Health Financial Systems ST VINCENT SALE	M HOSPI TAL	In Lieu	of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Fa			
payments made since the beginning of the cost reporting period bein	g deemed overpayments (42	2 USC 1395g).	OMB NO. 0938-0050 EXPIRES 03-31-2022
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1314	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/25/2019 6:21 pm
PART I - COST REPORT STATUS			
Provider 1. [X] Electronically filed cost report		Date: 11/25/20	019 Time: 6:21 pm
use only 2. [] Manually submitted cost report 3. [0] If this is an amended report enter the number	of times the provider r	outhin the of the or	ot conort
3.[0]If this is an amended report enter the number 4.[F]Medicare Utilization. Enter "F" for full or "	L" for low.	esubmitted this co	st report
Contractor 5. [1] Cost Report Status 6. Date Received:		IPR Date:	
use only (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N]Initial Report f	I11. (Tor this Provider CCN 12. [Contractor's Vendo	r Code: 4
(3) Settled with Audit 9. [N] Final Report for	this Provider CCN		es reopened = 0-9.
(4) Reopened			
(5) Amended			
PART II – CERTIFICATION			
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN	THIS COST REPORT MAY BE F	PUNISHABLE BY CRIM	INAL CLVII AND
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.	FURTHERMORE, IF SERVICES	S IDENTIFIED IN TH	IS REPORT WERE
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF	A KICKBACK OR WERE OTHERW	ISE ILLEGAL, CRIM	INAL, CIVIL AND
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.			
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR C			
I HEREBY CERTIFY that I have read the above certification s			
electronically filed or manually submitted cost report and Expenses prepared by ST VINCENT SALEM HOSPITAL (15-1314)			
and ending 06/30/2019 and to the best of my knowledge and b			
complete and prepared from the books and records of the pro			
except as noted. I further certify that I am familiar with			
health care services, and that the services identified in t	his cost report were prov	vided in compliance	e with such
laws and regulations.			
[]I have read and agree with the above certification sta signature on this certification statement to be the le			
(Signed	0 3 0 1	, ,	5
	Officer or Admini	strator of Provide	er(s)
	Title		
	Date		

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	94, 618	-200, 096	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	105, 519	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	200, 137	-200, 096	0	0	200.00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENIIFICATION DA	IA	Provi d	AL er CCN:	15-1314	Period: From 07/01		Worksh Part I	rm CMS- eet S-2	
								/2019	Date/T 11/25/		
			00		3.00			4.00			
0	Hospital and Hospital Health Care Co Street: 911 N. SHELBY STREET	PO Box:									1.
0	City: SALEM	State: I	N	Zip Code	e: 47167	Coun	ty: WASHING	TON			2
		Component Na		CCN	CBSA	Provi dei			nt Syst		
				Number	Number	- Туре	Certified		0, or		_
		1.00		2.00	3.00	4.00	5.00	V 6.00	XVIII 7.00	-	-
	Hospital and Hospital-Based Componen			2.00	3.00	4.00	5.00	0.00	1.00	0.00	
)	Hospi tal	ST VINCENT SALEM		151314	31140	1	12/01/2002	2 N	0	0	3
_		HOSPI TAL									
0	Subprovider - IPF Subprovider - IRF										4
0 0	Subprovider - (Other)										6
))	Swing Beds - SNF	ST VINCENT SALEM		15Z314	31140		12/01/2002	2 N	0	N	7
5	Swing Beds - NF							-			8
C	Hospital-Based SNF										9
00	Hospital-Based NF										10
00	Hospital-Based OLTC										11
00 00	Hospital-Based HHA Separately Certified ASC									1	12
00	Hospi tal -Based Hospi ce										14
00	Hospital -Based Health Clinic - RHC									1	15
00	Hospital-Based Health Clinic - FQHC									1	16
00	Hospital-Based (CMHC) I										17
00	Renal Dialysis										18
)0	Other						From	1:	To):	19
							1.00		2.		1
00	Cost Reporting Period (mm/dd/yyyy)						07/01/2	2018	06/30	/2019	20
00	Type of Control (see instructions)						1				21
						1.00	2.0	0	3.	00	
	Inpatient PPS Information										
00	Does this facility qualify and is it					Ν	N				22
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo										
	facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo										
01	Did this hospital receive interim un	compensated care	payments	for thi	c						
	cost reporting period? Enter in colu					N	N				22
				For no f	or	N	N				22
		riod occurring pr	rior to Oc	⁻ or no f ctober 1	or	N	N				22
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03	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that 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. Did this hospital receive a geograph 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 reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me bel ow? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	" for no for the er October 1. (se requires final u port settlement? " for no, for the er 1. Enter in co e cost reporting ic reclassificati ds for delineatin olumn 1, "Y" for g period prior to no for the portic er October 1. (se 100 but not more 2.105)? Enter in dicaid days on li of admission, 2 i of identifying th method used in th	rior to Oc portion of the instruc- (see instruc- (see inst e portion olumn 2, " period or on from un g statist yes or "N o October on of the e instruc- than 499 column 3, nes 24 ar f census he days in he prior of "N" for r In-State Medicaid paid days	For no f ctober 1 of the c ctions) truction of the Y" for n or aft urban to tical ar " for n 1. Ente cost tions) beds (a "Y" for nd/or 25 days, c n this c cost beds (a s eligi unpa days	or ost e s) yes er eas o r s r r s r s r tate ble ble ble ys	N N Out-of State ledi cai d ai d days	2 N Out-of State Medi cai d el i gi bl e unpai d	HMO da	id C ys Mee)ther di cai d days	22
00	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that 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. Did this hospital receive a geograph 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 reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period? In column 2, ente	" for no for the er October 1. (se requires final u port settlement? " for no, for the er 1. Enter in co e cost reporting ic reclassificati ds for delineatin olumn 1, "Y" for g period prior to no for the portic er October 1. (se 100 but not more 2. 105)? Enter in dicaid days on li of admission, 2 i of identifying th method used in th r "Y" for yes or	rior to 0c portion c e instruc- (see instruc- (see instruc- portion c our on from u- ng statist yes or "N o October on of the se instruc- than 499 column 3, nes 24 ar f census he days ir "N" for r In-State Medicaic	For no f ctober 1 of the c ctions) ated car iruction of the 'Y" for n or aft urban to tical ar "' for n 1. Ente cost ctions) beds (a "Y" for n or aft urban to tical ar "' for n 1. Ente cost days, co n this c cost beds (a unp, day day day s elig unp, day day 2. 1	or ost ess) yes er eas or r s r s r s r s r s tate ble ble ble ble s ys	N N N Out-of State Medi cai d ai d days 3.00	2 N Out-of State Medicaid el i gi bl e unpai d 4.00		id C ys Mee)ther di cai d days 6. 00	22 22 23
00	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that 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. Did this hospital receive a geograph 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 reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me bel ow? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	" for no for the er October 1. (se requires final u port settlement?" " for no, for the er 1. Enter in co e cost reporting ic reclassificati ds for delineatin olumn 1, "Y" for g period prior to no for the portio er October 1. (se 100 but not more 2.105)? Enter in dicaid days on li of admission, 2 i of identifying th method used in th r "Y" for yes or	rior to Oc portion of the instruc- (see instruc- (see inst e portion olumn 2, " period or on from un g statist yes or "N o October on of the e instruc- than 499 column 3, nes 24 ar f census he days in he prior of "N" for r In-State Medicaid paid days	For no f ctober 1 of the c ctions) truction of the Y" for n or aft urban to tical ar " for n 1. Ente cost tions) beds (a "Y" for nd/or 25 days, c n this c cost beds (a s eligi unpa days	or ost e s) yes er eas o r s r r s r s r tate ble ble ble ys	N N Out-of State ledi cai d ai d days	2 N Out-of State Medi cai d el i gi bl e unpai d	HMO da	id C ys Mee)ther di cai d days 6. 00	22 22 23
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00	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that 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. Did this hospital receive a geograph 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 reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me bel ow? In column 1, enter 1 if date if date of discharge. Is the method reporting period? In column 2, enter If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in colum	" for no for the er October 1. (se requires final u port settlement? " for no, for the er 1. Enter in co e cost reporting ic reclassificati ds for delineatin olumn 1, "Y" for g period prior to no for the portice er October 1. (se 100 but not more 2.105)? Enter in dicaid days on li of admission, 2 i of identifying th method used in th r "Y" for yes or , enter the n 1, in-state umm 2, olumn 3,	rior to Oc portion of the instruc- (see instruc- (see inst e portion olumn 2, " period or on from un g statist yes or "N o October on of the e instruc- than 499 column 3, nes 24 ar f census he days in he prior of "N" for r In-State Medicaid paid days	For no f ctober 1 of the c ctions) ated car iruction of the 'Y" for n or aft urban to tical ar "' for n 1. Ente cost ctions) beds (a "Y" for n or aft urban to tical ar "' for n 1. Ente cost days, co n this c cost beds (a unp, day day day s elig unp, day day 2. 1	or ost ess) yes er eas or r s r s r s r s r s tate ble ble ble ble s ys	N N N Out-of State Medi cai d ai d days 3.00	2 N Out-of State Medicaid el i gi bl e unpai d 4.00	HMO da	id C ys Mee)ther di cai d days 6. 00	22 22 23
00	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that 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. Did this hospital receive a geograph 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 reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me bel ow? In column 1, enter 1 if date if date of discharge. Is the method reporting period? In column 2, enter If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in colum	" for no for the er October 1. (se requires final u port settlement? " for no, for the er 1. Enter in co e cost reporting ic reclassificati ds for delineatin olumn 1, "Y" for g period prior to no for the portic er October 1. (se 100 but not more 2. 105)? Enter in dicaid days on li of admission, 2 i of identifying th method used in th r "Y" for yes or , enter the n 1, in-state umn 2, olumn 3, d days in column	rior to Oc portion of the instruc- (see instruc- (see inst e portion olumn 2, " period or on from un g statist yes or "N o October on of the e instruc- than 499 column 3, nes 24 ar f census he days in he prior of "N" for r In-State Medicaid paid days	For no f ctober 1 of the c ctions) ated car iruction of the 'Y" for n or aft urban to tical ar "' for n 1. Ente cost ctions) beds (a "Y" for n or aft urban to tical ar "' for n 1. Ente cost days, co n this c cost beds (a unp, day day day s elig unp, day day 2. 1	or ost ess) yes er eas or r s r s r s r s r s tate ble ble ble ble s ys	N N N Out-of State Medi cai d ai d days 3.00	2 N Out-of State Medicaid el i gi bl e unpai d 4.00	HMO da	id C ys Mee)ther di cai d days 6. 00	22 22 22 23 23

