	0	91. 07
91. 08	04040 FAMILY PRACTICE	0. 000000	O		0 0	0	91. 08
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000	0		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				<u>.</u>		1
95.00	09500 AMBULANCE SERVICES						95. 00
98.00	09853 GERIATRIC CLINIC	0. 000000	0		0 0	0	98. 00
98. 01	09851 ELECTROCONVULSI VE THERAPY	0. 000000	0		0 0	0	98. 01
98. 02	09852 DI ABETES EDUCATION	0. 000000	0	1	0 0	0	1
200.00	Total (lines 50 through 199)		1, 729, 345	5	44 0	0	200. 00

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26, 352

43.00

200.00

11/25/2019 6:15 pm Y:\28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

43. 00 | 04300 NURSERY

Total (lines 30 through 199)

200.00

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Provider CCN: 15-0084 Peri od: Worksheet D From 07/01/2018 Part IV To 06/30/2019 Date/Time Prepared: THROUGH COSTS

Cost Center Description						10 06/30/2019	11/25/2019 6:	
Cost Center Description				Ti tI	e XIX	Hospi tal		то ріп
Americal Cost		Cost Center Description	Non Physician					
ANCILLARY SERVICE COST CENTERS								
NOLILLARY SERVICE COST CENTERS								
ANCILLARY SERVICE COST CENTERS					2.00		3. 00	
S2 00 05200 DELLYERY ROOM & LABOR ROOM 0 0 0 0 0 0 18.7.721 54.00		ANCILLARY SERVICE COST CENTERS		<u> </u>				
54. 00 05400 RADI OLOGY-DI AGNOSTIC 0 0 0 0 0 0 188, 721 54. 00	50.00	05000 OPERATI NG ROOM	0	C		0 0	1, 373	50. 00
54. 0 05402 AMBILLATORY CARDI OVASCULAR SVC 0	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52. 00
54. 02 05403 ILLTRASQUIND	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	188, 721	54.00
54. 02 05403 ILTRASOUND	54. 01	05402 AMBULATORY CARDIOVASCULAR SVC	0	0)	0	0	54. 01
54. 0 05401 0NCOLOGY	54. 02	05403 ULTRASOUND	0	0)	0	54, 941	1
54.04 05401 0NCOLOGY	54. 03	05404 ECHOCARDI OLOGY	0	0)	0	0	54. 03
SB.00 05800 NR 0 0 0 0 0 29,305 58. 00	54.04		0	0)	0	0	54. 04
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00	57.00	05700 CT SCAN	0	0	1	0	92, 809	57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59. 00	58.00		0	0)	0		
59.01 05901 CARDIAC REHAB 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	59.00	05900 CARDI AC CATHETERI ZATI ON	0	l o)	0		
65.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	59. 01		0	l o)	0	0	59. 01
66. 00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 71. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 71. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 0 0 0 0 0 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 76. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 77. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 78. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 79. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 79. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 79. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 79. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 79. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 79. 00 07400 RENAL DI ALYSI S 0 0 0 0 79. 00 07400 RENAL DI ALYSI S 0 0 0 0 79. 00 07400 RENAL DI ALYSI S 0 0 0 0 79. 00 07400 RENAL DI ALYSI S 0 0 0 0 79. 00 07400 RENAL DI ALYSI S 0 0 0 0 79. 00 07400 RENAL DI ALYSI S 0 0 0 0 79. 00 07400 RENAL DI ALYSI S 0 0 0 0 79. 00 07500 RENAL DI ALYSI S 0 0 0 0 79. 00 07500 RENAL DI ALYSI S 0 0 0 0 79. 00 07500 RENAL DI ALYSI S 0 0 0 0 79. 00 07500 RENAL DI ALYSI S 0 0 0 0 79. 00 07500 RENAL DI ALYSI S 0 0 0 0 79. 00 07500 RENAL DI ALYSI S 0 0 0 79. 00 0750	60.00	06000 LABORATORY	0	l o)	0	0	60.00
67. 00 06700 0CCUPATI (DNAL THERAPY 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 76. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 77. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 78. 00 07400 07400 07400 07500 79. 01 07900 07900 07900 07500 0 0 0 79. 01 07900 07900 07900 07500 0 0 0 79. 01 07900 07900 07900 07500 79. 01 07900 07900 07900 07500 0 0 79. 01 07900 07900 07900 07500 79. 01 07900 07900 07900 07900 07900 79. 02 07900 07900 07900 07900 0 79. 03 07900 07900 07900 07900 0 79. 04 07900 07900 07900 07900 07900 79. 04 07900 07900 07900 07900 07900 79. 05 07900 07900 07900 07900 07900 79. 07900 07900 07900 07900 07900 07900 79. 08 07900 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 79. 00 07900 07900 07900 79. 00 07900 07900 07900 07900 79. 00 07900 07900 07900 79. 00 07900 07900 07900 07900 79. 00 07900 07900 07900 79. 00 07900 07900 07900 79. 00 07900 07900 07900 79. 00 07900 07900 07900 79. 00 07900 07900 79. 00 07900 07900 79.	65.00	06500 RESPIRATORY THERAPY	0	l o)	0	0	65. 00
67. 00 06700 OCCUPATI (NAIL THERAPY 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 1, 149, 863 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 76. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 77. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 78. 00 07400 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 79. 01 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 79. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 79. 01 07400 RENAL DIALYSIS 0 0 0 0 0 0 79. 01 07900 DRUGS COPY 0 0 0 0 0 0 79. 00 07000 DRUGS COPY 0 0 0 0 0 79. 01 07900 DRUGS COPY 0 0 0 0 0 79. 01 07900 DRUGS COPY 0 0 0 0 0 79. 01 07900 DRUGS COPY 0 0 0 0 0 79. 02 07900 DRUGS COPY 0 0 0 0 0 79. 03330 ROUND CORE COST CENTERS 0 0 0 0 0 79. 01 07900 DRUGS COST CENTERS 0 0 0 0 79. 01 07900 DRUGS COST CENTERS 0 0 0 0 79. 02 07910 WOUND CARE OO2 0 0 0 0 79. 03 07910 WOUND CARE OO2 0 0 0 0 79. 04 07910 ST VI NCENT OUTPATIENT 0 0 0 0 79. 05 07910 SERVATION BEDS (NON-DISTINCT 0 0 0 0 79. 00 07910 SERVATION BEDS (NON-DISTINCT 0 0 0 0 79. 00 07910 SERVATION BEDS (NON-DISTINCT 0 0 0 0 79. 00 07910 SERVATION BEDS (NON-DISTINCT 0 0 0 0 79. 00 07910 SERVATION BEDS (NON-DISTINCT 0 0 0 0 79. 00 07910 SERVATION BEDS (NON-DISTINCT 0 0	66.00	06600 PHYSI CAL THERAPY	0	l o)	0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY		06700 OCCUPATI ONAL THERAPY	0	l o)	0	0	67.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 70.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 0 0 0 0 0 0 71.00 72. 00 07200 MEDI DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 1,149,863 73.00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 1,149,863 73.00 75. 00 03330 ENDOSCOPY 0 0 0 0 0 0 0 75.00 00.3330 ENDOSCOPY 0 0 0 0 0 0 0 0 75.00 00. 01 TPATIENT SERVICE COST CENTERS 00. 01 09001 PARTI AL HOSPITALI ZATI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	68. 00	06800 SPEECH PATHOLOGY	0	l o)	0	0	68. 00
71. 00			0	l o)	0	0	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 1,149,863 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 0	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0)	0	0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 1,149,863 73.00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 74.00 75. 00 03330 ENDOSCOPY 0 0 0 0 0 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 90.00 90. 01 09001 PARTIAL HOSPITALIZATION 0 0 0 0 0 0 0 90.01 91. 00 09100 EMERGENCY 0 0 0 0 0 0 1,483,268 91.00 91. 01 09101 WOUND CARE 002 0 0 0 0 0 0 91.02 91. 02 09102 WOUND CARE 001 0 0 0 0 0 91.02 91. 03 09103 LAFAYETTE RD CLINIC 0 0 0 0 0 0 0 91.03 91. 04 09104 ZI ONSVI LLE CLINIC 0 0 0 0 0 0 0 91.03 91. 05 09105 BROWNSBURG CLINIC 0 0 0 0 0 0 0 0 91.04 91. 07 09107 ST VINCENT OUTPATIENT TREATMENT 0 0 0 0 0 0 0 91.06 91. 07 09107 ST VINCENT OUTPATIENT TREATMENT 0 0 0 0 0 0 0 91.07 92. 00 09853 GERIATRIC CLINIC 0 0 0 0 0 0 0 91.08 93. 00 09853 GERIATRIC SERVICES 95. 00 09850 MBULLANCE SERVICES 95. 00 09851 ELECTROCONVULSI VE THERAPY 96. 00 09851 ELECTROCONVULSI VE THERAPY 97. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0)	0	0	71. 00
74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 74. 00 75. 00 03330 ENDOSCOPY 0 0 0 0 0 0 0 0 0 0 75. 00 03330 ENDOSCOPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	72.00		0	0)	0	0	72. 00
74.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 0 74.00 075.00 03330 ENDOSCOPY 0 0 0 0 0 0 0 0 0 0 75.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0)	0	1, 149, 863	73. 00
75.00 03330 ENDOSCOPY 0 0 0 0 0 0 0 0 0	74.00	07400 RENAL DIALYSIS	0	0)	0		
90. 00	75.00		0	0)	0	0	75. 00
90. 01		OUTPATIENT SERVICE COST CENTERS	,	<u>'</u>	,	•		
91. 00	90.00	09000 CLI NI C	0	C		0 0	0	90. 00
91. 01 09101 WOUND CARE 002 0 0 0 0 0 0 91. 01 91. 02 09102 WOUND CARE 001 0 0 0 0 0 0 91. 03 09103 LAFAYETTE RD CLINIC 0 0 0 0 0 0 91. 04 09104 ZI ONSVI LLE CLINIC 0 0 0 0 0 91. 05 09105 BROWNSBURG CLINIC 0 0 0 0 0 91. 06 09106 0P ANTI COAGULATI ON CLINIC 0 0 0 0 91. 07 09107 ST VI NCENT OUTPATI ENT TREATMENT 0 0 0 0 0 91. 08 04040 FAMILY PRACTI CE 0 0 0 0 0 91. 08 09200 OBSERVATI ON BEDS (NON-DI STI NCT 0 0 0 0 92. 00 09500 AMBULANCE SERVI CES 95. 00 98. 01 09851 ELECTROCONVULSI VE THERAPY 0 0 0 0 0 98. 02 09852 DI ABETES EDUCATI ON 0 0 0 0 99. 02 0 0 0 0 0 99. 02 0 0 0 0 0 99. 02 0 0 0 0 0 99. 02 0 0 0 0 99. 02 0 0 0 0 99. 02 0 0 0 0 99. 02 0 0 0 0 99. 02 0 0 0 99. 02 0 0 0 99. 03 0 0 0 99. 04 0 0 0 99. 05 0 0 0 99. 05 0 0 0 99. 06 0 0 99. 07 0 0 99. 08 0 99. 08 0 99. 09 0 0 99. 09 0 99. 00 0 99. 00 0 99. 00 0 99. 0	90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0	0	1	0	0	90. 01
91. 02	91.00	09100 EMERGENCY	0	0	1	0	1, 483, 268	91. 00
91. 03	91. 01	09101 WOUND CARE 002	0	l c	,	0	0	91. 01
91. 04	91. 02	09102 WOUND CARE 001	0	0)	0	0	91. 02
91. 05	91. 03	09103 LAFAYETTE RD CLINIC	0	0)	0	0	91. 03
91. 06	91. 04	09104 ZI ONSVI LLE CLI NI C	0	0)	0	0	91. 04
91. 07	91. 05	09105 BROWNSBURG CLINIC	0	0)	0	0	91. 05
91. 08	91.06	09106 OP ANTI COAGULATION CLINIC	0	0)	0	0	91.06
91. 08	91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	0	l o)	0	0	91. 07
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 95.00 09853 GERI ATRI C CLI NI C 0 0 0 0 0 98.00 98.01 09851 ELECTROCONVULSI VE THERAPY 0 0 0 0 0 98.01 98.02 09852 DI ABETES EDUCATI ON 0 0 0 0 98.02 09852 0	91. 08		0	l o)	0	0	91. 08
OTHER REIMBURSABLE COST CENTERS 95.00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0			0	0	92.00
95. 00			,		•	•		1
98. 01 09851 ELECTROCONVULSI VE THERAPY 0 0 0 0 98. 01 98. 02 09852 DI ABETES EDUCATI ON 0 0 0 98. 02	95.00							95. 00
98. 02 09852 DI ABETES EDUCATION 0 0 0 98. 02	98.00	09853 GERI ATRI C CLI NI C	0	0		0	0	98. 00
	98. 01	09851 ELECTROCONVULSI VE THERAPY	0	0		0	0	98. 01
200.00 Total (lines 50 through 199) 0 0 0 3,000,280 200.00	98. 02	09852 DI ABETES EDUCATION	0	0		0 (0	0	98. 02
	200.00	Total (lines 50 through 199)	0	0		0	3, 000, 280	200. 00

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From 07/01/2018 Part IV THROUGH COSTS 06/30/2019 Date/Time Prepared: 11/25/2019 6:15 pm Title XIX Hospi tal Cost Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols Outpati ent Education Cost Cost (sum of 1, 2, 3, and Part I, col. (col. 5 ÷ col 4) col s. 2, 3, 8) 7) and 4) 4.00 5.00 7.00 6.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 703, 873, 618 0.000002 50.00 1, 373 1, 373 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 66, 000, 687 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 91, 237, 447 54.00 00000000000000000000 188, 721 188, 721 0.002068 54.00 05402 AMBULATORY CARDIOVASCULAR SVC 47, 159, 362 0.000000 54.01 54.01 26, 554, 465 05403 ULTRASOUND 54.02 54, 941 54, 941 0.002069 54.02 54.03 05404 ECHOCARDI OLOGY 31, 299, 569 0.000000 54.03 54.04 05401 ONCOLOGY 86, 992, 872 0.000000 54.04 05700 CT SCAN 92.809 92.809 44, 857, 088 0.002069 57 00 57 00 05800 MRI 58.00 29, 305 29, 305 14, 164, 026 0.002069 58.00 59.00 05900 CARDIAC CATHETERIZATION 205, 724, 757 0.000000 59.00 05901 CARDI AC REHAB 59.01 0 3, 755, 202 0.000000 59.01 377, 885, 704 06000 LABORATORY 0 0 000000 60 00 60 00 65.00 06500 RESPIRATORY THERAPY 0 80, 118, 621 0.000000 65.00 06600 PHYSI CAL THERAPY 37, 875, 823 66.00 0.000000 66.00 8, 947, 957 06700 OCCUPATIONAL THERAPY 0 67 00 0.000000 67 00 68.00 06800 SPEECH PATHOLOGY 6, 466, 048 0.000000 68.00 06900 ELECTROCARDI OLOGY 29, 257, 088 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 20, 942, 629 0.000000 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PAT Ω 172, 421, 436 0.000000 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 170, 692, 919 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 149, 863 1, 149, 863 429, 946, 501 0.002674 73.00 0 74.00 07400 RENAL DIALYSIS 20, 357, 504 0.000000 74.00 50, 724, 200 03330 ENDOSCOPY 0 0.00000075.00 75.00 OUTPATIENT SERVICE COST CENTERS 0 11, 980, 025 0.000000 90.00 09000 CLI NI C 90.00 15, 378, 778 09001 PARTIAL HOSPITALIZATION 0.000000 90.01 0000000000 0 90.01 223, 713, 364 09100 EMERGENCY 1, 483, 268 1, 483, 268 0.006630 91.00 91.00 09101 WOUND CARE 002 16, 983, 023 0.000000 91.01 91.01 09102 WOUND CARE 001 91.02 0 2, 433, 359 0.000000 91.02 09103 LAFAYETTE RD CLINIC 0 0.000000 91.03 0 91.03 09104 ZIONSVILLE CLINIC 0 91.04 C 2, 861, 120 0.000000 91 04 09105 BROWNSBURG CLINIC 0.000000 91.05 91.05 91.06 09106 OP ANTICOAGULATION CLINIC 0 0 3, 226, 043 0.000000 91.06 09107 ST VINCENT OUTPATIENT TREATMENT 0 0.000000 91.07 91.07 C 3, 785, 623 91.08 04040 FAMILY PRACTICE C 0.000000 91.08 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 0 45, 560, 372 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 98.00 09853 GERIATRIC CLINIC 0 0.000000 98.00 98. 01 09851 ELECTROCONVULSI VE THERAPY 0 0 0 10, 148 0.000000 98.01 0 98. 02 09852 DI ABETES EDUCATION 0.000000 98.02 0 3, 000, 280 3, 053, 187, 378 200.00 Total (lines 50 through 199) 3, 000, 280 200. 00

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From 07/01/2018 THROUGH COSTS Part IV 06/30/2019 Date/Time Prepared: 11/25/2019 6:15 pm Title XIX Hospi tal Cost Outpati ent Cost Center Description Outpati ent Inpatient I npati ent Outpati ent Program Ratio of Cost Program Program Program Pass-Through to Charges Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. 8 x col . 12) 13.00 7) x col. 10) 9.00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000002 13, 744, 089 50.00 27 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0.000000 1,624,821 C 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.002068 1, 243, 139 54.00 54.00 2, 571 0 05402 AMBULATORY CARDIOVASCULAR SVC 0.000000 362, 708 54.01 54.01 0 05403 ULTRASOUND 0.002069 54.02 878, 247 54.02 1,817 0 54.03 05404 ECHOCARDI OLOGY 0.000000 113, 213 0 54.03 54.04 05401 ONCOLOGY 0.000000 175, 684 C 0 54.04 57.00 05700 CT SCAN 0.002069 0 57.00 875, 321 1 811 05800 MRI 58.00 0.002069 281, 205 582 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 2, 245, 400 0 59.00 05901 CARDI AC REHAB 59.01 0.000000 18, 722 0 0 59.01 06000 LABORATORY 0.000000 60.00 60 00 13, 141, 409 0 0 65.00 06500 RESPIRATORY THERAPY 0.000000 5, 641, 052 0 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 776, 086 0 0 66.00 06700 OCCUPATIONAL THERAPY 389, 598 0 67 00 0.000000 0 67 00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 173, 486 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 601, 253 0 0 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 260, 254 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 71 00 0.000000 2, 759, 312 Ω 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 2, 930, 415 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.002674 11, 848, 467 0 73.00 31, 683 0 74.00 07400 RENAL DIALYSIS 0.000000 1, 331, 395 0 0 74.00 03330 ENDOSCOPY 0.000000 534, 231 0 75.00 75.00 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 0 0 90.00 09000 CLI NI C 0 09001 PARTIAL HOSPITALIZATION 0.000000 0 0 0 0 0 0 0 0 0 90. 01 90.01 0 0 91.00 09100 EMERGENCY 0.006630 4, 261, 282 28, 252 91.00 0 91.01 09101 WOUND CARE 002 0.000000 59, 011 0 91.01 0 09102 WOUND CARE 001 0.000000 91.02 91.02 144, 682 0 0 09103 LAFAYETTE RD CLINIC 91.03 0.000000 0 0 91.03 09104 ZIONSVILLE CLINIC 0 91.04 91.04 0.000000 1, 529 0 09105 BROWNSBURG CLINIC 0.000000 0 91.05 91.05 09106 OP ANTICOAGULATION CLINIC 0 91.06 0.000000 66 0 91.06 09107 ST VINCENT OUTPATIENT TREATMENT 0 0 91.07 91.07 0.000000 0 C 04040 FAMILY PRACTICE 91.08 0.000000 0 91.08 92.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 0.000000 809, 135 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 98.00 09853 GERIATRIC CLINIC 0.000000 0 0 0 98.00 09851 ELECTROCONVULSI VE THERAPY 0.000000 0 0 0 98.01 98. 02 | 09852 | DI ABETES EDUCATION 0.000000 98.02 0 Ol 200.00 Total (lines 50 through 199) 67, 225, 212 66, 743 0 200.00

