Health Financial Systems ST. VINCENT MERCY HOSPITAL In Lieu of Form CKS-252-10 Phils report Es required by Law (42 USC 1395g; 42 CR F413.20(0)). Failure to report can result in all interim FONM APROVED OWB ND. 0938-0050 MOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1308 Period: For 07/07/2018 Period: Period: To 07/3072018 Period: Period: Period: To 07/3072018 Period: Period: Period: To 07/3072018 Period: Period: Period: To 07/3072018 Period: Period: Period: Period: To 07/2018 Period: Period				
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ICOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1308 Erric dc Ferric dc				
AND SETTLEMENT SUMMARY From 07/01/2018 Farts 1-111 PART 1 - COST REPORT STATUS Date/Time Prepared: 11/25/2019 Time: 3:08 pm Provider 1. [X] Electronically filed cost report Date: 11/25/2019 Time: 3:08 pm use only 2. [] Manually submitted cost report Date: 11/25/2019 Time: 3:08 pm Contractor 3. [] 0.] If this is an amended report enter the number of times the provider resubmitted this cost report 4. [F] Use only 5. [] 1.] Cost Report Status 6. Date Received: (2) Sottled with Audit 8. [] 111 or Time: 7* for full or 'L' for low. Contractor (2) Sottled with Audit 8. [] 1.] In This Provider COL (2) D JF files S, column 1 is 4: Enter number of times reopend = 0-9. (3) Sottled with Audit 4. 1. [] III I I I I I I I I I I I I I I I I I	payments made since the beginning of the cost reporting period bein	g deemed overpayments (4.	2 USC 1395g).	
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(3) Settied with Audit 9. [N] Final Report for this Provider CCN number of times reopened = 0-9. (4) Reopened (5) Amended number of times reopened = 0-9. PART 11 - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION 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 MERCY HOSPITAL (15-1308) 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. []] have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Signed) Officer or Administrator of Provider(s) Title Date <td>use only (1) As Submitted 7. Contractor No.</td> <td>or this Provider CCN 12</td> <td>Contractor's Vendo [0] f line 5 .co</td> <td>r Code: 4 Lumn 1 is 4[.] Enter</td>	use only (1) As Submitted 7. Contractor No.	or this Provider CCN 12	Contractor's Vendo [0] f line 5 .co	r Code: 4 Lumn 1 is 4 [.] Enter
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	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
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	PART III - SETTLEMENT SUMMARY					_	
1.00	Hospi tal	0	-22, 245	67, 858	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-20, 270	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
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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.

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		HOSPI TAL									
0	Subprovider - IPF										4
0 0	Subprovider - IRF Subprovider - (Other)										5
0	Swing Beds - SNF	SWING BED - SNF	15	Z308	26900		07/01/200	1 N	0	N	7
0	Swing Beds - NF			.2000 .	20700		0,7017200			1	8
0	Hospital-Based SNF										9
00	Hospital-Based NF										10
00	Hospital-Based OLTC										11
00 00	Hospi tal -Based HHA Separately Certified ASC										12
00	Separately Certified ASC Hospital-Based Hospice										13
00	Hospital-Based Health Clinic - RHC										15
00	Hospital-Based Health Clinic - FQHC										16
00	Hospital-Based (CMHC) I										17
00 00	Renal Dialysis Other										18
0	othei					1	From	n:	T	 D:	19
							1.0			00	
00	Cost Reporting Period (mm/dd/yyyy)						07/01/	2018	06/30	/2019	20
00	Type of Control (see instructions)						1				21
						1.00	2.0	0	3.	00	1
	Inpatient PPS Information										_
00	Does this facility qualify and is it disproportionate share hospital adju					Ν	N				22
	§412.106? In column 1, enter "Y" fo										
	facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo	r yes or "N" for	no.								
01	Did this hospital receive interim un					N	N				22
	cost reporting period? Enter in colu the portion of the cost reporting pe										
	Enter in column 2, "Y" for yes or "N				+						
	reporting period occurring on or aft				-						
02	Is this a newly merged hospital that					Ν	N				22
	payments to be determined at cost re										
	Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob				_						
	or "N" for no, for the portion of th										
	October 1.										
03	Did this hospital receive a geograph					Ν	N		I	N	22
	rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c				>						
	for the portion of the cost reportin										
	in column 2, "Y" for yes or "N" for	no for the portio	n of the c	ost							
	reporting period occurring on or aft										
	Does this hospital contain at least										
	counted in accordance with 42 CFR 41 yes or "N" for no.	Z. TUDJY ENTER IN	cui ullili 3,	T TOP							
00	Which method is used to determine Me	dicaid days on li	nes 24 and	/or 25			2 N				23
	below? In column 1, enter 1 if date	of admission, 2 i	f census d	ays, or							
	if date of discharge. Is the method				t						
	reporting period different from the reporting period? In column 2, enter										
			In-State	In-Stat		ut-of		Medi ca)ther	
			Medi cai d	Medi cai		State		HMO da	, I	di cai d	
			paid days	eligibl			Medicaid			days	
				unpai o days	par	d days	eligible unpaid				
				2.00		3.00	4.00	5.00		6.00	
		-	1.00	2.00				2.00			- 1 C
00	If this provider is an IPPS hospital	, enter the	<u> </u>		0	0	0		0	(0 24
00	in-state Medicaid paid days in colum	n 1, in-state			0	0	0		0	(0 24
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	n 1, in-state umn 2,			0	0	0		0	(0 24
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c	n 1, in-state umn 2, olumn 3,			0	0	0		0	(0 24
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	n 1, in-state umn 2, olumn 3, d days in column			0	0	0		0	C	0 24

	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	AIA	Provider CC	N: 15-1308	Period: From 07/0		Part I	eet S-2	
						80/2019	Date/Ti 11/25/2	2019 3:	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ys Med	ther di cai d days	
		1.00	2.00	3.00	4.00	5.00	0	5.00	25
5. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0		Rural S		ceour	25.
					1.		2.		
5.00 7.00 5.00	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	r rural. age) status r "2" for r ication in (at the end ural. If ap column 2.	l of the cos plicable,	t	1 1 0			26. 27. 35.
	effect in the cost reporting period.		·		Begi n	ni na:	Endi	na	
					1.	00	2.		
5. 00	of periods in excess of one and enter subsequent dat	es.	·						36.
7.00	If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.	r the numbe	r of period	ls MDH statu	s	0			37.
. 01	Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f instructions)								37.
. 00									38.
					Y/ 1.		Y/ 2.		-
9. 00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	er in colum its in	ine M		N		39.
0. 00	· · · · ·	ber 1. Ente	r "Y" for y				N		40.
						V 1.00	XVIII 2.00	XIX 3.00	-
	Prospective Payment System (PPS)-Capital						N	N	45.
. 00	Does this facility qualify and receive (anital navme	nt for disn	roporti opat	a chara in	accordance				45.
5.00 6.00		eption for	extraordi na	ıry circumst	ances	N N	N	N	46.
5. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	eption for t. L, Pt. I	extraordina II and Wkst	ry circumst : L-1, Pt.	ances I through	N	N	N	
5.00 7.00 3.00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals	eption for t. L, Pt. I capital? E t? Enter "	extraordina II and Wkst nter "Y for Y" for yes	ry circumst . L-1, Pt. yes or "N" or "N" for	ances I through for no. no.	N N N			47. 48.
. 00 . 00 . 00 . 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in or "N" for no.	eption for t. L, Pt. I capital? E t? Enter " approved G	extraordina II and Wkst nter "Y for Y" for yes ME programs	ry circumst . L-1, Pt. . yes or "N" or "N" for ? Enter "Y	ances I through for no. no. " for yes	N	N	N	47. 48. 56.
5. 00 7. 00 3. 00 5. 00	<pre>with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fof is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I</pre>	eption for t. L, Pt. I capital? E t? Enter " approved G period duri r yes or "N th of this Y", complet I, if appli	extraordina II and Wkst nter "Y for <u>Y" for yes</u> ME programs mg which re " for no in cost report e Worksheet cable.	ry circumst . L-1, Pt. yes or "N" or "N" for ? Enter "Y esidents in a column 1. ing period? E-4. If co	ances I through for no. no. " for yes approved If column ' Enter "Y Iumn 2 is	N N N 1	N	N	47. 48. 56. 57.
5. 00 7. 00 8. 00 5. 00 7. 00	<pre>with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim</pre>	eption for t. L, Pt. I capital? E t? Enter " approved G period duri r yes or "N th of this Y", complet I, if appli bursement f	extraordina II and Wkst nter "Y for Y" for yes ME programs mg which re " for no in cost report e Worksheet cable. or physicia	ry circumst . L-1, Pt. yes or "N" or "N" for ? Enter "Y esidents in a column 1. ing period? E-4. If co	ances I through for no. no. " for yes approved If column ' Enter "Y Iumn 2 is	N N N 1	N	N	47. 48. 56. 57.
5. 00 7. 00 3. 00 5. 00 7. 00 3. 00	<pre>with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" foi is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I</pre>	eption for t. L, Pt. I capital? E t? Enter " approved G period duri r yes or "N th of this Y", complet bursement f complete W	extraordina II and Wkst nter "Y for Y" for yes ME programs ng which re " for no in cost report e Worksheet cable. or physicia kst. D-5.	ry circumst . L-1, Pt. yes or "N" or "N" for	ances I through for no. no. " for yes approved If column ' Enter "Y Iumn 2 is s as	N N N N N N N eeet A e #	N	N N N	

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider C		Period: From 07/01/2018 To 06/30/2019	11/25/2019 3:	pared:
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N			0.00	0. 00	61.0
1. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
1. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
01.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
		Pro	ogram Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61. 1
						1.00	
0.00	ACA Provisions Affecting the Health Resources and Ser						
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	tions) 1 Teachi 1ram. (s	ng Health Cen see instruction	ter (THC) into			62.0 62.0
3.00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c	ost reporting 67. (see inst	period? Enter ructions)	N	63.0
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Soction EEOA of the ACA Base Year FTE Desident '	000000	lor Setting	1.00	2.00	3.00	
4.00	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June sy train a-primar all non l non-pr n column	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	This base yea	-		64.0

SPITAL AND HUSPITAL HEALTH CARE O	OMPLEX IDENTIFICATION D	ATA Provider (eriod:	Worksheet S-2	
			Fr To	om 07/01/201 0 06/30/201	9 Date/Time Pre	
	Program Name	Program Code	Unweighted	Unwei ghted	11/25/2019 3: Ratio (col. 3/	
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	(4))	
			Si te			
	1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, if line 6 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 column 4, the number of unweighted primary care			0.00	O. C	00 0. 000000	05.0
resident FTEs that trained in your hospital. Enter in colum 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	IN		Unweighted	Unweighted	Ratio (col. 1/	
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	•		
			1.00	2.00	3.00	
Section 5504 of the ACA Curre beginning on or after July 1,		n Nonprovider Settin	gsEffective fo	or cost report	ting periods	
	ns occurring in all nonp					
Enter in column 2 the number FTEs that trained in your hos (column 1 divided by (column	of unweighted non-prima spital. Enter in column <u>1 + column 2)). (see in</u> Program Name	ary care resident 3 the ratio of istructions) Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
Enter in column 2 the number FTEs that trained in your hos (column 1 divided by (column	of unweighted non-prima spital. Enter in column <u>1 + column 2)). (see in</u> Program Name <u>1.00</u>	ary care resident 3 the ratio of astructions)	FTĔs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	
Enter in column 2 the number FTEs that trained in your hos	of unweighted non-prima spital. Enter in column <u>1 + column 2)). (see in</u> Program Name <u>1.00</u> m n n ole in n	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site	FTEs in Hospital	(col. 3 + col. 4)) 5.00	_
 Enter in col umn 2 the number FTEs that trained in your hos (col umn 1 divided by (col umn 00 Enter in col umn 1, the program name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the program code. Enter in col umn 3, the number of unweighted primary care FTE residents attributab to rotations occurring in all non-provider settings. Enter col umn 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in col um 5, the ratio of (col umn 3 divided by (col umn 3 + col umr 	of unweighted non-prima spital. Enter in column <u>1 + column 2)). (see in</u> Program Name <u>1.00</u> m n n ole in n	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital 4.00 0.0	(col. 3 + col. 4)) 5.00 00 0.000000	
 Enter in col umn 2 the number FTEs that trained in your hos (col umn 1 divided by (col umn 00 Enter in col umn 1, the progra name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the progra code. Enter in col umn 3, the number of unweighted primary care FTE residents attributat to rotations occurring in all non-provider settings. Enter col umn 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in col um 5, the ratio of (col umn 3 divided by (col umn 3 + col umr 4)). (see instructions) 	of unweighted non-prima spital. Enter in column 1 + column 2)). (see in Program Name 1.00 m n n n n	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital 4.00 0.0	(col. 3 + col. 4)) 5.00	_
Enter in col umn 2 the number FTEs that trained in your hos (col umn 1 divided by (col umn) 00 Enter in col umn 1, the progra name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the progra code. Enter in col umn 3, the number of unweighted primary care FTE residents attributat to rotations occurring in all non-provider settings. Enter col umn 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in col um 5, the ratio of (col umn 3 divided by (col umn 3 + col umr 4)). (see instructions)	of unweighted non-prima spital. Enter in column 1 + column 2)). (see in Program Name 1.00 am ble in ble in ble sy PPS	ry care resident 3 the ratio of istructions) Program Code 2.00	FTĔs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.0	(col. 3 + col. 4)) 5.00 00 0.000000	
Enter in col umn 2 the number FTEs that trained in your hos (col umn 1 divided by (col umn 00 Enter in col umn 1, the progra name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the progra code. Enter in col umn 3, the number of unweighted primary care FTE residents attributate to rotations occurring in all non-provider settings. Enter col umn 4, the number of unweighted primary care resident FTEs that trained ir your hospital. Enter in col um 5, the ratio of (col umn 3 divided by (col umn 3 + col umr 4)). (see instructions) Inpatient Psychiatric Facilit 00 Is this facility an Inpatient Enter "Y" for yes or "N" for	of unweighted non-prima spital. Enter in column 1 + column 2)). (see in Program Name 1.00 m n n n n n n n n n n n n n n n n n n	TPF), or does it con	FTĔs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.0 1.1 rovider?	(col. 3 + col. 4)) 5.00 00 0.000000 00 0.000000 00 2.00 3.00	70. (
Enter in col umn 2 the number FTEs that trained in your hos (col umn 1 divided by (col umn ame associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the progra code. Enter in col umn 3, the number of unweighted primary care FTE residents attributat to rotations occurring in all non-provider settings. Enter col um 4, the number of unweighted primary care resident FTEs that trained ir your hospital. Enter in col umn 5, the ratio of (col umn 3 divided by (col umn 3 + col umr 4)). (see instructions) Inpatient Psychiatric Facilit Enter "Y" for yes or "N" for 15 this facility an Inpatient Enter "Y" for yes or "N" for 20 If line 70 is yes: Column 1: recent cost report filed on co 42 CFR 412.424(d)(1)(iii)(c)) program in accordance with 42 Column 3: If column 2 is Y, i (see instructions)	of unweighted non-prima spital. Enter in column 1 + column 2)). (see in Program Name 1.00 m n n n n n n n n n n n n n n n n n n	ary care resident 3 the ratio of istructions) Program Code 2.00 2.00 (IPF), or does it con approved GME teach 2004? Enter "Y" for the sident 2004? Enter "Y" for the sident (I) (D)? Enter "Y" for the sident	FTĔs Nonprovider Site 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.0 1.0 1.0 rovider? N he most o. (see ing o.	(col. 3 + col. 4)) 5.00 00 0.000000	70. (
Enter in col umn 2 the number FTEs that trained in your hos (col umn 1 divided by (col umn ame associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the progra code. Enter in col umn 3, the number of unweighted primary care FTE residents attributab to rotations occurring in all non-provider settings. Enter col umn 4, the number of unweighted primary care resident FTEs that trained ir your hospital. Enter in col um 5, the ratio of (col umn 3 divided by (col umn 3 + col umr 4)). (see instructions) Inpatient Psychiatric Facilit Enter "Y" for yes or "N" for 00 If line 70 is yes: Col umn 1: recent cost report filed on 42 CFR 412.424(d)(1)(iii)(c)) program in accordance with 42 Col umn 3: If col umn 2 is Y, i	of unweighted non-prima spital. Enter in column 1 + column 2)). (see in Program Name 1.00 m n n n n n n n n n n n n n n n n n n	TPF), or does it con an approved GME teach (D)? Enter "Y" for year began during this	FTEs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m s cost reporting	FTES in Hospital 4.00 0.0 1.0 1.0 rovider? N he most o. (see ing o.	(col. 3 + col. 4)) 5.00 00 0.000000 00 2.00 3.00 4 0	_

Heal th HOSPI TA	Financial Systems ST. VINCENT MER AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	RCY HOSPITAL Provider C	CN: 15-1308	Period: From 07/01/2018	u of Form CMS Worksheet S- Part I	2
				To 06/30/2019	Date/Time Pr 11/25/2019 3	epared: :08 pm
					1.00	_
	Long Term Care Hospital PPS					
81.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part o "Y" for yes and "N" for no.			g period? Enter	N N	80.00 81.00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)	TEFRA? Ente	r "Y" for ves	or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	ed unit) under	42 CFR Secti	on		86.00
	ls this hospital an extended neoplastic disease care hospita 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ar crassi fred	under section		Ν	87.00
				V 1.00	XI X 2.00	_
	Title V and XIX Services			1.00	2.00	
	Does this facility have title V and/or XIX inpatient hospita yes or "N" for no in the applicable column.	al services? E	nter "Y" for	N	Y	90.00
91.00	is this hospital reimbursed for title V and/or XIX through 1			Ν	Y	91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the appl Are title XIX NF patients occupying title XVIII SNF beds (du	ual certificat			Y	92.00
	instructions) Enter "Y" for yes or "N" for no in the applica Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	Ν	N	93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94.00
	applicable column. If line 94 is "Y", enter the reduction percentage in the app	olicable colum	n	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the app			0.00	0.00	97.00
	Does title V or XIX follow Medicare (title XVIII) for the ir stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" 1			N	Y	98.00
	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the re	eporting of ch	arges on Wkst	. N	Y	98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.	tle V, and in	column 2 for			
98. 02	Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			N	Y	98.02
98. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye			N	Ν	98.03
	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH	reimbursed 10	1% of	N	N	98.04
	outpatient services cost? Enter "Y" for yes or "N" for no ir in column 2 for title XIX.	n column 1 for	title V, and			
98. 05	Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				Y	98.05
1	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost	reimbursed fo	r Wkst. D,	Ν	Y	98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in columr column 2 for title XIX.	n 1 for title	V, and in			
	Rural Providers					105 00
106.00	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of paymen	t N		105. 00 106. 00
	for outpatient services? (see instructions) If this facility qualifies as a CAH, is it eligible for cos1	t reimbursemen	t for I&R	N		107.00
	training programs? Enter "Y" for yes or "N" for no in columr yes, the GME elimination is not made on Wkst. B, Pt. I, col.			+		
	reimbursed. If yes complete Wkst. D-2, Pt. II.		0			
	Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N		108.00
		Physi cal 1.00	Occupationa		Respi ratory 4.00	_
109.00	If this hospital qualifies as a CAH or a cost provider, are	N	2.00 N	3.00 N	4.00 N	109.00
	therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
					1.00	-
	Did this hospital participate in the Rural Community Hospita				N	110.00
	Demonstration)for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.					

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN		Period: From 07/01/ To 06/30/	2018 2019	Workshee Part I Date/Tir 11/25/20	et S-2 me Prep	pared:
		1.00		2.0	0	
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Com Health Integration Project (FCHIP) demonstration for this cost reporting pe "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, er integration prong of the FCHIP demo in which this CAH is participating in c Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	riod? Enter ter the column 2.	N				111.00
			1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 15.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 3 either "93" percent for short term hospital or "98" percent for long term psychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1.	E", enter care (inclu definition	in column µdes	N		0	115.00
16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" 17.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" no.		"N" for	N Y			116. 00 117. 00
18.00 is the malpractice insurance a claims-made or occurrence policy? Enter 1 if claim-made. Enter 2 if the policy is occurrence.	the policy	is	2			118.00
charmeniade. Enter 2 th the pointy is occurrence.	Premi ums	Losses	s	Insura	ance	
-	1.00	2.00		3.0	0	
18.01 List amounts of malpractice premiums and paid losses:	100, 33	35	0		0	118. 01
		1.00		2.0		
 18.02 Are mal practice premiums and paid losses reported in a cost center other th Administrative and General? If yes, submit supporting schedule listing cost and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) 	t centers sion in ACA for yes or outpatient	N		N		118. 02 119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devices	charged to	Y				121.00
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1903(w Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.		Y		5.0	0	122.00
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" f	orno.lf	N				125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter the certifi	cation date					126. 00
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certific	ation date					127.00
in column 1 and termination date, if applicable, in column 2. 28.00 of this is a Medicare certified liver transplant center, enter the certific	ation date					128. 00
 in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certifica column 1 and termination date, if applicable, in column 2. 	tion date ir	ו				129. 00
30.00 If this is a Medicare certified pancreas transplant center, enter the certified pancreas transplant center, enter the certified pancreas transplant center.	ficati on					130. 00
31.00 If this is a Medicare certified intestinal transplant center, enter the cer date in column 1 and termination date, if applicable, in column 2.	ti fi cati on					131.00
32.00 If this is a Medicare certified islet transplant center, enter the certific	ation date					132.00
 in column 1 and termination date, if applicable, in column 2. 33.00 If this is a Medicare certified other transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 	ation date					133. 00
 34.00 If this is an organ procurement organization (0P0), enter the 0P0 number ir and termination date, if applicable, in column 2. 	column 1					134.00
All Providers 40.00Are there any related organization or home office costs as defined in CMS F	ub. 15-1.	Y		15H0-	46] 140. 00
		· · ·	1		-	1

ealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		CENT MERCY	Provider CC	N: 15-1308	Peri o		u of Form CMS- Worksheet S-2	
UST THE AND HUST THE HEALTH UNKE COMPLE			rovider cc	N. 13-1300	From	07/01/2018 06/30/2019	Part I	epared
1.00		2.00				3.00	11/25/2019 5.	. 08 piii
If this facility is part of a chai		ter on line			e name ar		of the	
home office and enter the home of			actor numbe				-	
41.00Name: ST. VINCENT HEALTH 42.00Street: 250 WEST 96TH STREET SUITE	Contractor's N 215 PO Box:	Name: WPS		Contra	ctor's N	lumber: 0810	1	141. (
43. 00 City: INDIANAPOLIS	State:	I N		Zip Co	de:	4626	0	142.0
	1						-	1.101
							1.00	
44.00 Are provider based physicians' cos	sts included in Work	ksheet A?					Y	144. (
						1.00	2.00	-
 45.00 If costs for renal services are clipatient services only? Enter "Y" no, does the dialysis facility inceptiod? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in 	' for yes or "N" for clude Medicare utili for no in column 2. gy changed from the	r no in col zation for previously	umn 1. lfc this cost filed cost	olumn 1 is reporting report?		N		145. (
yes, enter the approval date (mm/o								
							1.00	_
47.00Was there a change in the statisti	cal basis? Enter "V	(" for ves	or "N" for	no			1.00 N	147.
48.00Was there a change in the order of							N	148.
49.00 Was there a change to the simplifi	ed cost finding met	thod? Enter					N	149.
			Part A	Part B		Title V	Title XIX	_
Does this facility contain a prov	ider that qualifies	for an exe	1.00	2.00 the appli	cation (3.00 of the Lowe	4.00 r.of.costs	-
or charges? Enter "Y" for yes or								
55.00Hospi tal		•	N	N		N	N	155.
56.00 Subprovider - IPF			N	N		N	N	156.
57.00 Subprovi der – IRF 58.00 SUBPROVI DER			N	Ν		N	N	157. 158.
59. 00 SNF			N	Ν		N	Ν	159.
60.00 HOME HEALTH AGENCY			N	N		N	Ν	160.
61.00 CMHC				N		N	N	161. (
							1.00	-
Multicampus							1.00	
65.00 Is this hospital part of a Multica	ampus hospital that	has one or	more campu	ses in dif	ferent (CBSAs?	N	165.
Enter "Y" for yes or "N" for no.	Namo	C		Ctoto	7 . n. Code	CDCA		
	Name 0		ounty 1.00	State 2.00	Zip Code 3.00	e CBSA 4.00	FTE/Campus 5.00	-
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0 166. (
							1.00	-
Health Information Technology (HI	T) incentive in the	American R	ecovery and	Reinvestn	nent Act			
57.00 s this provider a meaningful user 58.00 of this provider is a CAH (line 10 reasonable cost incurred for the H	D5 is "Y") and is a	meani ngful			"), ente	er the	Y	167. 0168.
58.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful u	? Enter "Y" for yes	or "N" for	no. (see i	nstruction	s)		0.0	168. 0169.
transition factor. (see instruction		,	iot a CAII (1116 100 1	JNJ,		0.0	0107.
· · · · · · · · · · · · · · · · · · ·					В	egi nni ng	Endi ng	
		and an all the	for all			1.00	2.00	170
	beginning date and e	enaing date	ror the re	porting	10	0/01/2017	09/30/2018	170.
70.00 Enter in columns 1 and 2 the EHR H period respectively (mm/dd/yyyy)								
70.00[Enter in columns 1 and 2 the EHR L period respectively (mm/dd/yyyy)						1.00	2.00	