	1 Financial Systems ST VINC TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC	N: 15-1314	Period:	In Lieu	Worksh	eet S-2	
					From 07/0 To 06/3	0/2018	Part I Date/Ti 11/25/2		
		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	id 0 ys Meo	ther di cai d days	
		1.00	2.00	3.00	4.00	5.00		5.00	-
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		25.0
					Urban/R	lural S	Date of 2.		-
6. 00			at the beg	jinning of t		2			26.0
7.00 5.00	reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status r "2" for r ication in	ural. If ap column 2.	plicable,		2			27.0
	effect in the cost reporting period.						Endi	na	
	1				Begi ni 1. (Endi 2.		
5.00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for numb	er				36.0
7.00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	r the numbe	·		s	О			37.
7. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37.
. 00									38.
					Y/		Y/ 2.		-
9. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	er in colum ts in	me N In		<u> </u>		39. (
0. 00	, , ,	ber 1. Ente	r "Y" for y				N		40.
						V 1.00	XVIII 2.00	XI X 3.00	
5. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for disp	roporti onat	e share in	accordance	N	N	N	45.
5. 00	<pre>with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.</pre>					N	N	N	46.
	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment	•		2		N N	N N	N N	47. 48.
	Teaching Hospitals			· 2	" for yes	N			56.
. 00	Is this a hospital involved in training residents in or "N" for no.	approved G	ME programs	S? Enter Y	-		1	1	57.
. 00	or "N" for no.	period duri r yes or "N th of this Y", complet	ng which re " for no in cost report e Worksheet	esidents in 1 column 1. 1 ng period?	lf column ' Enter "Y				
. 00 . 00 . 00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	period duri r yes or "N th of this Y", complet I, if appli bursement f complete W	ng which re " for no in cost report e Worksheet cable. or physicia kst. D-5.	esidents in a column 1. ing period? E-4. If co ans' service	lf column ´ ' Enter "Y' lumn 2 is				
3. 00 5. 00 7. 00 3. 00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N" "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	period duri r yes or "N th of this Y", complet I, if appli bursement f complete W	ng which re " for no in cost report e Worksheet cable. or physicia kst. D-5.	esidents in a column 1. ing period? E-4. If co ans' service	If column ' 'Enter "Y' lumn 2 is s as	N Neet A e #	Pass-T Qualifi Criteri	cation	1
7. 00 3. 00 5. 00 7. 00 3. 00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	period duri r yes or "N th of this Y", complet I, if appli bursement f complete W	ng which re " for no in cost report e Worksheet cable. Tor physicia kst. D-5.	esidents in a column 1. ing period? : E-4. If co ans' service Pt. I. NAHE 413.8	if column ' 'Enter "Y' lumn 2 is s as 35 Worksh	N Neet A e #	Qualifi	cation on Code	59.

iospi t	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der CC	F T		Worksheet S-2 Part I Date/Time Pre 11/25/2019 6:	pared:
		Y/N	IME	Direct GME	IME	Direct GME	
1 00	Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	5.00	61.0
	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
51.06	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	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 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61. 1
						1.00	
2.00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				od for which	0.00	62.0
	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62.0
3. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this co	67. (see instru	uctions)	N	63.0
				Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base year	2.00	<u> </u>	
4. 00	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 nor 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	<u>re June</u> ty train a-primar all nor d non-pr n columr	30, 2010. med residents ty care provider mary care mary care mary the ratio	0. 00	-		64.0

	HUSPITAL HEALTH CARE COMPL	LEX IDENTIFICATION D	ATA Provider (eriod: ⁻ om 07/01/2018	Worksheet S-2 Part I	
				To		Date/Time Pre	
		Program Name	Program Code	Unweighted	Unweighted	11/25/2019 6: Ratio (col. 3/	
		r rogram rianc		FTEs	FTEs in	(col . 3 + col .	
				Nonprovi der	Hospi tal	4))	
	-	4.00	0.00	Si te	1.00	5.00	-
00 Enter i	in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	65
trained year po associa FTEs fü prograu resided the pro column unweigl resided rotatio column unweigl resided	, or your facility d residents in the base eriod, the program name ated with primary care or each primary care m in which you trained nts. Enter in column 2, ogram code. Enter in 3, the number of hted primary care FTE nts attributable to ons occurring in all ovider settings. Enter in 4, the number of hted primary care nt FTEs that trained in ospital. Enter in column						
di vi de	ratio of (column 3 d by (column 3 + column see instructions)			Unweighted	Unweighted	Ratio (col. 1/	
				FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
				1.00	2.00	3.00	1
	n 5504 of the ACA Current ing on or after July 1, 20		n Nonprovider Settin	gsEffective fo	or cost report	ing periods	
	ttributable to rotations o in column 2 the number of						
Enter i FTEs tl	ttributable to rotations o in column 2 the number of hat trained in your hospit n 1 divided by (column 1 +	unweighted non-prima al. Enter in column	ry care resident 3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
Enter FTEs tl (colum	in column 2 the number of hat trained in your hospit n 1 divided by (column 1 +	unweighted non-prima al. Enter in column _column 2)). (see in	ry care resident 3 the ratio of structions)	FTĔs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
00 Enter i (column) 00 Enter i your pi which y Enter i code. I number care F to rota non-pro column unwei gi resi dei your hi 5, the di vi dei	in column 2 the number of that trained in your hospit	unweighted non-prima al. Enter in column <u>column 2)). (see in</u> Program Name	ry care resident 3 the ratio of structions) Program Code	FTËs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4)) 5.00	-
00 Enter i (column) 00 Enter i your pi which Enter i code. I number care F to rota non-pro column unwei gi resi dei your ho 5, the di vi dei	in column 2 the number of hat trained in your hospit n 1 divided by (column 1 + in column 1, the program ssociated with each of rimary care programs in you trained residents. in column 2, the program Enter in column 3, the of unweighted primary TE residents attributable ations occurring in all ovider settings. Enter in 4, the number of hted primary care nt FTEs that trained in ospital. Enter in column ratio of (column 3 d by (column 3 + column	unweighted non-prima al. Enter in column <u>column 2)). (see in</u> Program Name	ry care resident 3 the ratio of structions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital 4.00 0.00	(col . 3 + col . 4)) 5.00 0.000000	_
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Health Financial Systems ST VINCENT SALEM HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1314 Peri od: Worksheet S-2 From 07/01/2018 Part I 06/30/2019 Date/Time Prepared: То 11/25/2019 6:21 pm 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 Ν 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Ν 85 00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87 00 Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Y Ν 90 00 ves or "N" for no in the applicable column. $|I\,s\,$ this hospital reimbursed for title V and/or XIX through the cost report either in 91 00 Ν Ν 91 00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Υ 92.00 93.00 Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν Ν 94 00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0 00 95 00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν Ν 96.00 applicable column 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97 00 0 00 0.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Ν 98.00 Υ stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Υ 98.01 98.01 Ν C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation Ν γ 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and Ν 98.04 Ν in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in 98.05 γ 98.05 Ν column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Ν Ν 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Y 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R Ν 107.00 training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 108.00 Ν CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Respi ratory Physi cal Occupati onal Speech 1 00 2 00 4 00 3 00 109.00 If this hospital qualifies as a CAH or a cost provider, are 109.00 Ν Ν Ν Ν therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, 110.00 Ν complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e.