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Health Financial Systems	SI. VINCENI HO	SPITAL & HCC		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH	I SERVICES AND VACCINE COST	Provi der C		Period: From 07/01/2018 To 06/30/2019	Date/Time Pre	pared:
		Ti +I	e XIX	Hospi tal	11/25/2019 6: Cost	тэ рш
		11 (1	Charges	110Spi tai	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
cost center bescriptron	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
	Part I, col. 9		Subject To	Subject To		
	rait i, coi. 9		Ded. & Coins.	,		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	0. 098895	0	8, 015, 84	1 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM					0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 179788	l o			0	
54. 01 05402 AMBULATORY CARDI OVASCULAR			1		0	
54. 02 05403 ULTRASOUND	0. 174824		1		0	
the state of the s					0	
	0. 081962	0	1,			
54. 04 05401 ONCOLOGY	0. 169269				0	
57. 00 05700 CT SCAN	0. 076161	0			0	
58. 00 05800 MRI	0. 214809	0	1, ==		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 049446		., ,		0	
59. 01 05901 CARDI AC REHAB	0. 378738	l .			0	
60. 00 06000 LABORATORY	0. 089072	0	3, 046, 95	7 0	0	
65. 00 06500 RESPIRATORY THERAPY	0. 272402	0	104, 64	9 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 409643	0	1, 036, 16	5 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 193680	0	11, 49	6 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 256553	0	75, 76	9 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 147226	l 0	131, 88		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 431642	0			0	
71. 00 07100 MEDICAL SUPPLIES CHARGED	l l	Ö	1		0	
72. 00 07200 IMPL. DEV. CHARGED TO PATI		Ö	1		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 250473		1		0	
74. 00 07400 RENAL DIALYSIS	0. 342125		1		0	
75. 00 03330 ENDOSCOPY	0. 110749		1			
OUTPATIENT SERVICE COST CENTERS	0. 110747		1 303, 77	<u> </u>		73.00
90. 00 09000 CLINIC	0. 709603	0	3, 97	2 0	0	90.00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	0. 237318		-,	0 0	0	
91. 00 09100 EMERGENCY	0. 237318			-	0	
91. 01 09101 WOUND CARE 002	l				0	
	0. 154045		1 011,07		0	
	0. 342389		7 0, 1,			
91. 03 09103 LAFAYETTE RD CLINIC	0. 000000			0 0	0	
91. 04 09104 ZI ONSVI LLE CLINI C	0. 313258	0	26, 98	0	0	
91. 05 09105 BROWNSBURG CLINIC	0. 000000	l .	1	이	0	
91.06 09106 OP ANTI COAGULATION CLINIC	0. 293375	0	20,0.		0	
91. 07 09107 ST VINCENT OUTPATIENT TREA	l	0	6, 79	3 0	0	
91.08 04040 FAMILY PRACTICE	0. 000000	0		0 0	0	91. 08
92. 00 09200 OBSERVATION BEDS (NON-DIST	FI NCT 0. 381649	0	1, 454, 60	5 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 000000	0		0		95. 00
98.00 09853 GERIATRIC CLINIC	0. 000000	0		o o	0	98. 00
98. 01 09851 ELECTROCONVULSI VE THERAPY	0. 000000			o o	0	98. 01
98. 02 09852 DIABETES EDUCATION	0. 000000			o o	0	98. 02
200.00 Subtotal (see instructions		0	32, 572, 02	8 0		200.00
201.00 Less PBP Clinic Lab. Servi				ام ما	_	201. 00
Only Charges	3 -					
202.00 Net Charges (line 200 - li	ne 201)	0	32, 572, 02	8 0	0	202. 00

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From 07/01/2018 Part V 06/30/2019 Date/Time Prepared: 11/25/2019 6:15 pm Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 792, 727 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 24, 261 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 253, 554 05402 AMBULATORY CARDI OVASCULAR SVC 54.01 41, 573 0 54.01 54. 02 05403 ULTRASOUND 30, 646 0 54.02 54.03 05404 ECHOCARDI OLOGY 8.160 0 54.03 05401 ONCOLOGY 308, 122 0 54.04 54.04 57. 00 05700 CT SCAN 41, 318 0 57.00 05800 MRI 0 58.00 38,071 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59 00 51, 840 59 00 59.01 05901 CARDI AC REHAB 5, 903 0 59.01 60.00 06000 LABORATORY 271, 399 0 60.00 06500 RESPIRATORY THERAPY 28, 507 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 424, 458 66.00 67.00 06700 OCCUPATIONAL THERAPY 2, 227 0 67.00 06800 SPEECH PATHOLOGY 19, 439 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 19, 416 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 262, 557 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 384, 969 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 677, 684 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 601.114 0 73.00 07400 RENAL DIALYSIS 50, 204 74.00 0 74 00 03330 ENDOSCOPY 75.00 33,667 0 75.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 2,819 09001 PARTI AL HOSPI TALI ZATI ON 90. 01 0 90.01 1, 247, 126 09100 EMERGENCY 91.00 91.00 0 09101 WOUND CARE 002 0 91.01 48, 477 91.01 09102 WOUND CARE 001 91.02 0 91.02 2,798 0 91.03 09103 LAFAYETTE RD CLINIC 91.03 09104 ZIONSVILLE CLINIC 0 91. 04 8, 454 91.04 09105 BROWNSBURG CLINIC 0 91.05 91.05 Ω 09106 OP ANTICOAGULATION CLINIC 0 91.06 7.338 91.06 91.07 09107 ST VINCENT OUTPATIENT TREATMENT 1,749 0 91.07 91. 08 04040 FAMILY PRACTICE 0 91.08 09200 OBSERVATION BEDS (NON-DISTINCT 555, 149 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 09853 GERIATRIC CLINIC 0 0 98.00 98.00 09851 ELECTROCONVULSIVE THERAPY 98.01 98.01 0 0 98.02 09852 DIABETES EDUCATION 0 98.02 200.00 Subtotal (see instructions) 6, 245, 726 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201 00 Only Charges

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6, 245, 726

0

202.00

202.00

Net Charges (line 200 - line 201)

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		Ti tl	e XIX	Subprovi der -	Cost	15 piii
Cost Center Description	Non Physician	Nursing School	Nursi na School	IPF Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	(0	1, 373	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	188, 721	54. 00
54. 01 05402 AMBULATORY CARDI OVASCULAR SVC	0	0	(0	0	54. 01
54. 02 05403 ULTRASOUND	0	0	9	0	54, 941	54. 02
54. 03 05404 ECHOCARDI OLOGY	0	0	9	0	0	54. 03
54. 04 05401 0NCOLOGY	0	0		0	0	54. 04
57. 00 05700 CT SCAN	0	0		0	92, 809	57. 00
58. 00 05800 MRI		0		0	29, 305	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 59. 01 05901 CARDI AC REHAB		0	(0	0	59. 00 59. 01
60. 00 06000 LABORATORY		0			0	60.00
65. 00 06500 RESPI RATORY THERAPY		0			0	65. 00
66. 00 06600 PHYSI CAL THERAPY		0			0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0			0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0			0	68. 00
69. 00 06900 SELECT FATHOLOGY					0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0			0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT		0			0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0			0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0			1, 149, 863	73. 00
74. 00 07400 RENAL DI ALYSI S		0		0	0	74. 00
75. 00 03330 ENDOSCOPY	0	Ö		o o	Ö	75. 00
OUTPATIENT SERVICE COST CENTERS				,		
90. 00 09000 CLI NI C	0	0	(0	0	90. 00
90. 01 09001 PARTIAL HOSPITALIZATION	0	0	(0	0	90. 01
91. 00 09100 EMERGENCY	0	0	(0	1, 483, 268	91.00
91. 01 09101 WOUND CARE 002	0	0	(0	0	91. 01
91.02 09102 WOUND CARE 001	0	0	(0	0	91. 02
91.03 09103 LAFAYETTE RD CLINIC	0	0	(0	0	91. 03
91. 04 09104 ZI ONSVI LLE CLI NI C	0	0	(0	0	91. 04
91. 05 09105 BROWNSBURG CLINIC	0	0	(0	0	91. 05
91.06 O9106 OP ANTI COAGULATION CLINIC	0	0	(0	0	91. 06
91.07 09107 ST VINCENT OUTPATIENT TREATMENT	0	0	(0	0	91. 07
91. 08 04040 FAMILY PRACTICE	0	0	(0	0	91. 08
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0		()	0	92. 00
OTHER REIMBURSABLE COST CENTERS		I	1			
95. 00 09500 AMBULANCE SERVI CES		_				95. 00
98. 00 09853 GERIATRIC CLINIC	0	0	(0	0	98. 00
98. 01 09851 ELECTROCONVULSI VE THERAPY]	d o	0	98. 01
98. 02 09852 DI ABETES EDUCATION					-	98. 02
200.00 Total (lines 50 through 199)	1	0	l (0	3, 000, 280	200. UU

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Heal th	Financial Systems	ST. VINCENT HO	NOT B LATIGN		Inlie	u of Form CMS-2	2552_10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CN: 15-0084	Peri od:	Worksheet D	2002 10
	GH COSTS	WIGE OTHER TAG	J TTOVI dei 0		From 07/01/2018	Part IV	
11111000	W 00010		Component	CCN: 15-S084	To 06/30/2019	Date/Time Pre	
						11/25/2019 6:	15 pm
			Ti tl	e XIX	Subprovi der -	Cost	
					I PF		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
		4.00	5.00	and 4) 6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00	05000 OPERATING ROOM	0	1, 373	1, 37	3 703, 873, 618	0. 000002	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 3/3	1	0 66, 000, 687	0. 000002	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	188, 721	1		0. 002068	1
54. 00	05400 RADI OLOGI - DI AGNOSTI C	0	100, 721	1		0.002088	
	1 1	0	E4 041		0 47, 159, 362		
54. 02	05403 ULTRASOUND	0	54, 941	1		0.002069	
54. 03	05404 ECHOCARDI OLOGY	0	0	1	0 31, 299, 569	0.000000	1
54. 04	05401 ONCOLOGY	0	0		0 86, 992, 872	0.000000	
57. 00	05700 CT SCAN	0	92, 809			0. 002069	
58. 00	05800 MRI	0	29, 305	1		0. 002069	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 205, 724, 757	0.000000	
59. 01	05901 CARDI AC REHAB	0	0		0 3, 755, 202	0. 000000	
60. 00	06000 LABORATORY	0	0		0 377, 885, 704	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0		0 80, 118, 621	0. 000000	1
66. 00	06600 PHYSI CAL THERAPY	0	0		0 37, 875, 823	0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 8, 947, 957	0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	0	0	1	0 6, 466, 048	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 29, 257, 088	0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0 20, 942, 629	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	l .	0 172, 421, 436	0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 170, 692, 919	0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 149, 863	1, 149, 86	3 429, 946, 501	0. 002674	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 20, 357, 504	0. 000000	74. 00
75. 00	03330 ENDOSCOPY	0	C		0 50, 724, 200	0. 000000	75. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0			0 11, 980, 025	0. 000000	
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0	0)	0 15, 378, 778	0. 000000	90. 01
91. 00	09100 EMERGENCY	0	1, 483, 268	1, 483, 26	8 223, 713, 364	0. 006630	91.00
91. 01	09101 WOUND CARE 002	0	0	1	0 16, 983, 023	0.000000	91. 01
91. 02	09102 WOUND CARE 001	0	0		0 2, 433, 359	0.000000	91. 02
91. 03	09103 LAFAYETTE RD CLINIC	0	0)	0 0	0.000000	91. 03
91.04	09104 ZI ONSVI LLE CLI NI C	0	0)	0 2, 861, 120	0.000000	91. 04
91.05	09105 BROWNSBURG CLINIC	0	0)	0	0.000000	91.05
91.06	09106 OP ANTICOAGULATION CLINIC	0	0)	0 3, 226, 043	0.000000	91.06
91.07	09107 ST VINCENT OUTPATIENT TREATMENT	0	0	1	0 3, 785, 623	0.000000	91. 07
91.08	04040 FAMILY PRACTICE	0	0	1	o o	0.000000	91. 08
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0)	0 45, 560, 372	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
98.00	09853 GERIATRIC CLINIC	0	0		0	0. 000000	98. 00
98. 01	09851 ELECTROCONVULSI VE THERAPY	0	0		0 10, 148	0. 000000	98. 01
98. 02	09852 DI ABETES EDUCATION	0	0		0 0	0. 000000	98. 02
200.00	Total (lines 50 through 199)	0	3, 000, 280	3, 000, 28	0 3, 053, 187, 378		200. 00

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Hoal th	Financial Systems	ST. VINCENT HOS	DITAL & HCC		Inlie	eu of Form CMS-	2552_10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provi der C	CN: 15_0084	Peri od:	Worksheet D	2332-10
	GH COSTS	KVI CE OTHEK TASS	Trovider o	CIV. 15 0004	From 07/01/2018 Part IV		
11111001	317 00010		Component	CCN: 15-S084	To 06/30/2019 Date/Time P		pared:
			Ti tI	e XIX	11/25/2019 Subprovi der - Cost		15 piii
_					I PF		
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col . 6 ÷ col .		Costs (col.	8	Costs (col. 9	
		7)	10. 00	x col . 10) 11.00	12. 00	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00	05000 OPERATING ROOM	0. 000002	0	1	0 0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000002	0	1	0 0		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 002068	0	1	0 0		
54. 01	05402 AMBULATORY CARDI OVASCULAR SVC	0. 000000	696	1	0 0	ĺ	
54. 02	05403 ULTRASOUND	0. 002069	0		0 0	ĺ	
54. 03	05404 ECHOCARDI OLOGY	0. 000000	0	1	0 0	l ő	1
54. 04	05401 ONCOLOGY	0. 000000	0	1	0 0	0	1
57. 00	05700 CT SCAN	0. 002069	0		0 0	ĺ	
58. 00	05800 MRI	0. 002069	0		0 0	l ő	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	ĺ	1
59. 01	05901 CARDI AC REHAB	0. 000000	0	1	0 0	Ö	
60.00	06000 LABORATORY	0. 000000	69, 603	1	0 0	Ö	
65. 00	06500 RESPI RATORY THERAPY	0. 000000	07, 003	i	0 0	0	1
66. 00	06600 PHYSI CAL THERAPY	0. 000000	3, 549	1	0 0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	3, 347	I	0 0	l ő	1
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	1
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	ĺ	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	774	l .	0 0	ĺ	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000	,,,	1	0 0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 002674	81, 754	1	19 0	l ő	
74.00	07400 RENAL DIALYSIS	0. 000000	01, 754	1	0 0	l ő	
75. 00	03330 ENDOSCOPY	0. 000000	0	1	0 0		
75.00	OUTPATIENT SERVICE COST CENTERS	0.000000		1	0 0		75.00
90. 00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0. 000000	30, 534		0 0		
91. 00	09100 EMERGENCY	0. 006630	0	1	0 0	0	
91. 01	09101 WOUND CARE 002	0. 000000	0	1	0 0	Ö	
91. 02	09102 WOUND CARE 001	0. 000000	0	1	0 0	0	
91. 03	09103 LAFAYETTE RD CLINIC	0. 000000	0	1	0 0	Ö	1
91. 04	09104 ZI ONSVI LLE CLI NI C	0. 000000	0	1	0 0	0	1
91. 05	09105 BROWNSBURG CLINIC	0. 000000	0		0 0	0	1
91. 06	09106 OP ANTI COAGULATION CLINIC	0. 000000	0		0 0	o o	1
91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	0. 000000	0	1	0 0	o o	
91. 08	04040 FAMILY PRACTICE	0. 000000	0	1	0 0		1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000	0	1	0 0		1
00	OTHER REIMBURSABLE COST CENTERS			1	-, 0		1 00
95. 00	09500 AMBULANCE SERVI CES						95. 00
98. 00	09853 GERIATRIC CLINIC	0. 000000	0		0 0	0	
98. 01	09851 ELECTROCONVULSI VE THERAPY	0. 000000	0	1	0 0		1
98. 02	1	0. 000000	0		0 0	Ō	1
200.00	Total (lines 50 through 199)		186, 910	2	19 0	0	200. 00

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			Ti tl	e XIX	Subprovi der - I RF	Cost	•
Cost Center [Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE	COST CENTERS	•					
50.00 05000 OPERATING ROO	DM	C	0	(0	1, 373	50.00
52.00 05200 DELIVERY ROOM	1 & LABOR ROOM	C	0	(0	0	52.00
54. 00 05400 RADI OLOGY-DI A	AGNOSTI C	C	0	(0	188, 721	54.00
54. 01 05402 AMBULATORY CA	ARDI OVASCULAR SVC	C	0	(0	0	54. 01
54. 02 05403 ULTRASOUND		C	0	(0	54, 941	54. 02
54. 03 05404 ECHOCARDI OLO	GY	C	0	(0	0	54. 03
54. 04 05401 ONCOLOGY		C	0	(0	0	54. 04
57.00 05700 CT SCAN		C	0	(0	92, 809	57. 00
58. 00 05800 MRI		C	0) c	0	29, 305	58. 00
59. 00 05900 CARDI AC CATH		C	0) c	0	0	59. 00
59. 01 05901 CARDI AC REHA	3	C	0	(0	0	59. 01
60. 00 06000 LABORATORY		C	0	(0	0	60.00
65. 00 06500 RESPI RATORY		C	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THEF		C	0	(0	0	66. 00
67. 00 06700 OCCUPATI ONAL	THERAPY	C	0	(0	0	67. 00
68. 00 06800 SPEECH PATHOL		C	0	(0	0	68. 00
69. 00 06900 ELECTROCARDI (DLOGY	C	0	(0	0	69. 00
70. 00 07000 ELECTROENCEPI		C	0	(0	0	70. 00
71. 00 07100 MEDI CAL SUPPI	LIES CHARGED TO PAT	C	0	(0	0	71. 00
72. 00 07200 I MPL. DEV. CH		C	0	(0	0	72. 00
73. 00 07300 DRUGS CHARGEI		C	0	(0	1, 149, 863	73. 00
74. 00 07400 RENAL DI ALYSI	S	C	1	(,	0	74. 00
75. 00 03330 ENDOSCOPY		C	0	(0	0	75. 00
OUTPATIENT SERVICE	COST CENTERS	_	_	1			
90. 00 09000 CLI NI C		C	_	1	-	0	90. 00
90. 01 09001 PARTI AL HOSPI	TALI ZATI ON	C	0		0	0	90. 01
91. 00 09100 EMERGENCY					0	1, 483, 268	91.00
91. 01 09101 WOUND CARE OF					0	0	91. 01
91. 02 09102 WOUND CARE OF					0	0	91. 02
91. 03 09103 LAFAYETTE RD					0	0	91. 03
91. 04 09104 ZI ONSVI LLE CI					0	0	91.04
91. 05 09105 BROWNSBURG CI						0	91.05
91. 06 09106 OP ANTI COAGUI						0	91.06
	JTPATIENT TREATMENT				0	0	91. 07 91. 08
91. 08 04040 FAMI LY PRACTI		C			-	0	
92. 00 09200 OBSERVATI ON E OTHER REI MBURSABLE			<u>'</u>	1	<i>γ</i>	0	92. 00
95. 00 09500 AMBULANCE SER				1			95. 00
98. 00 09500 AMBULANCE SEF						0	98.00
98. 00 09853 GERTATRI C CLI						0	ł
98. 02 09851 ELECTROCONVOI						0	98. 01 98. 02
1 1	50 through 199)					_	
200.00 10tai (111165	Jo tili bugli 177)	1	'	ı C	ή υ	3,000,200	₁ 200.00

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Heal th	Financial Systems	ST. VINCENT HO	NOT B LATIGN		Inlie	u of Form CMS-2	2552_10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CN: 15-0084	Peri od:	Worksheet D	2002 10
	GH COSTS	WIGE OTHER TAG	J TTOVI dei 0		From 07/01/2018	Part IV	
11111001	W 00010		Component	CCN: 15-T084	To 06/30/2019	Date/Time Pre	
						11/25/2019 6:	15 pm
			Titl	e XIX	Subprovi der -	Cost	
		1 11 011	T	T	I RF	D 11 C 0 1	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3, and 4)	8)	7)	
		4.00	5.00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00	05000 OPERATING ROOM	0	1, 373	1, 37	3 703, 873, 618	0. 000002	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1,375	1	0 66, 000, 687	0. 000002	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		188, 721	1		0. 002068	1
54. 00	05402 AMBULATORY CARDI OVASCULAR SVC		100, 721	1	0 47, 159, 362	0.002008	
54. 01	05403 ULTRASOUND		54, 941			0. 000000	
54. 02	05404 ECHOCARDI OLOGY		34, 941	1	0 31, 299, 569	0.002009	
54. 04	05401 ONCOLOGY	0		1	0 86, 992, 872	0.000000	1
57. 00	05700 CT SCAN		92, 809			0.00000	
58. 00	05800 MRI		29, 305			0.002069	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	27, 303	1	0 205, 724, 757	0.002007	
59. 01	05901 CARDI AC REHAB	0		1	0 3, 755, 202	0.000000	
60.00	06000 LABORATORY	0			0 377, 885, 704	0.000000	
65. 00	06500 RESPIRATORY THERAPY	0			0 80, 118, 621	0.000000	
66. 00	06600 PHYSI CAL THERAPY	0			0 37, 875, 823	0.000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	0			0 8, 947, 957	0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	0			0 6, 466, 048	0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	0		1	0 29, 257, 088	0.000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0			0 20, 942, 629	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0		1	0 172, 421, 436	0. 000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		l .	0 170, 692, 919	0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 149, 863	1		0. 002674	
74. 00	07400 RENAL DIALYSIS	0	1, 147, 003	1	0 20, 357, 504	0.002074	
75. 00	03330 ENDOSCOPY	0	Ö		0 50, 724, 200	0. 000000	
73.00	OUTPATIENT SERVICE COST CENTERS			1	0 30, 724, 200	0.000000	73.00
90. 00	09000 CLINI C	0	С		0 11, 980, 025	0. 000000	90. 00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0			0 15, 378, 778	0. 000000	
91. 00	09100 EMERGENCY	0	1, 483, 268			0. 006630	
91. 01	09101 WOUND CARE 002	0	1, 100, 200	1	0 16, 983, 023	0. 000000	
91. 02	09102 WOUND CARE 001	0			0 2, 433, 359	0. 000000	1
91. 03	09103 LAFAYETTE RD CLINIC	0		1	0 2, 100, 00,	0. 000000	
91. 04	09104 ZI ONSVI LLE CLINI C	0		1	0 2, 861, 120	0. 000000	
91. 05	09105 BROWNSBURG CLINIC	0			0 2,001,120	0. 000000	
91. 06	09106 OP ANTI COAGULATION CLINIC	0			0 3, 226, 043	0. 000000	
91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	0		1	0 3, 785, 623	0. 000000	
91. 08	04040 FAMILY PRACTICE	0			0 0,755,525	0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	0	-	1	0 45, 560, 372	0. 000000	
, 2. 50	OTHER REIMBURSABLE COST CENTERS			1	-, .5,555,672	3. 333000	1
95. 00	09500 AMBULANCE SERVICES						95. 00
98. 00	09853 GERIATRIC CLINIC	0		,	o o	0. 000000	
98. 01	09851 ELECTROCONVULSI VE THERAPY	0			0 10, 148	0. 000000	
98. 02	09852 DI ABETES EDUCATION	0	C		0 0	0.000000	
200.00	i i	0	3, 000, 280	3, 000, 28	0 3, 053, 187, 378		200. 00
	•	•	•	•	•	•	