	Financial Systems ST. VINCENT ME AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE		CN: 15-1308	Peri od:	u of Form CMS- Worksheet S-2	
				From 07/01/2018 To 06/30/2019		
		- I		Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	I for all NO re	esponses. Ent	er all dates in "	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c		instructions	· · · · · · · · · · · · · · · · · · ·		
			Y/N 1.00	Date 2.00	V/I 3.00	
. 00	Has the provider terminated participation in the Medicare F	5	N	2.00	3.00	2.
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for				
. 00	Is the provider involved in business transactions, includir		N			3. (
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)					-
			Y/N 1.00	Type 2.00	Date 3.00	-
	Financial Data and Reports		1.00	2.00	3.00	
. 00	Column 1: Were the financial statements prepared by a Cert		Y	A		4. (
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f					
	or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	ailable in				
. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5.0
	those on the filed financial statements? If yes, submit rec					
				Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	-
. 00	Column 1: Are costs claimed for nursing school? Column 2:	lf yes, is th	ne provider i	s N		6.0
	the legal operator of the program?	5				
. 00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7.0
. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	d during the	N		8.0
. 00	Are costs claimed for Interns and Residents in an approved	graduate medio	cal education	Ν		9. (
	program in the current cost report? If yes, see instruction	is.				
0.00	Was an approved Intern and Resident GME program initiated of	or renewed in 1	the current	N		10.0
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& R in an Anr	roved	N		11. (
1.00	Teaching Program on Worksheet A? If yes, see instructions.		or oved			
					Y/N	
	Ded Debte				1.00	-
2 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	see instruct	tions		Y	12. (
	If line 12 is yes, did the provider's bad debt collection p			ost reporting	N	13. (
	period? If yes, submit copy.					
4.00		ents waived? If	Fyes, see in	structions.	N	14. (
5.00	Bed Complement Did total beds available change from the prior cost reporti	ng period? If	ves, see ins	tructions.	N	15. (
			rt A		tВ	
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3.00	4.00	-
6.00	Was the cost report prepared using the PS&R Report only?	Y	10/04/2019	Y	10/04/2019	16. (
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					1
7.00	instructions) Was the cost report prepared using the PS&R Report for	N		Ν		17. (
7.00	totals and the provider's records for allocation? If					''.
	either column 1 or 3 is yes, enter the paid-through date					
0 00	in columns 2 and 4. (see instructions)					10
8.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18.
	but are not included on the PS&R Report used to file this					1
		1	1	1		1
	cost report? If yes, see instructions.					
9. 00		N		Ν		19.

Health Financial Systems

ST. VINCENT MERCY HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CM	S-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provider CO	CN: 15-1308	Peri od: From 07/01/2018 To 06/30/2019	Date/Time P	repared:				
		Deperi	ntion	V /N	11/25/2019	3:08 pm				
			ption)	Y/N 1.00	Y/N 3.00					
20.00 If line 16 or 17 is yes, were adjustments mad Report data for Other? Describe the other adj)	N	N	20.00				
	us tillorres.	Y/N	Date	Y/N	Date					
		1.00	2.00	3.00	4.00					
21.00 Was the cost report prepared only using the p records? If yes, see instructions.	provi der' s	N		N		21.00				
					1.00					
COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT Capital Related Cost	ALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)							
22.00 Have assets been relifed for Medicare purpose	s? If ves, see	e instructions			N	22.00				
	00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost									
24.00 Were new leases and/or amendments to existing If yes, see instructions	leases entere	ed into during	this cost rep	oorting period?	N	24.00				
25.00 Have there been new capitalized leases entered instructions.	ed into during	the cost repor	ting period?	lf yes, see	N	25.00				
26.00 Were assets subject to Sec. 2314 of DEFRA acqu instructions.	ired during th	ne cost reporti	ng period? If	yes, see	Ν	26.00				
 27.00 Has the provider's capitalization policy char copy. 	nged during the	e cost reportin	g period?lf	yes, submit	N	27.00				
Interest Expense					N					
28.00 Were new loans, mortgage agreements or letter period? If yes, see instructions.			C		N	28.00				
29.00 Did the provider have a funded depreciation a treated as a funded depreciation account? If	yes, see instr	ructions			N	29.00				
30.00 Has existing debt been replaced prior to its instructions.		5	3		N	30.00				
31.00 Has debt been recalled before scheduled matur instructions.	ity without is	ssuance of new	debt? If yes,	see	N	31.00				
Purchased Services32.00Have changes or new agreements occurred in pa			d through cor	itractual	N	32.00				
33.00 arrangements with suppliers of services? If y 1f line 32 is yes, were the requirements of S			g to competit	ive bidding? If	N	33.00				
no, see instructions. Provider-Based Physicians						_				
34.00 Are services furnished at the provider facili If yes, see instructions.	ty under an ar	rrangement with	provi der-bas	ed physi ci ans?	Y	34.00				
35.00 If line 34 is yes, were there new agreements physicians during the cost reporting period?			ts with the p	orovi der-based	Y	35.00				
	11 100/ 000 11			Y/N 1.00	Date 2.00					
Home Office Costs				1.00	2.00					
36.00 Were home office costs claimed on the cost re 37.00 If line 36 is yes, has a home office cost sta		repared by the	home office?	Y		36.00 37.00				
If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of	•	. ,		N.		38.00				
the provider? If yes, enter in column 2 the f 39.00 If line 36 is yes, did the provider render se	iscal year end	d of the home o	ffi ce.			39.00				
see instructions. 40.00 If line 36 is yes, did the provider render se			3	N		40.00				
instructions.						10.00				
Cost Deport Deports Costact Information	00									
41.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title held by the cost report preparer in columns 1		JILL		HILL		41.00				
42.00 Enter the employer/company name of the cost r	report	ASCENSI ON				42.00				
43.00 preparer.43.00 Enter the telephone number and email address report preparer in columns 1 and 2, respective		317-583-3519		JI LL. HI LL1@ASC	ENSI ON. ORG	43.00				

Heal th	Financial Systems	ST. VINCENT	MERCY	Y HOSPI TAL		In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	UESTI ONNAI RE		Provider CCN: 15-1308		eriod:	Worksheet S-2	
					To	rom 07/01/2018 0 06/30/2019		
							11/23/2019 3.	
				3.00				
	Cost Report Preparer Contact Information							
	Enter the first name, last name and the ti-		MAN	NAGER OF REIMBURSEMENT				41.00
	held by the cost report preparer in columns	s 1, 2, and 3,						
	respecti vel y.							
	Enter the employer/company name of the cos	t report						42.00
	preparer.							
	Enter the telephone number and email addres							43.00
	report preparer in columns 1 and 2, respec	ti vel y.						l

^{11/25/2019 3:08} pm Y: \28650 - St. Vincent Mercy\300 - Medicare Cost Report\20190630\HFS Files\28650-19.mcrx

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	<u>ST. VINCENT MER</u> AL DATA	Provider CC	CN: 15-1308	Period: From 07/01/2018	u of Form CMS-: Worksheet S-3 Part I	
					To 06/30/2019		epared: 08 pm
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30. 00	25	9, 12	25 17, 616. 00	0	1.00
	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 4.00	HMO IPF Subprovider HMO IRF Subprovider						3.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation		25	9, 12	17, 616. 00	-	
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	0		0 0.00	0	
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
12.00	SURGICAL INTENSIVE CARE UNIT DETOXIFICATION INTENSIVE CARE UNIT	35.00	0		0 0.00	0	
13.00	NURSERY	33.00	0		0.00	0	13.00
14.00	Total (see instructions)		25	9, 12	17, 616. 00	0	
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER – IRF						17.00
18.00	SUBPROVI DER						18.0
19.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY OTHER LONG TERM CARE						20.0
21.00 22.00	HOME HEALTH AGENCY						21.0
22.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.0
24.10	HOSPICE (non-distinct part)	30.00					24.1
25.00	CMHC - CMHC						25.0
26.00	RURAL HEALTH CLINIC						26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
27.00	Total (sum of lines 14-26)		25				27.0
28.00	Observation Bed Days					0	
29.00	Ambulance Trips						29.0
30.00 31.00	Employee discount days (see instruction) Employee discount days - IRF						30.0
32.00	Labor & delivery days (see instructions)		0		0		32.0
32.00 32.01	Total ancillary labor & delivery room		0		Ŭ		32.0
	outpatient days (see instructions)						02.0
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.0

HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 07/01/2018 To 06/30/2019		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 22.00 23.00 24.00 24.00 24.00 25.00 26.00 26.25 27.00 28.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT DETOXIFICATION INTENSIVE CARE UNIT NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	0, 00 199 0 0 0 104 434 0 0 434 10, 063 0 0 0	22 40 0 0 22 0 0 22 1, 127 0 0 0 22 1, 127	73 16 89 33, 43	0 4 0 4 0 0 4 0 0 0 0 0 0 0 0 0 0 0 0 0	70. 10 0. 00 70. 10	15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 26. 25
30. 00 31. 00 32. 00 32. 01 33. 00	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0	0		4 0 0 0		30.00 31.00 32.00 32.0 33.00

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	<u>ST. VINCENT MER(</u> AL DATA	Provider C	CN: 15-1308	Period: From 07/01/2018 To 06/30/2019	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 11/25/2019 3:0	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00		76 12	218	1.00
2.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		Ū		54 14	210	2.00
3.00 4.00 5.00 6.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF				0 0		3.00 4.00 5.00 6.00
7.00 8.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						7.00 8.00
9.00 10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9.00 10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	DETOXIFICATION INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0		96 12	218	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00 21.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						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 Trips						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 33. 00	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days				0		32. 01 33. 00
55.00	LTCH site neutral days and discharges			1	0		00.00

Heal th	Financial Systems ST. VINCENT MERCY H	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA P	rovider CC	CN: 15-1308	Period: From 07/01/2018	Worksheet S-1	0
				To 06/30/2019		
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by li	ne 202 column	8)	0. 292829	1.00
	Medicaid (see instructions for each line)			-)		
2.00	Net revenue from Medicaid				649, 142	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 supplementa			i d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fro	om Medicai	d		0	5.00
6.00	Medi cai d charges				15, 344, 734	6.00
7.00	Medicaid cost (line 1 times line 6)		C 1 ·		4, 493, 383	7.00
8.00	Difference between net revenue and costs for Medicaid program (I < zero then enter zero)			es 2 and 5; IT	3, 844, 241	8.00
	Children's Health Insurance Program (CHIP) (see instructions for	each line	e)			
9.00	Net revenue from stand-al one CHIP				0	
10.00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10.00 11.00
11. 00 12. 00	Difference between net revenue and costs for stand-alone CHIP (I	ing 11 mi	nus lino 0 i	f < zero then	0	12.00
12.00	enter zero)		nus i ne 🧃 i		0	12.00
	Other state or local government indigent care program (see instr	uctions fo	or each line)			
13.00	Net revenue from state or local indigent care program (Not inclu)	0	13.00
14.00	Charges for patients covered under state or local indigent care	program (Not included	in lines 6 or	0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line 14)				0	15.00
16.00	Difference between net revenue and costs for state or local indi	gent care	program (lin	e 15 minus line	0	16.00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state	/local india	ont caro progra		
	instructions for each line)			ent care program	IIS (See	
17.00	Private grants, donations, or endowment income restricted to fur	nding char	ity care		0	17.00
18.00	Government grants, appropriations or transfers for support of ho				0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	i ndi gent	care programs	(sum of lines	3, 844, 241	19.00
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col. 2)	
			1.00	2.00	3.00	
~~ ~~	Uncompensated Care (see instructions for each line)		0 15 1 05	a	4 470 700	
20.00	Charity care charges and uninsured discounts for the entire faci (see instructions)	lity	3, 454, 07	3 1, 018, 650	4, 472, 723	20.00
21.00	Cost of patients approved for charity care and uninsured discour instructions)	nts (see	1, 011, 45	3 1, 018, 650	2, 030, 103	21.00
22.00	Payments received from patients for amounts previously written of charity care	off as	73, 57	7 28, 535	102, 112	22.00
23.00	Cost of charity care (line 21 minus line 22)		937, 87	6 990, 115	1, 927, 991	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patient	days bey	ond a length	of stay limit	N 1.00	24.00
25.00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the	orogram?	0	5	0	25.00
	stay limit	0	our o program	e rongen er	_	
26.00 27.00	Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex		ructions)		1, 085, 069 561, 706	
27.00	Medicare allowable bad debts for the entire hospital complex (se				864, 163	
28.00	Non-Medicare bad debt expense (see instructions)				220, 906	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (see	instructions)		367, 145	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				2, 295, 136	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus lir	ne 30)			6, 139, 377	
						-