ealth Financial Systems ST VINCENT SALEM HOSPITAL IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC	N: 15-1314	Period: From 07/01, To 06/30,	/2018	Workshe Part I	et S-2	
			2017	11/25/2		
		1.00	1	2.0	00	-
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	period? Enter enter the column 2.	N				111.00
			1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 i 3 either "93" percent for short term hospital or "98" percent for long ter psychiatric, rehabilitation and long term hospitals providers) based on th Pub. 15-1, chapter 22, §2208.1.	s "E", enter m care (incl me definition	in column udes	N		0	115.00
16.00 s this facility classified as a referral center? Enter "Y" for yes or "N" 17.00 s this facility legally-required to carry malpractice insurance? Enter "Y		"N" for	N Y			116. 00 117. 00
no. 18.00 is the malpractice insurance a claims-made or occurrence policy? Enter 1 i claim-made. Enter 2 if the policy is occurrence.	f the policy	is	2			118.00
jerann made. Enter zinn he porrey is decarrence.	Premiums	Losse	S	Insur	ance	
	1.00	2.00		3.0		-
18.01 List amounts of malpractice premiums and paid losses:	75, 4	06	0		(0118.01
18.02 Are malpractice premiums and paid losses reported in a cost center other t	han the	1.00 N	l	2.0	00	118. 02
Administrative and General? If yes, submit supporting schedule listing co						
and amounts contained therein. 19.00D0 NOT USE THIS LINE						119.00
20.00 s this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov \$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 th	for yes or ne Outpatient			N		120.00
Hold Harmless provision in ACA §3121 and applicable amendments? (see instr 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		Y				121.00
patients? Enter "Y" for yes or "N" for no. 22.00Does the cost report contain healthcare related taxes as defined in §1903(5.0	0	122.00
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.				5.0	0	122.00
Transplant Center Information 25.00Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no lf	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter the certifi						126. 00
in column 1 and termination date, if applicable, in column 2. 27.00[f this is a Medicare certified heart transplant center, enter the certifi						127. 0
in column 1 and termination date, if applicable, in column 2.						
28.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.						128.00
29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.		n				129.00
30.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2.						130.00
31.00 If this is a Medicare certified intestinal transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2.	erti fi cati on					131.00
32.00 If this is a Medicare certified islet transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.	cation date					132.00
33.00 If this is a Medicare certified other transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.	cation date					133. 00
34.00 If this is an organ procurement organization (OPO), enter the OPO number i and termination date, if applicable, in column 2.	n column 1					134.00
All Providers 40.00Are there any related organization or home office costs as defined in CMS	Pub 15-1	Y		15HC)46	140. 00
is separation of the origination	·	1 1		1010	0	1.10.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLE		ENT SALEM F	Provider CC	N: 15-1314	Per	ri od:	eu of Form CMS- Worksheet S-2	
						07/01/2018 06/30/2019	Part I Date/Time Pre	epared:
1.00		2.00				3.00	11/25/2019 6:	:21 pm
If this facility is part of a cha	n organization, ent		s 141 throu	uah 143 the	e name		of the	
home office and enter the home of	<u>Fice contractor name</u>	e and contr		er.				
41.00 Name: ST VINCENT HEALTH	Contractor's N	lame: WPS		Contra	ictor'	s Number: 080	01	141.0
42.00 Street: 250 WEST 96TH STREET SUITE 43.00 City: NDIANAPOLIS	215 PO Box: State:	IN		Zip Co	day	462	00	142. C
43. 00 CT LY. INDI ANAPOLI S	State.	I IN			ue.	402	90	143.0
							1.00	-
44.00 Are provider based physicians' cos	sts included in Work	ksheet A?					Y	144. C
					-	1.00	2.00	-
45.00 If costs for renal services are cl	aimed on Wkst A I	ine 74 ar	the costs	for		1.00	2.00	145.0
inpatient services only? Enter "Y					5			
no, does the dialysis facility in	lude Medicare utili	zation for						
period? Enter "Y" for yes or "N"			£			N		14/ 0
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in					lf	Ν		146. C
yes, enter the approval date (mm/c			chapter -	10, 34020)				
、 、								
17 00 Was there a change in the statist	ool bacic2 Enter "	/" for yos	an "N" for	20			1.00	147 (
47.00Was there a change in the statisti 48.00Was there a change in the order o							N N	147.0
49.00 Was there a change to the simplifi					or no		N	149. (
	<u> </u>		Part A	Part E		Title V	Title XIX	
			1.00	2.00		3.00	4.00	
Does this facility contain a prov								
or charges? Enter "Y" for yes or 55.00Hospi tal	N° TOR NO TOR each	component	<u>ror Part A</u> N	and Part I	3. (Se	<u>e 42 CFR 941</u> N	3. 13) N	155. (
56. 00 Subprovi der – I PF			N	N N		N	N	156. 0
57.00 Subprovi der – I RF			N	N		N	N	157. (
58. 00 SUBPROVI DER								158.0
59.00 SNF			N	N		N	N	159.0
60.00HOME HEALTH AGENCY 61.00CMHC			N	N N		N	N	160.0
				IN IN		N	N	161. C
							1.00	-
Multicampus								
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that	has one or	more campu	uses in dif	feren	t CBSAs?	N	165. C
Enter Y for yes of N for no.	Name	Co	ounty	State	Zip C	ode CBSA	FTE/Campus	
	0		1.00	2.00	3.0		5.00	1
66.00 If line 165 is yes, for each							0.0	0166.0
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)								
CBSA in column 4, FTE/Campus in								-
CBSA in column 4, FTE/Campus in column 5 (see instructions)	() inconting in the	Amori con D			mont A	uct.	1.00	
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI						Act	I	167 (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user	under §1886(n)? E	Enter "Y" fo	or yes or "	'N" for no.			N	
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the l	under §1886(n)? E 05 is "Y") and is a HT assets (see inst	Enter "Y" fo meaningful tructions)	or yes or " user (line	'N" for no. e 167 is "Y	/"), e	nter the	N	0168. (
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CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is a exception under §413.70(a) (6) (ii) 7 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I	under §1886(n)? E 5 is "Y") and is a HIT assets (see inst tot a meaningful use P Enter "Y" for yes user (line 167 is "Y nns)	Enter "Y" for meaningful cructions) er, does thi or "N" for (") and is u	or yes or " user (line s provider no. (see i not a CAH (N" for no. e 167 is "Y qualify f nstructior (line 105 i	/"), e ⁻ or a ns)	nter the hardshi p), enter the Begi nni ng	N Y O. O Endi ng	0168. (168. (0169. (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful of transition factor. (see instruction	under §1886(n)? E 5 is "Y") and is a HIT assets (see inst tot a meaningful use P Enter "Y" for yes user (line 167 is "Y nns)	Enter "Y" for meaningful cructions) er, does thi or "N" for (") and is u	or yes or " user (line s provider no. (see i not a CAH (N" for no. e 167 is "Y qualify f nstructior (line 105 i	/"), e ⁻ or a ns)	nter the hardshi p), enter the Begi nni ng	N Y O. O Endi ng	0168. (168. (0169. (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is a exception under §413.70(a) (6) (ii) 7 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I	under §1886(n)? E 5 is "Y") and is a HIT assets (see inst tot a meaningful use P Enter "Y" for yes user (line 167 is "Y nns)	Enter "Y" for meaningful cructions) er, does thi or "N" for (") and is u	or yes or " user (line s provider no. (see i not a CAH (N" for no. e 167 is "Y qualify f nstructior (line 105 i	/"), e ⁻ or a ns)	nter the hardship), enter the Beginning 1.00	N Y 0.0 Endi ng 2.00	167. C 0168. C 168. C 0169. C 0169. C
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is a exception under §413.70(a) (6) (ii) 7 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I	- under §1886(n)? E 5 is "Y") and is a 11 assets (see inst not a meaningful use 2 Enter "Y" for yes iser (line 167 is "Y ons) peginning date and e	Enter "Y" for meaningful cructions) er, does thi or "N" for (") and is n ending date	or yes or " user (line s provider no. (see i hot a CAH (for the re	N" for no. 167 is ") qualify f nstruction (line 105 i eporting	/"), e ⁻ or a ns)	nter the hardshi p), enter the Begi nni ng	N Y 0.0 Endi ng 2.00 2.00	0168. 0 168. 0 0169. 0
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	r under §1886(n)? E 15 is "Y") and is a 11 assets (see inst not a meaningful use 2 Enter "Y" for yes user (line 167 is "Y ons) peginning date and e rider have any days reported on Wkst. S-	Enter "Y" for meaningful rructions) er, does thi or "N" for ") and is i ending date	or yes or " user (line s provider no. (see i not a CAH (for the re duals enrol ine 2, col	N" for no. a 167 is ") r qualify f nstruction [line 105 i apporting led in . 6? Enter	/"), e for a ns) s "N"	nter the hardship), enter the <u>Beginning</u> 1.00 1.00	N Y 0.0 Endi ng 2.00 2.00	0168. (168. (0169. (- 170. (

SPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1314	Period: From 07/01/2018 To 06/30/2019		epared
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lforall NO re	esponses. Ente			
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	hoginning of	the east	N		1 1 /
00	reporting period? If yes, enter the date of the change in c					1. (
	reporting periods in yes, enter the date of the endige in t	Joi unin 2. (300	Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.
00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home of 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)	offices, drug ler or its of the board	Y			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cert 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.	for Compiled, Milable in	Y	A		4.
00	Are the cost report total expenses and total revenues diffe		N			5.
	those on the filed financial statements? If yes, submit rec	conciliation.				
				Y/N 1.00	Legal Oper. 2.00	_
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s N		6.
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N N		7. 8.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9.
0. 00	Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.			N		10.
. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R IN AN App	proved	N	Y/N	11.
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. 13.
. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	fyes, see ins	structions.	Ν	14.
. 00	Did total beds available change from the prior cost reporti	Par	yes, see inst t A	Par	N t B	15.
		Y/N	Date	Y/N	Date	
	DS&D Data	1.00	2.00	3.00	4.00	
00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	Y	10/07/2019	Y	10/07/2019	16.
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		Ν		17.
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19.

ST VINCENT SALEM HOSDITAL

Health Financial Systems ST VINCENT S	ALEM HOSPITAL		In Lie	eu of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	F	Period: From 07/01/2018 To 06/30/2019	Worksheet S Part II Date/Time P	-2
			1	11/25/2019	6:21 pm
		ption	Y/N	Y/N	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R)	1.00 N	3.00 N	20.00
Report data for Other? Describe the other adjustments:			IN	IN	20.00
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
21.00 Was the cost report prepared only using the provider's	N		N		21.00
records? If yes, see instructions.					
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS H	OSPI TALS)			
Capital Related Cost					
22.00 Have assets been relifed for Medicare purposes? If yes, se		ale mada duri r	a the cost	N N	22.00
23.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprais	ais made durir	ig the cost	N	23.00
24.00 Were new leases and/or amendments to existing leases enter	red into durina	this cost repo	orting period?	N	24.00
If yes, see instructions					
25.00 Have there been new capitalized leases entered into during	g the cost repor	ting period? I	f yes, see	N	25.00
instructions.					
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	the cost reporti	ng period? If	yes, see	N	26.00
27.00 Has the provider's capitalization policy changed during the	he cost reportir	g period? If y	ves, submit	N	27.00
сору.					
28.00 Were new Loans, mortgage agreements or letters of credit e	optorod into dur	ing the cost r	oporting	N	28.00
period? If yes, see instructions.		The cost i	eportring	IN	20.00
29.00 Did the provider have a funded depreciation account and/or	•	bt Service Res	erve Fund)	Y	29.00
treated as a funded depreciation account? If yes, see inst					20.00
30.00 Has existing debt been replaced prior to its scheduled mat instructions.	turity with new	debt? IF yes,	see	N	30.00
31.00 Has debt been recalled before scheduled maturity without i	issuance of new	debt? If yes,	see	N	31.00
instructions.		-			
Purchased Services					
32.00 Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		a through cont	ractual	N	32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap		a to competiti	ve bidding? If	N	33.00
no, see instructions.		9p			
Provi der-Based Physi ci ans				I	
34.00 Are services furnished at the provider facility under an a	arrangement with	provi der-base	ed physi ci ans?	Y	34.00
If yes, see instructions.	viating agroomon	to with the pr	avidan basad	Y	35.00
35.00 If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i		its with the pr	ovi del -based	ř	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs			N/		24 00
36.00 Were home office costs claimed on the cost report?37.00 If line 36 is yes, has a home office cost statement been p	propared by the	home offico?	Y Y		36.00 37.00
If yes, see instructions.	hicharea ny rife	HOME UTTICE!			37.00
38.00 If line 36 is yes, was the fiscal year end of the home of	ffice different	from that of	Ν		38.00
the provider? If yes, enter in column 2 the fiscal year er	nd of the home o	ffi ce.			
39.00 If line 36 is yes, did the provider render services to oth	her chain compor	ents? If yes,	N		39.00
40.00 If line 36 is yes, did the provider render services to the	e home office?	lf ves see	Ν		40.00
instructions.		11 yes, see	14		+0.00
	1.	00	2.	00	
41.00 Enter the first name, last name and the title/position					41 00
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JILL		HILL		41.00
respectively.					
42.00 Enter the employer/company name of the cost report	ASCENSI ON				42.00
preparer.					
43.00 Enter the telephone number and email address of the cost	317-583-3519		JI LL. HI LL1@ASC	ENSI ON. ORG	43.00
report preparer in columns 1 and 2, respectively.	I		1		

Health Financial Systems	ST VINCENT	SALEM	HOSPI TAL			In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT OF	UESTI ONNAI RE		Provi der	CCN: 15-1314		ri od:	Worksheet S-2	
					To	om 07/01/2018 06/30/2019		pared: 21 pm
			;	3.00				
Cost Report Preparer Contact Information								
41.00 Enter the first name, last name and the tit	tle/position	MAN	IAGER, REIM	MBURSEMENT				41.00
held by the cost report preparer in columns	s 1, 2, and 3,							
respecti vel y.								
42.00 Enter the employer/company name of the cost	t report							42.00
preparer.								
43.00 Enter the telephone number and email addres	ss of the cost							43.00
report preparer in columns 1 and 2, respect	ti vel y.							