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Hoal th	Financial Systems	ST. VINCENT HOSE	DITAL & HCC		In lie	eu of Form CMS-	2552_10
	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provi der Co	CN: 15-0084	Peri od:	Worksheet D	2332-10
	GH COSTS	WIGE OTHER TAGS	Trovider of	014: 10 0001	From 07/01/2018		
	3.1. 30010		Component	CCN: 15-T084	To 06/30/2019	Date/Time Pre	
			T' 11	VI V	6.1	11/25/2019 6:	15 pm
			liti	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	cost center bescription	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through	
		(col . 6 ÷ col .	onal ges	Costs (col.		Costs (col. 9	
		7)		x col. 10)		x col . 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS	<u> </u>		•	_		
50.00	05000 OPERATING ROOM	0. 000002	23		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	1	0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 002068	29	1	0 0	0	54.00
54. 01	05402 AMBULATORY CARDIOVASCULAR SVC	0. 000000	0	1	0 0	0	54. 01
54. 02	05403 ULTRASOUND	0. 002069	0	1	0 0	0	54. 02
54. 03	05404 ECHOCARDI OLOGY	0. 000000	0	1	0 0	0	54. 03
54.04	05401 ONCOLOGY	0. 000000	0)	0 0	0	54. 04
57.00	05700 CT SCAN	0. 002069	0	1	0 0	0	57. 00
58.00	05800 MRI	0. 002069	0	1	0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	1	0 0	0	59. 00
59. 01	05901 CARDI AC REHAB	0. 000000	0)	0 0	0	59. 01
60.00	06000 LABORATORY	0. 000000	514		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	26	,	0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	2, 839		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0)	0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0)	0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	4		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	6		0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000	0)	0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0)	0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 002674	365		1 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0)	0 0	0	74. 00
75.00	03330 ENDOSCOPY	0. 000000	0)	0 0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0. 000000	0)	0 0	0	90. 01
91.00	09100 EMERGENCY	0. 006630	0)	0 0	0	91.00
91. 01	09101 WOUND CARE 002	0. 000000	0)	0 0	0	91. 01
91. 02	09102 WOUND CARE 001	0. 000000	0)	0 0	0	91. 02
91. 03	09103 LAFAYETTE RD CLINIC	0. 000000	0)	0 0	0	91. 03
91. 04	09104 ZIONSVILLE CLINIC	0. 000000	0		0 0	0	91. 04
91. 05	09105 BROWNSBURG CLINIC	0. 000000	0		0 0	0	91. 05
91. 06	09106 OP ANTICOAGULATION CLINIC	0. 000000	0		0 0	0	91. 06
91. 07	09107 ST VINCENT OUTPATIENT TREATMENT	0. 000000	0	1	0 0	0	91. 07
91. 08	04040 FAMILY PRACTICE	0. 000000	0	1	0 0	0	91. 08
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000	0		0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES						95. 00
98. 00	09853 GERIATRIC CLINIC	0. 000000	0		0 0	0	
98. 01	09851 ELECTROCONVULSI VE THERAPY	0. 000000	0	l .	0 0	0	
98. 02	09852 DI ABETES EDUCATION	0. 000000	0		0 0	0	
200.00	Total (lines 50 through 199)		3, 806	1	1 0	0	200. 00

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Heal th	Financial Systems ST. VINCENT HOSPI	TAL & HCC	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0084	Peri od:	Worksheet D-1	
			From 07/01/2018 To 06/30/2019	Date/Time Pre	narod:
			10 00/30/2019	11/25/2019 6:	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
	DADT I ALL DROWLDED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days	s. excludina newborn)		136, 492	1.00
2.00	Inpatient days (including private room days, excluding swing-k			136, 492	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4 00	do not complete this line.	- d - d \		110 770	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	119, 778 0	4. 00 5. 00
3.00	reporting period	om days) thi odgir becembe	i 31 of the cost	ا	3.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	m davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)			- 1	
9. 00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	43, 714	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including privato r	oom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruct		uoiii uays)	ا ا	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	,	oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period	Conly (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	Conty (including privat	e room days)	0	13. 00
.0.00	after December 31 of the cost reporting period (if calendar ye			1	10.00
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period	9			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	0.00	19. 00
17.00	reporting period	s through becember 31 or	the cost	0.00	1 7. 00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00
04.00	reporting period	`		444 007 007	04.00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	141, 996, 937 0	21. 00 22. 00
22.00	5 x line 17)	si 31 of the cost report	ing period (ine	ا	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
04.00	x line 18)	04 6 11			04.00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	1 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)	(line 21 minus lins 24)		141 004 027	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE 21 MINUS TINE 26)		141, 996, 937	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		<i>3</i> ,	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0.000000	1
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	1
34. 00	Average per diem private room charge differential (line 32 mir	0.00	1		
35. 00	Average per diem private room cost differential (line 34 x lin		ŕ	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	141, 996, 937	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 040. 33	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		45, 476, 986	1
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (line 30)	•		0 45 476 986	40.00
41.00	Total Program general inpatient routine service cost (line 39	T IIIC 40)		45, 476, 986	1 41.00

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Health Financial Systems		ST. VINCENT HO	SPITAL & HCC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERAT	ING COST		Provider CC		eriod: rom 07/01/2018	Worksheet D-1	
				Ť		Date/Time Pre	
			Title	XVIII	Hospi tal	11/25/2019 6: PPS	15 pm
Cost Center Descri	oti on	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42.00 NURSERY (title V & XIX o		0	0	0.00	0	0	42. 00
Intensive Care Type Inpa 43.00 INTENSIVE CARE UNIT	tient Hospital Units	30, 596, 382	17, 782	1, 720. 64	4 401	11, 168, 674	43. 00
44. 00 CORONARY CARE UNIT		30, 590, 362	17, 782	0.00	6, 491 0	11, 100, 074	44.00
44. 01 CARDI OTHORACI C VASCULAR	TRANSPL	21, 579, 000	8, 200	2, 631. 59	3, 054	8, 036, 876	
45. 00 BURN INTENSIVE CARE UNIT		7 120 400	0	0.00	0	0	45. 00
45. 01 PEDIATRIC INTENSIVE CARE 46. 00 SURGICAL INTENSIVE CARE		7, 120, 488 0	2, 702 0	2, 635. 27 0. 00	10 0	26, 353 0	45. 01 46. 00
46. 01 NEONATAL INTENSIVE CARE		31, 922, 702	28, 663	1, 113. 73	0	0	46. 01
47. 00 OTHER SPECIAL CARE (SPEC							47. 00
Cost Center Descrip	THOM					1. 00	
48.00 Program inpatient ancill						97, 987, 233	48. 00
49.00 Total Program inpatient PASS THROUGH COST ADJUST		41 through 48)(see instruction	ns)		162, 696, 122	49. 00
50.00 Pass through costs appli		atient routine	services (from	Wkst. D, sum	of Parts I and	4, 267, 165	50.00
[11]						, , , , , ,	
51.00 Pass through costs appliand IV)	cable to Program inpa	atient ancillar	y services (fro	om Wkst. D, sui	m of Parts II	6, 977, 691	51.00
52.00 Total Program excludable						11, 244, 856	52. 00
53.00 Total Program inpatient			lated, non-phys	sician anesthe	tist, and	151, 451, 266	53. 00
medical education costs TARGET AMOUNT AND LIMIT		02)					
54.00 Program discharges						0	
55.00 Target amount per discha 56.00 Target amount (line 54 x						0.00	55. 00 56. 00
57. 00 Di fference between adjus		ng cost and ta	rget amount (li	ne 56 minus I	ne 53)	0	57.00
58.00 Bonus payment (see instr						0 0. 00	58. 00 59. 00
59.00 Lesser of lines 53/54 or market basket							
60.00 Lesser of lines 53/54 or						0.00	60. 00
61.00 If line 53/54 is less th						0	61. 00
which operating costs (I amount (line 56), otherw			s (Tines 54 x 6	50), OF 1% OF	the target		
62.00 Relief payment (see inst	ructions)	•				0	
63.00 Allowable Inpatient cost PROGRAM INPATIENT ROUTIN		ent (see instru	ctions)			0	63. 00
64.00 Medicare swing-bed SNF i		ts through Dece	mber 31 of the	cost reportin	g period (See	0	64. 00
instructions)(title XVII			04 6 11				/F 00
65.00 Medicare swing-bed SNF i instructions) (title XVII		ts after Decemb	er 31 of the co	ost reporting	period (See	0	65. 00
66.00 Total Medicare swing-bed	3 -	ne costs (line	64 plus line 65	5)(title XVIII	only). For	0	66. 00
CAH (see instructions) 67.00 Title V or XIX swing-bed	NE inpationt routing	o costs through	Docombor 21 of	f the cost ron	arting pariod	0	67. 00
(line 12 x line 19)	ni inpatrent routine	e costs till ough	becember 31 of	the cost rep	or tring period	O	07.00
68.00 Title V or XIX swing-bed	NF inpatient routine	e costs after D	ecember 31 of t	the cost repor	ting period	0	68. 00
(line 13 x line 20) 69.00 Total title V or XIX swi	ng-bed NF inpatient i	routine costs (line 67 + line	68)		0	69. 00
PART III - SKILLED NURSI							
70.00 Skilled nursing facility 71.00 Adjusted general inpatie							70. 00 71. 00
72.00 Program routine service			70 . 11116 2	-/			72.00
73.00 Medically necessary priv	• • • • • • • • • • • • • • • • • • • •			ne 35)			73.00
74.00 Total Program general in 75.00 Capital-related cost all	•	,		orksheet B Pa	rt II column		74. 00 75. 00
26, line 45)	odatod to impationi	041110 0011100	00010 (110 110	5. No.1001 B, Ta	C 117 GGT GIIII.		70.00
76.00 Per diem capital-related	•						76. 00 77. 00
78.00 Inpatient routine service	* .						78.00
79.00 Aggregate charges to ben	eficiaries for excess	s costs (from p		*.			79. 00
80.00 Total Program routine se 81.00 Inpatient routine service	•		ost limitation	(line 78 minus	s line 79)		80. 00 81. 00
82.00 Inpatient routine service	•)				82.00
83.00 Reasonable inpatient rou	tine service costs (see instruction	* .				83. 00
84.00 Program inpatient ancill 85.00 Utilization review - phy	•		ns)				84. 00 85. 00
86.00 Total Program inpatient	•	•	•				86. 00
PART IV - COMPUTATION OF						44 744	07.00
87.00 Total observation bed da 88.00 Adjusted general inpatie	-		line 2)			16, 714 1, 040. 33	87. 00 88. 00
89.00 Observation bed cost (li	•	•	· · · · - /			17, 388, 076	1

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Health Financial Systems	ST. VINCENT H	IOSPI TAL & HCC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 07/01/2018 To 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	9, 254, 59	6 141, 996, 937	0. 06517	5 17, 388, 076	1, 133, 268	90. 00
91.00 Nursing School cost		0 141, 996, 937	0.00000	0 17, 388, 076	0	91. 00
92.00 Allied health cost	280, 79	3 141, 996, 937	0. 00197	7 17, 388, 076	34, 376	92. 00
93.00 All other Medical Education		0 141, 996, 937	0.00000	0 17, 388, 076	0	93. 00

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	Financial Systems ST. VINCENT HOS ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0084	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-S084	From 07/01/2018 To 06/30/2019	Date/Time Prep 11/25/2019 6:	
		Title XVIII	Subprovi der -	PPS	10 pi
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days)	ave eveluding newborn)		15, 796	1.
00	Inpatient days (including private room days, excluding swing			15, 796	
00	Private room days (excluding swing-bed and observation bed of do not complete this line.	<i>y</i>	rivate room days,	0	
00	Semi-private room days (excluding swing-bed and observation			15, 796	
00	Total swing-bed SNF type inpatient days (including private r reporting period	room days) through Decembe	er 31 of the cost	0	5.
00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	room days) after December	31 of the cost	0	6.
00	Total swing-bed NF type inpatient days (including private re reporting period	oom days) through December	31 of the cost	0	7.
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	31 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (excluding	g swing-bed and	2, 502	9.
00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII		coom days)	0	10.
00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	room days) after	0	11.
00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or)		ce room days)	0	12.
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X			0	13.
00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog			0	14.
00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
00	SWING BED ADJUSTMENT			0	10.
00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through December 31 c	of the cost	0.00	17.
00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces after December 31 of	the cost	0. 00	18.
00	Medicaid rate for swing-bed NF services applicable to service reporting period	ces through December 31 of	the cost	0. 00	19.
00	Medicaid rate for swing-bed NF services applicable to service reporting period	ces after December 31 of t	the cost	0. 00	20.
00	Total general inpatient routine service cost (see instruction	ons)		10, 171, 359	21.
00	Swing-bed cost applicable to SNF type services through Decem 5×1 ine 17)	mber 31 of the cost report	ing period (line	0	22
00	Swing-bed cost applicable to SNF type services after December $x \text{ line } 18$)	er 31 of the cost reportin	ng period (line 6	0	23
00	Swing-bed cost applicable to NF type services through Decemb 7×1 ine 19)	per 31 of the cost reporti	ng period (line	0	24
00	Swing-bed cost applicable to NF type services after December x line 20)	r 31 of the cost reporting	period (line 8	0	25.
00	Total swing-bed cost (see instructions)	. (): 01 : 1: 0()		0	
00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	t (line 21 minus line 26)		10, 171, 359	27
00	General inpatient routine service charges (excluding swing-b	oed and observation bed ch	narges)	0	28
00	Private room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges)	7 . lino 20)		0 000000	
00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	/ - ITHE 28)		0. 000000 0. 00	1
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
	Average per diem private room charge differential (line 32 m		ctions)	0.00	1
00			5115)	0.00	1
00 00	Average per grew birvate room cost differential tribe 34 x i			0.00	36
00 00 00 00	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35)			10, 171, 359	
00 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost		fferential (line	10, 171, 339	
00 00 00 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	t and private room cost di	fferential (line	10, 171, 339	
00 00 00 00 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	t and private room cost di	fferential (line		20
00 00 00 00 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD Adjusted general inpatient routine service cost per diem (se	t and private room cost di DJUSTMENTS ee instructions)	fferential (line	643. 92	1
00 00 00 00 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	t and private room cost di DJUSTMENTS ee instructions) ne 38)	fferential (line		39.

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	Financial Systems	ST. VINCENT HOSE		ON 45 0004		eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST			CN: 15-0084	Peri od: From 07/01/2018		
			Component	CCN: 15-S084	To 06/30/2019	Date/Time Pre 11/25/2019 6:	
			Ti tl e	e XVIII	Subprovi der -	PPS	
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
	Sout contain beact that on	Inpatient Cost Ir				(col. 3 x col.	
		1 00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00				42. 00
	Intensive Care Type Inpatient Hospital Units	-	_			_	
43.00	INTENSIVE CARE UNIT	0	(
44. 00 44. 01	CORONARY CARE UNIT CARDIOTHORACIC VASCULAR TRANSPL	0	(1		1	44. 00 44. 01
45. 00	BURN INTENSIVE CARE UNIT		(1		l	
45. 01	PEDIATRIC INTENSIVE CARE UNIT	0	C	1		0	
46. 00	SURGICAL INTENSIVE CARE UNIT	0	C			0	
46. 01 47. 00	NEONATAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	C	0.	00	0	46. 01 47. 00
171.00	Cost Center Description						171.00
10.00						1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			nns)		363, 211 1, 974, 299	
47.00	PASS THROUGH COST ADJUSTMENTS	41 (111 ough 40) (31	ee mstructro) iii		1, 774, 277	47.00
50.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	n Wkst. D, su	m of Parts I and	106, 335	50. 00
51. 00	III) Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	30, 091	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				136, 426	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital rela	ated, non-phy	ysician anest	netist, and	1, 837, 873	1
E 4 .00	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0.00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					0.00	56.00
57. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	57. 00
58. 00	Bonus payment (see instructions)					0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period e	naing 1996, t	updated and co	ompounded by the	0.00	59. 00
60. 00 61. 00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						60. 00 61. 00
(2.00	amount (line 56), otherwise enter zero (see	instructions)					(2.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	ber 31 of the	e cost report	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the d	cost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	55)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through I	December 31 d	of the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil)		 70. 00
71. 00	Adjusted general inpatient routine service c	-			,		71.00
72. 00	Program routine service cost (line 9 x line	71)		•			72. 00
73. 00 74. 00	Medically necessary private room cost applic	•	•				73.00
75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II. column		74. 00 75. 00
	26, line 45)		•	,	,		
76. 00	Per diem capital related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		ovi der record	ds)			79.00
80.00	Total Program routine service costs for comp		st limitation	n (line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
82.00	Reasonable inpatient routine service cost ilmitation (i)				83.00
84. 00	Program inpatient ancillary services (see in		-				84. 00
85.00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)				86. 00
87. 00	Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per	•	line 2)			0.00	
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				1 0	89.00

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Health Financial Systems	ST. VINCENT HO	SPITAL & HCC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-S084	From 07/01/2018 To 06/30/2019		
		Title	XVIII	Subprovi der - I PF	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	587, 502	10, 171, 359	0. 0577 <i>6</i>	0 0	0	90.00
91.00 Nursing School cost	0	10, 171, 359	0. 00000	0 0	0	91.00
92.00 Allied health cost	83, 909	10, 171, 359	0. 00825	0	0	92.00
93.00 All other Medical Education	0	10, 171, 359	0. 00000	0 0	0	93.00

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OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0084	Peri od:	Worksheet D-1	
		Component CCN: 15-T084	From 07/01/2018 To 06/30/2019		
		Title XVIII	Subprovider -	11/25/2019 6: PPS	15 pn
	Cost Center Description		I RF		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				1
. 00	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing			1, 264	1
. 00 . 00	Private room days (excluding private room days, excluding swing Private room days (excluding swing-bed and observation bed d		ivate room days	1, 264 0	1
. 00	do not complete this line.	ays). It you have omly pr	rvate room days,	· ·	0.
00	Semi-private room days (excluding swing-bed and observation			1, 264	
00	Total swing-bed SNF type inpatient days (including private r reporting period	oom days) through Decembe	er 31 of the cost	0	5.
00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)	•			
00	Total swing-bed NF type inpatient days (including private ro	om days) through December	31 of the cost	0	7.
00	reporting period Total swing-bed NF type inpatient days (including private ro	om days) after December 3	1 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember s	i or the cost	O	"
00	Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	708	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII	anly (including private r	soom dovo)	0	10
. 00	through December 31 of the cost reporting period (see instru		oolii days)	U	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	oom days) after	0	11
	December 31 of the cost reporting period (if calendar year,				
00	Swing-bed NF type inpatient days applicable to titles V or X through December 31 of the cost reporting period	IX only (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar				
. 00	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)	0	1
. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT			0	10
00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 c	of the cost	0.00	17
00	reporting period	aca after December 21 of	the cost	0.00	10
00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after becember 31 of	the cost	0. 00	16
00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
	reporting period				١
00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es after December 31 of t	he cost	0. 00	20
. 00	Total general inpatient routine service cost (see instructio	ns)		2, 141, 890	21
00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost report	ing period (line	0	1
00	5 x line 17)	04 6 11 1			
00	Swing-bed cost applicable to SNF type services after Decembe x line 18)	r 31 of the cost reportin	ig period (line 6	0	23
00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost reporti	ng period (line	0	24
	7 x line 19)			_	
00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 141, 890	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		,		١.,
00	General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges)	ed and observation bed cr	larges)	0	
00	Semi -private room charges (excluding swing bed charges)			0	1
00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
00	Average per diem private room charge differential (line 32 m	inus line 33)(see instruc	tions)	0.00	34
00	Average per diem private room cost differential (line 34 x $\rm I$	ine 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	2, 141, 890	37
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	HISTMENTS			1
00	Adjusted general inpatient routine service cost per diem (se			1, 694. 53	38
. 00	Program general inpatient routine service cost (line 9 x lin			1, 199, 727	
. 00					