Cost Center Description Salaries Other Tatal (cc.) Reclassified Blance (col. 3) EXEMPAL SERVICE COST CENTERS 1 00 2.00 3.00 4.00 5.00 1.00 00000 (FF CAP RL COSTS-BLG A FXT (col. 4) 535,417 535,417 536,417 536,417 0.00 00000 (FF CAP RL COSTS-BLG A FXT (col. 4) 535,417 535,417 536,417 536,417 0.00 00000 (FF CAP RL COSTS-BLG A FXT (col. 4) 532,678 632,678<		ST. VINCENT MER				u of Form CMS-	2552-10
Cost Center Description Salaries Other Total (col.) Reciassification Reciassification 1 00 200 3.00 4.00 5.00 100 1 00 200 3.00 4.00 5.00 100 1 00 200 3.00 4.00 5.00 5.00 1 00 200 3.00 4.00 5.00 5.00 2.00 00200 (HB CAP REL COSTS-MPULE EQUIP 632, 678 632, 678 632, 678 632, 678 3.00 00400 (EMR CAP REL COSTS-MPULE EQUIP 642, 601 1.367, 324 3.00 1, 365, 622 0 1, 365, 622 0 1, 365, 622 0 1, 365, 622 0 3.60, 35, 622 0 1, 365, 622 0 3.60, 35, 622 0 3.60, 35, 622 0 3.60, 35, 622 0 3.60, 30 9.60, 644, 313 384, 433 87, 662 0 3.60, 30 9.60, 644, 313 384, 433 87, 662 0 1.62, 135, 622 0 1.62, 135, 622 0 1.	RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider C			Worksheet A	
Cast Center Description Salaries Other Total (col. 2) (col. 3) (col. 3) (col. 3) (col. 4) Total (col. 2) (col. 3) (col. 4) Reclassificati (col. 3) (col. 4) Reclassificati (col. 3) (col. 4) 0 00000 [EE COST CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 00100 [EE COST S-MDL 6 [INT 535, 417 535, 417 -3, 924 531, 493 2.00 00400 [EPLCVE BNFT IS DEPARTMENT -4, 906 1, 392, 218 1, 363, 394 3, 924 6, 39, 908 2.00 000400 [EPLCVE BNFT IS DEPARTMENT -4, 906 1, 352, 218 0, 2, 33, 934 3, 924 6, 39, 908 2.00 000200 [EPLCVE BNFT IS DEPARTMENT 193, 406 1, 162, 216 1, 355, 622 0 1, 355, 623 3, 33, 030 0.00 00020 [AUROVA & LINEN SLEW/CE 0 544, 31, 31 3, 443 3, 344, 313 3, 443, 33 3, 443, 33 3, 443, 33 3, 443, 33 3, 443, 33 3, 443, 33 3, 443, 33 3, 443, 33 3, 443, 33 3, 443, 33 3, 443, 33 3, 443, 33 3, 443, 33 3, 443, 33 3, 443, 33 3, 433 <t< td=""><td></td><td></td><td></td><td></td><td>To 06/30/2019</td><td>Date/Time Pre</td><td></td></t<>					To 06/30/2019	Date/Time Pre	
Image: service in the servic	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
Image: constraint of the						Trial Balance	
ENERAL SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 00100 KPI CAP REL COSTS - MURE E OUP 535, 417 -3.924 531, 493 3.00 00300 OTHER CAP TAL DECASTS - BUDP 632, 678 632, 678 0 632, 678 3.00 00300 OTHER CAP TAL DELATEINS DEPARTMENT -4.906 1, 397, 312 0 1, 387, 312 0 1, 387, 312 0 1, 387, 312 0 1, 387, 312 0 1, 387, 312 0 1, 387, 312 0 1, 387, 312 0 1, 387, 312 0 1, 387, 312 0 1, 387, 312 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 313 0 1, 387, 312 0						(col. 3 +-	
ENERGL SERVICE COST CENTERS 535, 417 535, 417 535, 417 537, 473 1.00 00100 NEW CAP REL COSTS-BLDE & FIXT 632, 678 0						col. 4)	
1.00 00100 NEW CAP REL COSTS-MULE CAP LID & FLXT 535, 417 535, 417 -3, 924 531, 493 2.00 00200 OTHER CAP REL COSTS-WULE CAUTA 632, 678		1.00	2.00	3.00	4.00	5.00	
2.00 00200 NEW CAP REL COSTS-MUBLE EQUIP 6.32, 678 6.32, 678 6.32, 678 6.32, 678 6.32, 678 3.00 00300 OTHER CAPTIAL RELATED COSTS 0 0 0 0 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT -4,906 1, 392, 218 1, 387, 312 0 1, 387, 312 7.00 00700 OPERATION OF PLANT 193, 406 1, 162, 216 1, 355, 622 0 1, 355, 622 0 1, 355, 622 0 1, 355, 622 0 1, 355, 622 0 1, 355, 622 0 1, 355, 622 0 1, 355, 622 0 1, 355, 622 0 1, 355, 622 0 1, 355, 623 0, 315, 030 355, 030 557, 473 443, 313 87, 065 11.00 01100 CAFETERIA 0 0 1 1<3					-		
3.00 00300 OTHER CAPITAL RELATE COSTS 0							
4.00 00400 EMPLOYEE EBREFITS DEPARTMENT -4.906 1, 392, 218 1, 387, 312 0 1, 387, 312 5.00 00500 ADMINISTRATION OF PLANT 1193, 406 1, 162, 216 1, 355, 622 0 1, 355, 622 0.00000 (DERATION OF PLANT 193, 406 1, 162, 216 1, 355, 622 0 1, 355, 622 0.00000 (DUSEKEPING 0 542, 504 542, 504 -355, 030 557, 7474 10.00 01000 (ARESING ADMINISTRATION 79, 921 143 80, 604 0 80, 004 15.00 01500 (PHARMACY 271, 899 3, 375, 262 3, 647, 161 -1, 150 3, 644, 011 17.00 01700 SOCIAL SERVICE 82, 323 41, 443 308, 286 786, 729 -705 766, 024 0.00 03000 ADULTS & PEDI ATRICS 478, 443 308, 286 7.1, 725 705 766, 024 22, 278 1 472, 575 705 766, 024 22, 278 1 472, 575 705 766, 024 20, 0 0 0 0 0 0 0			632, 678	632, 67	8 0	632, 678	
5.00 00500 ADMI IN STRATI VE & GENERAL 414.652 6.231,322 6.635,964 3,924 6.639,908 8.00 009800 LAUNDRY & LINEN SERVICE 0 5.62 0.1355,622 0.355,632 9.00 00900 DUSKEEPING 0 542,504 543,030 557,622 9.00 00000 DIETARY 0 431,318 -344,313 87,005 10.00 01000 EFETERIA 0 0 344,313 87,005 -36,040,011 13.00 01300 INURSI KG ADMI NI STRATION 79,921 143 80,064 0 800,044 10.00 01000 PIRAMACY 271,899 3,35,220 3,647,161 -1,150 3,640,011 10.00 01000 MURIS AL ERCORDS & LIBRARY 0 133 133 133 133 133 10.00 01000 MULTS & PEDIATIRI CS 478,443 308,286 786,729 -705 786,024 2 31.00 03100 INTERNS VE CARE UNIT 0 0 0 0 0 0			0		0	0	3.00
7.00 00700 (DEEARTION OF PLANT 193, 406 1, 162, 216 0, 355, 652 0 1, 355, 622 0 1, 355, 622 9.00 00900 (HOUSEKEEPING 0 542, 504 -542, 504 -53, 530 507, 474 10.00 0100 (CAFETERIA 0 0 344, 313 344, 313 344, 313 344, 313 344, 313 344, 313 344, 313 344, 313 344, 313 344, 313 344, 313 344, 313 344, 313 344, 313 360, 0040 0 0 00, 0040 0 36, 064 0 36, 064 0 36, 064 0 36, 064 0 36, 064 0 36, 064 0 36, 064 0 36, 064 0 36, 064 0 36, 064 0 36, 064 0 36, 064 0 36, 064 0 36, 064 0 36, 064 0		-4, 906					4.00
8.00 000000 LAUNDRY & LINEN SERVICE 0 0 35, 030 35, 030 9.00 00000 HUSEKEEPING 0 431, 318 431, 318 -344, 313 87, 005 13.00 01000 LIETARY 0 431, 318 431, 318 -344, 313 87, 005 13.00 01300 NURSI NG ADMINI STRATI ON 79, 921 143 80, 064 0 80, 064 15.00 01500 PHARMACY 21, 999 3, 352, 262 3, 647, 161 -1, 150 3, 646, 011 16.00 01600 MEDI ALL RECORDS & LIBRARY 0 13 13 -1 10 0 3, 647, 161 -1, 150 3, 647, 161 -705 766, 024 -705 766, 024 -705 766, 024 -775 50 02 04000 0	5. 00 00500 ADMI NI STRATI VE & GENERAL	414, 652	6, 221, 332			6, 639, 908	5.00
9.00 009000 HOUSEKEEPING 0 542,504 -35,030 507,474 10.00 01000 CAFETERIA 0 0 030,01100 344,313 344,313 344,313 11.00 01500 PHARMACY 271,899 3,375,262 3,647,161 -1,150 3,646,011 15.00 01500 PHARMACY 271,899 3,375,262 3,647,161 -1,150 3,646,011 17.00 00100 SOCIAL SERVICE 82,323 41,443 123,766 0 133 0 133 0.00 0000 ADULTS & PEDIATRICE COST CENTERS 9 -705 786,024 - - 786,024 - - - - 0	7.00 00700 OPERATION OF PLANT	193, 406	1, 162, 216	1, 355, 62	2 0	1, 355, 622	7.00
10.00 01000 DETARY 0 431,318 431,318 -344,313 B7,005 13.00 01300 NURSING ADMINISTRATION 79,921 143 80,064 0 80,064 15.00 01500 NURSING ADMINISTRATION 79,921 143 80,064 0 344,313 344,313 16.00 01600 MEDICAL, RECORDS & LIBRARY 0 3,375,262 3,647,161 -1,150 3,646,011 16.00 05001 ALSERVICE 82,323 41,443 123,766 0 123,766 0.00 03000 ADULTS & PEDIATRICS 478,443 308,286 786,729 -705 786,024 0.00 02040 DETOXIFICARE UNIT 0 </td <td>8.00 00800 LAUNDRY & LINEN SERVICE</td> <td>0</td> <td>0</td> <td></td> <td>0 35, 030</td> <td>35, 030</td> <td>8.00</td>	8.00 00800 LAUNDRY & LINEN SERVICE	0	0		0 35, 030	35, 030	8.00
11:00 01100 CAFETERIA 0 0 344, 313 344, 313 11:00 01500 PHARMACY 271, 899 3, 375, 262 3, 647, 161 -1, 150 3, 646, 011 16:00 01500 PHARMACY 271, 899 3, 375, 262 3, 647, 161 -1, 150 3, 646, 011 16:00 01500 PHARMACY 82, 323 41, 443 123, 766 0 123, 766 11:00 01700 SOCIAL SERVICE COST CENTERS 0	9. 00 00900 HOUSEKEEPI NG	0	542, 504	542, 50	4 -35, 030	507, 474	9.00
13:00 NURSING ADMINISTRATION 79, 921 14.3 80, 064 0 80, 064 10:00 NURSING ADMINISTRATION 271, 899 3, 375, 262 3, 647, 161 -1, 150 3, 640, 01 16:00 01500 MEDICAL, RECORDS & LIBRARY 82, 323 41, 443 123, 766 0 123, 766 00 03000 ADULTS & PEDIATRICS 82, 323 41, 443 123, 766 0	10. 00 01000 DI ETARY	0	431, 318	431, 31	8 -344, 313	87,005	10.00
15:00 PHARMACY 271,899 3,375,262 3,647,161 -1,150 3,646,011 17:00 000 MEDICAL RECORDS & LIBRARY 0 13 13 0 133 17:00 000 MEDICAL SERVICE 82,323 41,443 123,766 0 123,766 10:00 000 ADULTS & PEDIATRICS 478,443 308,286 786,729 -705 786,024 0 30:00 03000 INTENSIVE CARE UNIT 0 <t< td=""><td>11. 00 01100 CAFETERI A</td><td>0</td><td>0</td><td></td><td>0 344, 313</td><td>344, 313</td><td>11.00</td></t<>	11. 00 01100 CAFETERI A	0	0		0 344, 313	344, 313	11.00
15:00 01500 PHARMACY 271.899 3.375,262 3.647,161 -1,150 3.646,011 17:00 001700 SOLAL SERVICE 82,323 41.443 123,766 0 123,766 10:00 00000 ADULTS & PEDIATRICS 478,443 308,286 786,729 -705 786,024 2 30:00 03000 ADULTS & PEDIATRICS 478,443 308,286 786,729 -705 786,024 2 30:00 000 DETOXI FICATION INTENSIVE CARE UNIT 0	13.00 01300 NURSING ADMINISTRATION	79, 921	143	80, 06	4 0	80, 064	13.00
16. 00 01400 MEDICAL RECORDS & LIBRARY 0 13 <td>15.00 01500 PHARMACY</td> <td>271, 899</td> <td>3, 375, 262</td> <td>3, 647, 16</td> <td>1 -1, 150</td> <td>3, 646, 011</td> <td>15.00</td>	15.00 01500 PHARMACY	271, 899	3, 375, 262	3, 647, 16	1 -1, 150	3, 646, 011	15.00
17.00 OD 1700 SOCI AL SERVICE 82, 323 41, 443 123, 766 0 123, 766 INPART ENT ROUTINE SERVICE COST CENTERS 308, 286 786, 729 -705 786, 024 3 30.00 03100 INTENSIVE CARE UNIT 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>							1
INPATIENT ROUTINE SERVICE COST CENTERS		82, 323					1
30: 00 02000 ADULTS & PEDI ATRI CS 478, 443 308, 286 786, 729 -705 786, 024 31: 00 02040 INTENSI VE CARE UNI T 0					· ·		
31. 00 00 00 0 0 0 0 0 0 35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT 0		478, 443	308, 286	786, 72	9 - 705	786, 024	30.00
35.00 Q2040 DETOXI FICATION INTENSIVE CARE UNIT 0 </td <td>31.00 03100 INTENSIVE CARE UNIT</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>31.00</td>	31.00 03100 INTENSIVE CARE UNIT						31.00
ANCI LLARY SERVICE COST CENTERS ANCI LLARY SERVICE COST CENTERS 54.00 05000 (OPERATI NG ROOM 358, 807 329, 442 688, 249 -215, 674 472, 575 5 54.00 05400 (RADI OLOGY – DI AGNOSTI C 716, 716 86, 807 803, 523 -1, 225 802, 298 5 50.00 05000 CT SCAN 0							
50.00 OSDOO OPERATI NG ROOM 358, 807 329, 442 688, 249 -215, 674 472, 575 54.00 05400 RADI OLOGY-DI AGNOSTI C 716, 716 86, 807 803, 523 -1, 225 802, 298 5 56.00 05600 RADI OL SOTOPE 0				I	0	<u> </u>	00.00
54.00 05400 RADI OLOGY - DI AGNOSTI C 716, 716 86, 807 803, 523 -1, 225 802, 298 5 50.00 05600 RADI OLOGY - DI AGNOSTI C 0		358 807	329 442	688 24	9 -215 674	472 575	50.00
56.00 05600 RADI 0I SOTOPE 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
57.00 OS700 CT SCAN 0		, 10, , 10					
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0<		0	0				
60.00 06000 LABORATORY 0 1,084,845 1,084,845 0 1,084,845 0 435,044 0 65.00 06500 RESPI RATORY THERAPY 398,710 36,334 435,044 0 435,044 0 66.00 06600 PHYSI CAL THERAPY 369,634 14,134 383,768 0 333,768 0 40,333 25,573 0 70,00 10,048 241,331 251,579 7 7 181,815 181,815 0 181,815 181,815 181,815 181,815 181,816 0 343,93 0 439,93 148		0	0				
65.00 06500 RESPI RATORY THERAPY 398,710 36,334 435,044 0 435,044 0 66.00 06600 PHYSI CAL THERAPY 369,634 14,134 383,768 0 40,333 0 40,333 0 40,333 0 40,333 0<		0	1 004 045	1 001 01	5 0		
66.00 06600 PHYSI CAL THERAPY 369, 634 14, 134 383, 768 0 383, 768 0 67.00 0CCUPATI ONAL THERAPY 40, 333 0 0 <td< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></td<>		0					
67.00 06700 OCCUPATI ONAL THERAPY 40,333 0 40,333 0 40,333 0 40,333 0 40,333 0 40,333 0 40,333 0 40,333 0 40,333 0 40,333 0 50,253 0 0 0 0 0 0 0 0 0 70,00 0 0 0 0 0 0 0 10,248 124,131 125,1579 7 7 181,815 181,815 0 148,323 0 48,323 0 48,323 7 7 7							
68.00 06800 SPEECH PATHOLOGY 50, 203 50 50, 253 0 50, 253 0 07.00 06900 ELECTROCARDI OLOGY 0							
69.00 06900 ELECTROCARDI OLOGY 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
70.00 07000 ELECTROENCEPHALOGRAPHY 0 <th< td=""><td></td><td>50, 203</td><td>50</td><td></td><td></td><td></td><td></td></th<>		50, 203	50				
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 10,248 10,248 241,331 251,579 7 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 181,815 181,815 0 181,815 0 181,815 0 181,815 0 181,815 0 181,815 0 181,815 0 181,815 0 439 439 0 439 439 0 439 439 0 439 439 0 48,323 0 48,323 0 207,060 0 207,060 0 207,060 0 207,060 0 207,060 0 207,060 0 207,060 0 207,060 0 207,060 0 207,060 0 207,060 0 207,060 0 207,060 0 0 0 2,526,576 0 0 0 0 0 2,526,576 0 0 0 0 2,857,233 0 22,857,233 0 22,857,233 0 22,857,233 1 1 1 1 1 1 1 0		0	0				
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 0 181, 815 181, 815 181, 815 0 181, 815 73.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 439 439 0 48, 323 76.00 03610 SLEEP LAB 47, 641 682 48, 323 0 48, 323 0 48, 323 0 207, 060 0 207, 060 0 207, 060 0 207, 060 0 207, 060 0 207, 060 0 207, 060 0 207, 060 0 207, 060 0 207, 060 0 207, 060 0 207, 060 0 207, 060 0 207, 060 0 207, 058 -11, 446 215, 612 9 9 900 9000 CLI NI C 197, 539 29, 519 227, 058 -11, 446 215, 612 9 9 9000 9200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 905, 547 1, 632, 160 2, 537, 707 -11, 131 2, 526, 576 9 9 9 9 9 9 9 9 9 9 9 9 9 <t< td=""><td></td><td>0</td><td>10 249</td><td>10.04</td><td>0 0/1 221</td><td></td><td></td></t<>		0	10 249	10.04	0 0/1 221		
PATIENTS PATIENTS O 439 439 O 439 439 O 439 7 73.00 03610 SLEEP LAB 47,641 682 48,323 O 48,323 O 48,323 O 248,323 O 248,323 O 248,323 O 248,323 O 248,323 O 207,060 O 207,060 O 207,060 O 207,060 O 207,060 200 207,060 O 207,060 200 200 0000 CLI NI C 197,539 29,519 227,058 -11,446 215,612 9 9 900,00 09000 0000 0000 0000 20,537,707 -11,131 2,526,576 9 9 905,547 1,632,160 2,537,707 -11,131 2,526,576 9 9 9 9 9 22,857,233 0 22,857,233 1 9 1 9 1 9 9 9 9 9 9 9 9		0					
73.00 07300 DRUGS CHARGED TO PATIENTS 0 439 439 0 439 7 76.00 03610 SLEEP LAB 47,641 682 48,323 0 48,323 0 76.01 03480 ONCOLOGY 176,526 30,534 207,060 0 207,060 0 00.00 09000 CLI NI C 197,539 29,519 227,058 -11,446 215,612 9 91.00 09100 EMERGENCY 905,547 1,632,160 2,537,707 -11,131 2,526,576 9 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 90,00 SPECI AL PURPOSE COST CENTERS 9 9 9 9 22,857,233 0 22,857,233 1 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 4,777,394 18,079,839 22,857,233 0 22,857,233 0 22,857,233 0 22,857,233 1 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 <td< td=""><td></td><td>0</td><td>181, 815</td><td>181, 81</td><td>5 0</td><td>181, 815</td><td>72.00</td></td<>		0	181, 815	181, 81	5 0	181, 815	72.00
76.00 03610 SLEEP LAB 47, 641 682 48, 323 0 48, 323 7 76.01 03480 ONCOLOGY 176, 526 30, 534 207, 060 0 207, 060 7 90.00 09000 CLINIC 197, 539 29, 519 227, 058 -11, 446 215, 612 7 91.00 OP100 EMERGENCY 905, 547 1, 632, 160 2, 537, 707 -11, 131 2, 526, 576 7 92.00 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 1 <td></td> <td>0</td> <td>420</td> <td>12</td> <td>0</td> <td>420</td> <td>72 00</td>		0	420	12	0	420	72 00
76.01 03480 ONCOLOGY 176, 526 30, 534 207, 060 0 207, 060 7 0UTPATIENT SERVICE COST CENTERS 0000 CLINIC 197, 539 29, 519 227, 058 -11, 446 215, 612 0 90.00 09100 EMERGENCY 905, 547 1, 632, 160 2, 537, 707 -11, 131 2, 526, 576 9 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 905, 547 1, 632, 160 2, 537, 707 -11, 131 2, 526, 576 9 92.00 OBSERVATION BEDS COST CENTERS SPECIAL PURPOSE COST CENTERS 0 22, 857, 233 0 22, 857, 233 12 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 4, 777, 394 18, 079, 839 22, 857, 233 0 22, 857, 233 12 190.00 I9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 14 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 14 194.00 07951 FOUNDATI ON		47 (41					
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 197, 539 29, 519 227, 058 -11, 446 215, 612 90 91.00 09100 EMERGENCY 905, 547 1, 632, 160 2, 537, 707 -11, 131 2, 526, 576 90 92.00 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 90 0 22, 857, 233 0 22, 857, 233 10 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 4, 777, 394 18, 079, 839 22, 857, 233 0 22, 857, 233 1 190.00 I9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 11 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 11 194.00 07950 MARKETI NG 0 0 0 0 11 19 194.02 07952 CLI NI C 0 0 0 0 11 194.02 07952 CLI NI C 0 0							
90.00 09000 CLINIC 197, 539 29, 519 227, 058 -11, 446 215, 612 9 91.00 09100 EMERGENCY 905, 547 1, 632, 160 2, 537, 707 -11, 131 2, 526, 576 9 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 905, 547 1, 632, 160 2, 537, 707 -11, 131 2, 526, 576 9 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 4, 777, 394 18, 079, 839 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 22, 857, 233 0 23, 857, 233 0 22, 857, 233 0 20, 857, 233 0 16		170, 520	30, 534	207,06	0 0	207,060	76.01
91.00 09100 EMERGENCY 905, 547 1, 632, 160 2, 537, 707 -11, 131 2, 526, 576 92 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 905, 547 1, 632, 160 2, 537, 707 -11, 131 2, 526, 576 92 SPECI AL PURPOSE COST CENTERS 900, 547 18, 079, 839 22, 857, 233 0 22, 857, 233 1 NONREI MBURSABLE COST CENTERS 9000 0 0 0 0 0 1 1 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 1 1 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 1 1 194.00 07950 MARKETI NG 0 0 0 0 1 1 194.02 07952 CLI NI C 0 0 0 0 0 0 1 194.03 07953 VACANT 0 0 0 0 0 0		107 520	20 510	227.05	0 11 444	215 (12	00.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 22,857,233 0 22,857,233 1 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 4, 777, 394 18, 079, 839 22, 857, 233 0 22, 857, 233 1 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 16 190.00 19200 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 17 194.00 07950 MARKETI NG 0 0 0 0 16 194.02 07952 CLINIC 0 0 0 17 194.02 07953 VACANT 0 0 0 0 17		905, 547	1, 032, 100	2, 537, 70	-11,131	2, 520, 570	
SUBTOTALS SUBTOTALS <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>92.00</td></t<>							92.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 19 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 16 194. 00 07950 MARKETI NG 0 0 0 17 194. 00 07951 FOUNDATI ON 0 59 59 0 18 194. 02 07952 CLI NI C 0 0 0 14 194. 03 07953 VACANT 0 0 0 17		4 777 204	10 070 020	22.057.22		22.057.222	110 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 14 194.00 07950 MARKETING 0 0 0 0 14 194.01 07951 FOUNDATION 0 59 59 0 59 14 194.02 07952 CLINIC 0 0 0 0 14 194.03 07953 VACANT 0 0 0 0 14		4, 777, 394	18, 079, 839	22,857,23	3 0	22,857,233	1118.00
194.00 07950 MARKETING 0 0 0 19 194.01 07951 FOUNDATION 0 59 59 0 59 19 194.02 07952 CLINIC 0 0 0 0 19 194.03 07953 VACANT 0 0 0 0 19		0	0		0 0	0	190.00
194. 00 07950 MARKETING 0 0 0 14 194. 01 07951 FOUNDATION 0 59 59 0 59 16 194. 02 07952 CLINIC 0 0 0 0 17 194. 02 07953 VACANT 0 0 0 0 16	192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
194. 01 07951 FOUNDATION 0 59 0 59 19 194. 02 07952 CLINIC 0 0 0 0 19 194. 03 07953 VACANT 0 0 0 0 19		0	0		0 0		194.00
194. 02 07952 CLINIC 0 0 0 0 19 194. 03 07953 VACANT 0 0 0 0 0			59	5	9 0		194.01
194. 03 07953 VACANT 0 0 0 0 0							194.02
		0					194.03
200.00 TOTAL (SUM OF LINES 118 through 199) 4, 777, 394 18, 079, 898 22, 857, 292 0 22, 857, 292 20		-			-		

CLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provider C	CN: 15-1308	B Period: From 07/01/201	Worksheet A	
					To 06/30/201		
	Cost Center Description		Net Expenses				
			or Allocation				
	GENERAL SERVICE COST CENTERS	6.00	7.00				-
00	00100 NEW CAP REL COSTS-BLDG & FIXT	226, 044	757, 537				1.0
00	00200 NEW CAP REL COSTS-DEDG & TTXT	220, 044	632, 678				2.0
00	00300 OTHER CAPITAL RELATED COSTS	0	032, 070				3.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-327	1, 386, 985				4.0
00	00500 ADMI NI STRATI VE & GENERAL	-763, 133	5, 876, 775				5.0
00	00700 OPERATI ON OF PLANT	-445	1, 355, 177				7.0
00	00800 LAUNDRY & LINEN SERVICE	0	35, 030				8.0
00	00900 HOUSEKEEPING	0	507, 474				9.0
0.00	01000 DI ETARY	-44, 544	42, 461				10.0
1.00	01100 CAFETERI A	-44, 344	344, 313				11.0
3.00	01300 NURSI NG ADMI NI STRATI ON	-27	80, 037				13. (
5.00	01500 PHARMACY	-3, 633	3, 642, 378				15.0
5.00	01600 MEDICAL RECORDS & LIBRARY	-3,033	3, 042, 378	1			16.0
7.00		150					17. 0
. 00	INPATIENT ROUTINE SERVICE COST CENTERS	-150	123, 616				
0. 00	03000 ADULTS & PEDIATRICS	-266, 400	519, 624				30. (
1.00	03100 I NTENSI VE CARE UNI T	-200, 400	024				31. 0
5.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0				35.
5.00	ANCI LLARY SERVICE COST CENTERS	U	0				
0. 00	05000 OPERATING ROOM	-180	472, 395				50.
1.00	05400 RADI OLOGY-DI AGNOSTI C	-5, 202	797, 096				54.
5.00	05600 RADI OL SOTOPE	0	0				56.
7.00	05700 CT SCAN	0	0				57.0
3.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.
). 00	06000 LABORATORY	-725	1, 084, 120				60.
5.00	06500 RESPIRATORY THERAPY	0	435, 044				65.
5.00	06600 PHYSI CAL THERAPY	0	383, 768				66.
7.00	06700 OCCUPATI ONAL THERAPY	0	40, 333				67.
3.00	06800 SPEECH PATHOLOGY	0	50, 253				68.
	06900 ELECTROCARDI OLOGY	0	0	1			69.
). 00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	251, 579				71.
2.00	07200 I MPLANTABLE DEVICES CHARGED TO	0	181, 815				72.0
	PATIENTS	0	101, 010				/2.
3. 00	07300 DRUGS CHARGED TO PATIENTS	0	439				73. (
5.00	03610 SLEEP LAB	0	48, 323				76. (
5. 01	03480 ONCOLOGY	0	207, 060				76.
	OUTPATIENT SERVICE COST CENTERS		2017000				
0. 00		0	215, 612				90. (
1.00		-150,000	2, 376, 576				91. (
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		_, _, _, _, _, _				92. (
	SPECIAL PURPOSE COST CENTERS	I					
18.00		-1, 008, 722	21, 848, 511				118.0
	NONREI MBURSABLE COST CENTERS						
0. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.
	07950 MARKETI NG	0	0				194.
	07951 FOUNDATI ON	0	59				194.
	207952 CLINIC	0	0				194.
	07953 VACANT	0	0				194.
	TOTAL (SUM OF LINES 118 through 199)	-1,008,722	21, 848, 570				200.