^{11/25/2019 6:21} pm Y: \28800 - St. Vincent Salem\300 - Medicare Cost Report\20190630\HFS\20190630 Salem.mcrx

	Financial Systems	ST VINCENT SAL				eu of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-1314	Period: From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 6:2	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9, 12		0	1.00
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	2.00 3.00 4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		25	9, 12	25 5, 928. 00	0	6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
$\begin{array}{c} 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00 \end{array}$	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)		25	9, 12	25 5, 928. 00	0 0	$\begin{array}{c} 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ \end{array}$
24.00 24.10 25.00 26.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30. 00 88. 00				0	24.00 24.10 25.00 26.00
26. 25 27. 00 28. 00 29. 00 30. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction)	89.00	25			0	26. 25 27. 00 28. 00 29. 00 30. 00
31.00 32.00 32.01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)		0		0		31.00 32.00 32.01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC,	<u>ST VINCENT SALE</u> AL DATA	Provider C	CN: 15-1314		eriod: com 07/01/2018	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 11/25/2019 6:	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	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	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider	117 49 0 0	2 7 0		21			1.00 2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	205 322	0002	:	50 25 96			5.00 6.00 7.00
$\begin{array}{c} 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ 20.00\\ 21.00\\ 22.00\\ 23.00\\ \end{array}$	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	322 11, 089	2 927	4 34, 10	96 04	0.00	63.96	8.00 9.00 10.00 11.00 12.00 13.00 15.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00
24. 00 24. 10 25. 00 26. 00 26. 02 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	HOSPICE HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0 0 0 0	0 0 0		0 0 42 13 0 0 0	0.00 0.00 0.00	0.00 0.00 63.96	24.00 24.10 25.00 26.00 26.25
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges	0 0						33. 00 33. 01

Heal th Financial Systems ST VINCENT SALEM HOSPI TAL AND HOSPI TAL HEALTH CARE COMPLEX STATISTICAL DATA		Provider CO	N· 15_1314	Period:	u of Form CMS-2 Worksheet S-3		
HUSFT				JN. 13-1314	From 07/01/2018 To 06/30/2019	Part I Date/Time Pre 11/25/2019 6:3	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
1		11.00	12.00	13.00	<u>14.00</u>	15.00	1 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 23.00 24.00 23.00 24.00 25.00 24.00 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 SNF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0. 00 0. 00 0. 00 0. 00	0		36 1 9 2 0 0 36 1	64	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 16. 00 17. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 24. 00 25. 00 26. 00 26. 00 26. 00 27. 00 28. 00 28. 00 28. 00 29. 00 20. 00 21. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 29. 00 20. 00 21. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 26. 00 27. 00 28. 00 29. 00 20. 00 21. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 26. 00 27. 00 28. 00 29. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 20. 00
29.00 30.00 31.00 32.00 32.01 33.00 33.01	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		29. 00 30. 00 31. 00 32. 00 32. 01 33. 00 33. 01

Heal th	Financial Systems ST VINCENT SALEM	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10			
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCI	N: 15-1314	Peri od:	Worksheet S-1	2			
				From 07/01/2018 To 06/30/2019	Date/Time Pre	harod			
					11/25/2019 6:				
					1.00				
	Uncompensated and indigent care cost computation								
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)									
	Medicaid (see instructions for each line)								
2.00	Net revenue from Medicaid				669, 681	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?		с и I	. 10	N	3.00 4.00			
4.00 5.00	4.00 fline 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? 5.00 fline 4 is no, then enter DSH and/or supplemental payments from Medicaid								
6.00	Medicaid charges		1		0 13, 420, 011	5.00 6.00			
7.00	Medicaid cost (line 1 times line 6)				3, 817, 161	7.00			
8.00	Difference between net revenue and costs for Medicaid program	(line 7 minu	ıs sum of lin	es 2 and 5; if	3, 147, 480	8.00			
	< zero then enter zero)	-							
	Children's Health Insurance Program (CHIP) (see instructions for	or each line	2)						
9.00	Net revenue from stand-al one CHIP				0	9.00			
10.00	Stand-alone CHIP charges				0	10.00			
11.00 12.00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP	(lino 11 min	us lino 0. i	f < zoro thon		11. 00 12. 00			
12.00	enter zero)		ius i i ie 🧃 i		0	12.00			
	Other state or local government indigent care program (see ins	tructions fo	r each line)		I				
13.00	Net revenue from state or local indigent care program (Not inc	luded on lin	nes 2, 5 or 9		0	13.00			
14.00	Charges for patients covered under state or local indigent care	e program (N	lot included	in lines 6 or	0	14.00			
	10)				0	15.00			
15.00	5 1 5 7								
16.00	Difference between net revenue and costs for state or local ine 13; if < zero then enter zero)	digent care	program (III	e 15 minus line	0	16.00			
	Grants, donations and total unreimbursed cost for Medicaid, CH	P and state	/local indio	ent care program	ns (see				
	instructions for each line)			1.5					
17.00	Private grants, donations, or endowment income restricted to f				0	17.00			
18.00	Government grants, appropriations or transfers for support of			(C.I.I	0	18.00			
19.00	Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16)	i indigent c	are programs	(sum of lines	3, 147, 480	19.00			
			Uni nsured	Insured	Total (col. 1				
		_	patients	patients	+ col . 2)				
	Uncomponented Corp (and instructions for each line)		1.00	2.00	3.00				
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa	cility	2, 006, 40	2 728, 036	2, 734, 438	20 00			
20.00	(see instructions)		2,000,40	120,030	2,754,450	20.00			
21.00	Cost of patients approved for charity care and uninsured discon	unts (see	570, 69	7 728, 036	1, 298, 733	21.00			
22.00	instructions) Payments received from patients for amounts previously written	off as	84, 14	.8 26, 435	110, 583	22.00			
	chari ty care								
23.00	Cost of charity care (line 21 minus line 22)		486, 54	.9 701, 601	1, 188, 150	23.00			
					1.00				
24.00	Does the amount on line 20 column 2, include charges for patient	nt days beyo	nd a length	of stay limit	N	24.00			
25.00	imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of								
	stay limit								
26.00									
27.00									
27. 01 28. 00									
28.00 29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	nense (see i	nstructions)		575, 682				
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 763, 832				
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			4, 911, 312				

1.00 2.00 3.00 4.00 5.00	Cost Center Description GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	Sal ari es	Provider CC Other	Total (col.	Period: From 07/01/2018 To 06/30/2019 1 Reclassificati	Worksheet A Date/Time Pre 11/25/2019 6:	
1.00 2.00 3.00 4.00 5.00	GENERAL SERVI CE COST CENTERS		Other		To 06/30/2019	11/25/2019 6:	
1.00 2.00 3.00 4.00 5.00	GENERAL SERVI CE COST CENTERS		Other		1 Reclassi ficati		
1.00 2.00 3.00 4.00 5.00						Recl assi fi ed	
1.00 2.00 3.00 4.00 5.00				+ col. 2)	ons (See A-6)	Trial Balance	
1.00 2.00 3.00 4.00 5.00						(col. 3 +-	
1.00 2.00 3.00 4.00 5.00		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
1.00 2.00 3.00 4.00 5.00		1.00	2.00	3.00	4.00	5.00	
2.00 3.00 4.00 5.00			17, 386	17, 38	36 0	17, 386	1.00
3.00 4.00 5.00	00200 CAP REL COSTS-MVBLE EQUI P		0	,	0 0	0	2.00
5.00	00300 OTHER CAP RELATED COST		0		0 0	0	3.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 360	1, 231, 638	1, 232, 99	98 0	1, 232, 998	4.00
	00500 ADMINI STRATI VE & GENERAL	556, 579	4, 912, 054	5, 468, 63	33 0	5, 468, 633	5.00
7.00	00700 OPERATION OF PLANT	0	1, 138, 776	1, 138, 7	76 0	1, 138, 776	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	66, 267	66, 20	57 0	66, 267	8.00
9.00	00900 HOUSEKEEPI NG	0	359, 353	359, 35	53 0	359, 353	9.00
10.00	01000 DI ETARY	0	353, 502	353, 50	-314, 258	39, 244	10.00
11.00	01100 CAFETERI A	0	0		0 314, 258	314, 258	11.00
13.00	01300 NURSING ADMINISTRATION	147, 889	15, 564	163, 4	53 0	163, 453	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	29, 118	29, 1 ⁻	0 8	29, 118	14.00
15.00	01500 PHARMACY	207, 928	39, 224	247, 15	52 0	247, 152	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	25		25 0	25	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	737, 194	85, 199	822, 39	-1, 048	821, 345	30.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	574, 850	444, 289	1, 019, 13	-112, 943	906, 196	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	612, 117	431, 864	1, 043, 98	-1, 141	1, 042, 840	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	1, 162, 898	1, 162, 89	98 0	1, 162, 898	60.00
	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0		0 0	0	61.00
65.00	06500 RESPI RATORY THERAPY	159, 199	15, 216	174, 41	15 0	174, 415	65.00
66.00	06600 PHYSI CAL THERAPY	514, 665	10, 484	525, 14	-83, 740	441, 409	66.00
	06700 OCCUPATI ONAL THERAPY	0	0		0 83, 514	83, 514	67.00
	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
	06900 ELECTROCARDI OLOGY	133, 519	45, 799	179, 3 ⁻	0 8	179, 318	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11, 733	11, 7:		135, 854	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	84, 707	84, 70	07 0	84, 707	72.00
	PATIENTS						
	07300 DRUGS CHARGED TO PATIENTS	0	430, 764	430, 70		430, 764	73.00
	07400 RENAL DIALYSIS	0	0		0 0	0	74.00
	07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0	75.00
	03950 SLEEP DI SORDER	67, 863	71, 893	139, 75		139, 756	
	07501 ADULT MENTAL HEALTH	0	399, 553	399, 5		399, 553	
	07697 CARDI AC REHABI LI TATI ON	107, 045	10, 213	117, 2	58 0	117, 258	76.97
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
	09000 CLINIC	0	0		0 0	0	90.00
	09100 EMERGENCY	758, 027	1, 110, 646	1, 868, 6	73 -8, 763	1, 859, 910	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
110 00	SPECIAL PURPOSE COST CENTERS	4 570 225	10 470 145	17 05 4 4		17.054.400	110 00
118.00		4, 578, 235	12, 478, 165	17, 056, 40	0 0	17, 056, 400	1118.00
	NONREIMBURSABLE COST CENTERS		0		0	^	190.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		•
	19100 RESEARCH	о •	0 דכד	10/ 4		106, 447	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	105, 720	727	106, 44	+/ U		•
	19300 NONPAID WORKERS 19301 MARKETING/ PUBLIC RELATIONS	0	1 104	1 1/	0 0		193.00 193.01
		0	1, 104	1, 1(193.01
193.02 200.00	19302 NEW HORIZON OP TOTAL (SUM OF LINES 118 through 199)		0 12, 479, 996	17, 163, 9	0 0 51 0	0 17, 163, 951	
200.00	TOTAL (SUM OF LINES ITO UNOUGH 199)	4, 683, 955	12, 4/9, 990	17, 103, 93	0 ויי	17, 105, 751	l≤00. 00