40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 41.00 Total Program general inpatient routine service cost (line 39 + line 40)

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40.00

1, 199, 727 41. 00

	Financial Systems	ST. VINCENT HOSE		ON 45 0004		eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST			CN: 15-0084	Peri od: From 07/01/2018		
			Component	CCN: 15-T084	To 06/30/2019	Date/Time Pre 11/25/2019 6:	
			Titl∈	e XVIII	Subprovi der -	PPS	
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	South Control Boson Per on	Inpatient Cost Ir				(col. 3 x col.	
		1 00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00 C				42. 00
	Intensive Care Type Inpatient Hospital Units	-				_	
43.00	INTENSIVE CARE UNIT	0	C				
44. 00 44. 01	CORONARY CARE UNIT CARDIOTHORACIC VASCULAR TRANSPL	0	C	1		1	44. 00 44. 01
45. 00	BURN INTENSIVE CARE UNIT		C	1		l	
45. 01	PEDIATRIC INTENSIVE CARE UNIT	0	C	1		0	
46. 00	SURGICAL INTENSIVE CARE UNIT	0	C			0	
46. 01 47. 00	NEONATAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	C	0.	00	0	46. 01 47. 00
17.00	Cost Center Description						17.00
						1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ne)		403, 717 1, 603, 444	48. 00 49. 00
47.00	PASS THROUGH COST ADJUSTMENTS	41 thi ough 40) (3	ee mstructro) iis)		1, 003, 444	47.00
50.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	n Wkst. D, su	m of Parts I and	132, 028	50. 00
51. 00		atient ancillary	services (fr	om Wkst. D,	sum of Parts II	31, 195	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				163, 223	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital rela	ated, non-phy	ysician anest	netist, and	1, 440, 221	
E 4 .00	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0.00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					0.00	56.00
57. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	57. 00
58. 00	Bonus payment (see instructions)					0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period ei	nαing 1996, ι	updated and c	ompounded by the	0.00	59. 00
60. 00 61. 00							60. 00 61. 00
	amount (line 56), otherwise enter zero (see	instructions)					
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	har 31 of the	a cost report	ng pariod (Saa	0	64. 00
	instructions)(title XVIII only)	· ·		•			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)					0	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	4 plus line 6	65)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through I	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after De	cember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil)		70. 00
71. 00	Adjusted general inpatient routine service c		ne 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	(line 14 v li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	•	•				74.00
75. 00	Capital-related cost allocated to inpatient				Part II, column		75. 00
74 00	26, line 45)	no 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu						78. 00
79. 00	Aggregate charges to beneficiaries for exces			*.	>		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st limitation	n (line 78 mii	nus line 79)		80. 00 81. 00
81.00	Inpatient routine service cost per drem inmi Inpatient routine service cost limitation (I						82.00
83. 00	Reasonable inpatient routine service costs (see instructions)				83. 00
84.00	Program inpatient ancillary services (see in		c)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
23.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						1
87. 00	Total observation bed days (see instructions	•				0	87.00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	rine 2)			0.00	88. 00 89. 00
57.50	(3e					, 0	, 57.00

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Heal th	Financial Systems	ST. VINCENT HO	SPITAL & HCC		In Lie	eu of Form CMS-2	2552-10
COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
			Component (CCN: 15-T084	From 07/01/2018 To 06/30/2019		pared·
			oomponone (3011. 10 1001	00, 00, 201,	11/25/2019 6:	
			Title	XVIII	Subprovi der -	PPS	
					I RF		
	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
			(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	Capi tal -rel ated cost	227, 819	2, 141, 890	0. 10636	04	0	90.00
91. 00	Nursing School cost	0	2, 141, 890	0. 00000	0 0	0	91.00
92.00	Allied health cost	7, 893	2, 141, 890	0. 00368	0	0	92.00
93. 00	All other Medical Education	0	2, 141, 890	0. 00000	0 0	0	93. 00

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Heal th	Financial Systems ST. VINCENT HOSPI	TAL & HCC	In Lie	eu of Form CMS-2	2552-10	
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0084	Peri od:	Worksheet D-1		
			From 07/01/2018 To 06/30/2019	Data/Time Dro	narod:	
			10 06/30/2019	Date/Time Prep 11/25/2019 6:		
		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	s oveluding newbern)		136, 492	1. 00	
2. 00	Inpatient days (including private room days and swing-bed days) Inpatient days (including private room days, excluding swing-b			136, 492	2.00	
3. 00	Private room days (excluding swing-bed and observation bed day		ivate room davs.	0	3. 00	
	do not complete this line.	, . ,				
4.00	Semi-private room days (excluding swing-bed and observation be			119, 778	4. 00	
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00	
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	21 of the cost	0	6. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	on days) arter becember	31 OF THE COST		0.00	
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00	
	reporting period	3 7				
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	the Dreamen (evaluating	owing bod and	F 204	0.00	
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	5, 296	9. 00	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10.00	
	through December 31 of the cost reporting period (see instruct					
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00	
12.00	December 31 of the cost reporting period (if calendar year, er		a raam daya)	0	12. 00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	confy (including privat	e room days)		12.00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	o	13. 00			
	after December 31 of the cost reporting period (if calendar ye					
14. 00	Medically necessary private room days applicable to the Progra	0				
15. 00	Total nursery days (title V or XIX only)			3, 656		
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			3, 448	16. 00	
17. 00	Medicare rate for swing-bed SNF services applicable to service	0.00	17. 00			
	reporting period					
18. 00	Medicare rate for swing-bed SNF services applicable to service	the cost	0.00	18. 00		
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombon 21 of	the cost	0.00	19. 00	
19.00	reporting period	s till ought beceiliber 31 of	the cost	0.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00	
	reporting period	_				
21. 00	Total general inpatient routine service cost (see instructions			150, 087, 272	1	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (iine	0	22. 00	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00	
	x line 18)	·				
24. 00	Swing-bed cost applicable to NF type services through December	131 of the cost reporti	ng period (line	0	24. 00	
25 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	R1 of the cost reporting	neriod (line 0	0	25. 00	
25.00	x line 20)	or the cost reporting	porrou (Title 0		25.00	
26. 00	Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		150, 087, 272	27. 00	
	PRI VATE ROOM DIFFERENTI AL ADJUSTMENT					
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cn	arges)	0	28. 00 29. 00	
30. 00	Semi-private room charges (excluding swing-bed charges)				30.00	
31. 00	General inpatient routine service cost/charge ratio (line 27	+ line 28)		0. 000000	•	
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0.00	1	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00	
34.00						
35. 00						
36. 00 37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 150, 087, 272	36. 00 37. 00	
57.00	27 minus line 36)	and private roull cost ar	(IIIIe	130,007,272	37.00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU					
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 099. 60	1	
39.00	Program general inpatient routine service cost (line 9 x line	•		5, 823, 482	1	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 5, 823, 482	40. 00 41. 00	
	1.22 og. am gono. a inputi ont i outrino soi vi oc cost (11116-37			5, 525, 402	50	

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Interestive Care Type Impattent Hospital Units 1.0 INTEREST CARE UNIT		Financial Systems	ST. VINCENT HOS			In Lie	u of Form CMS-2	2552-10
Cost Center Description	COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der CCI	F	rom 07/01/2018		
Total Newgap Program Duys Program Duys Program Duys Program Cost					1	o 06/30/2019		
Propertient Cash Impetition		Cost Center Description	Total					
1.00		cost center bescription			Diem (col. 1 ÷		(col. 3 x col.	
			1.00	2.00		4.00		
MINISTRY CARE UNIT	42. 00							42. 00
0	43. 00		31, 946, 837	17, 782	1, 796. 58	807	1, 449, 840	43. 00
5.50 BIRDIA INTENSIVE CARE UNIT 7, 244,88 2,702 2,681 12 356 959,841 45 01			0	0	0.00	o	0	44. 00
			21, 727, 674	8, 200				
46.01	45. 01	PEDIATRIC INTENSIVE CARE UNIT	7, 244, 383	2, 702	2, 681. 12	358		45. 01
27.00 OTHER SPECIAL CASE (SPECIFY)			32 096 155	28 663		I		
1,00		OTHER SPECIAL CARE (SPECIFY)	32,070,133	20,003	1, 117. 70	5, 224	3, 010, 171	47. 00
48.00 Program Inpatient ancillary service cost (West, 0-3, col. 3, line 200) 12, 750, 431, 48, 00 Program Inpatient costs (sum of lines 41 hrough 48) (see Instructions) 29,895, 720, 49, 49, 60 Program Inpatient costs (sum of lines 41 hrough 48) (see Instructions) 29,895, 720, 49, 49, 60 Program Inpatient costs (sum of lines 41 hrough 48) (see Instructions) 29,895, 720, 49, 49, 60 Program Inpatient portains (sum of lines 50 and 51) 1,800 Program Inpatient operating cost excluding capit later leated, non-physician anesthetist, and seed call education costs (time 49 minus line 52) 1,800 Program Inpatient operating cost excluding capit later leated, non-physician anesthetist, and seed call education costs (time 49 minus line 52) 1,800 Program Inpatient operating cost excluding capit later leated, non-physician anesthetist, and seed call education costs (time 49 minus line 52) 1,800		Cost Center Description					1 00	
PASS THROUGH COST ADJUSTNEWITS 50.00 Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and 0 50.00 for through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 0 51.00 for an incidence of the program inpatient post and program inpatient ancillary services (from West. D. sum of Parts II 0 51.00 for an incidence december of parts II 0 51.00 for an incidence of the program inpatient operating cost excluding capital related, non-physician anesthetist, and 0 53.00 for an incidence december of personal gost excluding capital related, non-physician anesthetist, and 0 53.00 for an incidence december of the program inpatient operating cost and target amount (line 54 minus II no 54 minus II no 52 minus II no 52 minus II no 54 minus II no 54 minus II no 54 minus II no 55 minus II no 55 minus payment (see instructions) 0 55.00 for 1 for an incidence of the parts of		Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			12, 750, 431	48. 00
50.00 Pass through costs applicable to Program inpatient routine services (From West. D. sum of Parts I and D. 11) 51.00 Pass through costs applicable to Program inpatient ancillary services (From West. D. sum of Parts II and D. 15) 51.00 Pass through costs applicable to Program inpatient ancillary services (From West. D. sum of Parts II and D. 15) 51.00 Pass through costs (June 49 minus I Ine 50 and 51) 51.00 Pass (June 1) 51.00 Pass (June	49. 00		41 through 48)(see instruction	ıs)		29, 895, 720	49. 00
9.1.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II on 10 Total Program inpatient program inpatient program inpatient program inpatient operating cost excluding capital related, non-physician anesthetist, and nexicial education costs (line 49 minus line 52) 7.1.00 Parts (MMONI AND LINE COMPUTATION CASE) 8.1.00 Parts (MMONI AND LINE COMPUTATION CASE) 8.1.00 Parts (MMONI AND LINE COMPUTATION CASE) 8.1.00 Parts (MMONI AND LINE GAS LINE 55) 8.1.00 Parts (MMONI AND LINE 54 LINE 55) 8.1.00 Parts (MMONI AND LINE 55) 8.1.00 Parts (MMONI AND LINE 54 LINE 55) 8.1.00 Parts (MMONI AND LINE 54 LINE 55) 8.1.00 Parts (MMONI PARTS LINE 55) 8.1.00 P	50. 00	Pass through costs applicable to Program inp	atient routine :	services (from	Wkst. D, sum	of Parts I and	0	50. 00
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70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Utilization review - physician compensation (see instructions) 83.00 Utilization review - physician compensation (see instructions) 84.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 70.00 Total observation bed days (see instructions) 85.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	70. 00							70. 00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost (see instructions) 83.00 Program inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 10,099.60 88.00	71. 00	Adjusted general inpatient routine service c	ost per diem (li					71. 00
Total Program general inpatient routine service costs (line 72 + line 73) 75.00 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Bioutilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 74.00 75.00 76.00 77.00 76.00 77.		·		(line 14 v lin	na 35)			
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,099.60 88.00		3		•	ie 33)			74.00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 76.00 77.00 77.00 78.00 78.00 78.00 78.00 79.00 80.00 81.00 82.00 82.00 82.00 83.00 84.00 85.00 86.00 87.00 88.00 88.00 88.00 88.00 88.00	75. 00		routine service	costs (from Wo	orksheet B, Pa	rt II, column		75. 00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,099.60 88.00	76. 00		ne 2)					76. 00
79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 80. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Total observation bed days (see instructions) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 79. 00 80. 00 81. 00 81. 00 82. 00 83. 00 84. 00 85. 00 86. 00 86. 00 87. 00 88. 00 88. 00 88. 00		•						77. 00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,099.60 88.00		•		rovi der records	;)			
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 89.00 Reasonable inpatient routine services (see instr	80. 00	Total Program routine service costs for comp	arison to the c		*.	s line 79)		80. 00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 83.00 83.00 83.00 84.00 84.00 84.00 85.00 86.00 87.00 88.00 88.00 88.00		·)				81. 00 82. 00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 85.00 1 16,714 1 16,714 1 17,099.60 1 18,099.6		·						83. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				20)				84. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,099.60 88.00								85. 00 86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,099.60 88.00		PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	<i>J</i> /				
				line 2)				87. 00 88. 00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 18,378,714 89.00	89. 00	Observation bed cost (line 87 x line 88) (se	•					

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Health Financial Systems	ST. VINCENT H	OSPITAL & HCC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 07/01/2018	Worksheet D-1	
				To 06/30/2019	Date/Time Prep 11/25/2019 6:	oared: 15 pm_
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	9, 254, 596	150, 087, 272	0. 06166	1 18, 378, 714	1, 133, 250	90.00
91.00 Nursing School cost		150, 087, 272	0. 000000	18, 378, 714	0	91.00
92.00 Allied health cost	280, 793	150, 087, 272	0. 00187	1 18, 378, 714	34, 387	92.00
93.00 All other Medical Education		150, 087, 272	0. 000000	18, 378, 714	0	93. 00

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	Financial Systems ST. VINCENT HOSP			u of Form CMS-2	
JOMPU I	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0084 Component CCN: 15-S084	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Pre 11/25/2019 6:	pared
		Title XIX	Subprovi der -	Cost	15 pi
	Cost Center Description		I PF		
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
. 00	Inpatient days (including private room days and swing-bed day	9		15, 796	
. 00	Inpatient days (including private room days, excluding swing-		·	15, 796	
. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	nys). It you have only pr	ivate room days,	0	3.
. 00	Semi-private room days (excluding swing-bed and observation between the semi-private room days (excluding swing-bed and observation between the semi-private room days (excluding swing-bed and observation between the semi-private room days).	oed days)		15, 796	4.
. 00	Total swing-bed SNF type inpatient days (including private re	oom days) through Decembe	r 31 of the cost	0	5.
. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom davs) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)	-		-	
. 00	Total swing-bed NF type inpatient days (including private room	om days) through December	31 of the cost	0	7.
. 00	reporting period Total swing-bed NF type inpatient days (including private roo	om davs) after December 3	1 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)	3 .		_	
. 00	Total inpatient days including private room days applicable t newborn days)	to the Program (excluding	swi ng-bed and	1, 064	9.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	oom days)	0	10.
	through December 31 of the cost reporting period (see instruc	ctions)		-	
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		oom days) after	0	11.
2. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.
	through December 31 of the cost reporting period	3 (, ,	-	
8. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
1. 00	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)			3, 656	
5. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			3, 448	16
7. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 o	f the cost	0.00	17
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
	reporting period				
9. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	0.00	19
0. 00		es after December 31 of t	he cost	0.00	20
	reporting period			40 505 07/	
1. 00 2. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line	10, 505, 876 0	21. 22.
2. 00	5 x line 17)	ser 31 of the cost report	riig perrod (rriic	O	22
3. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23
4 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.
+. 00	7 x line 19)	or or the cost reporti	ing period (iffic	O	27.
5. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.
6. 00	x line 20) Total swing-bed cost (see instructions)			0	26.
7. 00	,	(line 21 minus line 26)		10, 505, 876	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		, ,		
3. 00 9. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed ch	arges)	0	
). 00	Semi -private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	31.
2. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
3. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		\	0.00	
. 00	Average per diem private room charge differential (line 32 mi		TI ONS)	0.00	
5. 00	Average per diem private room cost differential (line 34 x line 35)	ne 31)		0.00	
7. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 10, 505, 876	36 37
, . 00	27 minus line 36)	and private room cost di		10, 303, 676	"
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see			665. 10	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			707, 666	39 40
	DWELL COLLY DECESSORY DILVATE LUCID COST ADDITIONDE TO THE PROOF	LIDE 14 X LIDE 35)	l l	()	4()

40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 41.00 Total Program general inpatient routine service cost (line 39 + line 40)

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40.00 707, 666 41. 00

	Financial Systems	ST. VINCENT HOS		CN 15 0004		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST			CN: 15-0084	Period: From 07/01/2018	Worksheet D-1	
			Component	CCN: 15-S084	To 06/30/2019	Date/Time Pre 11/25/2019 6:	
			Ti tl	e XIX	Subprovi der -	Cost	
	Cost Center Description	Total	Total	Average Per	I PF Program Days	Program Cost	
	oost contor bescription	Inpatient Cost				(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00				42. 00
.2. 00	Intensive Care Type Inpatient Hospital Units	Y		,	5		12.00
43.00	INTENSIVE CARE UNIT	0	C				
44. 00 44. 01	CORONARY CARE UNIT CARDIOTHORACIC VASCULAR TRANSPL	0	C			_	44. 00 44. 01
45. 00	BURN INTENSIVE CARE UNIT	0	C	1		0	
45. 01	PEDIATRIC INTENSIVE CARE UNIT	0	C	1		0	
46. 00 46. 01	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	0	C			0	
47. 00)	50		47. 00
	Cost Center Description	'		•			
40.00	Program inpatient ancillary service cost (Wk	o+ D 2 ool 2	line 200)			1. 00	40.00
48. 00 49. 00	Total Program inpatient costs (sum of lines		,	ons)		35, 833 743, 499	
	PASS THROUGH COST ADJUSTMENTS			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
50. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from	n Wkst. D, sur	n of Parts I and	0	50.00
51. 00	<pre>III) Pass through costs applicable to Program inp and IV)</pre>	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phy	ysician anestl	netist, and	0	53. 00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0	56. 00 57. 00
57. 00 58. 00	57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						
59. 00							58. 00 59. 00
60. 00 61. 00	60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target					0. 00 0	60. 00 61. 00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decembe	er 31 of the d	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	4 plus line 6	55)(title XVI	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil)		70.00
71.00	Adjusted general inpatient routine service c		ne 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	(line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	9	•				74. 00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from V	Vorksheet B, I	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78.00	Inpatient routine service cost (line 74 minu	,					78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			*.	nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on		. (81.00
82.00	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ıs)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per	•	line 2)			0.00	
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00

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Health Financial Systems	ST. VINCENT HO	SPITAL & HCC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-S084	From 07/01/2018 To 06/30/2019		pared·
		oomponome (7011. 10 0001	10 00,00,201,	11/25/2019 6:	
		Ti tl	e XIX	Subprovi der -	Cost	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	587, 502	10, 505, 876	0. 05592	1 0	0	90. 00
91.00 Nursing School cost	0	10, 505, 876	0.00000	0	0	91. 00
92.00 Allied health cost	83, 909	10, 505, 876	0. 00798	7 0	0	92.00
93.00 All other Medical Education	0	10, 505, 876	0.00000	ol o	0	93.00