RECLASSIFICATIONS Provider CCN: 15-1308 Period: Workshee	
	A-6
From 07/01/2018 To 06/30/2019 Date/Time	Prepared:
	9 3:08 pm
<u>Cost Center</u> Line # Salary Other	
<u>2.00</u> <u>3.00</u> <u>4.00</u> <u>5.00</u>	
A - CAFETERI A	
1. 00 CAFETERIA	1.00
TOTALS 0 344, 313	
B - LAUNDRY	
1.00 LAUNDRY & LINEN SERVICE 8.00 35,030	1.00
TOTALS 0 35, 030	
C - INTEREST	
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 3, 924	1.00
TOTALS 0 3, 924	
D - BILLABLE MED SUPPLIES	
1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 241, 331	1.00
PATI ENTS	
2.00 0.00 0 0	2.00
3.00 0.00 0 0	3.00
4.00 0.00 0 0	4.00
5.00 0.00 0 0	5.00
6.00 0.00 0 0	6.00
TOTALS 0 241, 331	
500.00 Grand Total: Increases 0 624, 598	500.00

Heal th	Financial Systems		ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS-	-2552-10
RECLAS	SIFICATIONS			Provi der (CCN: 15-1308	Peri od:	Worksheet A-	6
						From 07/01/2018 To 06/30/2019	Date/Time Pr 11/25/2019 3	epared: :08 pm
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	·		
	6.00	7.00	8.00	9.00	10.00			
	A – CAFETERIA							
1.00	DI ETARY		0	34 <u>4, 3</u> 13		<u>0</u>		1.00
	TOTALS		0	344, 313				
	B - LAUNDRY				1			_
1.00	HOUSEKEEPING	9.00	0	3 <u>5, 0</u> 30		0		1.00
	TOTALS		0	35, 030				
	C - INTEREST		-1-			-1		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	3, 924		9		1.00
	FIXT	<u>├──</u>	— — — _			_		
	TOTALS D - BILLABLE MED SUPPLIES		0	3, 924	•			_
1 00		15.00	0	1 150	1	0		1 00
1.00	PHARMACY ADULTS & PEDIATRICS	15.00	0	1, 150		0		1.00
2.00		30.00	0	705				2.00
3.00 4.00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00	0	215, 674				3.00 4.00
4.00 5.00	CLINIC	90.00	0	1, 225 11, 446		0		4.00
5.00 6.00	EMERGENCY	90.00	0	11, 131				6.00
0.00	TOTALS	91.00	— — — 0			<u>u</u>		0.00
500.00	Grand Total: Decreases		0	624, 598				500.00
500. UL	Decreases	I I	U	024, 398	1			1 500. 00

Heal th	Financial Systems	ST. VINCENT ME	RCY HOSPI TAL			In Lie	u of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1308		i od: m 07/01/2018 06/30/2019		pared:
				Acqui si ti on	s			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		_				
1.00	Land	457, 300	0		0	0	0	1.00
2.00	Land Improvements	528, 489	0		0	0	0	2.00
3.00	Buildings and Fixtures	30, 100, 713	3, 426, 364		0	3, 426, 364	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	0	0		0	0	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31, 086, 502	3, 426, 364		0	3, 426, 364	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	31, 086, 502	3, 426, 364		0	3, 426, 364	0	10.00
		Endi ng Bal ance	Fully					
		J	Depreci ated					
			Assets					
		6.00	7.00	1				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES		•				
1.00	Land	457, 300	0					1.00
2.00	Land Improvements	528, 489	0					2.00
3.00	Buildings and Fixtures	33, 527, 077	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	0	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	34, 512, 866	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	34, 512, 866	0					10.00
								•

Heal th	Financial Systems	ST. VINCENT ME	RCY_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1308	Peri od:	Worksheet A-7	
					From 07/01/2018 To 06/30/2019		narod
					10 00/30/2019	11/25/2019 3:	08 pm
			SL	JMMARY OF CAP	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	•	
		0.00	10.00	11.00		instructions)	
	DADT LL DECONCLULATION OF ANOUNTS FOON WOD	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			na 2		ā	1 00
1.00	NEW CAP REL COSTS-BLDG & FIXT	535, 417			0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	632, 678			0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 168, 095	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	535, 417				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	632, 678				2.00
3.00	Total (sum of lines 1-2)	0	1, 168, 095				3.00

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 07/01/2018 To 06/30/2019		pared:
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		I	-			
1.00 NEW CAP REL COSTS-BLDG & FIXT	33, 527, 077	0			0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0.00000	0	2.00
3.00 Total (sum of lines 1-2)	33, 527, 077	L OF OTHER (33, 527, 07		0	3.00
	ALLUCA	TION OF OTHER (JAPITAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS		1			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 757, 537	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 632, 678	0	2.00
3.00 Total (sum of lines 1-2)	0	0	I JMMARY OF CAPI	0 1, 390, 215	0	3.00
		50	JWWARY OF CAPT	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	11.00	10.00	10.00	instructions)	45.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	11.00	12.00	13.00	14.00	15.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 0	757, 537	1.00
2.00 NEW CAP REL COSTS-BEDG & FIXT	0			0 0	632,678	2.00
3.00 Total (sum of lines 1-2)	0	0		0 0	1, 390, 215	3.00
	0	. 0	I		1, 0, 0, 210	0.00

ealth Financial Systems DJUSTMENTS TO EXPENSES		ST. VINCENT ME	Provi der CCN: 15-1308	Peri od:	u of Form CMS-2 Worksheet A-8	
				From 07/01/2018 To 06/30/2019		
			Expense Classification o To/From Which the Amount is			
			TO/TTOIL WITCH THE AMOUNT TS	s to be Aujusteu		
Cost Center Description	Basis/Code (2)	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapt	В		NEW CAP REL COSTS-BLDG & FIXT	1.00		1.
2) 00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapt	er	С	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
2) 00 Investment income - other	В	-3, 924	ADMI NI STRATI VE & GENERAL	5.00	0	3.
<pre>(chapter 2) 00 Trade, quantity, and time discounts (chapter 8)</pre>		C		0.00	0	4.
00 Refunds and rebates of expenses (chapter 8)		C		0.00	0	5.
00 Rental of provider space by suppliers (chapter 8)		C		0.00	0	6.
Telephone services (pay stations excluded) (chapter 21)	A	-7, 352	ADMINISTRATIVE & GENERAL	5.00	0	7.
00 Television and radio service (chapter 21)		C		0.00	0	8.
00 Parking Iot (chapter 21) 00 Provider-based physician adjustment	A-8-2	0 -462, 118		0.00	0	9. 10.
.00 Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.
.00 Related organization transactions (chapter 10)	A-8-1	1, 456, 805	5		0	12
 .00 Laundry and linen service .00 Cafeteria-employees and gues .00 Rental of quarters to employ 		-44, 544) DI ETARY	0.00 10.00 0.00	0	14
and others .00 Sale of medical and surgical supplies to other than		C		0.00	0	16
patients .00 Sale of drugs to other than patients	В	-1, 175	PHARMACY	15.00	0	17
.00 Sale of medical records and abstracts		C		0.00	0	18
.00 Nursing and allied health education (tuition, fees, books, etc.)		C		0.00	0	19
. 00 Vending machines				0.00		
00 Income from imposition of interest, finance or penalty charges (chapter 21)						
.00 Interest expense on Medicare overpayments and borrowings		C		0.00	0	22
.00 Adjustment for respiratory therapy costs in excess of	A-8-3	с	RESPI RATORY THERAPY	65.00		23
limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSICAL THERAPY	66.00		24
limitation (chapter 14) 00 Utilization review - physicians' compensation		c	*** Cost Center Deleted ***	114.00		25
(chapter 21) .00 Depreciation - NEW CAP REL		c	NEW CAP REL COSTS-BLDG &	1.00	0	26
COSTS-BLDG & FIXT .00 Depreciation - NEW CAP REL		C	FIXT NEW CAP REL COSTS-MVBLE	2.00	0	27
COSTS-MVBLE EQUIP .00 Non-physician Anesthetist		0	EQUIP *** Cost Center Deleted ***			28
 00 Physicians' assistant 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 	A-8-3		OCCUPATIONAL THERAPY	0.00 67.00		29 30
.99 Hospice (non-distinct) (see		c	ADULTS & PEDIATRICS	30.00		30
instructions) .00 Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68.00		31.

OSPEECH PATHOLOGY

31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)

31.00

Heal th	Financial Systems		ST. VINCENT ME	u of Form CMS-2552-10			
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 07/01/2018 To 06/30/2019		harod
					10 00/ 30/ 2019	11/25/2019 3: 0	
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	LAB REVENUE	В	-725	LABORATORY	60.00		33.00
34.00	ADMIN REVENUE	В	-32,053	ADMI NI STRATI VE & GENERAL	5.00	0	34.00
35.00	SOCIAL SERVICE REVENUE	В		SOCI AL SERVI CE	17.00		35.00
36.00	LOBBYI NG	A	-459	ADMI NI STRATI VE & GENERAL	5.00	0	36.00
38.00	PLANT OPERATIONS REVENUE	В		OPERATION OF PLANT	7.00	0	38.00
40.00	MARKETING AND COMMUNITY	A	-327	EMPLOYEE BENEFITS DEPARTMEN	4.00	0	40.00
	RELATI ONS						
41.00	MARKETING AND COMMUNITY	A	-5, 637	ADMINISTRATIVE & GENERAL	5.00	0	41.00
	RELATI ONS						
42.00	PROVIDER TAX	А		ADMI NI STRATI VE & GENERAL	5.00		42.00
42.05	MEDICAL AFFAIRS ADMIN	A		ADMI NI STRATI VE & GENERAL	5.00		42.05
42.06	GI FTS/DONATI ONS EXPENSE	А		ADMI NI STRATI VE & GENERAL	5.00		42.06
43.00	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	5.00		43.00
43.01	PROMOTIONAL ITEMS	A		ADMI NI STRATI VE & GENERAL	5.00		43.01
43.02	CORPORATE SPONSORSHI P	A		ADMINISTRATIVE & GENERAL	5.00		43.02
43.03	ADVERTI SI NG	A		OPERATION OF PLANT	7.00		43.03
43.04	MARKETING	A		OPERATING ROOM	50.00		43.04
43.05	PHYSICIAN FUND EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00		43.05
43.07	LATE PENALTY FEES	A		NURSING ADMINISTRATION	13.00	0	43.07
50.00	TOTAL (sum of lines 1 thru 49)		-1, 008, 722				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

 column 6, line 200.)

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

(2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	ST. VINCENT M	ERCY HOSPI TAL	In Lie	eu of Form CMS-	2552-10
STATEME OFFICE	NT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019		pared:
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount	<u></u>
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR	CLAI MED	
1.00		ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	416,020	0	1.00
2.00			HOME OFFICE - INTEREST	5, 862		2.00
3.00			HOME OFFICE - OTHER	4, 998, 759		3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION CHARGEBACK	3, 587	3, 587	3. 01
4.00	5.00	ADMINISTRATIVE & GENERAL	ASCENSION CHARGEBACK	18, 540	18, 540	4.00
4.01	15.00	PHARMACY	ASCENSION CHARGEBACK	4,000	4,000	4.01
4.02	50.00	OPERATING ROOM	ASCENSION CHARGEBACK	-2, 159	-2, 159	4.02
4.03	54.00	RADI OLOGY-DI AGNOSTI C	ASCENSION CHARGEBACK	32, 500	32, 500	4.03
4.04	65.00	RESPI RATORY THERAPY	ASCENSION CHARGEBACK	3, 744	3, 744	4.04
4.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	934, 227	934, 227	4.05
4.06	1.00	NEW CAP REL COSTS-BLDG & FIX	INTEREST EXPENSE	408, 503	0	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	2, 923	0	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
4.11	0.00			0	0	4.11
4.12	0.00			0	0	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4.21
4.22	0.00			0	0	4.22
4.23	0.00			0	0	4.23
4.24	0.00			0	0	4.24
5.00	0		0	6, 826, 506	5, 369, 701	5.00

* 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.

nas n	ot been	posteu to	WULKSHEEL A	A, CC	Junins i		Ζ,	the amoun	it allowable si	ouru be i	nui cateu ini co	rumr 4	or this part.	
										Rel ated	Organization(s) and/o	r Home Office	
		Symbol	(1)			Name	е		Percentage of		Name		Percentage of	
									Ownership				Ownershi p	
		1.00	0			2.00	0		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	ST. VINCENT HEA	100.00 ST. VINCENT HEALTH	100.00	6.00
7.00	В	ASCENSI ON	100.00 ASCENSI ON	100.00	7.00
8.00	В	ST. VINCENT HOS	100.00 ST. VINCENT HOSPITAL	100.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

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

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

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

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

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

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

Health Financial Systems	ST. VINCENT MERCY HOSPITAL	In Lieu of Form CMS-255	52-10
STATEMENT OF COSTS OF SERVICES FROM RELA	ATED ORGANIZATIONS AND HOME Provider CCN: 15-1308	Period: Worksheet A-8-1 From 07/01/2018	
OFFICE COSTS		To 06/30/2019 Date/Time Prepar	
		11/25/2019 3:08	pm
Net Wkst A-7 Ref			

			11/20/201/ 3	.00 pm
		Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1.00	416, 020			1.00
2.00	5, 862			2.00
3.00	623, 497	0		3.00
3.01	0	0		3.01
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	408, 503			4.06
4.07	2, 923	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4. 21
4.22	0	0		4. 22
4.23	0	0		4.23
4.24	0	-		4.24
5.00	1, 456, 805			5.00

* 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

Has not	been posted to worksheet A,	corumns r and/or 2, the amount arrowable should be thurcated th corumn 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	Type of Busiliess		
	6. 00		
	6. <u>UU</u>		
	B. INTERRELATIONSHIP TO RELA	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

T CT IIIDUT 3C			
6.00 AD	DMI NI STRATI ON		6.00
7.00 AD	DMI NI STRATI ON		7.00
8.00 HC	OSPI TAL		8.00
9.00			9.00
10.00			10.00
100.00		1	100.00
(1) lles +	the following symbols to ind	li pata internal ati anchin, ta nal atad angoni zati ano.	

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

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

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

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

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

Ε.	I ndi vi dual	is director,	offi cer,	administrator,	or	key	person	of	provi der	and	rel ated	organi zati on.	
----	---------------	--------------	-----------	----------------	----	-----	--------	----	-----------	-----	----------	-----------------	--

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

 Health Financial Systems
 ST. VINCENT MERCY HOSPITAL
 In Lieu of Form CMS-2552-10

nearth	i i nanci al Syste	CIIIS	ST. VINCENT M	LIKET HOSTTIKE				2002 10		
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider CCN: 15-1308 Period: From 07/01/2018 To 06/30/2019				Worksheet A-8-2 Date/Time Prepared:		
							11/25/2019 3:	08 pm		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov			
		I denti fi er	Remuneration	Component	Component		ider Component			
							Hours			
	1.00	2.00	3.00	4.00	5.00	6.00	7.00			
1.00	5.00	ADMI NI STRATI VE & GENERAL	38, 058	38, 058	C	0	0	1.00		
2.00		PHARMACY	2, 458	2, 458	C	0	0	2.00		
3.00	30,00	ADULTS & PEDIATRICS	266, 400	266, 400	C	0	0	3.00		
4.00		RADI OLOGY-DI AGNOSTI C	5, 202		0	0	0	4.00		
5.00		EMERGENCY	1, 325, 165		1, 325, 165	0		5.00		
6.00		EMERGENCY	150,000					6.00		
7.00	0.00		130,000	130,000		0		7.00		
8.00	0.00		0			0		8.00		
			0	0		0	0			
9.00	0.00		0	0	L L	0	0	9.00		
10.00	0.00		0	0	0	0	0	10.00		
200.00			1, 787, 283				0	200.00		
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost			
		I denti fi er	Limit		Memberships &		of Malpractice			
				Limit	Conti nui ng	Share of col.	Insurance			
					Educati on	12				
	1.00	2.00	8.00	9.00	12.00	13.00	14.00			
1.00		ADMINISTRATIVE & GENERAL	0	-			0			
2.00		PHARMACY	0	-		-	0	2.00		
3.00		ADULTS & PEDIATRICS	0	0	C	0	0	3.00		
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	4.00		
5.00	91.00	EMERGENCY	0	0	C	0	0	5.00		
6.00	91.00	EMERGENCY	0	0	C	0	0	6.00		
7.00	0.00		0	0	C	0	0	7.00		
8.00	0.00		0	l o	C	0	l ol	8.00		
9.00	0, 00		0	0	0	0	0	9,00		
10.00	0.00		0	0	0	0		10.00		
200.00	0.00		0	0		0	0			
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200.00		
	π	I denti fi er	Component	Limit	Di sal l owance	Aujustment				
		rdentifier	Share of col.	LI 111 L	DISALIUWANCE					
			14							
	1.00	2.00	15.00	16.00	17.00	18.00				
1.00		ADMI NI STRATI VE & GENERAL	13.00					1.00		
2.00		PHARMACY					ļ	2.00		
2.00 3.00		ADULTS & PEDIATRICS		Ŭ Ŭ	-			3.00		
					-		ļ			
4.00		RADI OLOGY-DI AGNOSTI C	0	U U	C	0,202		4.00		
5.00		EMERGENCY	0	0	-	-	ļ	5.00		
6.00		EMERGENCY	0	0	C			6.00		
7.00	0.00		0	, s	-	0		7.00		
8.00	0.00		0	0	-	0		8.00		
9.00	0.00		0			-	ļ	9.00		
10.00	0.00		0	-	C		ļ	10.00		
200.00			0	0	C	462, 118	, I	200.00		

Health Financial Systems	ST. VINCENT MER	RCY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	1	Provider CC		Period: From 07/01/2018 To 06/30/2019	Worksheet B Part I Date/Time Pre 11/25/2019 3:	pared:
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	757, 537	757, 537	(22.47	10		1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	632, 678	0	632, 67			2.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	1, 386, 985 5, 876, 775	280, 115	12, 73 13, 70		6, 291, 955	4.00 5.00
7. 00 00700 OPERATION OF PLANT	1, 355, 177	122, 937	12, 78		1, 547, 511	7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	35,030	9, 024	12,70	0 0	44, 054	8.00
9. 00 00900 HOUSEKEEPING	507, 474	5, 500		0 0	512, 974	9.00
10. 00 01000 DI ETARY	42, 461	14, 964		0 0	57, 425	10.00
11. 00 01100 CAFETERIA	344, 313	9, 490		0 0	353, 803	11.00
13.00 01300 NURSING ADMINISTRATION	80, 037	10, 935		0 23, 392	114, 364	13.00
15.00 01500 PHARMACY	3, 642, 378	8, 415	54, 18		3, 784, 558	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	13	13, 182		0 0	13, 195	16.00
17.00 01700 SOCIAL SERVICE	123, 616	2, 598		0 24, 095	150, 309	17.00
INPATIENT ROUTINE SERVICE COST CENTERS	1 1					
30. 00 03000 ADULTS & PEDI ATRI CS	519, 624	51, 564	78, 17		789, 398	30.00
31.00 03100 I NTENSI VE CARE UNI T	0	0		0 0	0	31.00
35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	35.00
ANCI LLARY SERVI CE COST CENTERS	470.005	F0 (25	1/4 02	105 010	702 072	
50. 00 05000 OPERATING ROOM	472, 395	50, 625	164, 93			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OI SOTOPE	797, 096	32, 500 0	232, 37	6 209, 774 0 0	1, 271, 746 0	54.00 56.00
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	1,084,120	14, 232		0 0	1, 098, 352	60.00
65. 00 06500 RESPIRATORY THERAPY	435,044	11, 103	15, 36	-	578, 213	
66. 00 06600 PHYSI CAL THERAPY	383, 768	33, 387	17		525, 520	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	40, 333	1, 179		0 11,805	53, 317	67.00
68.00 06800 SPEECH PATHOLOGY	50, 253	0		0 14,694	64, 947	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	251, 579	0		0 0	251, 579	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	181, 815	0		0 0	181, 815	72.00
PATIENTS						
73. 00 07300 DRUGS CHARGED TO PATIENTS	439	0		0 0	439	73.00
76.00 03610 SLEEP LAB	48, 323	4, 729		0 13, 944		76.00
76. 01 03480 ONCOLOGY OUTPATI ENT SERVICE COST CENTERS	207,060	2, 241		0 51, 667	260, 968	76.01
90. 00 09000 CLINIC	215, 612	9, 374		0 57, 817	282, 803	
91. 00 09100 EMERGENCY	2, 376, 576	46, 751	48, 23		2, 736, 605	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 370, 370	40,731	40, 20	200,041	2,730,003	92.00
SPECIAL PURPOSE COST CENTERS					0	72.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	21, 848, 511	734, 845	632, 67	1, 399, 722	21, 825, 819	118.00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 196		0 0	2, 196	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	9, 276		0 0	9, 276	192.00
194. 00 07950 MARKETI NG	0	4, 761		0 0	4, 761	194.00
194. 01 07951 FOUNDATI ON	59	2, 015		0 0	2, 074	194.01
194. 02 07952 CLI NI C	0	0		0 0		194. 02
194. 03 07953 VACANT	0	4, 444		0 0		194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	04 0 00	0	(<u>.</u>	0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	21, 848, 570	757, 537	632, 67	1, 399, 722	21, 848, 570	202.00

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Peri od:	Worksheet B	
				From 07/01/2018 To 06/30/2019	Part I Date/Time Pre	narod
				10 00/30/2019	11/25/2019 3:	08 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS	Т	[1			
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	(001 055					4.00
5.00 00500 ADMINISTRATIVE & GENERAL	6, 291, 955					5.00
7.00 00700 OPERATION OF PLANT	625, 899					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	17,818					8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	207, 475				172 200	9.00 10.00
11. 00 01100 CAFETERIA	23, 226				172, 398 0	11.00
13. 00 01300 NURSING ADMINISTRATION	46, 255			0 1,230	0	13.00
15. 00 01500 PHARMACY	1, 530, 687			0 1,230	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	5, 337			2,562	0	16.00
17. 00 01700 SOCIAL SERVICE	60, 793			2, 302 0 410	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS	00,793	15, 727		410	0	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	319, 276	316, 148	36, 14	2 298, 531	172, 398	30.00
31. 00 03100 I NTENSI VE CARE UNI T	017,270			0 0	0	31.00
35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0			0 0	0	35.00
ANCI LLARY SERVICE COST CENTERS		, <u> </u>		<u> </u>	<u> </u>	
50. 00 05000 OPERATI NG ROOM	320, 722	310, 391	6, 55	8 92, 198	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	514, 364	199, 262			0	54.00
56. 00 05600 RADI 0I SOTOPE	0	0		o c	0	56.00
57.00 05700 CT SCAN	0	0		o o	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	o o	0	58.00
60. 00 06000 LABORATORY	444, 234	87, 259		0 11, 685	0	60.00
65. 00 06500 RESPI RATORY THERAPY	233, 861	68, 075		5, 022	0	65.00
66. 00 06600 PHYSI CAL THERAPY	212, 549	204, 703	9, 51	5 37, 259	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	21, 564	7, 229		o o	0	67.00
68.00 06800 SPEECH PATHOLOGY	26, 268	0)	o o	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0)	o o	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	101, 752	0		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	73, 536	0		0 0	0	72.00
PATI ENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	178			52, 890	0	73.00
76.00 03610 SLEEP LAB	27,097				0	76.00
76. 01 03480 ONCOLOGY	105, 550	13, 742		2, 614	0	76.01
OUTPATIENT SERVICE COST CENTERS	1		1		-	
90. 00 09000 CLINIC	114, 381	57, 471	1	0 71, 852	0	90.00
91.00 09100 EMERGENCY	1, 106, 834	286, 640	22, 18	7 136, 735	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
SPECIAL PURPOSE COST CENTERS	(202 752	2 024 201	117 10		170,000	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 282, 753	2, 034, 281	117, 19	8 782, 739	172, 398	118.00
	000	12 464			0	100.00
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	888 3, 752					190. 00 192. 00
				-		
194. 00 07950 MARKETI NG 194. 01 07951 FOUNDATI ON	1, 926			0 461 0 461		194. 00 194. 01
194. 02 07952 CLINIC	039	12, 332		401		194.01
194. 03 07953 VACANT	1, 797	27 246				194.02
	1, /9/	27, 246	1		0	200.00
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0			0	200.00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	6, 291, 955	-		8 783, 661		
	0,271,700	2,175,410	1 117,17	, 00, 001	172, 370	1202.00

Health Financial Systems	ST. VINCENT MERC	CY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	Period: From 07/01/2018 To 06/30/2019	Worksheet B Part I	pared:
Cost Center Description	CAFETERI A AI	NURSI NG DMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
	11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						4.00 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	555, 086					11.00
13.00 01300 NURSING ADMINISTRATION	8, 953	237, 845				13.00
15.00 01500 PHARMACY	0	0	5, 366, 838	3		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	(16.00
17.00 O1700 SOCIAL SERVICE	8, 953	816	(0 0	237, 208	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00 577	44 020		2 202	230, 077	20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	80, 577 0	46, 938 0	(0 3, 282 0 0	230, 077	30.00 31.00
35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0			0	
ANCI LLARY SERVICE COST CENTERS	0	0		0	0	33.00
50. 00 05000 OPERATING ROOM	53, 718	35, 796	(13, 716	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	89, 530	539		28, 872	0	54.00
56. 00 05600 RADI OI SOTOPE	0	0	(0 0	0	56.00
57.00 05700 CT SCAN	0	0	(0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(-	0	58.00
60. 00 06000 LABORATORY	0	0	(15, 900	0	60.00
65. 00 06500 RESPI RATORY THERAPY	53, 718	17, 596	(3, 531	0	65.00
66.00 06600 PHYSI CAL THERAPY	53, 718	0	(4, 195	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	8, 953	0	(404	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	8, 953 0	0	() 429) 0	0	68.00 69.00
70. 00 07000 ELECTROEARD OLOGT	0	0	(0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO	0	0	(-	0	72.00
PATI ENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	26, 859	0	5, 366, 838	3 0	0	73.00
76.00 03610 SLEEP LAB	8, 953	0		721	0	76.00
76. 01 03480 ONCOLOGY	17, 906	490	(2, 896	0	76.01
	26.050	10.007		1, 791	0	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	26, 859 107, 436	18, 007 117, 663	(26, 182	7, 131	90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	107,430	117,003	(20, 102	7,131	92.00
SPECIAL PURPOSE COST CENTERS		I				72.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	555, 086	237, 845	5, 366, 838	3 101, 919	237, 208	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0		192.00
194.00 07950 MARKETI NG	0	0	(0 0		194.00
194. 01 07951 FOUNDATI ON	0	0	(0		194.01
194. 02 07952 CLI NI C	0	0	(194. 02 194. 03
194.03 07953 VACANT 200.00 Cross Foot Adjustments	0	0	l	0	0	200.00
200.00 Regative Cost Centers	0	0	ſ		0	200.00
202.00 TOTAL (sum lines 118 through 201)	555, 086	237, 845	5, 366, 838	101,919		
	200,000	_0.,010	2, 000, 000	101,717	207,200	