Health Financial Systems	ST VINCENT SAL	EM_HOSPITAL
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CCN: 15-1314
Cost Center Description	Adjustments	Net Expenses
	(See A-8)	For Allocation
	6.00	7.00

Cost Center Description		Net Expenses		
		For Allocation		
	6.00	7.00		
GENERAL SERVICE COST CENTERS			I	
1.00 00100 CAP REL COSTS-BLDG & FIXT	0	,		1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00 00300 OTHER CAP RELATED COST	0	0		3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 232, 998		4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	154, 855	5, 623, 488		5.00
7.00 00700 OPERATION OF PLANT	0	1, 138, 776		7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	66, 267		8.00
9. 00 00900 HOUSEKEEPI NG	0	359, 353		9.00
10. 00 01000 DI ETARY	0	39, 244		10.00
11. 00 01100 CAFETERIA	-54,607	259, 651		11.00
13.00 01300 NURSING ADMINISTRATION	0	163, 453		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	-12	29, 106		14.00
15. 00 01500 PHARMACY	0	247, 152		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0			16.00
INPATIENT ROUTINE SERVICE COST CENTERS			1	1
30. 00 03000 ADULTS & PEDI ATRI CS	-21,600	799, 745		30.00
ANCI LLARY SERVICE COST CENTERS		,		
50. 00 05000 OPERATI NG ROOM	0	906, 196		50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0			54.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			58.00
60. 00 06000 LABORATORY	0	-		60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	1, 102, 070		61.00
65. 00 06500 RESPI RATORY THERAPY	0	174, 415		65.00
66. 00 06600 PHYSI CAL THERAPY	0	441, 409		66.00
67. 00 06700 OCCUPATIONAL THERAPY	0	83, 514		67.00
68. 00 06800 SPEECH PATHOLOGY	0	03, 514		68.00
69. 00 06900 ELECTROCARDI OLOGY	-	-		69.00
	-60, 482	118, 836		70.00
	0	125 054		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	135, 854		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	84, 707		72.00
		400 7/4		70.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	430, 764		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DI STI NCT PART)	0	0		75.00
75. 01 03950 SLEEP DI SORDER	-165	139, 591		75.01
75.03 07501 ADULT MENTAL HEALTH	0			75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	117, 258	<u>.</u>	76.97
OUTPATIENT SERVICE COST CENTERS		-	1	
88.00 08800 RURAL HEALTH CLINIC	0			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			89.00
90. 00 09000 CLINIC	0	0		90.00
91. 00 09100 EMERGENCY	-150,000	1, 709, 910		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-132, 011	16, 924, 389		118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
191. 00 19100 RESEARCH	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	106, 447	/	192.00
193.00 19300 NONPALD WORKERS	0	0		193.00
193.01 19301 MARKETING/ PUBLIC RELATIONS	0	1, 104		193.01
193. 02 19302 NEW HORIZON OP	0	0		193.02
200.00 TOTAL (SUM OF LINES 118 through 199)	-132,011	17, 031, 940		200.00
			•	

In Lieu of Form CMS-2552-10 Worksheet A

Date/Time Prepared: 11/25/2019 6:21 pm

Peri od: From 07/01/2018 To 06/30/2019

Health Financial Systems RECLASSIFICATIONS		ST VINCENT S	ALEM HOSPITAL Provider	CCN: 15-1314	In Lie Period: From 07/01/2018 To 06/30/2019	u of Form CMS Worksheet A- Date/Time Pr	6 epared:
	Inorocoo					11/25/2019 6	:21 pm
Cost Center	Li ne #	Salary	Other	-			
2.00	3.00	<u> </u>	5.00	_			
A - CAFETERIA	3.00	4.00	5.00				
1.00 CAFETERIA	11.00	(314, 25	8			1.00
TOTALS			314, 25				1.00
B - BILLABLE MEDICAL SUPPLI	FS		011720	<u> </u>			
1.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS			124, 12	1			1.00
2.00							2.00
3.00							3.00
4.00							4.00
5.00							5.00
		(124, 12	1			1
C - PT / OT							1
1.00 OCCUPATI ONAL THERAPY	67.00	81, 84	7 1, 66	7			1.00
TOTALS		81,84	7 1, 66	7			
500.00 Grand Total: Increases		81, 84	7 440, 04	6			500.00

Heal th	Financial Systems		ST VINCENT	SALEM	HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS				Provider (CCN: 15-1314	Peri od:	Worksheet A-	6
							From 07/01/2018 To 06/30/2019	Date/Time Pr	oparod
							10 00/30/2019	11/25/2019 6	:21 pm
		Decreases							
	Cost Center	Line #	Sal ary		Other	Wkst. A-7 Ref	· .		
	6. 00	7.00	8.00		9.00	10.00			
	A – CAFETERIA								
1.00	DI ETARY			0	<u>314, 2</u> 58		0		1.00
	TOTALS			0	314, 258				
	B - BILLABLE MEDICAL SUPPLIES	5							
1.00	ADULTS & PEDIATRICS	30.00			1, 048				1.00
2.00	OPERATING ROOM	50.00			112, 943				2.00
3.00	RADIOLOGY - DIAGNOSTIC	54.00			1, 141				3.00
4.00	PHYSI CAL THERAPY	66.00			226				4.00
5.00	EMERGENCY	91.00			8, 763				5.00
				0	124, 121				
	C - PT / OT								
1.00	PHYSICAL THERAPY	66.00	81, 8	47	1, 667		0		1.00
	TOTALS		81, 84	47	1, 667				
500.00	Grand Total: Decreases		81, 84	47	440, 046				500.00

Heal th	Financial Systems	ST VINCENT SAL	EM HOSPITAL		In Lie	eu of Form CMS-:	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 07/01/2018 To 06/30/2019	Worksheet A-7 Part I	
				Acqui si ti ons			
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES					
1.00	Land	180, 000	0		0 0	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	1, 986, 748	0		0 0	10, 774	3.00
4.00	Building Improvements	859, 079	0		0 0	0	4.00
5.00	Fixed Equipment	1, 869, 764	0		0 0	0	5.00
6.00	Movable Equipment	2, 320, 804	230, 258		0 230, 258	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	7, 216, 395	230, 258		0 230, 258	10, 774	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	7, 216, 395	230, 258		0 230, 258	10, 774	10.00
		Ending Balance	Fully				
		-	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES					
1.00	Land	180, 000	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	1, 975, 974	0				3.00
4.00	Building Improvements	859, 079	0				4.00
5.00	Fixed Equipment	1, 869, 764	0				5.00
6.00	Movable Equipment	2, 551, 062	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	7, 435, 879	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	7, 435, 879	0				10.00

Heal th	Financial Systems	ST VINCENT SAL	EM HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1314	Peri od:	Worksheet A-7	
					From 07/01/2018 To 06/30/2019		norod.
					To 06/30/2019	Date/Time Pre 11/25/2019 6:	pareu: 21 nm
			SL	JMMARY OF CAP	TAL	1172072017 01	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK		N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	17, 386	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	17, 386			0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	45.00				
	DADT LL DECONCLULATION OF AMOUNTS FROM WORL	14.00	15.00				
4 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEEL A, COLUM					1 00
1.00	CAP REL COSTS-BLDG & FIXT	0	17, 386				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)		17, 386				3.00

Health Financial Systems	ST VINCENT SAL	EM HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	_	Provider CO		Period: From 07/01/2018 Fo 06/30/2019		
	COMF	PUTATION OF RAT	-1 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 CAP REL COSTS-BLDG & FIXT	<u>=NTERS</u> 7, 435, 880	0	7, 435, 880		0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0 7, 435, 880	0	(7, 435, 880	0.000000 1.000000	0 0	2.00 3.00
	ALLOCAT	TION OF OTHER O	CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	1			1		
1.00 CAP REL COSTS-BLDG & FIXT	0	0	(0 17, 386	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0	(0	0	2.00 3.00
3.00 Total (sum of lines 1-2)		SL	IMMARY OF CAPI	D 17, 386 TAL	0	3.00
Cost Center Description	Interest	Insurance (see instructions)			Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C					17.00/	
1. 00 CAP REL COSTS-BLDG & FIXT 2. 00 CAP REL COSTS-MVBLE EQUIP	0	0			17, 386 0	1.00 2.00
3.00 Total (sum of lines 1-2)	0	0			17, 386	2.00 3.00