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)MPU I	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0084	Peri od:	Worksheet D-1		
		Component CCN: 15-T084	From 07/01/2018 To 06/30/2019	Date/Time Prep 11/25/2019 6:		
		Title XIX	Subprovi der - I RF	Cost		
	Cost Center Description			1. 00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
	I NPATI ENT DAYS					
00	Inpatient days (including private room days and swing-bed day			1, 264	1.	
00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed days)		ivata maam daya	1, 264 0	2.	
00	do not complete this line.	ays). IT you have only pr	ivate room days,	U	3.	
00	Semi-private room days (excluding swing-bed and observation I	bed days)		1, 264	4.	
00	Total swing-bed SNF type inpatient days (including private re	oom days) through Decembe	r 31 of the cost	0	5.	
00	reporting period Total swing-bed SNF type inpatient days (including private re	oom days) after December	21 of the cost	0	6.	
00	reporting period (if calendar year, enter 0 on this line)	dom days) arter becember	of the cost	O	0.	
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7.	
00	reporting period		4 6 11			
00	Total swing-bed NF type inpatient days (including private round reporting period (if calendar year, enter 0 on this line)	om days) after December 3	or the cost	0	8.	
00	Total inpatient days including private room days applicable newborn days)	to the Program (excluding	swi ng-bed and	9	9	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		oom days)	0	10	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII $_{\rm C}$ December 31 of the cost reporting period (if calendar year, $_{\rm C}$	enter O on this line)		0		
00	through December 31 of the cost reporting period					
00	after December 31 of the cost reporting period (if calendar) Medically necessary private room days applicable to the Prog	year, enter O on this lin	e)	0		
00	Total nursery days (title V or XIX only)	Talli (exertaining swing bea	days)	3, 656		
00	Nursery days (title V or XIX only)			3, 448	16	
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	cos through Docombor 21 o	f the cost	0.00	 17	
00	reporting period	ces till odgir beceiliber 31 o	i the cost	0.00	' /	
00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost	0. 00	18	
00	Medical d rate for swing-bed NF services applicable to service reporting period $$	G		0.00		
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period		he cost	0.00		
00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through December 1		ing period (line	2, 141, 890 0	21 22	
00	5 x line 17) Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	g period (line 6	0	23	
00	x line 18) Swing-bed cost applicable to NF type services through December 7×1 line 19)	er 31 of the cost reporti	ng period (line	0	24	
00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25	
00	Total swing-bed cost (see instructions)			0	26	
00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 141, 890	27	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ed and observation had ob	arnes)	0	28	
. 00	Private room charges (excluding swing-bed charges)	od and observation bed Ch	a. gos)	0		
00	Semi-private room charges (excluding swing-bed charges)			0	30	
00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000		
00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00		
00	Average per diem private room charge differential (line 32 m	inus line 33)(see instruc	tions)	0.00		
00	Average per diem private room cost differential (line 34 x li		-,	0. 00		
. 00	Private room cost differential adjustment (line 3 x line 35)		FF	0	36	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rrerential (line	2, 141, 890	37	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	HICTMENTS				
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see			1, 694. 53	38	
	Program general inpatient routine service cost per drein (ser			15, 251		
. 00	Medically necessary private room cost applicable to the Progr			0	40	
	Total Program general inpatient routine service cost (line 3			15, 251		

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	Financial Systems	ST. VINCENT HOS				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0084	Peri od: From 07/01/2018	Worksheet D-1	
			Component	CCN: 15-T084	To 06/30/2019	Date/Time Pre 11/25/2019 6:	
			Ti tl	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description	Total Inpatient Cost	Total npatient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	0				42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	l ol	0	0.0	00 0	0	43. 00
44. 00	CORONARY CARE UNIT	o	0	1		_	
44. 01	CARDI OTHORACI C VASCULAR TRANSPL	0	0			_	
45. 00 45. 01	BURN INTENSIVE CARE UNIT PEDIATRIC INTENSIVE CARE UNIT	0	0			0	
46. 00	SURGICAL INTENSIVE CARE UNIT	0	0	1		0	
46. 01	NEONATAL INTENSIVE CARE UNIT	0	0	1		0	
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					1, 318	1
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	ee instructio	ons)		16, 569	49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	ı Wkst. D, sun	n of Parts I and	0	50.00
51. 00	III) Pass through costs applicable to Program inp		`			0	
F2 00	and IV) Total Program excludable cost (sum of lines !	EO and E1)				0	52. 00
52. 00 53. 00	Total Program excludable cost (sum of Tries : Total Program inpatient operating cost exclumedical education costs (line 49 minus line :	ding capital rel	ated, non-phy	vsician anesth	netist, and	0	
E 4 00	TARGET AMOUNT AND LIMIT COMPUTATION	•]
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	
56. 00	Target amount (line 54 x line 55)		0				
57. 00	Difference between adjusted inpatient operat	line 53)	0				
58. 00 59. 00							
37.00	market basket	portring perrou e	narng 1770, c	ipuateu anu co	inpounded by the	0. 00	59. 00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						0. 00 0	
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decembe	r 31 of the c	cost reportino	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing (CAH (see instructions)	ne costs (line 6	4 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 \times line 19)	3			. 3.	0	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)			•	orting period	0	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facil	,		` ,	1		70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne /U ÷ line	2)			71.00
73. 00	Medically necessary private room cost applications		(line 14 x li	ne 35)			73. 00
74. 00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)				74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	lorksheet B, F	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for exces:		ovider record	le)			78. 00 79. 00
80. 00	Total Program routine service costs for compa			*	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limit						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (:						82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		,				84. 00
85.00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)				86. 00
87. 00	Total observation bed days (see instructions)				0	
88. 00	Adjusted general inpatient routine cost per (•	line 2)			0.00	1
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00

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Health Financial Systems	ST. VINCENT HO	SPITAL & HCC		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (From 07/01/2018 To 06/30/2019		nared·
		Component	30N: 10 1001	10 00/00/2017	11/25/2019 6:	
		Ti tl	e XIX	Subprovi der -	Cost	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	227, 819	2, 141, 890	0. 10636	4 0	0	90.00
91.00 Nursing School cost	0	2, 141, 890	0. 00000	0	0	91.00
92.00 Allied health cost	7, 893	2, 141, 890	0. 00368	5 0	0	92.00
93.00 All other Medical Education	0	2, 141, 890	0.00000	ol o	0	93.00

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Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

200.00

201.00

202.00

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511, 737, 739

511, 737, 739

97, 987, 233

200.00

201.00

202.00

NPATI EN	IT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0084	Peri od:	Worksheet D-3	
		Component	CCN: 15-S084	From 07/01/2018 To 06/30/2019		pared:
		Titl∈	e XVIII	Subprovi der - I PF	PPS	то рііі
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3.00	
	NPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT				1	30.00
	3200 CORONARY CARE UNIT					32. 0
	3201 CARDI OTHORACI C VASCULAR TRANSPL					32. 0
	3300 BURN INTENSIVE CARE UNIT			C		33. 0
	2080 PEDIATRIC INTENSIVE CARE UNIT			C		33.0
	3400 SURGI CAL INTENSIVE CARE UNIT			C)	34.0
	2060 NEONATAL INTENSIVE CARE UNIT 4000 SUBPROVIDER - IPF			6, 454, 996)	34. 0 40. 0
	4100 SUBPROVIDER - TPF			0, 454, 990		41. 0
1	4300 NURSERY				1	43. 0
	NCILLARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 0937			
1	5200 DELIVERY ROOM & LABOR ROOM		0. 1370		0	
1	5400 RADI OLOGY-DI AGNOSTI C		0. 1725		1	
	5402 AMBULATORY CARDIOVASCULAR SVC 5403 ULTRASOUND		0. 1724 0. 0763		1	1
	5404 ECHOCARDI OLOGY		0. 0764		i .	1
	5401 ONCOLOGY		0. 1614		2, 393	1
	5700 CT SCAN		0. 0756		1	
	5800 MRI		0. 2130		1	1
	5900 CARDIAC CATHETERIZATION 5901 CARDIAC REHAB		0. 0485 0. 3721		0	
- 1	6000 LABORATORY		0. 3721		1	1
	6500 RESPI RATORY THERAPY		0. 2690			
6. 00 0	6600 PHYSI CAL THERAPY		0. 4057			66.0
	6700 OCCUPATI ONAL THERAPY		0. 1936			1
	6800 SPEECH PATHOLOGY		0. 2565		1	
	6900 ELECTROCARDI OLOGY 7000 ELECTROENCEPHALOGRAPHY		0. 1340 0. 4198			
4	7100 MEDICAL SUPPLIES CHARGED TO PAT		0. 3928			
	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 4849			1
	7300 DRUGS CHARGED TO PATIENTS		0. 2504		1	1
	7400 RENAL DI ALYSI S		0. 3299		1	1
	3330 ENDOSCOPY JTPATIENT SERVICE COST CENTERS		0. 1048	87 C) 0	75. 0
	9000 CLINIC		0. 6547	91 9, 733	6, 373	90.0
	9001 PARTIAL HOSPITALIZATION		0. 2373		1	
	9100 EMERGENCY		0. 1853			
1	9101 WOUND CARE 002		0. 1394		0	
1	9102 WOUND CARE 001		0. 3423		0	
	9103 LAFAYETTE RD CLINIC 9104 ZIONSVILLE CLINIC		0. 0000 0. 3132		0	1
	9105 BROWNSBURG CLINIC		0.0000		o o	1
1.06 0	9106 OP ANTICOAGULATION CLINIC		0. 2933	75 C	0	1
1	9107 ST VINCENT OUTPATIENT TREATMENT		0. 2574		0	
1	4040 FAMILY PRACTICE		0.0000		0	91.0
	9200 OBSERVATION BEDS (NON-DISTINCT THER REIMBURSABLE COST CENTERS		0. 3816	49 33, 985	12, 970	92. 0
	9500 AMBULANCE SERVICES					95. 0
	9853 GERI ATRI C CLI NI C		0.0000	00 0	0	1
8. 01 0	9851 ELECTROCONVULSI VE THERAPY		0. 0000		0	98.0
	9852 DIABETES EDUCATION		0.0000		0	
200.00	Total (sum of lines 50 through 94 and 96 through 98)	(1)		2, 240, 540	363, 211	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(IIne 61)	I	C)	201.0

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I NPATI E	NT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0084	Peri od:	Worksheet D-3	3
		Component	CCN: 15-T084	From 07/01/20 To 06/30/20		
		Ti tl e	× XVIII	Subprovi der I RF		. 13 piii
	Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
			To Charges		Program Costs (col. 1 x col.	
				Charges	2)	
1.			1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		T		O	30.00
	03100 INTENSIVE CARE UNIT				0	31.00
	03200 CORONARY CARE UNIT				O	32. 00
	03201 CARDI OTHORACI C VASCULAR TRANSPL				0	32. 01
	03300 BURN INTENSIVE CARE UNIT 02080 PEDIATRIC INTENSIVE CARE UNIT					33. 00 33. 0°
	03400 SURGI CAL I NTENSI VE CARE UNI T				ő	34. 0
	02060 NEONATAL INTENSIVE CARE UNIT				0	34. 0
	04000 SUBPROVI DER - I PF			4 007	0	40.00
- 1	04100 SUBPROVIDER - IRF 04300 NURSERY			1, 327, 6	024	41. 00
-	NCI LLARY SERVI CE COST CENTERS					75.00
	05000 OPERATING ROOM		0. 0937		· ·	
- 1	05200 DELIVERY ROOM & LABOR ROOM		0. 1370		0 0	
- 1	05400 RADI OLOGY-DI AGNOSTI C 05402 AMBULATORY CARDI OVASCULAR SVC		0. 1725 0. 1724		•	
	05403 ULTRASOUND		0. 0763		i i	
	05404 ECHOCARDI OLOGY		0. 0764		i i	
	05401 ONCOLOGY		0. 1614		- 1	54.0
	05700 CT SCAN 05800 MRI		0. 0756 0. 2130			
	05900 CARDI AC CATHETERI ZATI ON		0. 0485		•	
1	05901 CARDI AC REHAB		0. 3721		0 0	
	06000 LABORATORY		0. 0881			
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0. 2690 0. 4057			
	06700 OCCUPATI ONAL THERAPY		0. 1936		•	
	06800 SPEECH PATHOLOGY		0. 2565			
	06900 ELECTROCARDI OLOGY		0. 1340		0 0	
- 1	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 4198 0. 3928		l e	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4849			
	07300 DRUGS CHARGED TO PATIENTS		0. 2504			
	07400 RENAL DIALYSIS 03330 ENDOSCOPY		0. 3299 0. 1048			
	DUTPATIENT SERVICE COST CENTERS		0. 1048	0,	7/ 000	75.00
90.00	09000 CLI NI C		0. 6547		•	90.00
	09001 PARTI AL HOSPI TALI ZATI ON		0. 2373			90.0
	09100 EMERGENCY 09101 WOUND CARE 002		0. 1853 0. 1394		٩	91. 00 91. 0
- 1	09102 WOUND CARE 001		0. 3423		l e	91.0
91. 03	09103 LAFAYETTE RD CLINIC		0.0000		0 0	91.0
	09104 ZI ONSVI LLE CLI NI C		0. 3132		0	
	09105 BROWNSBURG CLINIC 09106 OP ANTICOAGULATION CLINIC		0. 0000 0. 2933		0 0	1
	09107 ST VINCENT OUTPATIENT TREATMENT		0. 2574			1
1	04040 FAMILY PRACTICE		0.0000		0 0	
	09200 OBSERVATION BEDS (NON-DISTINCT		0. 3816	49	0 0	92.00
	OTHER REIMBURSABLE COST CENTERS OP500 AMBULANCE SERVICES					95. 00
4	19853 GERIATRIC CLINIC		0.0000	000	0	98.00
98. 01	9851 ELECTROCONVULSI VE THERAPY		0.0000	000		98. 0°
	09852 DI ABETES EDUCATION		0.0000			98. 0
200. 00 201. 00	Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges	(line 61)		1, 729, 3	403, 717	7 200. 00 201. 00
_0 00	Net charges (line 200 minus line 201)	(11110 01)	1	1, 729, 3	1	202. 00

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98. 02 09852 DI ABETES EDUCATION

Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

200.00

201.00

202.00

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0.000000

67, 225, 212

67, 225, 212

0 98.02

200.00

201.00

202. 00

12, 750, 431

201.00

202.00

Net charges (line 200 minus line 201)

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201.00

202.00

186, 910

Net charges (line 200 minus line 201)

202.00

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3, 806

202.00

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⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.

⁽²⁾ Organs procured outside your center by a procurement team from your center are included in the count.

11/25/2019 6:15 pm Y: \28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

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⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.

⁽²⁾ Organs procured outside your center by a procurement team from your center are included in the count.

11/25/2019 6:15 pm Y: \28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

0

0

11

82.00

83.00 84.00

82.00 Organs Used for Research

83. 00 Unusabl e/Di scarded Organs

84.00 Total (sum of lines 75 through 83 should equal line 74)

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⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

11/25/2019 6:15 pm Y:\28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

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⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.

⁽²⁾ Organs procured outside your center by a procurement team from your center are included in the count.

11/25/2019 6:15 pm Y: \28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

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⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.

⁽²⁾ Organs procured outside your center by a procurement team from your center are included in the count.

11/25/2019 6:15 pm Y: \28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

0

0

82.00

83.00 84.00

82.00 Organs Used for Research

83. 00 Unusabl e/Di scarded Organs

84.00 Total (sum of lines 75 through 83 should equal line 74)

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⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

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			10 00/30/2019	11/25/2019 6:	
		Title XVIII	Hospi tal	PPS	
	DART A LABORT FUT HOODITH OFFINIORS INVESTIGATION			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri	ing prior to October 1 (see	0 28, 271, 772	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurri	ing on or after October	1 (see	87, 851, 760	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for	prior to October	0	1. 03	
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			5, 990, 910	2.00
2. 01	Outlier reconciliation amount	l ana)		0	2. 01
2. 02 3. 00	Outlier payment for discharges for Model 4 BPCI (see instructi	ions)		49, 130, 760	2. 02 3. 00
4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost report	rting period (see instru	ctions)	735. 76	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	t recent cost reporting	period ending on	92. 11	5. 00
6. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet the	he criteria for an add-o	n to the cap for	0.00	6. 00
7. 00	new programs in accordance with 42 CFR 413.79(e)	undon 40 CED \$410 105(5)	(1) (i v) (D) (1)	0. 00	7. 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under			0.00	7. 00
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.73(b), 2001	0. 00	8. 00		
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sloreport straddles July 1, 2011, see instructions.	18. 00	8. 01		
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital				8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see				9. 00
10.00	instructions) FTE count for allopathic and osteopathic programs in the curre	ent year from your recor	ds	151. 03	
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			8. 88 118. 99	
13. 00	Total allowable FTE count for the prior year.			118. 82	13. 00
14. 00	Total allowable FTE count for the penultimate year if that year	ar ended on or after Sep	tember 30, 1997,	118. 78	
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			118. 86	15. 00
16. 00	Adjustment for residents in initial years of the program			0.00	
17. 00	Adjustment for residents displaced by program or hospital clos	sure		0.00	
18. 00	Adjusted rolling average FTE count	341 0		118. 86	
19. 00	Current year resident to bed ratio (line 18 divided by line 4))		0. 161547	19. 00
20. 00	Prior year resident to bed ratio (see instructions)	<i>,</i> .		0. 165598	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 161547	21. 00
22. 00	IME payment adjustment (see instructions)			9, 802, 103	
22. 01	IME payment adjustment - Managed Care (see instructions)	of the MMA		4, 147, 177	
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 Number of additional allopathic and osteopathic IME FTE reside		FR 412. 105	0. 02	23. 00
24. 00	<pre>(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)</pre>			40.02	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the	lower of line 23 or line	24 (see	0. 02	
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000027	26. 00
27. 00				0. 000027	
	IME payments adjustment factor. (see instructions)				
28. 00	IME add-on adjustment amount (see instructions)			813	
28. 01	IME add-on adjustment amount - Managed Care (see instructions))		344 9, 802, 916	28. 01
29. 00 29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29. 00 29. 01
20.00	Disproportionate Share Adjustment	ationt days ('	ti ana)	4.00	20.00
30.00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	4. 09	
31.00	Percentage of Medicaid patient days (see instructions)			30. 98	
32. 00	Sum of lines 30 and 31			35. 07	
33. 00	Allowable disproportionate share percentage (see instructions))		18. 15	
34.00	Disproportionate share adjustment (see instructions)		l	5, 269, 106	34.00

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ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0084	Peri od: From 07/01/2018 To 06/30/2019	Date/Time Prepared	
		T: +1 - \0.0111		11/25/2019 6:	15 pm
		Title XVIII	Hospital Prior to 10/1	PPS On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment			_	
5. 00 5. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000000000	0. 000000000	
5. 02	Hospital uncompensated care payment (If line 34 is zero, enter	r zero on this line) (se		12, 147, 189	1
J. 02	instructions)	20.0 0 10 110, (00	7,017,000	12/11//10/	00.0
5. 03	Pro rata share of the hospital uncompensated care payment amount	,	2, 482, 189		1
5. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03 Additional payment for high percentage of ESRD beneficiary dis		11, 567, 618		36.0
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs				40.
	652, 682, 683, 684 and 685 (see instructions)				
			Before 1/1	On/After 1/1	
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	83 684 an 685 (see	1.00	1. 01	41. (
1.00	instructions)	03, 004 an 003. (see		O	41.0
1. 01	Total ESRD Medicare covered and paid discharges excluding MS-D	DRGs 652, 682, 683, 684	0	0	41. (
2. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qualit	fir for adjustment)	0.00		42. (
2. 00 3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682				43. (
J. 00	instructions)	2, 666, 66. a 666. (666			
4. 00	Ratio of average length of stay to one week (line 43 divided by	by line 41 divided by 7	0. 000000		44. (
5. 00	days) Average weekly cost for dialysis treatments (see instructions)		0.00	0. 00	45. (
5. 00	Total additional payment (line 45 times line 44 times line 41.		0.00	0.00	46.
7. 00	Subtotal (see instructions)		148, 754, 082		47.
3. 00	Hospital specific payments (to be completed by SCH and MDH, sm	mall rural hospitals	0		48. (
	only. (see instructions)			Amount	
				1. 00	
9. 00	Total payment for inpatient operating costs (see instructions)			152, 901, 603	
0. 00 1. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and			11, 142, 357 0	1
2. 00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions) Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			3, 503, 974	1
3. 00	Nursing and Allied Health Managed Care payment			338, 966	1
4. 00	Special add-on payments for new technologies			4, 726	1
4. 01 5. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0 10, 285, 146	54. 55.
5. 00				10, 283, 140	56.
7. 00	Routine service other pass through costs (from Wkst. D, Pt. II	•	hrough 35).	147, 380	
3. 00				397, 316	
9. 00 0. 00				178, 721, 468 43, 531	
1. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		178, 677, 937	
2. 00	Deductibles billed to program beneficiaries			8, 604, 664	
3. 00	Coinsurance billed to program beneficiaries			604, 649	1
	Allowable bad debts (see instructions)			368, 719	1
5. 00 5. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		239, 667 251, 124	1
7. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	1 40 11 0113)		169, 708, 291	1
3. 00	Credits received from manufacturers for replaced devices for \boldsymbol{a}			0	
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction	s)	0	
). 00). 50	OTHER ADJUSTMENTS Rural Community Hospital Demonstration Project (§410A Demonstr	ration) adjustment (see	instructions)	-2 0	1
0. 87	Demonstration payment adjustment amount before sequestration			0	1
). 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.
). 89	Pioneer ACO demonstration payment adjustment amount (see instr	ructions)		5	70.
	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	1
	nor pondo payment mix aujustilient allibunt (See Histructi UIIS)				1
0. 90 0. 91 0. 92	Bundled Model 1 discount amount (see instructions)			0	70.
0. 91	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-511, 984	1