		ST. VINCENT MER		N 15 1000		ieu of Form CMS-2552-
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provider CC	:N: 15-1308	Period: From 07/01/201 To 06/30/201	Worksheet B 8 Part I 9 Date/Time Prepared 11/25/2019 3:08 pt
	Cost Center Description	Subtotal R	Intern & esidents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	AL SERVICE COST CENTERS					
	NEW CAP REL COSTS-BLDG & FIXT					1.
	NEW CAP REL COSTS-MVBLE EQUIP					2.
	EMPLOYEE BENEFITS DEPARTMENT					4.
	ADMINISTRATIVE & GENERAL					5.
	OPERATION OF PLANT					7.
	LAUNDRY & LINEN SERVICE					8.
	HOUSEKEEPING					9.
	DI ETARY					10.
	CAFETERIA					11.
	NURSING ADMINISTRATION					13.
	PHARMACY					15.
	MEDICAL RECORDS & LIBRARY					16.
	SOCIAL SERVICE					
	IENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS	2, 292, 767	0	2, 292,		30.
	INTENSIVE CARE UNIT	0	0		0	31.
	DETOXIFICATION INTENSIVE CARE UNIT	0	0		0	35.
	LARY SERVICE COST CENTERS					
	OPERATING ROOM	1, 626, 072	0	1, 626,		50.
	RADI OLOGY-DI AGNOSTI C	2, 184, 658	0	2, 184,		54.
	RADI OI SOTOPE	0	0		0	56.
	CT SCAN	0	0		0	57.
	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	58.
	LABORATORY	1,657,430	0	1, 657,		60.
	RESPI RATORY THERAPY	960, 016	0		016	65.
	PHYSI CAL THERAPY	1,047,459	0	1, 047,		66.
	OCCUPATIONAL THERAPY	91, 467	0		467	67.
	SPEECH PATHOLOGY	100, 597	0	100,	597	68.
	ELECTROCARDI OLOGY	0	0		0	69.
		0	0	050	0	70.
	MEDICAL SUPPLIES CHARGED TO PATIENTS	353, 331	0	353,		71.
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	255, 351	0	255,	351	72.
73.00 07300	DRUGS CHARGED TO PATIENTS	E 447 204	0	E 447	204	73.
	SLEEP LAB	5, 447, 204 135, 471	0	5, 447, 135,		75.
	ONCOLOGY	404, 166	0		166	76.
	TI ENT SERVICE COST CENTERS	404, 100	U	404,	100	/0.
	CLINIC	573, 164	0	573	164	90.
	EMERGENCY	4, 547, 413	0	4, 547,		91.
	OBSERVATION BEDS (NON-DISTINCT PART)	1, 57, 715	0			92.
	AL PURPOSE COST CENTERS	L				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	21, 676, 566	0	21, 676,	566	118.
	IMBURSABLE COST CENTERS	2., 3, 5, 550	9	21, 0, 0,		110.
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16, 548	0	16	548	190.
	PHYSI CLANS' PRI VATE OFFI CES	69, 903	0		903	192.
194.0007950		36, 340	0		340	194.
194.0107951		15, 726	0		726	194.
194.0207952		0	0	10,	0	194.
194.0307953		33, 487	0	33	487	194.
200.00	Cross Foot Adjustments	0	0	55,	0	200.
201.00	Negative Cost Centers	0	0		õ	200.
		°,				
202.00	TOTAL (sum lines 118 through 201)	21, 848, 570	0	21, 848,	570	202.

Heal th	Financial Systems	ST. VINCENT MER	CY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	F	Period: From 07/01/2018 To 06/30/2019	Worksheet B Part II Date/Time Pre 11/25/2019 3:	
			CAPI TAL REL	ATED COSTS		11/25/2014 5.	
	Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	I	0	1.00	2.00	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	12, 737	12, 737	12, 737	4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL	416, 020	280, 115	13, 701		1, 104	5.00
7.00	00700 OPERATION OF PLANT	410,020	122, 937	12, 789		515	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	9, 024	(0	
9.00	00900 HOUSEKEEPING	0	5, 500		5, 500	0	9.00
10,00	01000 DI ETARY	0	14, 964	0	14, 964	0	10.00
11.00	01100 CAFETERIA	0	9, 490		9, 490	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	10, 935	C		213	
15.00	01500 PHARMACY	0	8, 415	54, 183		724	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	13, 182	C		0	16.00
17.00	01700 SOCIAL SERVICE	0	2, 598	C	2, 598	219	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	51, 564	78, 175	129, 739	1, 274	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	C	0 0	0	31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0	C	0 0	0	35.00
	ANCILLARY SERVICE COST CENTERS	1 1			1 1		
50.00	05000 OPERATI NG ROOM	0	50, 625	164, 934		956	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	32, 500	232, 376	264, 876	1, 909	54.00
56.00	05600 RADI OI SOTOPE	0	0	C	0	0	56.00
57.00	05700 CT SCAN	0	0	C	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	14 000		0	0	58.00
60.00		0	14, 232	15 2/0	14, 232	0	60.00
65.00		0	11, 103	15, 368		1,062	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	33, 387 1, 179	178		984 107	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	1, 179		1, 1/9	134	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0			0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	71.00
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	0	0		0	0	72.00
72.00	PATIENTS		Ū			Ū	/ 2: 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0 0	0	73.00
76.00	03610 SLEEP LAB	0	4, 729	C	4, 729	127	76.00
76.01	03480 ONCOLOGY	0	2, 241	C	2, 241	470	76.01
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	9, 374			526	1
	09100 EMERGENCY	0	46, 751	48, 237		2, 413	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		416, 020	734, 845	632, 678	1, 783, 543	12, 737	118.00
	NONREI MBURSABLE COST CENTERS		0.10/		0.10/		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 196				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	9,276	C			192.00
	07950 MARKETI NG	0	4, 761		4, 761		194.00
	07951 FOUNDATI ON	0	2, 015		2, 015		194.01
	07952 CLI NI C 07953 VACANT	0					194. 02 194. 03
		0	4, 444		4, 444	0	200.00
200.00 201.00	5		0			0	200.00
201.00		416, 020	757, 537	632, 678	1, 806, 235		201.00
202.00		+10,020	131, 331	052,070	, 1, 000, 230	12, 131	1202.00

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod:	Worksheet B	
				rom 07/01/2018		
			1	06/30/2019	Date/Time Pre 11/25/2019 3:	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
cost center bescription	& GENERAL	PLANT	LINEN SERVICE	HOUSEREELTING	DIEIMA	
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMI NI STRATI VE & GENERAL	710, 940					5.00
7.00 00700 OPERATION OF PLANT	70, 721	206, 962				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	2,013					8.00
9. 00 00900 HOUSEKEEPI NG	23, 443		4, 103			9.00
10. 00 01000 DI ETARY	2,624	8, 737			26, 325	10.00
11. 00 01100 CAFETERI A	16, 169	5, 541			0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	5, 226	6, 384		57	0	13.00
15. 00 01500 PHARMACY	172, 958				0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	603			-	0	16.00
17. 00 01700 SOCIAL SERVICE	6,869	1, 517			0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS	0,007	1, 517		17	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	36, 075	30, 105	5, 028	13, 811	26, 325	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0				20, 323	31.00
35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0				0	35.00
ANCI LLARY SERVICE COST CENTERS	0	0	1 0	0	0	35.00
50. 00 05000 OPERATI NG ROOM	36, 239	29, 557	912	4, 266	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	58, 119				0	54.00
56. 00 05600 RADI OLOGI - DI AGNOSTI C	0 0 0				0	56.00
57. 00 05700 CT SCAN	0				0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		-	0	0	57.00
	50, 195	-	-	-		
					0	60.00
65. 00 06500 RESPI RATORY THERAPY	26, 424	6, 482			0	65.00 66.00
66.00 06600 PHYSI CAL THERAPY	24,016				0	
67.00 06700 OCCUPATI ONAL THERAPY	2,437	688			0	67.00
68. 00 06800 SPEECH PATHOLOGY	2,968			0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	11, 497	0	0	-	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	8, 309	0	0	0	0	72.00
	20			0 447		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	20		-		0	73.00
76.00 03610 SLEEP LAB	3,062				0	76.00
76. 01 03480 ONCOLOGY	11, 926	1, 309	0	121	0	76. 01
OUTPATIENT SERVICE COST CENTERS	10.004	E 470		2.224	0	00.00
90. 00 09000 CLINIC	12, 924				0	90.00
91.00 09100 EMERGENCY	125,063	27, 295	3, 087	6, 326	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
SPECIAL PURPOSE COST CENTERS	700.000	100 744	4 4 9 9 5	04.045	04.005	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	709, 900	193, 714	16, 305	36, 215	26, 325	118.00
NONREI MBURSABLE COST CENTERS			-	-	-	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	100					190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	424					192.00
194. 00 07950 MARKETI NG	218					194.00
194. 01 07951 FOUNDATI ON	95					194.01
194. 02 07952 CLI NI C	0		-	-		194. 02
194. 03 07953 VACANT	203	2, 594	0	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0			0		201. 00
202.00 TOTAL (sum lines 118 through 201)	710, 940	206, 962	16, 305	36, 257	26, 325	202.00

Heal th	Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet B Part II Date/Time Pre 11/25/2019 3:	pared: 08 pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		11.00	13.00	15.00	16.00	17.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.00 5.00	00500 ADMI NI STRATI VE & 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	31, 200					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	503	23, 318				13.00
15.00	01500 PHARMACY	0	0	241, 19			15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 21,600	44.005	16.00
17.00	01700 SOCIAL SERVICE	503	80		0 0	11, 805	17.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	4, 529	4, 602		0 695	11, 450	30.00
30.00	03100 I NTENSI VE CARE UNI T	4, 529	4, 002		0 0	0	31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	35.00
	ANCI LLARY SERVICE COST CENTERS		-1				1
50.00	05000 OPERATI NG ROOM	3, 019	3, 509		0 2,905	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 032	53		0 6, 127	0	54.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
60.00		0	0		0 3, 368 0 748	0	60.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 019 3, 019	1, 725 0		0 748 0 889	0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	503	0		0 86	0	67.00
68.00	06800 SPEECH PATHOLOGY	503	0		0 91	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
	PATIENTS					_	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 510	0	241, 19		0	73.00
76. 00 76. 01	03610 SLEEP LAB 03480 ONCOLOGY	503 1, 006	0 48		0 153 0 613	0	76.00 76.01
70.01	OUTPATIENT SERVICE COST CENTERS	1,000	40		0 013	0	70.01
90, 00	09000 CLINIC	1, 510	1, 765		0 379	0	90.00
91.00	09100 EMERGENCY	6,041	11, 536		0 5, 546	355	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		31, 200	23, 318	241, 19	21,600	11, 805	118.00
	NONREI MBURSABLE COST CENTERS		-		-	-	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	07950 MARKETING 07951 FOUNDATION	0	0		0 0		194.00
	207952 CLINIC		0				194. 01 194. 02
	07953 VACANT	0	0		0 0		194.02
200.00			0		0	0	200.00
201.00	5	o	о		0 0	0	201.00
202.00		31, 200	23, 318	241, 19	21, 600		202.00
			-				

	cial Systems DF CAPITAL RELATED COSTS		RCY HOSPITAL Provider C	CN: 15-1308	Peri od:	Worksheet B
					From 07/01/2018 To 06/30/2019	Part II Date/Time Prepare
	Cost Center Description	Subtotal	Intern &	Total		11/25/2019 3:08 p
		Gubtotui	Residents Cost			
			& Post			
			Stepdown			
		24.00	Adjustments	26.00		
GENER	AL SERVICE COST CENTERS	24.00	25.00	26.00		
	NEW CAP REL COSTS-BLDG & FIXT					1.
	NEW CAP REL COSTS-MVBLE EQUIP					2.
	EMPLOYEE BENEFITS DEPARTMENT					4.
.00 00500	ADMINISTRATIVE & GENERAL					5.
	OPERATION OF PLANT					7.
	LAUNDRY & LINEN SERVICE					8.
. 00 00900	HOUSEKEEPING					9.
0.00 01000	DIETARY					10.
1.00 01100	CAFETERIA					11.
3.00 01300	NURSING ADMINISTRATION					13.
	PHARMACY					15.
	MEDICAL RECORDS & LIBRARY					16.
	SOCIAL SERVICE					
	IENT ROUTINE SERVICE COST CENTERS	1		1		
	ADULTS & PEDIATRICS	263, 633	C			30.
	INTENSIVE CARE UNIT	0	0		0	31.
	DETOXIFICATION INTENSIVE CARE UNIT	0	0		0	35.
	LARY SERVICE COST CENTERS					
	OPERATING ROOM	296, 922	0			50.
	RADI OLOGY-DI AGNOSTI C	359, 902	0			54.
	RADI OI SOTOPE	0	0		0	56.
	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0			0	57.
1	LABORATORY	76, 645		76,6	45	60.
-	RESPI RATORY THERAPY	66, 163		66, 2		65.
1	PHYSI CAL THERAPY	85, 014		85,0		66.
	OCCUPATIONAL THERAPY	5,000				67.
-	SPEECH PATHOLOGY	3, 696				68.
-	ELECTROCARDI OLOGY	0	0		0	69.
	ELECTROENCEPHALOGRAPHY	0	C)	0	70.
	MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 497	C C	11,4	197	71.
	IMPLANTABLE DEVICES CHARGED TO	8, 309	c	8,3		72.
	PATIENTS					
3.00 07300	DRUGS CHARGED TO PATIENTS	245, 170	0	245, 1	170	73.
6.00 03610	SLEEP LAB	11, 603	0	11, 6	503	76.
6.01 03480		17, 734	0	17, 1	734	76.
	TIENT SERVICE COST CENTERS	1	1	-		
	CLINIC	35, 275				90.
1.00 09100		282, 650			550	91.
	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.
	AL PURPOSE COST CENTERS	1	1	1		
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 769, 213	0	1, 769, 2	213	118.
	IMBURSABLE COST CENTERS	0.5=5	-		-70	
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 578				190
	PHYSICIANS' PRIVATE OFFICES	15, 116		15, 1		192.
94.0007950		7, 780		7, 7		194
	FOUNDATION	3, 307		3, 3	su /	194
94.0207952		0			0	194
94.0307953		7, 241		7,2		194.
00.00	Cross Foot Adjustments	0	0	1	0	200.
01.00	Negative Cost Centers				0	201.

	nancial Systems	ST. VINCENT ME				u of Form CMS-2	
COST ALLO	CATION - STATISTICAL BASIS		Provider CC		Period: From 07/01/2018	Worksheet B-1	
				۲	o 06/30/2019	Date/Time Pre 11/25/2019 3:	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	cost center bescription	FLXT	EQUI P	BENEFITS	Reconciliation	& GENERAL	
		(SQUARE	(DIRECT COST)	DEPARTMENT		(ACCUM.	
		FEET)		(GROSS SALARI ES)		COST)	
		1.00	2.00	4.00	5A	5.00	
	VERAL SERVICE COST CENTERS						
	100 NEW CAP REL COSTS-BLDG & FIXT 200 NEW CAP REL COSTS-MVBLE EQUIP	116, 942	632, 937				1.00 2.00
	400 EMPLOYEE BENEFITS DEPARTMENT	0	12, 742	4, 782, 300)		4.00
	500 ADMINISTRATIVE & GENERAL	43, 242		414, 652		15, 556, 615	5.00
	700 OPERATION OF PLANT	18, 978		193, 406		1, 547, 511	
	300 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING	1, 393 849			-	44, 054 512, 974	
	DOO DI ETARY	2, 310			-	57, 425	
	100 CAFETERI A	1, 465		(0	353, 803	
	300 NURSI NG ADMI NI STRATI ON	1, 688		79, 921		114, 364	
		1, 299		271, 899		3, 784, 558	
	500 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE	2, 035 401		82, 323		13, 195 150, 309	
	PATIENT ROUTINE SERVICE COST CENTERS	101		02, 020	,	100,007	17.00
	DOO ADULTS & PEDIATRICS	7, 960		478, 443		789, 398	
	100 INTENSIVE CARE UNIT D40 DETOXIFICATION INTENSIVE CARE UNIT	0		(0	31.00
	CILLARY SERVICE COST CENTERS	0	0	(0	0	35.00
	DOO OPERATING ROOM	7, 815	165, 001	358, 807	0	792, 973	50.00
	400 RADI OLOGY-DI AGNOSTI C	5, 017	232, 472	716, 716	0	1, 271, 746	
	500 RADI OI SOTOPE	0	0	(0	
	700 CT SCAN 300 MAGNETIC RESONANCE IMAGING (MRI)	0	0		-	0	
	DOO LABORATORY	2, 197	0	(-	1, 098, 352	
	500 RESPIRATORY THERAPY	1, 714		398, 710	0	578, 213	
	500 PHYSI CAL THERAPY	5, 154		369, 634		525, 520	
	700 OCCUPATI ONAL THERAPY	182		40, 333		53, 317	
	300 SPEECH PATHOLOGY 200 ELECTROCARDI OLOGY	0	0	50, 203		64, 947 0	1
	DOO ELECTROENCEPHALOGRAPHY	0	0	(-	0	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0 0	251, 579	71.00
72.00 072	200 IMPLANTABLE DEVICES CHARGED TO	0	0	(0 0	181, 815	72.00
73.00 073	PATIENTS 300 DRUGS CHARGED TO PATIENTS	0	0	(0	439	73.00
	510 SLEEP LAB	730	-	47, 641	-	66, 996	
	480 ONCOLOGY	346				260, 968	
	IPATIENT SERVICE COST CENTERS			107 50			
	DOO CLINIC 100 EMERGENCY	1, 447 7, 217					
	200 OBSERVATION BEDS (NON-DISTINCT PART)	1,217	40, 237	905, 547	0	2, 736, 605	91.00
	ECIAL PURPOSE COST CENTERS						12:00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	113, 439	632, 937	4, 782, 300	-6, 291, 955	15, 533, 864	118.00
	NREIMBURSABLE COST CENTERS	220		· · · · · · · · · · · · · · · · · · ·		2 104	100 00
	DOO GIFT, FLOWER, COFFEE SHOP & CANTEEN 200 PHYSICIANS' PRIVATE OFFICES	339					190.00 192.00
	950 MARKETI NG	735		(194.00
194.01 079	951 FOUNDATI ON	311	0	C	-	2, 074	194.01
	952 CLINIC	0		(194.02
194.03079 200.00	953 VACANT Cross Foot Adjustments	686	0	(0	4, 444	194.03 200.00
200.00	Negative Cost Centers						200.00
202.00	Cost to be allocated (per Wkst. B,	757, 537	632, 678	1, 399, 722	2	6, 291, 955	1
	Part I)		0.00055			o <i></i>	000 05
203.00 204.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	6. 477886	0. 999591	0. 292688		0. 404455 710, 940	
204.00	Part II)			12, 737		710, 940	204.00
205.00	Unit cost multiplier (Wkst. B, Part			0.002663	3	0.045700	205.00
201 22							001 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

		cial Systems	ST. VINCENT ME		N 15 1000		u of Form CMS-	
COST A	LLUCAT	ION - STATISTICAL BASIS		Provider CC		Period: From 07/01/2018	Worksheet B-1	
						To 06/30/2019	Date/Time Pre 11/25/2019 3:	
		Cost Center Description	OPERATI ON OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NO (HOURS OF SERVI CE)	G DI ETARY (PATI ENT DAYS)	CAFETERI A (FTE)	
	OFNED		7.00	8.00	9.00	10.00	11.00	
		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00 5.00 7.00 8.00 9.00	00200 00400 00500 00700 00800 00900	NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMI NI STRATI VE & GENERAL OPERATION OF PLANT LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG DI ETARY	54, 722 1, 393 849 2, 310	112, 145 28, 220 0	15, 29	01 0 734		2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00
		CAFETERIA	1, 465	0		0 0	62	
13.00	01300	NURSING ADMINISTRATION	1, 688	0		24 0	1	13.00
		PHARMACY	1, 299	0		0 0	0	
		MEDI CAL RECORDS & LI BRARY SOCI AL SERVI CE	2, 035 401	0	5	50 0 8 0	0 1	
17.00		IENT ROUTINE SERVICE COST CENTERS	401	0		<u>oj</u> U	1	17.00
31.00	03000 03100	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	7,960 0 0	34, 585 0 0	5, 82	25 734 0 0 0 0	9 0 0	31.00
		DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	35.00
		OPERATING ROOM	7, 815	6, 275	1, 79	9 0	6	50.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	5,017	11, 265	1, 33		10	54.00
		RADI OI SOTOPE	0	0		0 0	0	
		CT SCAN	0	0		0 0	0	
		MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	
			2, 197	0	22		0	60.0
		RESPI RATORY THERAPY PHYSI CAL THERAPY	1,714		72	0	6	65.0
		OCCUPATIONAL THERAPY	5, 154 182	9, 105 0	12	0 0	6	66. 0 67. 0
		SPEECH PATHOLOGY	0	0		0 0	1	68.0
		ELECTROCARDI OLOGY	0	0		0 0	0	
		ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.0
		PATIENTS						
		DRUGS CHARGED TO PATIENTS	0	0	1, 03		3	
		SLEEP LAB ONCOLOGY	730	1, 465 0		23 0 51 0	1	
		TI ENT SERVICE COST CENTERS	540	0	[î		2	70.0
			1, 447	0	1,40	02 0	3	90.0
		EMERGENCY	7, 217	21, 230	2, 66		12	
		OBSERVATION BEDS (NON-DISTINCT PART)						92.0
		AL PURPOSE COST CENTERS				-		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51, 219	112, 145	15, 27	73 734	62	118. 0
100 00	NUNRE	MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	220				0	100.0
		CIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	339 1, 432			0 0		190. 0 192. 0
		MARKETING	735			9 0		192.0
		FOUNDATION	311	0		9 0	0	194.0
		CLINIC	0	0		0 0		194.0
194.03	07953	VACANT	686	0		0 0	0	194. 0
200. 00		Cross Foot Adjustments						200. 0
201.00		Negative Cost Centers						201.0
202.00		Cost to be allocated (per Wkst. B,	2, 173, 410	117, 198	783, 66	51 172, 398	555, 086	202. 0
203.00		Part I) Unit cost multiplier (Wkst. B, Part I)	39. 717298	1. 045058	51.24982	20 234.874659	8 053 00000	202 0
203.00 204.00		Cost to be allocated (per Wkst. B, Part I)	206, 962				8, 953. 000000 31, 200	
	1	Unit cost multiplier (Wkst. B, Part	3. 782062	0. 145392	2. 37113	35. 865123	503. 225806	205.0
		11)						
205.00 206.00 207.00								206.0