Heal th	Fi nanc	i al	Systems
AD JUST	MENTS 1	0 F	XPENSES

Health Financial Systems ADJUSTMENTS TO EXPENSES		ST VINCENT SAL		In Lie Period:	u of Form CMS-2 Worksheet A-8	
ADJUSTIMENTS TO EXPENSES				From 07/01/2018 To 06/30/2019	pared:	
			Expense Classification or		11/25/2019 6:	21 pm
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00 Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 0	1.00
COSTS-BLDG & FIXT (chapter 2)						
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2.00		
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by		0		0.00	0	6.00
suppliers (chapter 8)7.00Telephone services (pay		О		0.00	0	7.00
stations excluded) (chapter 21)						
8.00 Television and radio service (chapter 21)		0		0.00	0	8. 00
9.00 Parking lot (chapter 21)		0		0.00	0	
adjustment	A-8-2	-171, 600				
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1, 536, 557			0	12.00
13.00 Laundry and linen service 14.00 Cafeteria-employees and guests	В	-54 607	CAFETERI A	0.00 11.00		
15.00 Rental of quarters to employee		-54, 807	CAFETERIA	0.00		
and others 16.00 Sale of medical and surgical		О		0.00	0	16.00
supplies to other than patients						
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and		0		0.00	0	18.00
abstracts 19.00 Nursing and allied health		О		0.00	0	19.00
education (tuition, fees, books, etc.)						
20.00 Vending machines 21.00 Income from imposition of		0		0.00 0.00		
interest, finance or penalty		U		0.00	0	21.00
charges (chapter 21) 22.00 Interest expense on Medicare		0		0.00	0	22.00
overpayments and borrowings to repay Medicare overpayments						
23.00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
limitation (chapter 14) 24.00 Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
therapy costs in excess of	N 0 3	U	THISTORE HIERAT	00.00		24.00
25.00 Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
physicians' compensation (chapter 21)						
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***			28.00
29.00 Physicians' assistant 30.00 Adjustment for occupational	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00		29.00 30.00
therapy costs in excess of limitation (chapter 14)						
30. 99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00 Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
pathology costs in excess of limitation (chapter 14)						
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		
33.00 OTHER REVENUE - ADMINISTRATION			ADMINISTRATIVE & GENERAL t Report\20190630\HFS\20190	5.00	0	33.00

Heal th	Financial Systems		ST VINCENT SA	LEM HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1314	Peri od:	Worksheet A-8	
					From 07/01/2018 To 06/30/2019		
				Expense Classification c	n Worksheet A		
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3.00	4.00	5.00	
33.01	BUILDING RENTAL INCOME	B		ELECTROCARDI OLOGY	69.00		33.01
33.02	BUILDING RENTAL INCOME	B		SLEEP DI SORDER	75.01		33.02
33.03	BI OTERRORI SM GRANT	B		ADMI NI STRATI VE & GENERAL	5.00		33.03
33.04	CHARI TABLE EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		33.04
33.05	PROVIDER TAX ADJUSTMENT	А		ADMI NI STRATI VE & GENERAL	5.00		33.05
33.06	MEDICAL RECORDS FOR SPN	A	-3, 362	ADMI NI STRATI VE & GENERAL	5.00	0	33.06
33.07	ASSOCIATION DUES LOBBYING	A	-459	ADMINISTRATIVE & GENERAL	5.00	0	33.07
	EXPENSE						
33.08	LATE PENALTY FEES	А	-12	CENTRAL SERVICES & SUPPLY	14.00	0	33.08
33.09	IC PHYSICIAN FUND	A	-472, 264	ADMINISTRATIVE & GENERAL	5.00	0	33.09
50.00	TOTAL (sum of lines 1 thru 49)		-132, 011				50.00
	(Transfer to Worksheet A,						
-	column 6, line 200.)						

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

(2) Basis for adjustment (see instructions).

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 S	ALEM HOSPITAL	In Lie	Lieu of Form CMS-2552-10	
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1314	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS		From 07/01/2018 To 06/30/2019			
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	312, 658	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST	4, 406	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	4, 538, 834	3, 319, 341	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	6,000	6,000	3.01
3.02	15.00	PHARMACY	SVH CHARGEBACKS	24,000	24,000	3.02
3.03	54.00	RADIOLOGY - DIAGNOSTIC	SVH CHARGEBACKS	16, 483	16, 483	3.03
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	868, 838	868, 838	4.00
5.00	TOTALS (sum of lines 1-4).			5, 771, 219	4, 234, 662	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and	'or Home Office			
Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership			
1.00	2.00	3.00	4.00	5.00			
B INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE							

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

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

6.00	G	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	6.00
7.00	G	ST VINCENT HEAL	100.00	ST VINCENT HEAL	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	HOME OFFICE				100.00
	non-financial) specify:					

(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 SALEN	HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1314	Period: From 07/01/2018 To 06/30/2019	Worksheet A-8-1 Date/Time Prepared:

					11/25/2019 6	: <u>21 pm</u>
	Net	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 C	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	312, 658	0				1.00
2.00	4, 406	0				2.00
3.00	1, 219, 493	0				3.00
3.01	0	0				3.01
3.02	0	0				3. 02
3.03	0	0				3.03
4.00	0	0				4.00
5.00	1, 536, 557					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.

nus not	been posted to norksheet h,		
	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

reriibui	Sement under title Aviii.	
6.00	HOME OFFICE	6.00
7.00	HOME OFFICE	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

(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.

								0550 40
	Financial Syste ER BASED PHYSIC		ST VINCENT S	ALEM HOSPITAL Provider (Period: From 07/01/2018		3-2
						To 06/30/2019	Date/Time Pre 11/25/2019 6:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	intot. A Erno #	I denti fi er	Remuneration	Component	Component		ider Component	
				oomportorre	oomportorre		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	21, 600					1.00
2.00		EMERGENCY	150,000			0	0	
3.00		EMERGENCY	825, 911					3.00
4.00	0.00		0				0	4.00
5.00	0.00		0	-	-		0	5.00
6.00	0.00			0	-	0	0	6.00
7.00	0.00			0	-	0	0	7.00
8.00	0.00			0	-			8.00
9.00	0.00		0	0	-			9.00
7.00 10.00	0.00			0		0	0	10.00
200.00	0.00		997, 511	171, 600		0		200.00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	200.00
	WKSL A LINE #	I denti fi er		Unadjusted RCE			of Malpractice	
		ruenti i rei			Continuing	Share of col.		
					Education	12	Thourance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0					1.00
2.00		EMERGENCY	0					2.00
3.00		EMERGENCY	0	0			0	3.00
4.00	0.00			0	-			4.00
5.00	0.00			0	-		0	5.00
6.00	0.00			0	-	-	0	
7.00	0.00			0	-	0	0	7.00
8.00	0.00			0			0	8.00
9.00	0.00			0	-	0	0	9.00
10.00	0.00			0	-		0	10.00
200.00	0.00		0	0	-	-	-	200.00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WRSt. A LINC #	I denti fi er	Component	Limit	Di sal I owance	Aujustment		
		i deliti i i ei	Share of col.		Di Sul i Gildnee			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	C	21, 600		1.00
2.00	91.00	EMERGENCY	0	0	C	150,000		2.00
3.00	91.00	EMERGENCY	0	0	C	0		3.00
4.00	0.00		0	0	C	0		4.00
5.00	0.00		0	0	C	0		5.00
6.00	0.00		0	0	C	0		6.00
7.00	0.00			0	-			7.00
8.00	0.00		0	-	-			8.00
9.00	0.00			0				9.00
10.00	0.00			0	-			10.00
200.00	0.00			-	-	-		200.00
200.00	1			. 0		1, 1, 1, 000	1	

Health Financial Systems	ST VINCENT SAL	EM HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2018 To 06/30/2019	Worksheet B Part I Date/Time Pre 11/25/2019 6:	pared:
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS	17 20/	17 00/				1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP	17, 386	17, 386		0		1.00 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 232, 998	202		0 1, 233, 200		4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	5, 623, 488	1, 902		0 146, 580	5, 771, 970	
7.00 00700 OPERATION OF PLANT	1, 138, 776	2, 825		0 0	1, 141, 601	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	66, 267	0		0 0	66, 267	8.00
9.00 00900 HOUSEKEEPI NG	359, 353	530		0 0	359, 883	•
10. 00 01000 DI ETARY	39, 244	1, 669		0 0	40, 913	•
	259, 651	0		0 0	259, 651	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	163, 453	66		0 38, 948	202, 467	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	29, 106 247, 152	0 170		0 0 0 54,760	29, 106 302, 082	•
16. 00 01600 MEDI CAL RECORDS & LI BRARY	247, 152	809		0 54,700	834	•
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	20				001	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	799, 745	1, 922		0 194, 146	995, 813	30.00
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	906, 196	1, 850		0 151, 391	1, 059, 437	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	1, 042, 840	1, 122		0 161, 206	1, 205, 168	•
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
60.00 06000 LABORATORY 61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	1, 162, 898	324		0 0	1, 163, 222 0	60.00 61.00
65. 00 06500 RESPIRATORY THERAPY	174, 415	187		0 41, 926	216, 528	
66. 00 06600 PHYSI CAL THERAPY	441, 409	396		0 113, 986	555, 791	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	83, 514	75		0 21, 555	105, 144	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	118, 836	482		0 35, 163	154, 481	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	135, 854	0		0 0	135, 854	•
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	84, 707	0		0 0	84, 707	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	430, 764	0		0	430, 764	73.00
74. 00 07400 RENAL DI ALYSI S	430,704	0		0 0	430, 704	74.00
75.00 07500 ASC (NON-DI STINCT PART)	0	0		0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	139, 591	489		0 17, 872	157, 952	•
75.03 07501 ADULT MENTAL HEALTH	399, 553	402		0 0	399, 955	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	117, 258	227		0 28, 191	145, 676	76.97
OUTPATIENT SERVICE COST CENTERS		-				00.00
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0		•
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0		0 0	0	89.00 90.00
91. 00 09100 EMERGENCY	1, 709, 910	775		0 199, 634	1, 910, 319	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,707,910	115		0 177,034	1, 910, 519	92.00
SPECIAL PURPOSE COST CENTERS						/2.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	16, 924, 389	16, 424		0 1, 205, 358	16, 895, 585	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		190. 00
191.00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	106, 447	850		0 27, 842	135, 139	
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
193.01 19301 MARKETING/ PUBLIC RELATIONS 193.02 19302 NEW HORIZON OP	1, 104	0 112				193. 01 193. 02
200.00 Cross Foot Adjustments		112		0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	17, 031, 940	17, 386		0 1, 233, 200		202.00
						-