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M/S E, Part A Amounts (from Pre/Post Peri od P	Total (Col 2 through 4) 5.00 0 0 28,271,772 ,760 87,851,760 0 0 0 ,731 5,990,909 0 0 0	1. 00 1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 3. 00
Tine E, Part A) Entitlement to 10/01 On/After 1	0/01 through 4) 5.00 0 0 28, 271, 772 , 760 87, 851, 760 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01
1.00 DRG amounts other than outlier payments 1.00 DRG amounts other than outlier payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 1.02 BRG amounts other than outlier payments for discharges occurring on or after October 1 1.02 BRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 O O O O O O O O O	5.00 0 0 28, 271, 772 , 760 87, 851, 760 0 0 0 0 , 731 5, 990, 909 0 0	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01
payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI occurring outlier 2.01 Outlier payments for discharges for Model 4 BPCI occurring outlier 2.01 Outlier payments for discharges for Model 4 BPCI occurring outlier 2.01 Outlier payments for outlier outli	28, 271, 772 , 760 87, 851, 760 0 0 0 0 0 0 0 0 0 0 0 0	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1 2.00 Outlier payments for discharges occurring on or after October 1 2.00 Outlier payments for discharges (see instructions) Outlier payments for discharges for Model 4 BPCl occurring outlier 2.01 Outlier payments for October 1 2.00 Operating outlier 2.01 October 1	, 760 87, 851, 760 0 0 0 0 , 731 5, 990, 909 0 0	1. 02 1. 03 1. 04 2. 00 2. 01
occurring prior to October 1 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see instructions)	0 0 0 731 5,990,909 0 0 0	1. 03 1. 04 2. 00 2. 01
occurring on or after October 1 1.03 DRG for Federal specific	0 0 , 731 5, 990, 909 0 0	1. 04 2. 00 2. 01
operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for 2.00 5,990,910 0 1,484,178 4,506 discharges (see instructions) 2.01 Outlier payments for 2.02 0 0 discharges for Model 4 BPCI 3.00 Operating outlier 2.01 0 0 0	0 0 , 731 5, 990, 909 0 0	1. 04 2. 00 2. 01
1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI 3.00 Operating outlier 2.01 O O O O	, 731 5, 990, 909 0 0	2. 00 2. 01
2.00 Outlier payments for discharges (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI 3.00 Operating outlier 2.00 5,990,910 0 1,484,178 4,506 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0	2. 01
2.01 Outlier payments for 2.02 0 0 0 0 discharges for Model 4 BPCI 3.00 Operating outlier 2.01 0 0 0	0 0	
	0 0 980 49, 130, 760	3.00
reconciliation	. 980 49, 130, 760	
4.00 Managed care simulated 3.00 49,130,760 0 10,757,780 38,372 payments Indirect Medical Education Adjustment		4.00
5.00 Amount from Worksheet E, Part 21.00 0.161547 0.161547 0.161547 0.16	1547	5. 00
A, line 21 (see instructions) 6.00 IME payment adjustment (see 22.00 9,802,103 0 2,386,449 7,415		6. 00
instructions) 6.01 IME payment adjustment for 22.01 4,147,177 0 0 4,147		6. 01
managed care (see instructions)		
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	0007	7.00
7.00 IME payment adjustment factor 27.00 0.000007 0.0000007 0.000007 0.000007 0.000007 0.000007 0.000007 0.0000007 0.0000007 0.0000007 0.0000007 0.0000007 0.0000000007 0.0000000000		7. 00
8.00 IME adjustment (see 28.00 813 0 198 instructions)	615 813	8. 00
8.01 IME payment adjustment add on 28.01 344 0 75 for managed care (see instructions)	269 344	8. 01
9.00 Total IME payment (sum of 29.00 9,802,916 0 2,386,647 7,416 lines 6 and 8)	, 269 9, 802, 916	9. 00
9.01 Total IME payment for managed 29.01 4,147,521 0 75 4,147 care (sum of lines 6.01 and 8.01)	, 446 4, 147, 521	9. 01
Disproportionate Share Adjustment		
10.00 Allowable disproportionate 33.00 0.1815 0.1815 0.1815 0.	1815	10.00
share percentage (see		
instructions) 11.00 Disproportionate share 34.00 5,269,106 0 1,282,832 3,986	, 274 5, 269, 106	11. 00
adj ustment (see instructions) 11.01 Uncompensated care payments 36.00 11,567,618 0 2,482,189 9,085	, 429 11, 567, 618	11. 01
Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment	0 0	12. 00
13.00 Subtotal (see instructions) 47.00 148,754,082 0 35,907,618 112,846		
14.00 Hospital specific payments 48.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0	14. 00
15. 00 Total payment for inpatient 49. 00 152, 901, 603 0 35, 907, 693 116, 993 operating costs (see instructions)	, 910 152, 901, 603	15. 00
16.00 Payment for inpatient program 50.00 11,142,357 0 2,718,602 8,423 capital (from Wkst. L, Pt. I, if applicable)	, 755 11, 142, 357	16. 00
	, 726 4, 726	17. 00
17. 01 Net organ aquisition cost 17. 02 Credits received from 68. 00 0 0 manufacturers for replaced devices for applicable MS-DRGs	0 0	17. 01 17. 02

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						rom 07/01/2018 o 06/30/2019	Part A Exhibit Date/Time Prep 11/25/2019 6:	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	93. 00	0	0	C	0	0	18. 00
	adjustment amount (see							
	instructions)							
19.00	SUBTOTAL			0	38, 626, 295	125, 422, 391	164, 048, 686	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	9, 450, 926	0	2, 303, 015	7, 147, 911	9, 450, 926	20. 00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	(0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	341, 839	0	86, 716	255, 123	341, 839	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	(0	0	21. 01
	outlier payments							
22.00	Indirect medical education	5. 00	0. 0692	0.0692	0.0692	0.0692		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	654, 004	0	159, 369	494, 635	654, 004	23. 00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0. 0736	0. 0736	0. 0736	0. 0736		24. 00
	share percentage (see							
	instructions)							
25.00	Di sproporti onate share	11.00	695, 588	0	169, 502	526, 086	695, 588	25. 00
	adjustment (see instructions)							
26.00	Total prospective capital	12.00	11, 142, 357	0	2, 718, 602	8, 423, 755	11, 142, 357	26. 00
	payments (see instructions)							
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 000000	0.000000		27. 00
28. 00	Low volume adjustment	70. 96			(0	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100.00	Transfer low volume		Υ					100. 00
	adjustments to Wkst. E, Pt. A.							
			•					

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HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO	F	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Exhibi Date/Time Pre 11/25/2019 6:	oared:
			Title	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	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	28, 271, 772	28, 271, 772	2	28, 271, 772	1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	87, 851, 760		87, 851, 760	87, 851, 760	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	C		0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	5, 990, 910	1, 484, 178	4, 506, 731	5, 990, 909	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0	(0	0	2. 01
3.00	Operating outlier reconciliation	2. 01	0	(0	0	3. 00
4. 00	Managed care simulated payments Indirect Medical Education Adjustment	3. 00	49, 130, 760	10, 757, 780	38, 372, 980	49, 130, 760	4. 00
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 161547	0. 161547	0. 161547		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	9, 802, 103	2, 386, 449	7, 415, 654	9, 802, 103	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	4, 147, 177	908, 075	3, 239, 102	4, 147, 177	6. 01
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000007	0. 000007		0.1.0	7. 00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	813 344	198 75		813 344	8. 00 8. 01
9. 00	care (see instructions) Total IME payment (sum of lines 6 and 8)	29. 00	9, 802, 916			9, 802, 916	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	4, 147, 521	908, 150		4, 147, 521	9. 01
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1815				10. 00
11. 00	Disproportionate share adjustment (see instructions)	34.00	5, 269, 106	1, 282, 832	3, 986, 274	5, 269, 106	11. 00
11. 01	Uncompensated care payments	36.00	11, 567, 618	2, 482, 189	9, 085, 429	11, 567, 618	11. 01
40.00	Additional payment for high percentage of ESR					0	40.00
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	() O	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	148, 754, 082	35, 907, 618	112, 846, 464	148, 754, 082	13. 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48. 00	0	(0	0	14. 00
15. 00	<pre>instructions) Total payment for inpatient operating costs (see instructions)</pre>	49. 00	152, 901, 603	36, 815, 768	116, 085, 835	152, 901, 603	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	11, 142, 357	2, 718, 602	8, 423, 755	11, 142, 357	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	4, 726	(4, 726	4, 726	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	(0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	(0	18. 00
19. 00	SUBTOTAL			39, 534, 370	124, 514, 316	164, 048, 686	19. 00

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				T	o 06/30/2019	Date/Time Pre 11/25/2019 6:	pared:
				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	9, 450, 926	2, 303, 015	7, 147, 911	9, 450, 926	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	20. 01
21.00	Capital DRG outlier payments	2.00	341, 839	86, 716	255, 123	341, 839	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	21. 01
22.00	Indirect medical education percentage (see	5. 00	0. 0692	0.0692	0. 0692		22. 00
	instructions)						
23. 00	Indirect medical education adjustment (see instructions)	6. 00	654, 004	159, 369	494, 635	654, 004	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0736	0. 0736	0. 0736		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	695, 588	169, 502	526, 086	695, 588	25. 00
26. 00	Total prospective capital payments (see	12.00	11, 142, 357	2, 718, 602	8, 423, 755	11, 142, 357	26. 00
	instructions)						
	•	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2. 00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	0		0	
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-511, 984	-160, 480	-351, 504	-511, 984	1
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31. 00	HRR adjustment (see instructions)	70. 94	-5, 654	-5, 654	0	-5, 654	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0	0	0	0	31. 01
	instructions)			_		_	
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99		0	0	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Υ				100. 00

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	Title XVIII Hospital	PPS	
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	24, 743	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	57, 836, 229	2.00
3.00	OPPS payments	54, 537, 812	3.00
4.00	Outlier payment (see instructions)	281, 121	4. 00
4. 01 5. 00	Outlier reconciliation amount (see instructions)	0.000	4. 01 5. 00
6.00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5	0.000	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7. 00
8.00	Transitional corridor payment (see instructions)	0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	310, 746	9. 00
10.00	Organ acqui si ti ons	0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	24, 743	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges		
12.00	Ancillary service charges	106, 487	12. 00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	106, 487	14.00
	Customary charges		
	Aggregate amount actually collected from patients liable for payment for services on a charge basis		15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasi had such payment been made in accordance with 42 CFR §413.13(e)	s 0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17. 00
	Total customary charges (see instructions)	106, 487	18. 00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	81, 744	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	Lesser of cost or charges (see instructions)	24, 743	21. 00
	Interns and residents (see instructions)	24, 743	22. 00
	Cost of physicians' services in a teaching hospital (see instructions)	0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	55, 129, 679	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	0.004	
	Deductibles and coinsurance amounts (for CAH, see instructions)	2, 304	25. 00
	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	9, 246, 101 45, 906, 017	26. 00 27. 00
27.00	instructions)	43, 700, 017	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	1, 154, 667	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
	Subtotal (sum of lines 27 through 29)	47, 060, 684	30.00
	Primary payer payments Subtotal (line 30 minus line 31)	5, 287 47, 055, 397	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	47,055,347	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	958, 312	34.00
	Adjusted reimbursable bad debts (see instructions)	622, 903	35.00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	716, 930	36.00
	Subtotal (see instructions)	47, 678, 300	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-71 0	38. 00 39. 00
	Pioneer ACO demonstration payment adjustment (see instructions)	١	39. 50
39. 97		0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
	Subtotal (see instructions)	47, 678, 371	40.00
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	953, 567 0	40. 01 40. 02
	Interim payments	46, 768, 150	41. 00
	Tentative settlement (for contractors use only)	0	42. 00
	Balance due provider/program (see instructions)	-43, 346	43.00
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44.00
	§115. 2		
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	0	90. 00
	Outlier reconciliation adjustment amount (see instructions)		91.00
	The rate used to calculate the Time Value of Money	0.00	92. 00
	Time Value of Money (see instructions)	0	93. 00
94. 00	Total (sum of lines 91 and 93)	0	94. 00

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Date 6. MEDICAL AND OTHER METALTH SERVICES 1.00 Nedical and other Services (dee Instructions) 1.80 1.0			Title XVIII	Subprovi der - I PF	PPS	
New Teach and other services (see instructions) 188 1.00					1.00	
Medical and other services relabursed under OPPS (see Instructions) 534 2.00		PART B - MEDICAL AND OTHER HEALTH SERVICES				
00PS payments						
0.00 0.00			tions)			
0.000 0.00		, ,				
Enter the hospital specific payment to cost ratio (see instructions)						
Line 2 times il ine 5		· · · · · · · · · · · · · · · · · · ·	ctions)		- 1	
1.00 Content	6.00		ŕ		اه	6. 00
Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200						
0.00 Organ acquisitions 10.00		1			-	
1.00 Total cost (sum of lines 1 and 10) (see instructions) 188 11.00		, ,	V, col. 13, line 200		· ·	
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 750 12.00					_	
Reasonable charges 12.00 Ancil Tary SerVice Charges 750 12.00 13.00 12.00 12.00 12.00 13.0	11.00				100	11.00
12.00 Ancil lary service charges 750 12.00 12.00 10tal reasonable charges (rom Wast. D-4, Pt. III, col. 4, line 69) 0 13.00 10tal reasonable charges (sum of lines 12 and 13) 750 14.00 750 14.00 750 14.00 750 14.00 750 14.00 750 14.00 750 14.00 750 14.00 750 14.00 750 14.00 750 14.00 750 14.00 750 14.00 750 14.00 750 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00						
14.00 Total reasonable charges (sum of lines 12 and 13) 15.00 16.00 15.00 16.00	12.00	Ancillary service charges			750	12. 00
Customary charges 15.00 Agrogate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 Agrogate amount actually collected from patients liable for payment for services on a chargebasis 0 16.00 Amounts that would have been rade in accordance with the 2 CFR \$413.13(e) 0.000000 17.00 17.00 17.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00			ne 69)			
15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 15.00	14. 00				750	14. 00
16.00 Amounts that would have been realized from patients Iable for payment for services on a chargebasis 0 16.00 National Companies 17.00 Nation	15 00		normant for convices on	a charge basis	0	1 = 00
had such payment been made in accordance with 42 CFR §413. 13(e)		, 00 0				
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00	10.00	· ·	1 3	ir a chargebasi's	ا	10.00
19. 00 Excess of customary charges over reasonable cost (complete only if fline 18 exceeds line 11) (see 562 19. 00	17.00				0. 000000	17. 00
Instructions	18. 00	Total customary charges (see instructions)			750	18. 00
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00	19. 00	, ,	y if line 18 exceeds li	ne 11) (see	562	19. 00
Instructions 188 21.00 22.00 10 10 10 10 10 10 10	20.00	1	vifling 11 avegads li	no 10) (coo	ام	20 00
1.00 Lesser of cost or charges (see instructions) 0.22.00 22.00 Cost of physicians' services in a teaching hospital (see instructions) 0.22.00 23.00 20.00 2	20.00		y II IIIle II exceeds II	(See	ا	20.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 760 24.00	21. 00	1			188	21. 00
Total prospective payment (sum of lines 3 4, 4, 01, 8 and 9) 760 24, 00	22. 00	,			ol	22. 00
COMPUTATION OF REINBURSEMENT SETTLEMENT Compute			ructions)		_	
25.00 Deductibles and coin surance amounts (for CAH, see instructions) 6.26.00 Deductibles and Coin surance amounts relating to amount on line 24 (for CAH, see instructions) 16.26.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 Detect graduate medical education payments (from Wkst. E-4, line 50) 0.29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0.29.00	24. 00				760	24. 00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 16 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 0 28.00 27.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 29.00 28.00 Direct graduate medical education costs (from Wkst. E-4, line 36) 0 29.00 30.00 Subtotal (sum of lines 27 through 29) 932 30.00 30.00 Subtotal (sum of lines 27 through 29) 932 30.00 31.00 Subtotal (line 30 minus line 31) 932 32.00 32.00 Subtotal (line 30 minus line 31) 932 32.00 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 34.00 34.00 Allowable bad debts (see instructions) 0 35.00 35.00 Allowable bad debts (see instructions) 0 36.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 932 37.00 38.00 MSP-LCC reconciliation amount from PSR 932 37.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.90 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.90 39.99 RECOVERY OF ACCELERATED DEPRECIATION 93.99 39.99 RECOVERY OF ACCELERATED DEPRECIATION 93.99 40.00 Subtotal (see instructions) 93.99 40.00 Sequestration adjustment amount before sequestration 93.99 40.00 Subtotal (see instructions) 93.99 40.00 Sequestration adjustment amount after sequestration 94.00 40.00 Demonstration payment adjustment amount see instructions) 94.00 40.00 Demonstration payment adjustment amount see instructions 94.00 40.00 Other in payments 94.00 40.00 Other in payments 94.00 40.00 Other in payments 94.00 40.00 Other in payment 94.00 40.00 Other in payment 94.00	25 00		-)		0	25 00
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				uctions)	-	
Instructions		· ·	•	'		
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.0				- `		
30.00 Subtotal (sum of lines 27 through 29) 932 30.00 97 imary payer payments 0 31.00 97 imary payer payments 932 32.00 20 20 20 20 20 20 20			ne 50)			
31.00 Primary payer payments 932.00 Subtotal (line 30 minus line 31) 932.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 932.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 933.00 934.00 Allowable bad debts (see instructions) 934.00 935.00		, , , , , , , , , , , , , , , , , , , ,			-	
32.00 Subtotal (ine 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		,				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 34. 00 34. 00 34. 00 35. 00 34. 00 35. 00 35. 00 35. 00 36. 0						
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35.00 Adjusted reimbursable bad debts (see instructions) 0 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 932 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 932 40.00 40.01 Sequestration adjustment (see instructions) 934 40.00 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 41.00 Interim payments 878 41.00 42.00 Tentative settlement (for contractors use only) 81 ance due provider/program (see instructions) 35 43.00 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	33.00				0	33. 00
36.00		,				
37.00 Subtotal (see instructions) 932 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.50 97 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.97 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 932 40.00 40.01 Sequestration adjustment (see instructions) 19 40.01 40.02 Demonstration payment adjustment amount after sequestration 19 40.01 40.02 Demonstration payment adjustment amount after sequestration 19 40.01 41.00 Interim payments 878 41.00 42.00 Tentative settlement (for contractors use only) 0 42.00 43.00 Balance due provider/program (see instructions) 35 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Filips 1515.2 TO BE COMPLETED BY CONTRACTOR 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 90.00 92.00 The rate used to calculate the Time Value of Money 0 93.00 93.00 Time Value of Money (see instructions) 0 93.00 93.00 0 93.00						
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39. 00 39. 50 39. 50 39. 50 39. 70 39. 70 39. 70 39. 80 39. 97 39. 98 39. 99 39. 99 39. 99 39. 99 39. 99 39. 99 40. 00 39. 50 39. 99 40. 00 39. 50 39. 99 40. 00 39. 90 40. 01 39. 90 40. 02 40. 01 40. 02 40. 02 41. 00 41. 00 42. 00 43. 00 43. 00 43. 00 44. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 49. 00 40						
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40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8115.2 89.00 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Time Value of Money (see instructions) 97.00 Og 40.01 98.00 Time Value of Money (see instructions) 99.00 Og 40.01 90.00 Og 40.00 90.00 Og 40.00 90.00 Og 90.00 90.00 Og 90.00 90.00 Og 90.00						
40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments Tentative settlement (for contractors use only) 42.00 Balance due provider/program (see instructions) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Quilier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Quilier reconciliation adjustment amount (see instructions) 95.00 Quilier reconciliation adjustment amount (see instructions) 96.00 Quilier reconciliation adjustment amount (see instructions) 97.00 Quilier reconciliation adjustment amount (see instructions) 97.00 Quilier reconciliation adjustment amount (see instructions) 97.00 Quilier reconciliation adjustment amount (see instructions) 98.00 Quilier reconciliation adjustment amount (see instructions) 99.00 Quilier reconciliation adjustment amount (see instructions) 99.00 Quilier reconciliation adjustment amount (see instructions)						
41.00						
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 91.52	41.00	Interim payments			878	41. 00
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{\sqrt{115.2}}{\sqrt{10 BE COMPLETED BY CONTRACTOR}}\$ 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00 Time Value of Money (see instructions) 0 93.00					-	
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 1 Time Value of Money (see instructions) 0 93.00		, , , , , , , , , , , , , , , , , , , ,				
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)	44.00	,	nce with CMS Pub. 15-2,	chapter 1,	ا	44.00
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91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 0.00 92.00 93.00	90. 00				0	90.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0 93.00		, ,			-	
		1				
94.00 Total (Sum of lines 91 and 93) 0 94.00						
	94.00	Tiotal (Sum of lines 91 and 93)		l	0	94.00

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Provider CCN: 15-0084 Worksheet E-1 From 07/01/2018 Part I 06/30/2019 Date/Time Prepared: 11/25/2019 6:15 pm Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 160, 649, 042 46, 768, 150 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 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) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 02/06/2019 1,005,500 0 3.01 3.02 06/13/2019 415, 800 0 3.02 3.03 3.03 0 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 3.51 0 3.51 0 0 3.52 3.52 0 3.53 3.53 0 3.54 \cap 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 1, 421, 300 Ω 3.99 3.50-3.98) 162, 070, 342 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 46, 768, 150 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER 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 0 0 5. 51 0 5.52 0 5.52 0 5. 99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5. 99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 3, 736, 496 0 6.01 6.02 SETTLEMENT TO PROGRAM 43, 346 6.02 7.00 Total Medicare program liability (see instructions) 165, 806, 838 46, 724, 804 7.00 Contractor NPR Date (Mo/Day/Yr) Number 0 1 00 2 00 8.00 Name of Contractor 8.00