COST A	Financial Systems ALLOCATION - STATISTICAL BASIS		Provider CC		<u>In Lie</u> Period: From 07/01/2018 To 06/30/2019	Worksheet B-1 Date/Time Prepared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	PHARMACY (COSTED REQUI S.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	11/25/2019 3:08 pm
		13.00	15.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS	· · · · ·			- H	
15. 00 16. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW 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 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	48, 093 0 0 165	1, 000 0 0	58, 498, 77	0 0 4, 990	1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 15.00 16.00
30.00	03000 ADULTS & PEDI ATRI CS	9, 491	0	1, 883, 90	2 4, 840	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0		0 0	31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS	0	0		0 0	35.00
50.00	05000 OPERATING ROOM	7, 238	0	7, 873, 96	4 0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	109	0	16, 565, 36		54.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			57.00 58.00
60.00	06000 LABORATORY	0	0	9, 127, 41	6 0	60.00
65.00	06500 RESPI RATORY THERAPY	3, 558	0	2, 027, 01		65.00
66.00	06600 PHYSI CAL THERAPY	0	0	2, 408, 13	6 0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	232, 14		67.00
	06800 SPEECH PATHOLOGY	0	0	246, 45		68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	69.00 70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			70.00
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	0	0		0 0	72.00
	PATIENTS					
	07300 DRUGS CHARGED TO PATIENTS	0	1,000		0 0	73.00
	03610 SLEEP LAB	0	0	413, 99		76.00
76. 01	03480 ONCOLOGY OUTPATI ENT SERVICE COST CENTERS	99	0	1, 662, 23	1 0	76. 01
90.00	09000 CLINIC	3, 641	0	1, 028, 02	7 0	90.00
		23, 792	0	15, 030, 11		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
	SPECIAL PURPOSE COST CENTERS	10.000	1 000	50 100 77		
118.00		48, 093	1, 000	58, 498, 77	0 4, 990	118.00
190 00	NONREIMBURSABLE COST CENTERS	ol	0		0 0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	192.00
194.00	07950 MARKETI NG	0	0		o o	194.00
	07951 FOUNDATI ON	0	0		0 0	194. 01
		0	0		0 0	194. 02
200.00	307953 VACANT	0	0		0 0	194. 03
200.00						200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	237, 845	5, 366, 838	101, 91	9 237, 208	
	Part I)	4.045500	5 9// 999999	0 00171	47 50((70	
203.00 204.00		4. 945522 23, 318	5, 366. 838000 241, 193	0. 00174 21, 60		203. 00 204. 00
205.00	Unit cost multiplier (Wkst. B, Part	0. 484852	241. 193000	0. 00036	9 2. 365731	205.00
206.00	(per Wkst. B-2)					206.00
207.00						

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1308	Peri od:	Worksheet C	
				From 07/01/2018 To 06/30/2019		narod
				10 00/ 30/ 2019	11/25/2019 3:	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	2, 292, 767		2, 292, 76	7 0	0	30,00
31. 00 03100 I NTENSI VE CARE UNI T	2, 292, 707		2, 272, 70	0 0	0	30.00
35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0			0 0	0	35.00
ANCI LLARY SERVICE COST CENTERS			1	0 0	0	00.00
50. 00 05000 OPERATI NG ROOM	1, 626, 072		1, 626, 07	/2 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 184, 658		2, 184, 65		0	54.00
56. 00 05600 RADI 0I SOTOPE	0			0 0	0	56.00
57.00 05700 CT SCAN	0			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
60. 00 06000 LABORATORY	1, 657, 430		1, 657, 43		0	60.00
65. 00 06500 RESPI RATORY THERAPY	960, 016	0	960, 01	6 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 047, 459		1, 047, 45		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	91, 467		91, 46		0	67.00
68.00 06800 SPEECH PATHOLOGY	100, 597	0	100, 59		0	68.00
69.00 06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	353, 331		353, 33		0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	255, 351		255, 35	0	0	72.00
PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	5, 447, 204		5, 447, 20	NA 0	0	73.00
76. 00 03610 SLEEP LAB	135, 471		135, 47, 20		0	76.00
76. 01 03480 ONCOLOGY	404, 166		404, 16		-	76.01
OUTPATIENT SERVICE COST CENTERS	404,100	1	404, 10		0	70.01
90. 00 09000 CLINIC	573, 164		573, 16	04 0	0	90.00
91. 00 09100 EMERGENCY	4, 547, 413		4, 547, 41		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	646, 395		646, 39		0	92.00
200.00 Subtotal (see instructions)	22, 322, 961		22, 322, 96		0	200. 00
201.00 Less Observation Beds	646, 395		646, 39	95		201.00
202.00 Total (see instructions)	21, 676, 566	0	21, 676, 56	06 0	0	202.00

	ancial Systems N OF RATIO OF COSTS TO CHARGES	ST. VINCENT MEI	RCY HOSPITAL Provider C	CN: 15 1200	In Lie Period:	eu of Form CMS- Worksheet C	2552-10
COMPUTATIC	IN OF RAILO OF COSTS TO CHARGES		Provider C	CN. 15-1506	From 07/01/2018		
					To 06/30/2019	Date/Time Pre	epared:
						11/25/2019 3:	08 pm
				XVIII	Hospi tal	Cost	
		· · · · ·	Charges				
	Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other		
				+ col. 7)	Ratio	Inpatient Ratio	
		6.00	7.00	8.00	9,00	10.00	
LND	ATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	-
	00 ADULTS & PEDIATRICS	1, 369, 093		1, 369, 0	22		30.00
	00 I NTENSI VE CARE UNI T	1, 307, 073		1, 307, 0	0		31.00
	40 DETOXIFICATION INTENSIVE CARE UNIT	0			0		35.00
	I LLARY SERVICE COST CENTERS	<u> </u>		I	0		33.00
	OO OPERATI NG ROOM	968, 525	6, 905, 439	7, 873, 9	64 0. 206513	0, 000000	50.00
	00 RADI OLOGY-DI AGNOSTI C	461, 869	16, 103, 497				
	00 RADI OI SOTOPE	0	0,100,17	10,000,0	0 0.000000		
	00 CT SCAN	0	0		0 0.000000		
	00 MAGNETIC RESONANCE I MAGING (MRI)	0	C		0 0.000000		
	00 LABORATORY	588, 201	8, 539, 215	9, 127, 4			
65.00 0650	00 RESPI RATORY THERAPY	393, 101	1, 633, 918	2,027,0	0. 473610	0. 000000	65.00
66.00 0660	00 PHYSI CAL THERAPY	179, 458	2, 190, 558	2, 370, 0	0. 441963	0. 000000	66.00
67.00 0670	00 OCCUPATIONAL THERAPY	21,003	214, 355	235, 3	0. 388629	0. 000000	67.00
68.00 0680	00 SPEECH PATHOLOGY	14, 025	267, 341	281, 3	66 0. 357531	0. 000000	68.00
69.00 0690	00 ELECTROCARDI OLOGY	0	0)	0 0.000000	0. 000000	69.00
70.00 070	00 ELECTROENCEPHALOGRAPHY	0	0)	0 0.000000	0. 000000	70.00
71.00 0710	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	372, 959	1, 170, 339	1, 543, 2	0. 228945	0. 000000	71.00
72.00 0720	00 IMPLANTABLE DEVICES CHARGED TO	9, 759	60, 260	70, 0	3. 646882	0. 000000	72.00
	PATI ENTS						
	00 DRUGS CHARGED TO PATIENTS	780, 143	13, 132, 466				
	10 SLEEP LAB	0	413, 993				
	80 ONCOLOGY	2, 597	1, 659, 634	1, 662, 2	0. 243147	0. 000000	76.01
	PATIENT SERVICE COST CENTERS				-	1	
	00 CLINIC	9, 061	1, 018, 966				
	00 EMERGENCY	170, 952	14, 859, 159				
	00 OBSERVATION BEDS (NON-DISTINCT PART)	21, 633	493, 176			0. 000000	
200.00	Subtotal (see instructions)	5, 362, 379	68, 662, 316	74, 024, 6	95		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	5, 362, 379	68, 662, 316	74, 024, 6	95		202.00

Health Financial Systems	ST. VINCENT MERC	Y HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared: 11/25/2019 3:08 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient		· · · · · ·	
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT				35.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0.000000			50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000			54.00
56. 00 05600 RADI 0I SOTOPE	0.000000			56.00
57.00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00 06800 SPEECH PATHOLOGY	0, 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO	0. 000000			72.00
PATIENTS				
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76.00 03610 SLEEP LAB	0. 000000			76.00
76.01 03480 ONCOLOGY	0. 000000			76.01
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0.000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 000000			92.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
	1			202.00

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 07/01/2018 To 06/30/2019		narod
				10 00/30/2019	11/25/2019 3:	
		Titl	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)	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	2, 292, 767	1	2, 292, 76	7 0	2, 292, 767	30,00
31. 00 03100 I NTENSI VE CARE UNI T	2, 292, 707		2, 272, 70		2, 292, 707	
35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0				0	1
ANCI LLARY SERVI CE COST CENTERS			I	0 0	0	00.00
50. 00 05000 OPERATI NG ROOM	1, 626, 072		1, 626, 07	2 0	1, 626, 072	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 184, 658		2, 184, 65		2, 184, 658	
56. 00 05600 RADI OI SOTOPE	0			0 0	0	
57.00 05700 CT SCAN	0			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
60. 00 06000 LABORATORY	1, 657, 430		1, 657, 43	0 0	1, 657, 430	
65. 00 06500 RESPI RATORY THERAPY	960, 016		960, 01		960, 016	•
66. 00 06600 PHYSI CAL THERAPY	1, 047, 459		1, 047, 45		1, 047, 459	•
67.00 06700 OCCUPATI ONAL THERAPY	91, 467		91, 46		91, 467	
68.00 06800 SPEECH PATHOLOGY	100, 597	0	100, 59	7 0	100, 597	
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	353, 331		353, 33		353, 331	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	255, 351		255, 35	0	255, 351	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	5, 447, 204		5, 447, 20	1 0	5, 447, 204	73 00
76. 00 03610 SLEEP LAB	135, 471		135, 47		135, 471	•
76. 01 03480 ONCOLOGY	404, 166		404, 16		404, 166	•
OUTPATIENT SERVICE COST CENTERS	101,100	<u> </u>	101,10	0 0	101,100	70.01
90. 00 09000 CLINIC	573, 164		573, 16	4 0	573, 164	90.00
91.00 09100 EMERGENCY	4, 547, 413		4, 547, 41		4, 547, 413	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	646, 395		646, 39		646, 395	
200.00 Subtotal (see instructions)	22, 322, 961	0	22, 322, 96		22, 322, 961	
201.00 Less Observation Beds	646, 395		646, 39	5	646, 395	201.00
202.00 Total (see instructions)	21, 676, 566	0	21, 676, 56	6 0	21, 676, 566	202.00

Heal th Financial Syst COMPUTATION OF RATIO		ST. VINCENT ME	Provider C	CN: 15-1308	In Li Period:	eu of Form CMS- Worksheet C	2552-10
COMPUTATION OF RATIO	OI COSTS TO CHARGES		FIOVICEI C	CN. 15-1506	From 07/01/201		
					To 06/30/201	9 Date/Time Pre	epared:
						11/25/2019 3:	08 pm
				e XIX	Hospi tal	Cost	
Coot Coo		Inpatient	Charges	Tatal (aal	6 Cost or Other	TEFRA	
Cost Cen	ter Description	Inpatient	Outpati ent	$+ \operatorname{col}$. 7)	Ratio	Inpatient	
				+ COL. 7)	Ratio	Ratio	
		6.00	7.00	8.00	9, 00	10.00	
INPATIENT ROUT	INE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30.00 03000 ADULTS &		1, 369, 093		1, 369, 0	93		30.00
31.00 03100 I NTENSI V		0		1,007,0	0		31.00
	CATION INTENSIVE CARE UNIT	0			0		35.00
	I CE COST CENTERS				3		
50.00 05000 OPERATI N		968, 525	6, 905, 439	7, 873, 9	64 0. 20651	3 0. 000000	50.00
54.00 05400 RADI OLOG	Y-DI AGNOSTI C	461, 869	16, 103, 497			1 0.000000	54.00
56.00 05600 RADI 0I SO	TOPE	0	0)	0 0.00000	0. 000000	56.00
57.00 05700 CT SCAN		0	0		0 0.00000	0. 000000	57.00
58.00 05800 MAGNETIC	RESONANCE IMAGING (MRI)	0	0		0 0.00000	0. 000000	58.00
60.00 06000 LABORATO	RY	588, 201	8, 539, 215	9, 127, 4	16 0. 18158	8 0. 000000	60.00
65. 00 06500 RESPI RAT	ORY THERAPY	393, 101	1, 633, 918	2, 027, 0	0. 47361	0. 000000	65.00
66. 00 06600 PHYSI CAL	THERAPY	179, 458	2, 190, 558	2, 370, 0	0. 44196	3 0. 000000	66.00
67.00 06700 0CCUPATI		21,003	214, 355	235, 3			
68.00 06800 SPEECH P		14, 025	267, 341	281, 3			
69.00 06900 ELECTROC		0	0		0 0.00000		
70.00 07000 ELECTROE		0	0		0 0.00000		
	SUPPLIES CHARGED TO PATIENTS	372, 959	1, 170, 339				
	BLE DEVICES CHARGED TO	9, 759	60, 260	70, 0	19 3. 64688	2 0. 000000	72.00
PATI ENTS							
	ARGED TO PATIENTS	780, 143	13, 132, 466				
76.00 03610 SLEEP LA		0	413, 993				
76.01 03480 ONCOLOGY		2, 597	1, 659, 634	1, 662, 2	0. 24314	7 0.000000	76.01
	VICE COST CENTERS	0.0(1	1 010 0//	1 000 0	0.7.7.7.0		
90.00 09000 CLINIC		9,061	1, 018, 966				
91.00 09100 EMERGENC		170, 952	14, 859, 159				
	ION BEDS (NON-DISTINCT PART)	21,633	493, 176			2 0.00000	
	(see instructions) ervation Beds	5, 362, 379	68, 662, 316	74, 024, 6	70		200.00
		E 242 270	40 440 014	74, 024, 6	75		201.00
202.00 10tal (S	ee instructions)	5, 362, 379	68, 662, 316	pj 74,024,0	90	I	1202.00

Health Financial Systems	ST. VINCENT MERC	Y HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared: 11/25/2019 3:08 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31.00
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT				35.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
56. 00 05600 RADI 0I SOTOPE	0. 000000			56.00
57.00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00 06800 SPEECH PATHOLOGY	0, 000000			68,00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO	0. 000000			72.00
PATIENTS				
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76.00 03610 SLEEP LAB	0. 000000			76.00
76.01 03480 ONCOLOGY	0. 000000			76.01
OUTPATIENT SERVICE COST CENTERS	-1			
90. 00 09000 CLINIC	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
				1

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 3:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		·	•			
50.00 05000 OPERATING ROOM	296, 922	7, 873, 964	0. 03770	9 261, 980	9, 879	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	359, 902	16, 565, 366	0. 02172	6 100, 013	2, 173	54.00
56. 00 05600 RADI OI SOTOPE	0	0	0. 00000	0 0	0	56.00
57.00 05700 CT SCAN	0	C	0.00000	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	0.00000	0 0	0	58.00
60. 00 06000 LABORATORY	76, 645	9, 127, 416	0.00839	215, 277	1, 808	60.00
65. 00 06500 RESPI RATORY THERAPY	66, 163	2,027,019	0. 03264	1 218, 527	7, 133	65.00
66.00 06600 PHYSI CAL THERAPY	85,014		0. 03587	45, 397	1, 628	66.00
67.00 06700 OCCUPATI ONAL THERAPY	5,000	235, 358	0. 02124	4 12, 721	270	67.00
68.00 06800 SPEECH PATHOLOGY	3, 696					68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000		0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	c c	0.00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 497	1, 543, 298			1,029	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	8, 309					72.00
PATIENTS				,		
73.00 07300 DRUGS CHARGED TO PATIENTS	245, 170	13, 912, 609	0. 01762	2 246, 551	4, 345	73.00
76.00 03610 SLEEP LAB	11,603	413, 993	0, 02802	7 0	0	76.00
76. 01 03480 ONCOLOGY	17, 734	1, 662, 231	0, 01066	9 203	2	76.01
OUTPATIENT SERVICE COST CENTERS				-		
90, 00 09000 CLINIC	35, 275	1, 028, 027	0. 03431	3 3, 280	113	90.00
91. 00 09100 EMERGENCY	282,650					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	74, 326				0	92.00
200.00 Total (lines 50 through 199)	1, 579, 906			1, 252, 610	-	
······································	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,	1	.,, 0.0		

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS			Period: From 07/01/2018 To 06/30/2019		
			XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	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 OPERATI NG ROOM	0	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66,00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68,00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
PATIENTS				с с	, i i i i i i i i i i i i i i i i i i i	/2:00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 00 03610 SLEEP LAB	0	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		<u> </u>		70.01
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			ő	0	
200.00 Total (lines 50 through 199)	0	0		0 0	-	200.00
			1	S ₁ 0		

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Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 07/01/2018 To 06/30/2019	Worksheet D Part IV Date/Time Pre 11/25/2019 3:	
		Title	XVIII	Hospi tal	Cost	<u>oo piii</u>
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 7, 873, 964	0.000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 16, 565, 366	0.000000	54.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0.000000	56.00
57.00 05700 CT SCAN	0	0		0 0	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	
60. 00 06000 LABORATORY	0	0		0 9, 127, 416	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 2, 027, 019	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 370, 016	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 235, 358	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 281, 366	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 543, 298	0.000000	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 70,019		72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 13, 912, 609	0.000000	73.00
76.00 03610 SLEEP LAB	0	0		0 413, 993	0.000000	76.00
76. 01 03480 ONCOLOGY	0	0		0 1, 662, 231	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 1, 028, 027	0.00000	90.00
91. 00 09100 EMERGENCY	0	0		0 15, 030, 111		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 514, 809		
200.00 Total (lines 50 through 199)	0	0		0 72, 655, 602		200.00
	1		•			

Health Financial Systems	ST. VINCENT MERC	CY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 07/01/2018 To 06/30/2019		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n 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	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 000000	261, 980		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	100, 013		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	215, 277		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	218, 527		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	45, 397		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	12, 721		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	9, 036		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	138, 137		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 000000	1, 352		0 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	246, 551	1	0 0	0	73.00
76.00 03610 SLEEP LAB	0. 000000	0	1	0 0	0	76.00
76. 01 03480 ONCOLOGY	0. 000000	203	1	0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	3, 280		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	136		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		1, 252, 610		0 0	0	200. 00

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2018 To 06/30/2019	Worksheet D Part V Date/Time Pre 11/25/2019 3:	pared: 08 pm
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATING ROOM	0. 206513	0	1, 829, 59		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 131881	0	4, 144, 30	07 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000			0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 181588		2, 514, 91		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 473610	0	897, 56		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 441963	0	556, 00		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 388629	0	53, 63	34 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 357531	0	48, 72	21 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 228945	0	308, 65	52 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	3. 646882	0	15, 80	0 8	0	72.00
PATI ENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 391530		5, 724, 48	1, 309	0	73.00
76.00 03610 SLEEP LAB	0. 327230	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0. 243147	0	173, 26	0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 557538				0	
91. 00 09100 EMERGENCY	0. 302554	0	2, 998, 29		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 255602	0	196, 33		0	
200.00 Subtotal (see instructions)		0	19, 803, 33	30 1, 309	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	19, 803, 33	1, 309	0	202.00

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS·	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1308	Peri od: From 07/01/2018 To 06/30/2019	Worksheet D Part V Date/Time Pro 11/25/2019 3	epared: :08 pm
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	377, 836	0				50,00
54. 00 105000 RADI OLOGY-DI AGNOSTI C	546, 555		•			54.00
56. 00 05600 RADI 0LOGT-DI AGNOSTI C	540, 555					56.00
57. 00 05700 CT SCAN	0	-				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
60. 00 06000 LABORATORY	456, 678	°				60.00
65. 00 06500 RESPIRATORY THERAPY	430,078					65.00
66. 00 06600 PHYSI CAL THERAPY	245, 735					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	20,844					67.00
68. 00 06800 SPEECH PATHOLOGY	17, 419					68.00
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	-				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	70, 664	0				71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	57,650					72.00
PATI ENTS		-				
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 241, 307	513				73.00
76.00 03610 SLEEP LAB	0	0				76.00
76.01 03480 ONCOLOGY	42, 129	0				76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	190, 535	0				90.00
91.00 09100 EMERGENCY	907, 145	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	246, 520					92.00
200.00 Subtotal (see instructions)	5, 846, 114	513				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	5, 846, 114	513				202.00

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2018	Worksheet D Part V	
		Component (CCN: 15-Z308	To 06/30/2019	Date/Time Pre 11/25/2019 3:	pared: 08 pm
		Title	XVIII	Swing Beds - SNF	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services 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 SERVI CE COST CENTERS				-		
50.00 05000 OPERATING ROOM	0. 206513	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 131881	0		0 0	0	54.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 181588	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 473610	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 441963	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 388629	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 357531	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 228945	0		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	3. 646882	0		0 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 391530	0		0 0	0	73.00
76.00 03610 SLEEP LAB	0. 327230	0		0 0	0	76.00
76.01 03480 ONCOLOGY	0. 243147	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0. 557538	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 302554	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 255602	0		0 0	0	
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00
			•	,	•	

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS-2552-	-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1308	Peri od:	Worksheet D	
		Component	CCN: 15-Z308	From 07/01/2018 To 06/30/2019	Part V	d
		Component	CCN. 15-2506	10 00/30/2014	Date/Time Prepared 11/25/2019 3:08 pr	m.
		Title	XVIII	Swing Beds - SNF	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To Ded. & Coins.	Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	1			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	1			_
50. 00 05000 OPERATI NG ROOM	0	C)		50.	00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C			54.	00
56. 00 05600 RADI OI SOTOPE	0	0			56.	00
57.00 05700 CT SCAN	0	0			57.	00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.	00
60. 00 06000 LABORATORY	0	0			60.	00
65. 00 06500 RESPI RATORY THERAPY	0	0			65.	
66. 00 06600 PHYSI CAL THERAPY	0	0			66.	
67.00 06700 OCCUPATI ONAL THERAPY	0	0			67.	
68.00 06800 SPEECH PATHOLOGY	0	0			68.	
69. 00 06900 ELECTROCARDI OLOGY	0	0			69.	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C			70.	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0			71.	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0			72.	00
PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0				73.	00
73.00 07300 DR0GS CHARGED TO PATTENTS 76.00 03610 SLEEP LAB	0				73.	
76. 01 03480 0NC0L0GY	0				76.	
OUTPATIENT SERVICE COST CENTERS	0				70.	01
90. 00 09000 CLINIC	0	0			90.	00
91. 00 09100 EMERGENCY	0				91.	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				92.	
200.00 Subtotal (see instructions)	0)		200.	
201.00 Less PBP Clinic Lab. Services-Program	0				201.	
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	c			202.	00