Heal th	Financial Systems	ST VINCENT SA	LEM HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		eriod:	Worksheet B	
					rom 07/01/2018 o 06/30/2019	Part I Date/Time Pre	pared [.]
		1				11/25/2019 6:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	5, 771, 970					5.00
7.00	00700 OPERATION OF PLANT	585, 196					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	33, 969	0	100, 236			8.00
9.00	00900 HOUSEKEEPI NG	184, 480	73, 520	0	617, 883		9.00
10.00	01000 DI ETARY	20, 972		0	0	293, 264	10.00
11.00	01100 CAFETERIA	133, 100		0	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	103, 787		0	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	14, 920		0	0	0	14.00
15.00		154, 850			0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	428	112, 157	0	0	0	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	510, 464	266, 379	15, 999	110, 940	293, 264	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	510, 404	200, 379	10, 777	110, 940	293, 204	30.00
50.00	05000 OPERATI NG ROOM	543, 078	256, 422	17, 113	95, 296	0	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	617, 781	155, 551			0	54.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0	0	58.00
60.00	06000 LABORATORY	596, 279	44, 909		51, 662	0	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500 RESPI RATORY THERAPY	110, 994	25, 976	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	284, 904	54, 913	12, 007	31, 079	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	53, 898	10, 376		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	-	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	79, 189			40, 753	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	-	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	69, 640	0	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	43, 422	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	220, 814	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	220, 814		0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	03950 SLEEP DI SORDER	80, 968	67, 737	1, 929	0	0	75.01
75.03	07501 ADULT MENTAL HEALTH	205, 021	55, 705		26, 963	0	75.03
76.97	07697 CARDI AC REHABI LI TATI ON	74, 675			40, 341	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	979, 244	107, 423	37, 416	88, 710	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
110 00	SPECIAL PURPOSE COST CENTERS	E 702 072	1 502 200	00.055		202 264	110.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	5, 702, 073	1, 593, 398	99, 255	585, 569	293, 264	118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN			0	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	69, 274	117, 823	-	32, 314		192.00
	19300 NONPALD WORKERS	0,,2,1	0	0	02,011		193.00
	19301 MARKETING/ PUBLIC RELATIONS	566	0	0	0		193.00
	19302 NEW HORIZON OP	57		0	Ő		193.02
200.00		1					200.00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	5, 771, 970	1, 726, 797	100, 236	617, 883	293, 264	

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	ST VINCENT SAL	Provider CC	`N· 15_1314	Period:	u of Form CMS-: Worksheet B	2552-10
0001 7	LEUCATION - GENERAL SERVICE COSTS			N. 13-1314	From 07/01/2018	Part I	
					To 06/30/2019	Date/Time Pre 11/25/2019 6:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDICAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
		11.00	12.00	SUPPLY	15.00	LI BRARY	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI 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	392, 751					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	8, 503	323, 897				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	44, 02	1		14.00
15.00		13, 618	0		0 494, 124	110 110	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	113, 419	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	70, 907	75, 682	1, 64	2 0	21, 699	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	70, 907	75,002	1,04	FZ 0	21,099	30.00
50.00	05000 OPERATI NG ROOM	50, 265	85, 412	12, 81	5 0	15, 382	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	62, 391	0	4, 35	1	19,093	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	o	.,	0 0	0	
60.00	06000 LABORATORY	0	0		0 0	0	1
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500 RESPI RATORY THERAPY	15, 453	0		0 0	4, 729	65.00
66.00	06600 PHYSI CAL THERAPY	41, 076	0	52	26 0	14, 720	66.00
67.00	06700 OCCUPATI ONAL THERAPY	7,024	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	17, 186	1, 275		0 0	5, 259	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	12, 30	01 0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0	7,67	/3 0	0	72.00
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 494, 124	0	
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00	07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0	
75. 01 75. 03	03950 SLEEP DI SORDER 07501 ADULT MENTAL HEALTH	8, 722 0	0		0 0	2, 669 0	
76.97	07697 CARDI AC REHABI LI TATI ON	12, 417	13, 222		0 0	3, 800	1
70. 77	OUTPATIENT SERVICE COST CENTERS	12,417	15, 222		<u> </u>	5,000	/0. //
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ő		0 0	0	
90.00	09000 CLINIC	0	o		0 0	0	1
91.00	09100 EMERGENCY	71, 617	148, 089	4, 71	4 0	21, 915	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS				-		
118.00		379, 179	323, 680	44, 02	494, 124	109, 266	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		190.00
191.00	19100 RESEARCH	0	0		0 0		191.00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	13, 572	217		0 0		192.00
	19300 NONPAID WORKERS	0	0		0 0		193.00
	19301 MARKETING/ PUBLIC RELATIONS	0	0		0 0		193.01
		0	0		0	0	193.02
193.02	19302 NEW HORIZON OP	0	0			-	
193.02 200.00	Cross Foot Adjustments						200.00
193.02	Cross Foot Adjustments Negative Cost Centers	0 392, 751	0 0 323, 897	44, 02	0 0 26 494, 124		200. 00 201. 00

	Financial Systems	ST VINCENT SALE				MS-2552-10
COST AI	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1314	Peri od: Worksheet From 07/01/2018 Part I To 06/30/2019 Date/Time 11/25/2019 11/25/2019	Prepared:
	Cost Center Description	Subtotal	Intern &	Total		
		R	esidents Cost & Post			
			Stepdown			
			Adjustments			
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT					1.00
	00200 CAP REL COSTS-BEDG & TTXT					2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL					5.00
	00700 OPERATION OF PLANT					7.00
	00800 LAUNDRY & LINEN SERVICE					8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY					9.00
	01100 CAFETERI A					11.00
	01300 NURSI NG ADMI NI STRATI ON					13.00
	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15.00
	01600 MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	0.040.700			700	
	03000 ADULTS & PEDIATRICS ANCI LLARY SERVICE COST CENTERS	2, 362, 789	0	2, 362, 7	/89	30.00
	05000 OPERATI NG ROOM	2, 135, 220	0	2, 135, 2	220	50.00
	05400 RADI OLOGY - DI AGNOSTI C	2, 147, 385	0	2, 147, 3		54.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	58.00
	06000 LABORATORY	1, 856, 072	0	1, 856, 0	072	60.00
	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0			0	61.00
	06500 RESPIRATORY THERAPY	373, 680	0	373, 6		65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	995, 016 176, 442	0	995, (176, 4		66.00 67.00
	06800 SPEECH PATHOLOGY	170, 442	0	170, -	0	68.00
	06900 ELECTROCARDI OLOGY	368, 522	0	368, 5	522	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	217, 795	0	217, 7		71.00
72.00	07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	135, 802	0	135, 8	302	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 145, 702	0	1, 145, 7	702	73.00
	07400 RENAL DIALYSIS	0	0		0	74.00
	07500 ASC (NON-DI STINCT PART)	0	0		0	75.00
	03950 SLEEP DI SORDER 07501 ADULT MENTAL HEALTH	347,969	0	347, 9 687, 6		75.01
	07697 CARDIAC REHABILITATION	687, 644 321, 567	0	321, 5		76.97
	OUTPATIENT SERVICE COST CENTERS	021,007	0	021,0		/0. //
88.00	08800 RURAL HEALTH CLINIC	0	0		0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	89.00
	09000 CLINIC	0	0		0	90.00
	09100 EMERGENCY	3, 369, 447	0	3, 369, 4	447	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS		0			92.00
118.00		16, 641, 052	0	16, 641, 0	152	118.00
	NONREI MBURSABLE COST CENTERS	10,011,002		10,011,0	552	
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0	190. 00
	19100 RESEARCH	0	0		0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	373, 473	0	373, 4	473	192.00
	19300 NONPALD WORKERS	0	0		0	193.00
	19301 MARKETING/ PUBLIC RELATIONS 19302 NEW HORIZON OP	1, 670 15, 745	0	1, 6 15, 7		193. 01 193. 02
		10,740	U	10, 1		
	Cross Foot Adjustments		0		0	200 00
193.02 200.00 201.00		0	0 0		0	200.00 201.00