11/25/2019 6:15 pm Y:\28500 - St. Vincent Hospital (86th St)\300 - Medicare Cost Report\20190630\HFS Files\28500-19.mcrx

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				IPF		
		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		1, 970, 538		878	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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)					
	Program to Provider			T		
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program	ı	T	T		
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)		4 070 500			
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 970, 538		878	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider	l .				
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENNITY TO THOMBEN		Ö		l ol	5. 02
5. 03			Ö		0	5. 03
	Provider to Program	·				
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		o	5. 51
5. 52			0		o	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		o	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		16, 891		35	6. 01
6.02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 987, 429		913	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor	I		l	l	8. 00

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		Inpatien	it 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	1.00	1, 175, 865	3.00	0	
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		0		0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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. 01	Program to Provider ADJUSTMENTS TO PROVIDER	I	0		0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3. 02			0		Ö	
3. 04			l ő		Ö	
3.05			0		0	1
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	
3. 51			0		0	
3.52			0		0	
3. 53 3. 54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0			
3. 77	3. 50-3. 98)				Ĭ	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 175, 865		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider	1				
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provi der to Program	1	_			
5.50	TENTATIVE TO PROGRAM		0		0	
5. 51 5. 52		•	0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	
3. 77	5. 50-5. 98)				Ĭ	3. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER		0		0	
6. 02	SETTLEMENT TO PROGRAM		1, 032		0	1 0.02
7. 00	Total Medicare program liability (see instructions)		1, 174, 833	Contractor	NPR Date	7. 00
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	

8. 00

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8.00 Name of Contractor

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32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

31.00

32.00

31.00 Other Adjustment (specify)

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	I PF			
		L		
	DAR II. MEDIANE DAR ASSUME		1. 00	
1 00	PART II - MEDICARE PART A SERVICES - IPF PPS		2 201 1/2	1 00
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		2, 281, 163	1.00
2. 00 3. 00	Net IPF PPS Outlier Payments Net IPF PPS ECT Payments		0 49, 714	2. 00 3. 00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before Novem	nhor	0.00	4.00
4.00	15, 2004. (see instructions)	inei	0.00	4.00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced	t by	0.00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under		0.00	
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)			
5.00	New Teaching program adjustment. (see instructions)		0.00	5. 00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a	"new	0.00	6. 00
	teaching program" (see instuctions)			
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a	"new	0.00	7. 00
	teaching program" (see instuctions)			
8. 00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8. 00
9.00	Average Daily Census (see instructions)		43. 276712	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.		0. 000000	
11. 00 12. 00	Teaching Adjustment (line 1 multiplied by line 10).		0	11. 00 12. 00
12.00			2, 330, 877 0	
14. 00			Ü	14. 00
15. 00			0	
16. 00			2, 330, 877	
17. 00			2, 000, 077	
18. 00	1 3 1.3 . 1.3		2, 330, 877	
19. 00			274, 348	
20.00	Subtotal (line 18 minus line 19)		2, 056, 529	20.00
21. 00			45, 759	21. 00
22.00	Subtotal (line 20 minus line 21)		2, 010, 770	22. 00
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1, 340	23. 00
24.00	Adjusted reimbursable bad debts (see instructions)		871	24. 00
25. 00	· · · · · · · · · · · · · · · · · · ·		0	
26. 00			2, 011, 641	
27. 00			0	
28. 00			16, 348	
29. 00			0	
30.00			0	
30. 50	1		0	
30. 99	1		· ·	00. , ,
31. 00 31. 01	Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions)		2, 027, 989 40, 560	
31. 01			40, 560	
32. 00			1, 970, 538	
33. 00			1, 770, 550	
34. 00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		16, 891	
35. 00			0	
	§115. 2			
	TO BE COMPLETED BY CONTRACTOR			
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50. 00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	
52.00	- · · · · · · · · · · · · · · · · · · ·			52. 00
53. 00	Time Value of Money (see instructions)		0	53. 00

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NRT 111 - MEDICARE PART A SERVICES - IRF PPS		. I RF			
PART III - MDICARE PART A SERVICES - IRF PPS					
1.00		AND THE MEDIANE AND A SERVICE AND ADDRESS.		1. 00	
Medicare SSI ratio (IRF PPS only) (see instructions) 0.0261 2.00	1 00			1 000 (04	1 00
0.00 0.00		, , , , , , , , , , , , , , , , , , , ,			
Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)					
to November 15, 2004 (see instructions) 5, 01 cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$412, 424(d) (1) (11) (1) (1) (1) (1) (1) (1) (1) (
program or hospital closure, that would not be counted without a temporary cap adjustment under 42 (FR \$412.424(d) (1) (1) (1) (1) (1) (1) (1) (1) (2) (2) (see instructions)	5.00	to November 15, 2004 (see instructions)		0.00	
2.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 0.00 8.00	5. 01	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		0. 00	5. 01
teaching program" (see instructions) 8.00 teaching program" (see instructions) 0.00 teaching program" (see instructions) 0.00 teaching program" (see instructions) 0.00	6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
8.00 Current 'year's unwelghted I RR FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 0.00 0.00	7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "n	new	0.00	7. 00
teaching program" (see instructions) 10.00					
9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 9.00 1.00 1.00 1.00 Teaching Adjustment Factor (see instructions) 0.000000 1.00	8. 00		iew	0. 00	8. 00
10. 00 Average Daily Census (see instructions) 3. 463014 10. 00	0.00			0.00	0 00
11. 00 Teaching Adjustment Factor (see instructions) 0.000000 11. 00 12. 00 Teaching Adjustment (see instructions) 0.12. 00 12. 00		,			
12 00 Teaching Adjustment (see instructions) 1, 211, 388 13, 00 14, 00 15 00 00 00 00 00 00 0		, ,			
13.00 Total PPS Payment (see instructions) 1, 211, 388 13.00 14.00 15.00 15.00 15.00 15.00 15.00 16.00					
14. 00				-	
15.00 Cost of physicians' services in a teaching hospital (see instructions) 0 16.00 16.00 17.00 18.00 17.01 18.00 18.00 19.01 18.00 18.00 19.01 18.00 19.01 18.00 19.01					
16. 00 Cost of physicians' services in a teaching hospital (see instructions) 1, 211, 388 17. 00 18. 00 18. 00 19.				U	
17.00 Subtotal (see instructions) 1, 211, 388 17.00 18.00 Primary payer payments 0 18.00 Primary payer payments 18.00 Primary payer paye		,		0	
18.00 Primary payer payments 0 18.00 19.00		, , , , , , , , , , , , , , , , , , , ,			
19.00 Subtotal (line 17 less line 18). 1, 211, 388 19.00 20.					
20. 00 Deductibles 6,700 20. 00 21. 00 Subtotal (line 19 minus line 20) 1,204,688 21. 00 22. 00 23. 00 23. 00 24. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 26. 00 26. 00 26. 00 27.				-	
21.00 Subtotal (line 19 minus line 20) 1, 204, 688 21.00 22.00 Coinsurance 11, 055 22.00 23.00 Subtotal (line 21 minus line 22) 1, 193, 633 23.00 24.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 214 25.00 25.00 Adjusted reimbursable bad debts (see instructions) 214 25.00 26.00 27.00 Subtotal (sum of lines 23 and 25) 26.00 27.00 Subtotal (sum of lines 23 and 25) 1, 193, 847 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 28.00 0 0 0 0 0 0 0 0 0					
22.00 Coinsurance 11,055 22.00 23.00 Subtotal (line 21 minus line 22) 1,193,633 23.00 24.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 224,00 25.00 Adjusted reimbursable bad debts (see instructions) 214 25.00 26.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 26.00					
23.00 Subtotal (line 21 minus line 22) 1,193,633 23.00 24.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 224.00 25.00 Adjusted reimbursable bad debts (see instructions) 214 25.00 26.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 26.00 27.00 Subtotal (sum of lines 23 and 25) 1,193,847 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 28.00 29.00 Other pass through costs (see instructions) 4,962 29.00 30.00 00 00 00 00 00 0					
24. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 329 24. 00 25. 00 Adjusted reimbursable bad debts (see instructions) 214 25. 00 26. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 1, 193, 847 27. 00 27. 00 Subtotal (sum of lines 23 and 25) 1, 193, 847 27. 00 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 28. 00 29. 00 Other pass through costs (see instructions) 4, 962 29. 00 30. 00 Outlier payments reconciliation 0 30. 00 31. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31. 00 31. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 31. 50 31. 90 Demonstration payment adjustment amount before sequestration 0 32. 00 32. 01 Sequestration adjustment (see instructions) 1, 198, 809 32. 00 32. 01 Interim payments 23, 976 32. 01 33. 00 Interim payments 1, 175, 865 33. 00 34. 00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33,					
25.00 Adjusted reimbursable bad debts (see instructions) 214 25.00 26.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 26.00 27.00 Subtotal (sum of lines 23 and 25) 1,193,847 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 28.00 29.00 Other pass through costs (see instructions) 4,962 29.00 30.00 Outlier payments reconciliation 0 30.00 31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31.00 31.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 31.50 32.00 Total amount payable to the provider (see instructions) 1,198,809 32.00 32.01 Sequestration adjustment (see instructions) 23,976 32.01 32.02 Demonstration payment adjustment amount after sequestration 0 32.02 33.00 Interim payments 1,175,865 33.00 34.00 Tentative settlement (for contractor use only) 32.02 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) -1,032 35.00 <td></td> <td></td> <td></td> <td></td> <td></td>					
26.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 26.00 27.00 Subtotal (sum of lines 23 and 25) 1,193,847 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 28.00 29.00 Other pass through costs (see instructions) 4,962 29.00 30.00 Outlier payments reconciliation 0 30.00 31.50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31.00 31.90 Demonstration payment adjustment (see instructions) 0 31.50 31.90 Demonstration payment adjustment amount before sequestration 0 31.50 32.01 Sequestration adjustment (see instructions) 1,198,809 32.00 32.02 Demonstration payment adjustment amount after sequestration 23,976 32.01 32.02 Demonstration payment adjustment amount after sequestration 0 31.50 33.00 Interim payments 1,175,865 33.00 34.00 Tentative settlement (for contractor use only) 0 34.00 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) -1,032 3					
27. 00 Subtotal (sum of lines 23 and 25) 1,193,847 27. 00 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 28. 00 29. 00 Other pass through costs (see instructions) 4,962 29. 00 30. 00 Outlier payments reconciliation 0 30. 00 31. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31. 00 31. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 31. 50 32. 01 Demonstration payment adjustment amount before sequestration 0 31. 99 32. 00 Sequestration adjustment (see instructions) 1, 198, 809 32. 00 32. 01 Sequestration adjustment (see instructions) 23, 976 32. 01 32. 02 Demonstration payment adjustment amount after sequestration 0 32. 02 33. 00 33. 00 Interim payments 1, 175, 865 33. 00 34. 00 Tentative settlement (for contractor use only) 34. 00 34. 00 35. 00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) -1, 032 5. 00 30. 00 For tested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36. 00 00	26. 00	, ,		0	26. 00
28.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 28.00 29.00 Other pass through costs (see instructions) 4, 962 29.00 30.00 Outlier payments reconciliation 0 30.00 31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31.00 31.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 31.50 31.99 Demonstration payment adjustment amount before sequestration 0 31.99 32.01 Sequestration adjustment (see instructions) 1, 198, 809 32.00 32.02 Demonstration payment adjustment amount after sequestration 0 32.02 33.00 Interim payments 1, 175, 865 33.00 34.00 Tentative settlement (for contractor use only) 0 34.00 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) -1,032 35.00 70 Demonstration payment adjustment amount (see instructions) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 70 Outlier reconciliation adjustment amount (see instructions) 0 0 51.00 70 Outlier reconciliation				1, 193, 847	27. 00
29. 00 Other pass through costs (see instructions) 4, 962 29. 00 30. 00 Outlier payments reconciliation 0 30. 00 31. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31. 00 31. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 31. 90 31. 90 Demonstration payment adjustment amount before sequestration 0 31. 90 32. 00 Total amount payable to the provider (see instructions) 1, 198, 809 32. 00 32. 01 Sequestration adjustment (see instructions) 23, 976 32. 01 32. 02 Interim payments 0 32. 02 33. 00 Tentative settlement (for contractor use only) 1, 175, 865 33. 00 35. 00 Bal ance due provider/program (line 32 minus lines 32. 01, 32. 02, 33, and 34) -1, 032 35. 00 36. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36. 00 0 36. 00 50. 00 Original outlier amount from Wkst. E-3, Pt. III, line 4 80, 351 50. 00 51. 00 Outlier reconciliation adjustment amount (see instructions) 0 51. 00 52. 00 The rate used to calculate the Time Value of Money 0. 00					
31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31.00 31.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 31.50 31.99 32.00 Total amount payable to the provider (see instructions) 1,198,809 32.00 32.01 Sequestration adjustment (see instructions) 23,976 32.01 23.02 Demonstration payment adjustment amount after sequestration 23.00 Interim payments 23,976 33.00 Interim payments 1,175,865 33.00 Interim payments 1,175,865 33.00 34.00 Sequestration 25.00 Sequestration 26.00 Sequestration 27.00 Sequestration 28.00 Sequestration 29.00 Sequestratio				4, 962	29.00
31. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 31. 99 Demonstration payment adjustment amount before sequestration 31. 99 Total amount payable to the provider (see instructions) 32. 00 Sequestration adjustment (see instructions) 32. 01 Demonstration payment adjustment amount after sequestration 32. 02 Demonstration payment adjustment amount after sequestration 33. 00 Interim payments 31. 50 Tentative settlement (for contractor use only) 35. 00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 36. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36. 00 Since Provider (see instructions) 50. 00 Original outlier amount from Wkst. E-3, Pt. III, line 4 50. 00 The rate used to calculate the Time Value of Money 52. 00 The rate used to calculate the Time Value of Money 53. 00 The rate used to calculate the Time Value of Money 54. 55. 56. 57. 57. 57. 57. 57. 57. 57. 57. 57. 57	30.00	Outlier payments reconciliation		0	30.00
31.99 Demonstration payment adjustment amount before sequestration 0 31.99 32.00 Total amount payable to the provider (see instructions) 1,198,809 32.00 32.01 Sequestration adjustment (see instructions) 23,976 32.01 32.02 Demonstration payment adjustment amount after sequestration 0 32.02 33.00 Interim payments 1,175,865 33.00 Tentative settlement (for contractor use only) 0 34.00 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) -1,032 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Complete by Contractor 0 0 0 0 0 0 0 0 0	31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
32.00 Total amount payable to the provider (see instructions) 1,198,809 32.00 32.01 Sequestration adjustment (see instructions) 23,976 32.01 32.02 Demonstration payment adjustment amount after sequestration 0 32.02 33.00 Interim payments 1,175,865 33.00 34.00 Tentative settlement (for contractor use only) 0 34.00 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) -1,032 35.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Silbs 2 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 80,351 50.00 51.00 The rate used to calculate the Time Value of Money 0.00 52.00	31. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
32.01 Sequestration adjustment (see instructions) 23,976 32.01 32.02 33.00 Interim payment adjustment amount after sequestration 0 32.02 33.00 Interim payments 1,175,865 33.00 34.00 Tentative settlement (for contractor use only) 0 34.00 35.00 Bal ance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) -1,032 35.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 S15.2 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 80,351 50.00 51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00	31. 99	Demonstration payment adjustment amount before sequestration		0	31. 99
32. 02 Demonstration payment adjustment amount after sequestration 0 32. 02 33. 00 Interim payments 1,175,865 33. 00 34. 00 Tentative settlement (for contractor use only) 0 34. 00 35. 00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) -1,032 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36. 00 Solvential Section 1, 1,175,865 33. 00 To establish 1,175,865 33. 00 To establish 2,175,865 33. 00 To establish 2,175,865 33. 00 To establish 3,175,865 33. 00 To establish 4,175,865 33. 00 To establi	32.00	Total amount payable to the provider (see instructions)		1, 198, 809	32.00
33. 00	32. 01	Sequestration adjustment (see instructions)		23, 976	32. 01
34.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 \$\frac{115.2}{5115.2}\$ TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4 0 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money 0 34.00 34.00 35.00 36.00 36.00 36.00 36.00 37.00 38.00 38.00 39.00 39.00 30.00		Demonstration payment adjustment amount after sequestration			
35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) -1,032 35.00 Recompleted amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 00 36.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) -1,032 35.00 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 00 36.00 To BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4 0 0 Utilier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money 0.00 52.00	33.00	Interim payments		1, 175, 865	
36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 \$\frac{\sqrt{\gamma}}{\sqrt{\gamma}}\$115.2 \\ \tag{TO BE COMPLETED BY CONTRACTOR}\$ 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 80,351 50.00 0utlier reconciliation adjustment amount (see instructions) 0 51.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00					
\$115.2 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 50.00 Outlier reconciliation adjustment amount (see instructions) 51.00 The rate used to calculate the Time Value of Money 52.00 To BE COMPLETED BY CONTRACTOR 50.00 To BE COMPLETED BY CONTRACTOR					
TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 50.00 Outlier reconciliation adjustment amount (see instructions) 51.00 The rate used to calculate the Time Value of Money 52.00 The rate used to calculate the Time Value of Money	36. 00			0	36. 00
50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 50.00 Outlier reconciliation adjustment amount (see instructions) 51.00 The rate used to calculate the Time Value of Money 52.00 The rate used to calculate the Time Value of Money					
51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00	50. 00			80, 351	50. 00
52.00 The rate used to calculate the Time Value of Money 0.00 52.00		, , , ,			

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	Title XIX	Hospi tal	Cost	
		I npati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR	XIX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	29, 895, 720		1.00
2.00	Medical and other services		6, 245, 726	2. 00
3.00	Organ acquisition (certified transplant centers only)	(3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)	29, 895, 720	6, 245, 726	4. 00
5.00	Inpatient primary payer payments	(5. 00
6.00	Outpatient primary payer payments		0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	29, 895, 720	6, 245, 726	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonabl e Charges			
8.00	Routine service charges	56, 534, 124	1	8. 00
9.00	Ancillary service charges	67, 225, 212	32, 572, 028	9. 00
10.00	Organ acquisition charges, net of revenue	(10.00
11.00	Incentive from target amount computation	(11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)	123, 759, 336	32, 572, 028	12. 00
	CUSTOMARY CHARGES			1
13.00	Amount actually collected from patients liable for payment for services on a charge	(0	13. 00
	basis			
14.00	Amounts that would have been realized from patients liable for payment for services	on (0	14.00
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.000000	15. 00
16.00	Total customary charges (see instructions)	123, 759, 336	32, 572, 028	16. 00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	93, 863, 616	26, 326, 302	17. 00
	line 4) (see instructions)			
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds I	i ne C	0	18. 00
	16) (see instructions)			
19. 00	Interns and Residents (see instructions)	(0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	(0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	29, 895, 720	6, 245, 726	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS pro	vi ders.		
22. 00	Other than outlier payments	(0	22. 00
23.00	Outlier payments		0	23. 00
24.00	Program capital payments			24. 00
25.00	Capital exception payments (see instructions)			25. 00
26.00	Routine and Ancillary service other pass through costs	(0	26. 00
27.00	Subtotal (sum of lines 22 through 26)	(0	27. 00
28.00	Customary charges (title V or XIX PPS covered services only)	(0	
29. 00	Titles V or XIX (sum of lines 21 and 27)	29, 895, 720	6, 245, 726	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	(0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	29, 895, 720	6, 245, 726	31. 00
32.00	Deducti bl es	(0	32. 00
33.00	Coi nsurance	(0	33. 00
34.00	Allowable bad debts (see instructions)	(0	34.00
35.00	Utilization review	(35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	29, 895, 720	6, 245, 726	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(0	37. 00
38. 00	Subtotal (line 36 ± line 37)	29, 895, 720	6, 245, 726	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)			39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	29, 895, 720	6, 245, 726	40.00
41.00	Interim payments	29, 895, 720		41. 00
42.00	Balance due provider/program (line 40 minus line 41)		0	42. 00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,			43. 00
	chapter 1, §115.2			