Health Financial Systems	ST. VINCENT MER	CY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COSTS			Period: From 07/01/2018 To 06/30/2019		
			e XIX	Hospi tal	Cost	
Cost Center Description	Nursing School N Post-Stepdown Adjustments 1A	ursing School	Allied Healt Post-Stepdow Adjustments 2A	n Cost	All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	ZA	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT 200. 00 Total (lines 30 through 199)		000000000000000000000000000000000000000			000000000000000000000000000000000000000	31.00
Cost Center Description	Adjustment (Amount (see instructions) m	Total Costs (sum of cols. 1 through 3, ninus col. 4)	Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATI ENT ROUTI NE SERVICE COST CENTERS30. 0003000 ADULTS & PEDI ATRICS31. 0003100 INTENSIVE CARE UNIT35. 0002040 DETOXIFICATION INTENSIVE CARE UNIT200. 00Total (lines 30 through 199)	0	0 0 0 0	1, 08	0 0.00 0 0.00	0	31.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		1,00			200.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS30. 0003000ADULTS & PEDI ATRI CS31. 0003100INTENSI VE CARE UNI T35. 0002040DETOXI FI CATI ON INTENSI VE CARE UNI T200. 00Total (lines 30 through 199)	0 0 0 0					30.00 31.00 35.00 200.00

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS			Period: From 07/01/2018 To 06/30/2019		
			e XIX	Hospi tal	Cost	
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	_			-		
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0	C		0 0	0	56.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	Ċ		0 0	0	68,00
69.00 06900 ELECTROCARDI OLOGY	0	Ċ		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO	0	C		0 0	0	72.00
PATIENTS	-	-		-	-	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
76.00 03610 SLEEP LAB	0	C		0 0	0	76.00
76.01 03480 ONCOLOGY	0	C		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS	1	i				
90, 00 09000 CLINIC	0	C		0 0	0	90.00
91. 00 09100 EMERGENCY	0	C		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-		0	0	
200.00 Total (lines 50 through 199)	0	C		o o	0	200.00
	1			1		

^{11/25/2019 3:08} pm Y: \28650 - St. Vincent Mercy\300 - Medicare Cost Report\20190630\HFS Files\28650-19.mcrx

Health Financial Systems	ST. VINCENT ME	RCY HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 07/01/2018 To 06/30/2019	Worksheet D Part IV Date/Time Pre 11/25/2019 3:	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 7, 873, 964	0.000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 16, 565, 366	0.000000	54.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0.000000	56.00
57.00 05700 CT SCAN	0	0		0 0	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	58.00
60. 00 06000 LABORATORY	0	0		0 9, 127, 416	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 2, 027, 019	0.000000	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 2, 370, 016	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 235, 358	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 281, 366	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 543, 298	0.000000	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 70,019		72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 13, 912, 609	0.000000	73.00
76.00 03610 SLEEP LAB	0	0		0 413, 993	0.000000	76.00
76. 01 03480 ONCOLOGY	0	0		0 1, 662, 231	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 1, 028, 027	0.00000	90.00
91. 00 09100 EMERGENCY	0	0		0 15, 030, 111		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 514, 809		
200.00 Total (lines 50 through 199)	0	0		0 72, 655, 602		200.00
	1		•			

Health Financial Systems	ST. VINCENT MERC	CY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 07/01/2018 To 06/30/2019	Worksheet D Part IV Date/Time Pre 11/25/2019 3:	pared: 08 pm
			e XIX	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n 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	
ANCI LLARY SERVI CE COST CENTERS	1 1		r	1		
50.00 05000 OPERATI NG ROOM	0. 000000	21, 782		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	26, 094		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	36, 469		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	16, 788		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		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	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	8, 157		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 000000	0		0 0	0	72.00
PATI ENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	20, 031		0 0	0	73.00
76.00 03610 SLEEP LAB	0. 000000	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0. 000000	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	28, 425		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		157, 746		0 0	0	200. 00

	Financial Systems ST. VINCENT MERCY HOSPIT			u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provid	er CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Pre	
		itle XVIII	Hospi tal	11/25/2019 3:0 Cost	<u> 78 pm</u>
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	INPATIENT DAYS			1.045	1 00
1.00 2.00	Inpatient days (including private room days and swing-bed days, exclu Inpatient days (including private room days, excluding swing-bed and			1, 245 1, 081	1.00 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If		ivate room days,	0	3.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)			730	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days)		er 31 of the cost	92	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private room days)	after December	31 of the cost	72	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	arter becember	ST OF the cost	12	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) reporting period	through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days)	after December 3	1 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)			220	0.00
9.00	Total inpatient days including private room days applicable to the Pr newborn days)	ogram (excluding	swing-bed and	330	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (inc	luding private r	room days)	92	10.00
11.00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (inc	luding private r	oom davs) after	12	11.00
10.00	December 31 of the cost reporting period (if calendar year, enter 0 c	on this line)	5		40.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (through December 31 of the cost reporting period	including privat	e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (0	13.00
14.00	after December 31 of the cost reporting period (if calendar year, ent Medically necessary private room days applicable to the Program (excl	er 0 on this lin uding swing-bed	ie) davs)	0	14.00
15.00	Total nursery days (title V or XIX only)	aanng omnig ooa		0	15.00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to services through	Igh December 31 c	of the cost		17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to services after	December 31 of	the cost		18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to services throug reporting period			129. 14	
20.00	Medicaid rate for swing-bed NF services applicable to services after reporting period	December 31 of t	he cost	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)			2, 292, 767	
22.00	Swing-bed cost applicable to SNF type services through December 31 of 5×10^{-10} x line 17)	the cost report	ing period (line	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18)	he cost reportin	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 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 31 of th	e cost reportinc	period (line 8	0	25.00
	x line 20)			202.010	24 00
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21	minus line 26)		302, 019 1, 990, 748	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		· 1		
28.00 29.00	General inpatient routine service charges (excluding swing-bed and ob Private room charges (excluding swing-bed charges)	servation bed ch	narges)	0	28.00 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 2	.8)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line	33)(see instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		fferential (1)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and priv 27 minus line 36)	ate room cost di	TTERENTIAL (LINE	1, 990, 748	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instruc	tions)		1,841.58	
39.00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line	11 v line 2E)		607, 721 0	39.00 40.00
40. 00 41. 00	Total Program general inpatient routine service cost (line 39 + line			607, 721	
			I		

JMPUI	TATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1308	Period: From 07/01/2018		
					To 06/30/2019	Date/Time Pre 11/25/2019 3:	
	Cost Center Description	Total	Title Total	XVIII Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost				(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)						42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	, 0	0	0.	0 00	0	43.
. 00	CORONARY CARE UNIT						44.
. 00	BURN INTENSIVE CARE UNIT						45.
. 00	SURGICAL INTENSIVE CARE UNIT DETOXIFICATION INTENSIVE CARE UNIT	0	0	0.	0 0	0	46
. 00	Cost Center Description	0	0	0.	0	0	/ 47.
00			1: 000)			1.00	10
. 00	Program inpatient ancillary service cost (WH Total Program inpatient costs (sum of lines			ns)		373, 128 980, 849	
. 00	PASS THROUGH COST ADJUSTMENTS	41 through 40)(3		113)		700, 047	47
. 00	Pass through costs applicable to Program in	patient routine s	ervices (from	Wkst. D, su	n of Parts I and	0	50
. 00	<pre>III) Pass through costs applicable to Program ing</pre>	ationt ancillary	sorvicos (fr	om Wkst D	rum of Parts II	0	51
. 00	and IV)	attent and traig	services (II	UNI WKSL. D,	Sum OF Faits II		1 31.
2. 00	Total Program excludable cost (sum of lines	,				0	
3.00	Total Program inpatient operating cost exclu		ated, non-phy	sician anest	netist, and	0	53.
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operation	ting cost and tar	act amount (1	ino E4 minuc	Line E2)	0	
. 00	Bonus payment (see instructions)	ting cost and tar	get amount (i	The 50 millios	TTHE 53)		
. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	nding 1996, u	pdated and c	ompounded by the	0.00	
	market basket	aget report und	atad by the m	arkat baakat		0.00	
0.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less that	an expected costs				_	
	amount (line 56), otherwise enter zero (see	instructions)					
2.00 3.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payr	ment (see instruc	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST					-	
. 00	Medicare swing-bed SNF inpatient routine cos	sts through Decem	ber 31 of the	cost report	ng period (See	169, 425	64.
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	sts after Decembe	r 31 of the c	ost reportin	n period (See	22, 099	65.
	instructions)(title XVIII only)						
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	l only). For	191, 524	66
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 c	f the cost r	enorting period	0	67.
	(line 12 x line 19)				sporting period		
3. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after De	cember 31 of	the cost rep	orting period	0	68.
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (1	ine 67 + line	68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER N			,		-	
0. 00	Skilled nursing facility/other nursing facil	2		•)		70
. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne /U ÷ line	2)			71
. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv	•					74
5. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, I	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital-related costs (line 9 x line	e 76)					77
. 00	Inpatient routine service cost (line 74 minu		ovidor re				78
. 00 . 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	• •		· · ·	nus line 79)		79
. 00	Inpatient routine service cost per diem limi						81
. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82
. 00	Reasonable inpatient routine service costs	•)				83
. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84
. 00	Total Program inpatient operating costs (sur					<u> </u>	86
	PART IV - COMPUTATION OF OBSERVATION BED PAS						
		- 1				351	87.
7.00 3.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			1, 841. 58	

Health Financial Systems	ST. VINCENT M	ERCY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 3:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	263, 633	3 2, 292, 767	0. 11498	5 646, 395	74, 326	90.00
91.00 Nursing School cost	(2, 292, 767	0.00000	0 646, 395	0	91.00
92.00 Allied health cost	(2, 292, 767	0.00000	0 646, 395	0	92.00
93.00 All other Medical Education	(2, 292, 767	0.00000	0 646, 395	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Pre	
			10 00/30/2019	11/25/2019 3:0	
	Cost Costos Description	Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed days (including private room days and swing-bed days			1, 245	
00 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed of		rivate room davs	1, 081	2. 3.
00	do not complete this line.	days). If you have only p	Tvate Toolii uays,	0	3.
00	Semi-private room days (excluding swing-bed and observation	bed days)		730	4.
00	Total swing-bed SNF type inpatient days (including private	room days) through Decembe	er 31 of the cost	92	5.
00	reporting period Total swing-bed SNF type inpatient days (including private n	room dave) after December	21 of the cost	72	6.
00	reporting period (if calendar year, enter 0 on this line)	Tooli days) al ter becember	ST OF THE COST	12	0.
00	Total swing-bed NF type inpatient days (including private re	oom days) through December	r 31 of the cost	0	7.
	reporting period				
00	Total swing-bed NF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	oom days) after December 3	31 of the cost	0	8.
00	Total inpatient days including private room days applicable	to the Program (excluding	a swing-bed and	22	9.
00	newborn days)		g sinnig bed and	22	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.
	through December 31 of the cost reporting period (see instru				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		room days) atter	0	11.
2.00	Swing-bed NF type inpatient days applicable to titles V or 2		te room davs)	0	12
	through December 31 of the cost reporting period	5 5 1 1 1			
. 00	Swing-bed NF type inpatient days applicable to titles V or 2			0	13
. 00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Pro	year, enter 0 on this li	ne)	0	14
	Total nursery days (title V or XIX only)	gram (excruding swing-bed	uays)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servi	ices through December 31 (of the cost		17
8. 00	reporting period Medicare rate for swing-bed SNF services applicable to servi	ices after December 31 of	the cost		18.
. 00	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to servi	ces through December 31 of	f the cost	129.14	19
00	reporting period			100 11	
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	ces after December 31 of	the cost	129.14	20
. 00	Total general inpatient routine service cost (see instruction	ons)		2, 292, 767	21
. 00	Swing-bed cost applicable to SNF type services through Decen		ting period (line	0	
	5 x line 17)			_	
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	er 31 of the cost reportion	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decem	ber 31 of the cost reporti	na period (line	0	24
	7 x line 19)		0.		
. 00	Swing-bed cost applicable to NF type services after December	r 31 of the cost reporting	g period (line 8	0	25
00	x line 20) Total swing-bed cost (see instructions)			302, 019	24
. 00 . 00	General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26)		302, 019 1, 990, 748	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			1, 770, 710	1 - 1
00	General inpatient routine service charges (excluding swing-	bed and observation bed cl	narges)	0	
00	Private room charges (excluding swing-bed charges)			0	
. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2)	$7 \cdot 1$ inc. 28)		0	30
	Average private room per diem charge (line 29 ÷ line 3)	/ - (THE 28)		0. 000000 0. 00	
00	Average semi-private room per diem charge (line 27 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4))		0.00	
. 00 . 00	Average semi-private room per urem charge (rine so - rine 4		ati ana)	0.00	
00 00 00	Average per diem private room charge differential (line 32 i	minus line 33)(see instru	strons)	0.00	
. 00 . 00 . 00 . 00 . 00	Average per diem private room charge differential (line 32 n Average per diem private room cost differential (line 34 x	line 31)	strons)	0.00	35
. 00 . 00 . 00 . 00 . 00 . 00	Average per diem private room charge differential (line 32 n Average per diem private room cost differential (line 34 x Private room cost differential adjustment (line 3 x line 35	line 31))		0. 00 0	35 36
. 00 . 00 . 00 . 00 . 00	Average per diem private room charge differential (line 32 n Average per diem private room cost differential (line 34 x	line 31))		0.00	35 36

	PROGRAM INPATIENT OPERATING COST DEFORE PASS INROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 841. 58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	40, 515	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	40, 515	41.00

UMPUI	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1308	Period: From 07/01/2018	Worksheet D-1	1
					To 06/30/2019		
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)						42
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	;		0.	00 0	0	43
. 00	CORONARY CARE UNIT	0	C	0.	00 0		43
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00	DETOXIFICATION INTENSIVE CARE UNIT	0	C	0.	00 0	C) 47
	Cost Center Description					1.00	+
. 00	Program inpatient ancillary service cost (We	st. D-3, col. 3,	line 200)			40, 823	3 48
. 00	Total Program inpatient costs (sum of lines			ons)		81, 338	3 49
	PASS THROUGH COST ADJUSTMENTS					-	
. 00	Pass through costs applicable to Program inp [11])	batient routine s	ervices (from	n Wkst. D, su	m of Parts I and	0	50
. 00	Pass through costs applicable to Program ing	oatient ancillarv	services (fr	om Wkst. D.	sum of Parts II	l a	51
	and IV)	5	· ·				
. 00	Total Program excludable cost (sum of lines					0	
. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phy	sician anest	netist, and	C	53
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00	Program di scharges					C	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)	ting agost and tar	act cmount (1	ing E(minug	Line E2)		
. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ting cost and tar	get amount (i	The so minus	Time 53)		
0.00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	nding 1996, ι	updated and c	ompounded by the		
	market basket		0		. ,		
0.00	Lesser of lines 53/54 or 55 from prior year				the emount by	0.00	
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that						61
	amount (line 56), otherwise enter zero (see				i tho turgot		
2.00	Relief payment (see instructions)	· ·				C	
8. 00	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	nent (see instruc	tions)			0	63
. 00	Medicare swing-bed SNF inpatient routine cos	sts through Decem	ber 31 of the	e cost report	ing period (See	0	64
	instructions) (title XVIII only)	to through booon		, ocor i opor r	ing poired (eee		
6. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	r 31 of the c	cost reportin	g period (See	0	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (lino 6	1 plus lipo 4	5) (+i +l o V/l	LL only) For	0	66
5. 00	CAH (see instructions)	The costs (The o	4 prus rine c	55)(11118 XVI	ri oniy). Toi		/ 00
7.00	Title V or XIX swing-bed NF inpatient routir	ne costs through	December 31 c	of the cost r	eporting period	c d	67
	(line 12 x line 19)						
3. 00	Title V or XIX swing-bed NF inpatient routir	ne costs after De	cember 31 of	the cost rep	orting period	0	68
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (1	ine 67 + line	68)		c	69.
	PART III - SKILLED NURSING FACILITY, OTHER N			,		-	
. 00	Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service of		ne 70 ÷ líne	2)			71
. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72
. 00	Total Program general inpatient routine serv						74
. 00	Capital-related cost allocated to inpatient	routine service	costs (from V	lorksheet B,	Part II, column		75
00	26, line 45)	no ()					-,
. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					76
. 00	Inpatient routine service cost (line 74 minu						78
. 00	Aggregate charges to beneficiaries for exces	ss costs (from pr		•			79
00	Total Program routine service costs for comp		st limitation	n (line 78 mi	nus line 79)		80
. 00 . 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81
. 00	Reasonable inpatient routine service cost film tation (82
. 00	Program inpatient ancillary services (see in	•					84
. 00	Utilization review - physician compensation	(see instruction					85
. 00	Total Program inpatient operating costs (sum		ough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					351	87
	Adjusted general inpatient routine cost per		line 2)			1, 841. 58	
. 00	Adjusted general inpatrent routine cost per					1,011.00	

Health Financial Systems	ST. VINCENT M	RCY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 07/01/2018 To 06/30/2019		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	263, 633	2, 292, 767	0. 11498	5 646, 395	74, 326	90.00
91.00 Nursing School cost	0	2, 292, 767	0.00000	0 646, 395	0	91.00
92.00 Allied health cost	0	2, 292, 767	0.00000	0 646, 395	0	92.00
93.00 All other Medical Education	0	2, 292, 767	0. 00000	0 646, 395	0	93.00

Health Financial Systems ST. VINCENT MERCY I	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1308	Peri od:	Worksheet D-3	;
			From 07/01/2018 To 06/30/2019		narod
			10 00/30/2019	11/25/2019 3:	08 pm
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
30. 00 03000 ADULTS & PEDIATRICS			497, 846		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT			0		35.00
ANCI LLARY SERVI CE COST CENTERS		0.00/5	2/1 000	E4 102	
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2065 ⁻ 0. 13188			
56. 00 05600 RADI OLOGY-DI AGNOSTI C		0. 13188		13, 190 0	
57. 00 05700 CT SCAN		0.0000			
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000			
60. 00 06000 LABORATORY		0. 18158		-	
65. 00 06500 RESPI RATORY THERAPY		0. 18156			
66. 00 06600 PHYSI CAL THERAPY		0.4730			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 38862			
68. 00 06800 SPEECH PATHOLOGY		0. 35753			
69. 00 lo6900 ELECTROCARDI OLOGY		0.0000		0,231	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 22894		,	
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		3. 64688			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 39153			
76.00 03610 SLEEP LAB		0. 32723		0	
76. 01 03480 ONCOLOGY		0. 24314		-	
OUTPATIENT SERVICE COST CENTERS		012101	200		/ 0. 01
90. 00 09000 CLINIC		0. 55753	38 3, 280	1, 829	90.00
91. 00 09100 EMERGENCY		0. 3025			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 25560	02 0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 252, 610	373, 128	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges ((line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			1, 252, 610		202.00

Health Financial Systems	ST. VINCENT MERCY HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	3
			From 07/01/2018		
	Component	CCN: 15-Z308	To 06/30/2019		
	Title	e XVIII S	Swing Beds - SNF	11/25/2019 3: Cost	06 0111
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
		5		(col. 1 x col.	
			U U	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31.00 03100 I NTENSI VE CARE UNI T			0		31.00
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT			0		35.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 20651	3 2, 226	460	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 13188	1 25, 478	3, 360	54.00
56. 00 05600 RADI OI SOTOPE		0.00000	0 0	0	56.00
57.00 05700 CT SCAN		0.00000	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000	0 0	0	58.00
60. 00 06000 LABORATORY		0. 18158	8 35, 071	6, 368	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 47361	0 22, 128	10, 480	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 44196	3 29, 457	13, 019	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 38862	9 8, 282	3, 219	67.00
68.00 06800 SPEECH PATHOLOGY		0. 35753	1 2, 555	913	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.00000	0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 22894	5 7, 326	1, 677	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIE	NTS	3. 64688	2 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 39153	0 107, 039	41, 909	73.00
76.00 03610 SLEEP LAB		0. 32723	0 0	0	76.00
76.01 03480 ONCOLOGY		0. 24314	7 132	32	76.01
OUTPATIENT SERVICE COST CENTERS		_			
90. 00 09000 CLINIC		0. 55753	8 2, 128	1, 186	90.00
91.00 09100 EMERGENCY		0. 30255	4 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 25560	2 0	0	92.00
200.00 Total (sum of lines 50 through 94 an			241, 822	82, 623	200.00
201.00 Less PBP Clinic Laboratory Services-	Program only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		241, 822		202.00

Health Financial Systems ST. VINCENT MERCY HO	OSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Pr	rovider CO	CN: 15-1308	Peri od:	Worksheet D-3	
			From 07/01/2018 To 06/30/2019	Date/Time Pre	nared
			10 00/30/2019	11/25/2019 3:	08 pm
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			40.0(0		1 00 00
30. 00 03000 ADULTS & PEDIATRICS			48, 963		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
35. 00 02040 DETOXI FI CATI ON I NTENSI VE CARE UNI T			0		35.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0.20(5)	13 21, 782	4 400	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2065 ⁻ 0. 13188			
56. 00 05600 RADI 0L001-DI AGNOSTI C		0. 13180		, 3, 441 0	1
57. 00 05700 CT SCAN		0.0000			
58. 00 05500 MAGNETIC RESONANCE IMAGING (MRI)		0.0000			1
60, 00 06000 LABORATORY		0. 18158		-	
65. 00 06500 RESPIRATORY THERAPY		0. 4736			
66. 00 06600 PHYSI CAL THERAPY		0. 44196		0	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 38862		0	
68. 00 06800 SPEECH PATHOLOGY		0.35753			
69. 00 06900 ELECTROCARDI OLOGY		0.0000		0	•
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 22894		-	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		3. 64688		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 39153		7,843	
76.00 03610 SLEEP LAB		0. 32723		0	•
76. 01 03480 ONCOLOGY		0. 24314		0	76.01
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 55753	38 0	0	90.00
91.00 09100 EMERGENCY		0. 3025	28, 425	8, 600	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		1. 25560	02 0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			157, 746	40, 823	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			157, 746		202.00

	Financial Systems ST. VINCENT MER ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1308	Peri od:	u of Form CMS-2 Worksheet E	2002-10
			From 07/01/2018 To 06/30/2019	Part B	pared:
		Title XVIII	Hospi tal	11/25/2019 3: Cost	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		<u>_</u>	1.00	
1.00	Medical and other services (see instructions)			5, 846, 627	
2.00 3.00	Medical and other services reimbursed under OPPS (see instru OPPS payments	ictions)		0	
4.00	Outlier payment (see instructions)			0	4.00
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instr	cuctions)		0.000	
6.00	Line 2 times line 5	uctions)		0.000	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	
10.00	Organ acqui si ti ons	14, 661. 16, 1116 200		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			5, 846, 627	11.00
	Reasonable charges				
12.00	Ancillary service charges			-	12.00
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Total reasonable charges (sum of lines 12 and 13)	line 69)		0	13.00 14.00
11.00	Customary charges				
15.00	Aggregate amount actually collected from patients liable for	1 5	0	0	
16.00	Amounts that would have been realized from patients liable f had such payment been made in accordance with 42 CFR §413.13		on a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete c	only if line 18 exceeds li	ne 11) (see	0	
19.00	instructions)	ing in the to exceeds in		0	19.00
20.00	Excess of reasonable cost over customary charges (complete o	only if line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			5, 905, 093	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00 24.00	Cost of physicians' services in a teaching hospital (see ins Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on li		suctions)	33, 590 3, 477, 310	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	•		2, 394, 193	
20.00	instructions)	Line FO)		0	20.00
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, ESRD direct medical education costs (from Wkst. E-4, line 36			0	
30.00	Subtotal (sum of lines 27 through 29)	- /		2, 394, 193	30.00
31.00 32.00	Primary payer payments			313 2, 393, 880	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	/I CES)		2, 393, 880	32.00
	Composite rate ESRD (from Wkst. I-5, line 11)	·			33.00
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			858, 358 557, 933	
36.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		775, 428	
37.00	Subtotal (see instructions)			2, 951, 813	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		-	39.50
39.97	Demonstration payment adjustment amount before sequestration		-+:>	0	
39. 98 39. 99	Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION	aceu uevices (see instruc		0	
40.00	Subtotal (see instructions)			2, 951, 813	40.00
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			59, 036 0	
40.02	Interim payments			2, 824, 919	
	Tentative settlement (for contractors use only)			0	
43.00 44.00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub 15-2	chapter 1.	67, 858 0	1
	§115. 2				
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00 91.00	Outlier reconciliation adjustment amount (see instructions))		0	1
71.00				0.00	92.00
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)				93.00

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	N: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part I Date/Time Pre 11/25/2019 3:0	pared
		Title	XVIII	Hospi tal	Cost	
		Inpatient	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		893, 4	63 0	2, 824, 919 0	1. 2.
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
03 04				0	0	3
04				0	0	
	Provider to Program	L I.		-		
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52 53				0 0	0	
54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		893, 4	63	2, 824, 919	4
00	List separately each tentative settlement payment after					5
50	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5
02				0	0	
03				0	0	5
	Provider to Program	T		0		_
50 51	TENTATI VE TO PROGRAM			0 0	0	
52				0	0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER			0	67, 858	
02	SETTLEMENT TO PROGRAM		22, 2		0 2, 892, 777	
00	Total Medicare program liability (see instructions)		871, 2	Contractor	2,892,777 NPR Date	7
				Number	(Mo/Day/Yr)	
		0		1.00	2.00	

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1308 CCN: 15-Z308	Peri From To	od: 07/01/2018 06/30/2019		
		Component	0011. 10 2000	10	00/00/201/	11/25/2019 3	: 08 pr
			XVIII	Swi no	Beds - SNF		_
		Inpatien	it Part A		Par	t B	
		mm/dd/yyyy	Amount	m	m/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
00	Total interim payments paid to provider		286, 0	39		() 1.
00	Interim payments payable on individual bills, either			0		() 2.
	submitted or to be submitted to the contractor for						
	services rendered in the cost reporting period. If none,						
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment						3.
00	amount based on subsequent revision of the interim rate						J.
	for the cost reporting period. Also show date of each						
	payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						
01	ADJUSTMENTS TO PROVIDER			0			3.
)2				0			3.
23				0) 3.) 3.
)4)5				0 0) 3.) 3.
55	Provider to Program			0			J 3.
50	ADJUSTMENTS TO PROGRAM			0		(3.
51				0		(3.
52				0		(3.
53				0			3.
54				0			3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		(3.
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		286, 0	39			3 4.
00	(transfer to Wkst. E or Wkst. E-3, line and column as		200,0				
	appropri ate)						
	TO BE COMPLETED BY CONTRACTOR	-	1				
00	List separately each tentative settlement payment after						5.
	desk review. Also show date of each payment. If none,						
	write "NONE" or enter a zero. (1) Program to Provider						-
01	TENTATI VE TO PROVIDER			0		(5.
)2				0			5.
)3				0		() 5.
	Provider to Program						
0	TENTATI VE TO PROGRAM			0			5.
51				0 0) 5.) 5.
52 19	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0) 5.) 5.
7	5. 50-5. 98)			0			J 3.
00	Determined net settlement amount (balance due) based on						6.
	the cost report. (1)						
)1	SETTLEMENT TO PROVIDER			0) 6.
)2	SETTLEMENT TO PROGRAM		20, 2) 6.
00	Total Medicare program liability (see instructions)		265, 7) 7.
				C	ontractor	NPR Date (Mo/Day/Yr)	
			0		Number 1.00	2.00	
0	Name of Contractor		5		1.00	2.00	8.

Heal th	Financial Systems	ST. VINCENT MERCY	/ HOSPI TAL	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet E- Part II Date/Time Pr 11/25/2019 3	epared:
			Title XVIII	Hospi tal	Cost	
					1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAR					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTIO					
1.00	Total hospital discharges as defined in AARA			14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6		-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col					3.00
4.00	Total inpatient days from S-3, Pt. I col. 8		-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, c					5.00
6.00	Total hospital charity care charges from Wks					6.00
7.00	CAH only - The reasonable cost incurred for line 168	the purchase of ce	ertified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (se	e instructions)				8.00
9,00	Sequestration adjustment amount (see instruc					9.00
	Calculation of the HIT incentive payment aft	,	(see instructions)			10.00
101.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS &					
30, 00	Initial/interim HIT payment adjustment (see					30.00
	Other Adjustment (specify)					31.00
	Balance due provider (line 8 (or line 10) mi	nus line 30 and li	ne 31) (see instruction	s)		32.00
				- / 1		1 221 000

LCULA	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1308	Period: From 07/01/2018	Worksheet E-2	
		Component CCN: 15-Z308	To 06/30/2019	Date/Time Pre 11/25/2019 3:	pare 08 n
		Title XVIII	Swing Beds - SNF	Cost	<u>00 p</u>
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
	Inpatient routine services - swing bed-SNF (see instructions)		193, 439	0	
	Inpatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A and cum of Wkst D	83, 449	0	2
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins		03, 449	0	3
	Per diem cost for interns and residents not in approved teachi			0.00	4
	instructions)	31 3 (
1 OC	Program days		104	0	5
00 I	Interns and residents not in approved teaching program (see ir	nstructions)		0	6
	Jtilization review - physician compensation - SNF optional met	hod only	0		7
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		276, 888	0	
	Primary payer payments (see instructions)		0	0	
	Subtotal (line 8 minus line 9) Deductibles billed to program patients (svelude empunts applis	able to physician	276, 888	0	
	Deductibles billed to program patients (exclude amounts applic professional services)	able to physician	0	0	11
	Subtotal (line 10 minus line 11)		276, 888	0	12
	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	5, 695	0	
	for physician professional services)		0,0,0	Ū	
. 00 8	80% of Part B costs (line 12 x 80%)			0	14
. 00 5	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	271, 193	0	15
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions				16
	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16
	adjustment (see instructions)			0	
	Demonstration payment adjustment amount before sequestration		0	0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	
	Total (see instructions)		271, 193	0	
	Sequestration adjustment (see instructions)		5, 424	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
00	Interim payments		286, 039	0	20
00	Tentative settlement (for contractor use only)		0	0	21
00 8	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	-20, 270	0	22
	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	0	0	23
	chapter 1, §115.2				1
	Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per				200
	Century Cures Act? Enter "Y" for yes or "N" for no.	Tod under the 21st			200
	Cost Reimbursement				
	Medicare swing-bed SNF inpatient routine service costs (from W	/kst. D-1, Pt. II, line			201
	66 (title XVIII hospital))				
	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, lir	ne		202
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)	first year of the surre	nt E voor demonst	ration	204
	Computation of Demonstration Target Amount Limitation (N/A in period)	Thist year of the curre	ent o-year demonst	1 4 1 0 1	
	Medicare swing-bed SNF target amount				205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				1
'. 00 I	Program reimbursement under the §410A Demonstration (see instr	ructions)			207
3. 00 1	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	2, col. 1, sum of lines	1		208
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209
	Reserved for future use				210
	Comparision of PPS versus Cost Reimbursement				045
	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	vy plus line 210) (see			215

	Financial Systems ST. VINCENT MER			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part V Date/Time Pre	
			10 00/30/2019	11/25/2019 3:	
		Title XVIII	Hospi tal	Cost	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAF			1.00	
1.00	Inpatient services	RE PART A SERVICES - CUST	RETWOURSEWENT	980, 849	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruct	tions)		900, 049 0	2.00
3.00	Organ acquisition			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			980, 849	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			990, 657	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES			- 1	
	Reasonabl e charges				
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	
10.00	Total reasonable charges			0	10.00
11 00	Customary charges	a normant for condition on	a abarra basia	0	11.00
11.00 12.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable f	1 3	0	0	
12.00	had such payment been made in accordance with 42 CFR 413.13		ni a charge basis	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	(e)		0.000000	13.00
14.00	Total customary charges (see instructions)			0.000000	
15.00	Excess of customary charges over reasonable cost (complete o	only if line 14 exceeds li	ne 6) (see	0	
	instructions)			-	
16.00	Excess of reasonable cost over customary charges (complete o	only if line 6 exceeds lir	ne 14) (see	0	16.00
	instructions)				
17.00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	- 4 11 40			
18.00	Direct graduate medical education payments (from Worksheet E	<u>-</u> -4, line 49)		0	
19.00	Cost of covered services (sum of lines 6, 17 and 18)			990, 657	
20. 00 21. 00	Deductibles (exclude professional component) Excess reasonable cost (from Line 16)			105, 432 0	
21.00	Subtotal (line 19 minus line 20 and 21)			885, 225	
23.00	Coi nsurance			0005, 225	
24.00	Subtotal (line 22 minus line 23)			885, 225	
25.00	Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		5, 805	
26.00	Adjusted reimbursable bad debts (see instructions)			3, 773	
27.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		1, 340	
28.00	Subtotal (sum of lines 24 and 25, or line 26)	· · · · · · · · · · · · · · · · · · ·		888, 998	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration	า		0	29.99
30.00	Subtotal (see instructions)			888, 998	30.00
30. 01	Sequestration adjustment (see instructions)			17, 780	
30. 02	Demonstration payment adjustment amount after sequestration			0	
31.00	Interim payments			893, 463	
32.00	Tentative settlement (for contractor use only)			0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.			-22, 245	
34.00	Protested amounts (nonallowable cost report items) in accord §115.2	dance with CMS Pub. 15-2,	cnapter I,	0	34.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VII Date/Time Pre	pared:
				11/25/2019 3:	08 pm
		Title XIX	Hospital	Cost Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR X			
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		81, 338		1.00
2.00	Medical and other services			0	
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		81, 338	0	
5.00	Inpatient primary payer payments		0	0	5.00
6.00 7.00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		81, 338	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		01, 330	0	7.00
	Reasonabl e Charges				-
8.00	Routi ne servi ce charges		48, 963		8.00
9.00	Ancillary service charges		157, 746	0	1
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)		206, 709	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services 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 a charge basis had such payment been made in accordance with 4		in O	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 CFR 9413.13(e)	0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		206, 709	0.000000	1
17.00	Excess of customary charges over reasonable cost (complete onl)	125, 371	0	1	
	line 4) (see instructions)		- , -		
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds lin	ie 0	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instr		0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 1		81, 338	0	21.00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be a Other than outlier payments	completed for PPS provi		0	22.00
22.00	Outlier payments		0	0	
24.00	Program capital payments		0	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)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		81, 338	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	1
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		81, 338	0	
32.00 33.00	Deducti bl es Coi nsurance		0	0	1
34.00	Allowable bad debts (see instructions)		0	0	
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	81, 338	0	1	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	1	
38.00	Subtotal (line 36 ± line 37)	81, 338	0	1	
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00	
40.00	Total amount payable to the provider (sum of lines 38 and 39)		81, 338	0	
41.00	Interim payments		81, 338	0	
	Balance due provider/program (line 40 minus line 41)	0	0	42.00	
42.00 43.00	Protested amounts (nonallowable cost report items) in accordan		0	0	

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	eriod: rom 07/01/2018 o 06/30/2019	Worksheet G Date/Time Pre 11/25/2019 3:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS		1			
00	Cash on hand in banks	70, 372			0	
00	Temporary investments	0			0	
00	Notes receivable	0	-	-	0	
00	Accounts receivable	6, 739, 027			0	
00	Other receivable	1,097,320			0	
)0)0	Allowances for uncollectible notes and accounts receivable Inventory	-3, 777, 582 323, 464			0 0	
00 00	Prepaid expenses	172, 724			0	
00	Other current assets	0		-	0	
. 00	Due from other funds	0			0	
00	Total current assets (sum of lines 1-10)	4, 625, 325			0	
00	FI XED ASSETS	1,020,020	11/2/0			1
00	Land	457, 300	C	0	0	12
00	Land improvements	528, 489	C	0	0	13
00	Accumulated depreciation	-388, 093	C	0	0	14
00	Bui I di ngs	13, 353, 069			0	15
	Accumulated depreciation	-7, 704, 662			0	
00	Leasehold improvements	9, 743, 578			0	
. 00	Accumulated depreciation	-5, 014, 514			0	
. 00	Fixed equipment	3, 471, 205			0	
. 00	Accumulated depreciation	-2, 343, 917			0	
. 00 . 00	Automobiles and trucks	14, 695			0 0	
	Accumulated depreciation Major movable equipment	-14, 695 6, 798, 008			0	
. 00	Accumulated depreciation	-5, 262, 583			0	
	Mi nor equi pment depreci able	146, 521			0	
. 00	Accumulated depreciation	-120, 934			0	
	HIT designated Assets	0			0	
. 00	Accumulated depreciation	0	C	0	0	
. 00	Minor equipment-nondepreciable	0	C	0	0	29
. 00	Total fixed assets (sum of lines 12-29)	13, 663, 467	C C	0	0	30
	OTHER ASSETS					
	Investments	0	-		0	
. 00	Deposits on Leases	0	C		0	
. 00	Due from owners/officers	0	C C		0	
. 00	Other assets	0	C		0	
. 00	Total other assets (sum of lines 31-34)	0	47 202		0	
. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	18, 288, 792	47, 293	0	0	36
00	Accounts payable	856, 433	C	0	0	37
. 00	Salaries, wages, and fees payable	1, 156, 219			0	
. 00	Payroll taxes payable	0			0	
	Notes and Loans payable (short term)	0		0	0	
. 00	Deferred income	0	c	0	0	
. 00	Accelerated payments	0				42
. 00	Due to other funds	3, 862, 507	C	0	0	43
. 00	Other current liabilities	970, 607	C	0	0	44
. 00	Total current liabilities (sum of lines 37 thru 44)	6, 845, 766	C	0	0	45
	LONG TERM LIABILITIES		1	1		
. 00	Mortgage payable	0	C		0	
. 00	Notes payable	10, 579, 795			0	
. 00	Unsecured Loans		C		0	
. 00	Other long term liabilities		0		0	
00 00	Total long term liabilities (sum of lines 46 thru 49)	10, 579, 795			0	
00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	17, 425, 561		0	0	1 21
00	General fund balance	863, 231				52
00	Specific purpose fund	000,201	47, 293			53
00	Donor created - endowment fund balance - restricted		F7, 275	0		54
00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	
-	replacement, and expansion				-	
	Total fund balances (sum of lines 52 thru 58)	863, 231	47, 293	0	0	59
. 00	Total fund barances (sum of filles 52 third 56)	000,201	17,270	9	0	

	Financial Systems	ST. VINCENT MERC				u of Form CMS-2	2552-10
STATE	IENT OF CHANGES IN FUND BALANCES		Provider CC		Period: From 07/01/2018 To 06/30/2019	Worksheet G-1 Date/Time Pre	
		General	Fund	Special F	Purpose Fund	11/25/2019 3: Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-1, 557, 892		35, 260		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2, 352, 902				2.00
3.00 4.00	Total (sum of line 1 and line 2)	(0. 221	795, 010		35, 260	0	3.00
4.00 5.00	TRANSFER FROM AFFILIATES	68, 221			0	0	4.00 5.00
5.00 6.00	RELEASED CAPITAL	0			0	0	6.00
7.00	RELEASED OPERATING	0		1	1	0	7.00
8.00	OTHER	0		12, 02		0	8.00
9.00	ROUNDING	0		12,02	0	0	9.00
10.00	Total additions (sum of line 4-9)	, o	68, 221		12, 033	0	10.00
11.00	Subtotal (line 3 plus line 10)		863, 231		47, 293		11.00
12.00	TRANSFERS FROM AFFILIATES	0	000, 201		0	0	12.00
13.00	DEFERRED PENSION COST	0			0	0	13.00
14.00	OTHER	0			0	0	14.00
15.00	RELEASED CAPITAL	0			0	0	15.00
16.00	RELEASED OPERATING	0			0	0	16.00
17.00	ROUNDING	0			0	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		863, 231		47, 293		19.00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund	_		
		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 FROM AFFILIATES		0				4.00
5.00	DONATIONS		0				5.00
6.00	RELEASED CAPI TAL		0				6.00
7.00	RELEASED OPERATING		0				7.00
8.00	OTHER		0				8.00
9.00	ROUNDING		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	TRANSFERS FROM AFFILIATES		0				12.00
13.00	DEFERRED PENSION COST		0				13.00
	OTHER		0				14.00
14.00	RELEASED CAPI TAL	1	0				15.00
15.00		1	~				
15. 00 16. 00	RELEASED OPERATING		0				16.00
15. 00 16. 00 17. 00	RELEASED OPERATI NG ROUNDI NG		0 0		0		17.00
15.00 16.00 17.00 18.00	RELEASED OPERATING ROUNDING Total deductions (sum of lines 12-17)	0	0 0		0		17. 00 18. 00
15.00 16.00 17.00	RELEASED OPERATI NG ROUNDI NG	0	0 0		0 0		17.00

ATEMENT	nancial Systems ST. VINCENT MERCY OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-1308		riod: om 07/01/2018	u of Form CMS- Worksheet G-2 Parts I & II Date/Time Pre 11/25/2019 3:	epared:
	Cost Center Description		Inpati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	RT I - PATIENT REVENUES						-
	neral Inpatient Routine Services	r				1 0 1 0 0 0 0	1
	spi tal		1, 940, 3	38		1, 940, 338	
	BPROVIDER - IPF						2.0
	BPROVIDER - IRF						3.0
	BPROVIDER						4.0
	ing bed - SNF			0		0	
	ing bed - NF			0		0	
	ILLED NURSING FACILITY						7.0
	RSING FACILITY						8.0
	HER LONG TERM CARE						9.0
	tal general inpatient care services (sum of lines 1-9)		1, 940, 3	38		1, 940, 338	10.0
	tensi ve Care Type Inpatient Hospital Services			0			1 4 4 9
	TENSIVE CARE UNIT			0		0	
	RONARY CARE UNIT						12.0
	RN INTENSIVE CARE UNIT						13.0
	RGICAL INTENSIVE CARE UNIT						14.0
	TOXIFICATION INTENSIVE CARE UNIT			0		0	
	tal intensive care type inpatient hospital services (sum of I	ines		0		0	16.0
	-15)		1 040 0	20		1 040 000	17.0
	tal inpatient routine care services (sum of lines 10 and 16)		1, 940, 3			1, 940, 338	
	cillary services		3, 780, 6		51, 753, 316	55, 534, 012	
	tpatient services		197, 3	37 0	16, 353, 203 0	16, 550, 540 0	
	RAL HEALTH CLINIC DERALLY QUALIFIED HEALTH CENTER			0	0	0	
	ME HEALTH AGENCY			U	0	0	21.0
	BULANCE SERVICES						22.0
00 CMI							23.0
	BULATORY SURGICAL CENTER (D. P.)						24.0
	SPICE						26.0
	HER (SPECIFY)			0	0	0	
	tal patient revenues (sum of lines 17-27)(transfer column 3 1	to Wkst	5, 918, 3	0	68, 106, 519	74, 024, 890	
	3. Line 1)	to wikst.	5, 710, 5	<i>'</i> '	00, 100, 517	74,024,070	20.0
	RT II - OPERATING EXPENSES	I					
	erating expenses (per Wkst. A, column 3, line 200)				22, 857, 292		29.0
	D (SPECIFY)			0	22,007,272		30.0
00	- \			0			31.0
00				0			32.0
00				0			33.0
00				0			34.0
00				0			35.0
	tal additions (sum of lines 30-35)				0		36.0
	DUCT (SPECIFY)			0	Ű		37.0
00				0			38.0
00				0			39.0
00				0			40.0
00				0			41.0
	tal deductions (sum of lines 37-41)			Ŭ	0		42.0
	tal operating expenses (sum of lines 29 and 36 minus line 42)	(transfer			22, 857, 292		43.0
	Wkst. G-3, line 4)				22,007,272		'0.0

Heal th	Health Financial Systems ST. VINCENT MERCY HOSPITAL In Lieu						
	ENT OF REVENUES AND EXPENSES		Provider CCN: 15-1308	Peri od:	Worksheet G-3		
				From 07/01/2018	Date/Time Prep		
	To 06/30/2019						
	11/25/2019 3:0	Jo pili					
	1.00						
1.00	Total patient revenues (from Wkst. G-2, Par	t I, column 3, line	e 28)		74, 024, 890	1.00	
2.00	Less contractual allowances and discounts of	48, 942, 264	2.00				
3.00	Net patient revenues (line 1 minus line 2)				25, 082, 626	3.00	
4.00	Less total operating expenses (from Wkst. G	-2, Part II, line 4	43)		22, 857, 292	4.00	
5.00	Net income from service to patients (line 3	minus line 4)			2, 225, 334	5.00	
	OTHER INCOME						
6.00	Contributions, donations, bequests, etc				0	6.00	
7.00	Income from investments				1, 659	7.00	
8.00	Revenues from telephone and other miscelland	eous communication	servi ces		0	8.00	
9.00	Revenue from television and radio service				0	9.00	
10.00	Purchase di scounts				0	10.00	
11.00	Rebates and refunds of expenses				0	11.00	
	Parking lot receipts				0	12.00	
13.00	Revenue from Laundry and Linen service				0	13.00	
14.00	Revenue from meals sold to employees and gue	ests			44, 544	14.00	
15.00	Revenue from rental of living quarters				0	15.00	
16.00	Revenue from sale of medical and surgical surginal surg	upplies to other th	nan patients		0	16.00	
17.00	Revenue from sale of drugs to other than pa	tients			1, 175	17.00	
18.00	Revenue from sale of medical records and abs	stracts			6, 167	18.00	
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)			0	19.00	
20.00	Revenue from gifts, flowers, coffee shops, a	and canteen			0	20.00	
21.00	Rental of vending machines				0	21.00	
22.00	Rental of hospital space				56, 932	22.00	
23.00	Governmental appropriations				0	23.00	
24.00	MISC				14, 641	24.00	
24.01	NET ASSETS RELEASED FROM RESTRICTION				2, 450	24.01	
24.02	STATE PROGRAM REVENUE				0	24.02	
24.03	OTHER (SPECIFY)				0	24.03	
24.04	OTHER (SPECIFY)				0	24.04	
25.00	Total other income (sum of lines 6-24)				127, 568	25.00	
26.00	Total (line 5 plus line 25)				2, 352, 902	26.00	
27.00	OTHER RECURRING				0	27.00	
28.00	Total other expenses (sum of line 27 and sul				0	28.00	
29.00	Net income (or loss) for the period (line 20	6 minus line 28)			2, 352, 902	29.00	