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		II tie xix	Juppi ovi dei -	COST	
			I PF	Outpationt	
			Inpati ent	Outpati ent	
	DADT VILL CALCULATION OF DELADUDCEMENT ALL OTHER HEALTH CERVICES	FOR TITLES WAR VIX	1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	FUR TITLES V UR XI)	SERVICES		
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		742 400		1 00
1.00	Inpatient hospital/SNF/NF services		743, 499	•	1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		740 400	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		743, 499	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		743, 499	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		2, 524, 286		8. 00
9.00	Ancillary service charges		186, 910	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		2, 711, 196	0	12.00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for servi	ces on a charge	0	0	13.00
	basi s				
14. 00	Amounts that would have been realized from patients liable for payme		0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CFR	§413. 13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16. 00	Total customary charges (see instructions)		2, 711, 196	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if I	ine 16 exceeds	1, 967, 697	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only if I	ine 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instruction	ıs)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		743, 499	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comple	ted for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		o	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		743, 499	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		<u> </u>		
30.00	Excess of reasonable cost (from line 18)		0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		743, 499	0	31. 00
32. 00	Deducti bl es		0	0	32. 00
33. 00	Coinsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)		o	0	34. 00
35. 00	Utilization review		أم	-	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		743, 499	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		7 10, 177	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		743, 499	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		743, 477	O	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		743, 499	0	40. 00
41. 00	Interim payments		743, 499	0	40.00
42.00	Balance due provider/program (line 40 minus line 41)		743, 499	0	41.00
42.00	Protested amounts (nonallowable cost report items) in accordance wit	h CMC Dub 1E 2		0	42.00
43.00		.11 CWS PUD 13-2,	١	Ü	43.00
	chapter 1, §115.2		1		l

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		litle XIX	Subprovi der - I RF	Cost	
			Inpati ent	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES F	FOR TITLES V OR XI)		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	OK TITLES V OK XIT	COLITION		
1.00	Inpatient hospital/SNF/NF services		16, 569		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		o		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		16, 569	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		16, 569	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		3, 662		8. 00
9.00	Ancillary service charges		3, 806	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		7, 468	0	12. 00
	CUSTOMARY CHARGES		1		
13. 00	Amount actually collected from patients liable for payment for service	ces on a charge	0	0	13. 00
14.00	basis			0	14 00
14. 00	Amounts that would have been realized from patients liable for payment have been realized from patients liable for payment		0	0	14. 00
15. 00	a charge basis had such payment been made in accordance with 42 CFR s	9413. 13(e)	0. 000000	0. 000000	15. 00
	Ratio of line 13 to line 14 (not to exceed 1.000000)				16.00
16.00	Total customary charges (see instructions)	1/	7, 468	0	
17. 00	Excess of customary charges over reasonable cost (complete only if li	rne 16 exceeds	0	0	17. 00
18. 00	line 4) (see instructions)	ino 4 ovecede line	9, 101	0	18. 00
18.00	Excess of reasonable cost over customary charges (complete only if lile) (see instructions)	The 4 exceeds Time	9, 101	U	18.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instructions	e)		0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	5)	7, 468	0	21.00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete	ted for DDS provide		0	21.00
22. 00	Other than outlier payments	ted for 113 provide	0	0	22. 00
23. 00	Outlier payments			0	23. 00
24. 00	Program capital payments			O	24.00
25. 00	Capital exception payments (see instructions)				25. 00
26. 00	Routine and Ancillary service other pass through costs			0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)			0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)			0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		7, 468	0	29.00
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		7, 400		27.00
30.00	Excess of reasonable cost (from line 18)		9, 101	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		7, 468	0	31.00
32. 00	Deductibles		7, 400	0	32. 00
33. 00	Coinsurance			0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34. 00
35. 00	Utilization review			O	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		7, 468	0	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		7, 100	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		7, 468	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		,, 400	O	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		7, 468	0	40.00
41. 00	Interim payments		7, 468	0	41.00
42. 00	Balance due provider/program (line 40 minus line 41)		7, 400	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance with	h CMS Pub 15-2		0	43. 00
10.00	chapter 1, §115.2	55 1 00 10 2,		O	10.00
	1		1		1

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Heal th	Financial Systems ST. VINCENT HOSP	ITAL & HCC		In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C		Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 07/01/2018 To 06/30/2019	Date/Time Pre	pared:
					11/25/2019 6:	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng periods	98. 92	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CF	R 413.79(e)(1) (see instr	uctions)	0.00	2. 00
3.00	Amount of reduction to Direct GME cap under section 422 of MM	Α		ŕ	0.00	3. 00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance	with 42 CFR	§413.79 (m).	(see	0. 00	3. 01
4.00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and	osteopathi c	programs due	to a Medicare	0.00	4. 00
4. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	na periods	18. 00	4. 01
	straddling 7/1/2011)		·			
4. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0.00	4. 02
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus l	ines 4.01 and	116. 92	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	152. 51	6. 00
7. 00	Enter the lesser of line 5 or line 6		1		116. 92	7. 00
			Primary Care 1.00	0ther 2.00	Total 3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteop	athi c	113. 3			8. 00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw		86. 8			
7. 00	multiply line 8 times the result of line 5 divided by the amo 6.		0010	277.00		7.00
10.00	Weighted dental and podiatric resident FTE count for the curr	ent year		9. 13		10.00
10. 01	Unweighted dental and podiatric resident FTE count for the cu	rrent year		0.00		10. 01
11. 00	Total weighted FTE count	(86.8			11.00
12. 00	Total weighted resident FTE count for the prior cost reportin instructions)	g year (see	86. 9	8 36. 41		12. 00
13. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	porting	85. 6	9 35. 28		13. 00
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	86. 5			14. 00
15. 00	Adjustment for residents in initial years of new programs		0.0			15. 00
15. 01	Unweighted adjustment for residents in initial years of new p		0.0			15. 01
16. 00 16. 01	Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h		0.0			16. 00 16. 01
10. 01	closure	оѕрі таі	0.0	0.00		16.01
17. 00	Adjusted rolling average FTE count		86. 5	2 35. 95		17. 00
18. 00	Per resident amount		86, 477. 6			18.00
19. 00	Approved amount for resident costs		7, 482, 05	0 3, 108, 873	10, 590, 923	19. 00
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots rec	eived under 42	12. 89	20. 00
21. 00	Direct GME FTE unweighted resident count over cap (see instru	ctions)			35. 59	21. 00
22. 00	Allowable additional direct GME FTE Resident Count (see instr				12. 56	
23. 00	Enter the locality adjustment national average per resident a	mount (see i	nstructions)		101, 738. 49	
24. 00 25. 00	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				1, 277, 835 11, 868, 758	
23.00	Total direct own amount (sum of fines in and 24)		Inpatient Par	t Managed care	11, 000, 730	23.00
			. A			
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2. 00	3. 00	
26. 00	Inpatient Days (see instructions)		56, 47	9 24, 736		26. 00
27. 00	Total Inpatient Days (see instructions)		198, 00			27.00
28. 00	Ratio of inpatient days to total inpatient days		0. 28523	· ·		28.00
29. 00	Program direct GME amount		3, 385, 43			29.00
30. 00	Reduction for direct GME payments for Medicare Advantage			209, 508		30.00
31. 00	Net Program direct GME amount				4, 658, 641	31.00

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Heal th	Financial Systems ST. VINCENT HOSPI	ITAL & HCC	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0084	Peri od:	Worksheet E-4	
MEDI CA	AL EDUCATION COSTS		From 07/01/2018 To 06/30/2019	Date/Time Pre	narod:
			10 00/30/2019	11/25/2019 6:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLI EDUCATION COSTS)	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	20, 357, 504	33. 00
34.00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ line 33)		0.000000	34.00
35. 00	Medicare outpatient ESRD charges (see instructions)			0	35. 00
36. 00	Medicare outpatient ESRD direct medical education costs (line			0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
	Reasonable cost (see instructions)			166, 273, 865	
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			10, 285, 146	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39. 00
	Primary payer payments (see instructions)			43, 531	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu Part B Reasonable Cost	s line 40)		176, 515, 480	41. 00
42.00	Reasonable cost (see instructions)			58, 172, 444	42. 00
43. 00				5, 287	43.00
44. 00	Total Part B reasonable cost (line 42 minus line 43)			58, 167, 157	
45. 00	,			234, 682, 637	
	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line 45)		0. 752145	
	Ratio of Part B reasonable cost to total reasonable cost (line	,		0. 247855	
00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAI			0.217000	00
48. 00	Total program GME payment (line 31)			4, 658, 641	48. 00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		3, 503, 974	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			1, 154, 667	
		•	'		•

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Provider CCN: 15-0084

Peri od: Worksheet G From 07/01/2018 To 06/30/2019 Date/Time Prepared:

onl y)				10 06/30/2019	Date/Time Pre 11/25/2019 6:	
		General Fund	Speci fi c	Endowment Fund		, g , p
		1.00	Purpose Fund 2.00	3.00	4. 00	
	CURRENT ASSETS	11.00	2.00	0.00	1.00	
1.00	Cash on hand in banks	7, 917, 697		1 1	0	1. 00
2.00	Temporary investments	C			0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	EE4 202 240		0	0	3. 00 4. 00
5. 00	Other receivable	556, 292, 249 123, 761, 204	1		0	
6. 00	Allowances for uncollectible notes and accounts receivable	-288, 009, 246	1	ol ol	0	6. 00
7. 00	Inventory	23, 894, 462	1	o o	0	7. 00
8.00	Prepai d expenses	2, 022, 324		o	0	8. 00
9. 00	Other current assets	4, 731, 696	1	0	0	9. 00
10.00	Due from other funds	420 (40 20)			0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	430, 610, 386		0	0	11. 00
12. 00	Land	9, 137, 236		0	0	12.00
13. 00	Land improvements	13, 817, 505	1	1	0	13. 00
14.00	Accumulated depreciation	-10, 862, 535	1	o	0	14. 00
15. 00	Bui I di ngs	551, 173, 768	1	0	0	15. 00
16.00	Accumulated depreciation	-358, 120, 498	1	0	0	16. 00
17.00	Leasehold improvements	15, 323, 618		0	0	17.00
18. 00 19. 00	Accumulated depreciation Fixed equipment	-12, 640, 848 27, 906, 563	1	1 1	0	18. 00 19. 00
20. 00	Accumulated depreciation	-25, 845, 361	1	1 1	0	20.00
21. 00	Automobiles and trucks	2, 792, 875	1	o o	0	21. 00
22. 00	Accumulated depreciation	-2, 317, 935	1	o	0	22. 00
23. 00	Major movable equipment	287, 270, 978	1	0	0	23. 00
24. 00	Accumulated depreciation	-232, 330, 809		0	0	24. 00
25. 00	Mi nor equipment depreciable				0	25. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	1			0	26. 00 27. 00
28. 00	Accumulated depreciation				0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	C		o o	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	265, 304, 557	' (o	0	30.00
	OTHER ASSETS	70 550 440		ا ما		
31. 00 32. 00	Investments Deposits on Leases	78, 550, 110			0	31.00
33. 00	Deposits on leases Due from owners/officers				0	33. 00
34. 00	Other assets	64, 722, 182	1		0	34. 00
35. 00	Total other assets (sum of lines 31-34)	143, 272, 292	1	o o	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	839, 187, 235	5 (0	0	36. 00
	CURRENT LI ABI LI TI ES			1		
37. 00	Accounts payable	53, 167, 937		0	0	
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	26, 931, 475 997, 380	1	0	0	38. 00 39. 00
40. 00	Notes and Loans payable (short term)	777, 300			0	40.00
41. 00	Deferred income	Ċ		ol ol	0	41. 00
42.00	Accel erated payments	C				42. 00
43.00	Due to other funds	C		0	0	
44. 00		295, 929, 270		0	0	
45. 00	,	377, 026, 062	2 (0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable				0	46. 00
47. 00	Notes payable				0	
48. 00	Unsecured Loans	C		o o	0	1
49.00	Other long term liabilities	165, 475, 206		o	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	165, 475, 206	1	0	0	
51. 00	Total liabilities (sum of lines 45 and 50)	542, 501, 268	3 (0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	296, 685, 967	,			52.00
53. 00	Specific purpose fund	290,000,907				53.00
54. 00	Donor created - endowment fund balance - restricted		`	o		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	296, 685, 967	,		0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	839, 187, 235	1		0	
	[59]	, , , , , , , , , , , , , , , , , , , ,)			
						•

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Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0084

Peri od: Worksheet G-1 From 07/01/2018 To 06/30/2019 Date/Time Prepared:

					To 06/30/2019	Date/Time Prep 11/25/2019 6:	pared: 15 pm
		General	Fund	Speci al	Purpose Fund	Endowment Fund	то р
		1.00	2.00	2.00	4.00	F 00	
4.00		1.00	2.00	3. 00	4. 00	5. 00	4 00
1.00	Fund balances at beginning of period		222, 385, 202		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		239, 934, 808				2.00
3.00	Total (sum of line 1 and line 2)	0 (00 074	462, 320, 010		0		3.00
4.00	Transfer rstrr contrib	3, 638, 974			0	0	4. 00
5.00	Temp Restricted	516, 315			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8. 00		0			0	0	8. 00
9.00	Roundi ng	0			0	0	9.00
10. 00	Total additions (sum of line 4-9)		4, 155, 289		0		10.00
11. 00	Subtotal (line 3 plus line 10)		466, 475, 299		0		11. 00
12. 00	Transfer to Affiliate	156, 407, 039			0	0	12.00
13. 00	Dis of Cap Nonctrl Int	13, 382, 293			0	0	13.00
14. 00		0			0	0	14. 00
15. 00		0			0	0	15. 00
16. 00		0			0	0	16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		169, 789, 332	•	0		18. 00
19. 00	Fund balance at end of period per balance		296, 685, 967		0		19. 00
	sheet (line 11 minus line 18)	Frederiment Fred	DI+	- Franci			
		Endowment Fund	PI ant	Fullu			
		6. 00	7. 00	8.00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	Transfer rstrr contrib		0				4. 00
5.00	Temp Restricted		0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00	Roundi ng		0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11.00	Subtotal (line 3 plus line 10)	0			0		11.00
12.00	Transfer to Affiliate		0				12.00
13.00	Dis of Cap Nonctrl Int		0				13.00
14.00	·		0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17. 00
18.00	Total deductions (sum of lines 12-17)	0			0		18.00
19.00	Fund balance at end of period per balance	0			0		19. 00
	sheet (line 11 minus line 18)						

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			To 06/30/2019	Date/Time Prep 11/25/2019 6:	pared: 15 pm
	Cost Center Description	Inpatient	Outpati ent	Total	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1. 00	Hospi tal	419, 298, 67		419, 298, 675	1. 00
2.00	SUBPROVI DER - I PF	43, 260, 58		43, 260, 583	2. 00
3.00	SUBPROVI DER - I RF	2, 404, 70	4	2, 404, 704	3. 00
4.00	SUBPROVI DER				4. 00
5. 00 6. 00	Swing bed - SNF Swing bed - NF		0	0	5. 00 6. 00
7. 00	SKILLED NURSING FACILITY		U .	U	7. 00
8. 00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	464, 963, 96	2	464, 963, 962	10. 00
	Intensive Care Type Inpatient Hospital Services	1,,	=	10 17 1007 100	
11. 00	INTENSIVE CARE UNIT	115, 607, 55	6	115, 607, 556	11. 00
12.00	CORONARY CARE UNIT		0	0	12.00
12.01	CARDI OTHORACI C VASCULAR TRANSPL	58, 779, 81	2	58, 779, 812	12.01
13.00	BURN INTENSIVE CARE UNIT		0	0	13.00
13. 01	PEDIATRIC INTENSIVE CARE UNIT	30, 645, 06	7	30, 645, 067	13. 01
14. 00	SURGI CAL INTENSIVE CARE UNIT		0	0	14. 00
14. 01	NEONATAL INTENSIVE CARE UNIT	240, 305, 25	5	240, 305, 255	14. 01
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lin	es 445, 337, 69	0	445, 337, 690	16. 00
17. 00	11-15)	010 201 45		010 201 (52	17 00
17.00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services	910, 301, 65	2 0 1, 102, 091, 343	910, 301, 652 2, 737, 386, 133	17. 00 18. 00
19. 00	Outpatient services	88, 779, 34		330, 300, 627	19. 00
20. 00	RURAL HEALTH CLINIC	l '	0 241, 321, 287	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			Ö	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVI CES		o o	o	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		0 120, 467, 960	120, 467, 960	25. 00
26.00	HOSPI CE				26.00
27. 00	OTHER (SPECIFY)		0	0	27. 00
27. 01	Kidney Acquisition	6, 325, 64			27. 01
27. 02	Heart Acquisition	7, 837, 78			27. 02
27. 03	Physician Private Offices		0 66, 772, 489		27. 03
27. 04	Billing		0 57, 801, 697	57, 801, 697	27. 04
27. 05	Geriatric Clinic	10, 14		,	27. 05
27. 06	Sports Performance	MI+ 2 (40 E40 2)	0 4, 311, 404		27. 06
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to G-3, line 1)	WKSL. 2, 648, 549, 36	2 1, 596, 091, 869	4, 244, 041, 231	28. 00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		1, 141, 577, 835		29. 00
30. 00	ADD (SPECIFY)		0		30. 00
31. 00			o		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	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39. 00			0		39. 00
40. 00			0		40.00
41. 00	T		U _		41.00
42.00	Total deductions (sum of lines 37-41)	ronofor	0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t to Wkst. G-3, line 4)	anster	1, 141, 577, 835		43. 00
	10 WK31. U-3, TITIE 4)	I			

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0 28.00

239, 934, 808 29. 00

Total other expenses (sum of line 27 and subscripts)

29.00 Net income (or loss) for the period (line 26 minus line 28)

28.00

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	Financial Systems ST. VINCENT HOS ATION OF CAPITAL PAYMENT	Provider CCN: 15-0084	Peri od:	u of Form CMS-2 Worksheet L	
			From 07/01/2018 To 06/30/2019	Parts I-III Date/Time Pre	
		Title XVIII	Hospi tal	11/25/2019 6: PPS	15 pm
		THE AVIII	1103pi tai	113	
	T			1. 00	
	PART I - FULLY PROSPECTIVE METHOD				-
. 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			9, 450, 926	1.0
. 00	Model 4 BPCI Capital DRG other than outlier			9, 430, 920 O	1.
. 00	Capital DRG outlier payments			341, 839	1
. 01	Model 4 BPCI Capital DRG outlier payments			0 11, 007	1
. 00	Total inpatient days divided by number of days in the cost r	reporting period (see inst	ructions)	501. 67	1
. 00	Number of interns & residents (see instructions)		,	118. 88	4.
. 00	Indirect medical education percentage (see instructions)			6. 92	5.
. 00	Indirect medical education adjustment (multiply line 5 by th 1.01) (see instructions)	ne sum of lines 1 and 1.01	, columns 1 and	654, 004	6.
. 00	Percentage of SSI recipient patient days to Medicare Part A	patient days (Worksheet E	, part A line	4. 09	7.
	30) (see instructions)			20	_
. 00	Percentage of Medicaid patient days to total days (see instr	ructions)		30. 98	
00	Sum of lines 7 and 8	>		35. 07	1
0.00	Allowable disproportionate share percentage (see instruction	ns)		7. 36 695, 588	
2. 00	Disproportionate share adjustment (see instructions) Total prospective capital payments (see instructions)			11, 142, 357	
2.00	Total prospective capital payments (see Histi detrois)			11, 142, 337	12.
	PART II - PAYMENT UNDER REASONABLE COST			1. 00	
. 00	Program inpatient routine capital cost (see instructions)			0	1.
. 00	Program inpatient ancillary capital cost (see instructions)			0	1
. 00	Total inpatient program capital cost (line 1 plus line 2)			0	1
. 00	Capital cost payment factor (see instructions)			0	4.
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
. 00	Program inpatient capital costs (see instructions)	(!!		0	
. 00	Program inpatient capital costs for extraordinary circumstar Net program inpatient capital costs (line 1 minus line 2)	ices (see instructions)		0	
. 00	Applicable exception percentage (see instructions)			0. 00	
. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
. 00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	
00	i or correage and actiment for extract arriary or realistances (ede i				
	Adjustment to capital minimum payment level for extraordinar	ry circumstances (line 2 x	(line 6)	0	
. 00	Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7)	ry circumstances (line 2 x	(line 6)	0	1
. 00 . 00			(line 6)		8.
. 00 . 00 . 00	Capital minimum payment level (line 5 plus line 7)	i cabl e)	ŕ	0	8. 9.
. 00 . 00 . 00 0. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over	icable) capital payments (line 8	less line 9)	0	8. 9. 10.
. 00 . 00 . 00 0. 00 1. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to	icable) capital payments (line 8 capital payment (from pri	less line 9) or year	0 0	8. 9. 10. 11.
2.00 0.00 0.00 1.00 2.00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	icable) capital payments (line 8 capital payment (from pri payments (line 10 plus lir	less line 9) or year ne 11)	0 0 0	8. 9. 10. 11.
2. 00 0. 00 0. 00 1. 00 2. 00 3. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment level payme	icable) capital payments (line 8 capital payment (from pri payments (line 10 plus line er the amount on this line	less line 9) or year ne 11)	0 0 0 0	8. 9. 10. 11. 12. 13.
2.00 0.00 0.00 1.00 2.00 3.00 4.00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	icable) capital payments (line 8 capital payment (from pri payments (line 10 plus line er the amount on this line capital payment for the f	less line 9) or year ne 11)	0 0 0 0 0	8. 9. 10. 11. 12. 13. 14.
5. 00 7. 00 3. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital g Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over	icable) capital payments (line 8 capital payment (from pri payments (line 10 plus line er the amount on this line capital payment for the f	less line 9) or year ne 11)	0 0 0 0	8. 9. 10. 11. 12. 13. 14.

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