Health Financial Systems ST VINCENT SALEM HOSPITAL In Lieu of Form Cl ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1314 Period: Worksheet From 07/01/2018 To 06/30/2019 Part II Date/Time 11/25/2019	3 Prepared:
CAPITAL RELATED CUSTS	
Cost Center DescriptionDirectly Assigned New Capital Related CostsBLDG & FIXTMVBLE EQUIP 	-
0 1.00 2.00 2A 4.00 GENERAL SERVICE COST CENTERS	
1. 00 00100 CAP REL COSTS-BLDG & FIXT	1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 202 0 202 5. 00 00500 ADMI NI STRATI VE & GENERAL 370, 225 1, 902 0 372, 127 7. 00 00700 OPERATI ON OF PLANT 171, 617 2, 825 0 174, 442	2.00 4.00 24 5.00 0 7.00
8. 00 00800 LAUNDRY & LINEN SERVICE 0 0 0 0	0 8.00
9. 00 00900 HOUSEKEEPI NG 1, 824 530 0 2, 354	0 9.00
10. 00 DI ETARY 20, 092 1, 669 0 21, 761	0 10.00
11.00 01100 CAFETERIA 0 0 0 0	0 11.00
13. 00 O1300 NURSI NG ADMI NI STRATI ON 4, 231 66 0 4, 297 14. 00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0	6 13.00 0 14.00
15. 00 01500 PHARMACY 35, 582 170 0 35, 752	9 15.00
16.00 01600 MEDICAL RECORDS & LI BRARY 0 809 0 809	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 O3000 ADULTS & PEDI ATRI CS 23, 868 1, 922 0 25, 790 ANCI LLARY SERVI CE COST CENTERS	32 30.00
50. 00 05000 OPERATI NG ROOM 158, 895 1, 850 0 160, 745	25 50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 202, 790 1, 122 0 203, 912	26 54.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 0	0 58.00
60. 00 06000 LABORATORY 0 324 0 324	0 60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	61.00
65. 00 06500 RESPI RATORY THERAPY 9, 502 187 0 9, 689 66. 00 06600 PHYSI CAL THERAPY 799 396 0 1, 195	7 65.00 19 66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 75 0 75	4 67.00
68. 00 06800 SPEECH PATHOLOGY 0 0 0	0 68.00
69. 00 06900 ELECTROCARDI OLOGY 41, 305 482 0 41, 787	6 69.00
70.00 O <td>0 70.00</td>	0 70.00
71.00 O7100 MEDI CAL SUPPLIES CHARGED TO O <th< td=""><td>0 71.00</td></th<>	0 71.00
72. 00 07200 I MPLANTABLE DEVI CES CHARGED TO 0 0 0 0	0 72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0	0 73.00
74.00 07400 RENAL DI ALYSI S 0 0 0 0	0 74.00
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0	0 75.00
75. 01 03950 SLEEP DI SORDER 195 489 0 684	3 75.01
75. 03 07501 ADULT MENTAL HEALTH 0 402 0 402 76. 97 07697 CARDI AC REHABI LI TATI ON 4, 957 227 0 5, 184	0 75.03 5 76.97
OUTPATIENT SERVICE COST CENTERS	0 /0. //
88.00 08800 RURAL HEALTH CLINIC 0 0 0	0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0	0 89.00
	0 90.00
91.00 09100 EMERGENCY 23,092 775 0 23,867 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0	31 91.00 92.00
SPECIAL PURPOSE COST CENTERS	92.00
	97 118. 00
NONREI MBURSABLE COST CENTERS	
190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0	0 190.00
191.00 19100 RESEARCH 0 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE 0 850 0 850	0 191.00 5 192.00
192.00 19200 PHISICIANS PRIVATE OFFICES 0 850 0 850	0 193.00
193. 01 19301 MARKETI NG/ PUBLI C RELATI ONS 0 0 0 0	0 193.01
193. 02 19302 NEW HORIZON OP 0 112 0 112	0 193. 02
200.00 Cross Foot Adjustments 0	200.00
201.00 Negative Cost Centers 0 0 0 0 202.00 TOTAL (sum lines 118 through 201) 1.068.974 17.386 0 1.086.360	0 201.00
202.00 TOTAL (sum lines 118 through 201) 1,068,974 17,386 0 1,086,360	.02 1202. 00

Health Financial Systems	ST VINCENT SAI	LEM_HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	F	Period: From 07/01/2018 To 06/30/2019	Worksheet B Part II Date/Time Pre	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPING	11/25/2019 6: DI ETARY	21 pm
cost center bescription	& GENERAL	PLANT	LINEN SERVICE		DILIARI	
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS	1	I		1		
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	272 151					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT	372, 151 37, 731					5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE	2, 190	212, 173	2, 190			8.00
9. 00 00900 HOUSEKEEPI NG	11, 894					9.00
10. 00 01000 DI ETARY	1, 352				51, 543	
11. 00 01100 CAFETERIA	8, 582			0	0	11.00
13.00 01300 NURSING ADMINISTRATION	6, 692		0	0 0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	962	0	0	0 0	0	14.00
15. 00 01500 PHARMACY	9, 984	2, 897	(C	0 0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	28	13, 781	0	0 0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDI ATRI CS	32, 913	32, 729	350	4, 178	51, 543	30.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	35, 015				0	50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	39, 832				0	54.00
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0 38, 446	-	-		0	58.00
60.00 06000 LABORATORY 61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	38, 446	5, 518		1, 947	0	60.00 61.00
65. 00 06500 RESPIRATORY THERAPY	7, 156	3, 192	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	18, 369			-	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 475				0	67.00
68. 00 06800 SPEECH PATHOLOGY	0,1,0	0		-	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	5, 106	-			0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0			0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 490	0	0	0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	2,800	0	(c	0 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	14, 237	0	0	0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0	0	C	-	0	74.00
75.00 07500 ASC (NON-DI STINCT PART)	0	0	0		0	75.00
75. 01 03950 SLEEP DI SORDER	5, 220				0	75.01
75. 03 07501 ADULT MENTAL HEALTH	13, 219				0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	4, 815	3, 859		1, 520	0	76.97
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	ol	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-		-	0	89.00
90. 00 09000 CLINIC	0	0			0	90.00
91. 00 09100 EMERGENCY	63, 137	13, 199	817	3, 342	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS		•	•			1
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	367, 645	195, 782	2, 169	22, 063	51, 543	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	C	-		190. 00
191. 00 19100 RESEARCH	0	0	0			191.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES	4, 466	14, 477				192.00
193.00 19300 NONPALD WORKERS	0	0	0	0		193.00
193. 01 19301 MARKETING/ PUBLIC RELATIONS	36			0		193.01
193. 02 19302 NEW HORIZON OP	4	1, 914		0	0	193.02
200.00 Cross Foot Adjustments	_				~	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	372, 151	212, 173	2, 190	23, 281		201. 00 202. 00
202.00 TOTAL (Sum TIMES TO THE OUGH 201)	572,101	212,1/3	2, 190	23, 201	51, 545	1202.00

0.07	Financial Systems TION OF CAPITAL RELATED COSTS	ST VINCENT SALE	Provider CC	N: 15-1314	Period:	u of Form CMS-2 Worksheet B	2002-10
	THON OF GATTINE RELATED COSTS				From 07/01/2018 To 06/30/2019	Part II Date/Time Pre	narod
					10 00/30/2014	11/25/2019 6:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		A	OMI NI STRATI ON	SERVICES &		RECORDS &	
		11.00	10.00	SUPPLY	45.00	LIBRARY	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	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	8, 582					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	186	12, 304				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	96	2		14.00
15.00	01500 PHARMACY	298	0		0 48, 940		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	14, 618	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	1, 549	2, 875	3	6 0	2, 797	30.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 098	3, 245	28	0 0	1, 982	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	1, 363	0	9	5 0	2, 461	54.00
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
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500 RESPI RATORY THERAPY	338	0		0 0	609	65.00
66.00	06600 PHYSI CAL THERAPY	898	0		1 0	1, 897	66.00
67.00	06700 OCCUPATI ONAL THERAPY	153	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	376	48		0 0	678	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	26		0	71.00
72.00	07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	16	8 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 48, 940	0	73.00
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	o	0		0 0	0	75.00
75.01	03950 SLEEP DI SORDER	191	0		0 0	344	75.01
75.03	07501 ADULT MENTAL HEALTH	0	0		0 0	0	75.03
75.05					o ol	490	
76.97	07697 CARDI AC REHABI LI TATI ON	271	502		0 0		76.97
	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	271	502				76. 97
		271	502 0		0 0	0	76. 97 88. 00
76. 97	OUTPATIENT SERVICE COST CENTERS						
76. 97 88. 00	OUTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C	0	0		0 0	0	88.00
76.97 88.00 89.00 90.00 91.00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY	0	0		0 0 0 0 0 0	0	88. 00 89. 00 90. 00 91. 00
76.97 88.00 89.00 90.00 91.00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	88. 00 89. 00 90. 00
76. 97 88. 00 89. 00 90. 00 91. 00 92. 00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	0 0 1, 564	0 0 0 5, 626	10	0 0 0 0 0 0 0 3 0	0 0 0 2, 825	88.00 89.00 90.00 91.00 92.00
76.97 88.00 89.00 90.00 91.00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0 0 0	0 0 0		0 0 0 0 0 0 0 3 0	0 0 0	88.00 89.00 90.00 91.00 92.00
76. 97 88. 00 89. 00 90. 00 91. 00 92. 00 118. 00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0 0 1, 564 8, 285	0 0 5, 626 12, 296	10	0 0 0 0 0 0 3 0 2 48, 940	0 0 2, 825 14, 083	88. 00 89. 00 90. 00 91. 00 92. 00 118. 00
76. 97 88. 00 90. 00 91. 00 92. 00 118. 00 190. 00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0 0 1, 564 8, 285	0 0 0 5, 626	10 96	0 0 0 0 3 0 2 48, 940 0 0	0 0 2, 825 14, 083	88. 00 89. 00 90. 00 91. 00 92. 00 118. 00
76.97 88.00 90.00 91.00 92.00 118.00 190.00 191.00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19100 RESEARCH	0 0 1, 564 8, 285	0 0 5, 626 12, 296	10 96	0 0 0 0 0 0 3 0 2 48, 940 0 0 0	0 0 2, 825 14, 083 0 0	88.00 89.00 90.00 91.00 92.00 118.00 190.00 191.00
76.97 88.00 90.00 91.00 92.00 118.00 190.00 191.00 192.00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES	0 0 1, 564 8, 285	0 0 5, 626 12, 296	10 96	0 0 0 0 3 0 2 48, 940 0 0	0 0 2, 825 14, 083 0 0 535	88. 00 89. 00 90. 00 91. 00 92. 00 118. 00 190. 00 191. 00 192. 00
76.97 88.00 90.00 91.00 92.00 118.00 190.00 191.00 192.00 193.00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0 0 1, 564 8, 285	0 0 5, 626 12, 296	10 96	0 0 0 0 3 0 2 48, 940 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 2, 825 14, 083 0 535 0	88.00 89.00 90.00 91.00 92.00 118.00 190.00 191.00 192.00 193.00
76.97 88.00 89.00 90.00 91.00 92.00 118.00 190.00 191.00 192.00 193.00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19100 RESEARCH 19200 HYSI CLANS' PRIVATE OFFICES 19300 NONPAI D WORKERS 19301 MARKETING/ PUBLIC RELATIONS	0 0 1, 564 8, 285	0 0 5, 626 12, 296	10 96	0 0 0 0 0 0 3 0 2 48, 940 0 0 0	0 0 2, 825 14, 083 0 535 5 0 0 0 0 535 0 0 0	88.00 90.00 91.00 92.00 118.00 190.00 191.00 192.00 193.00 193.01
76.97 88.00 90.00 91.00 92.00 118.00 190.00 191.00 192.00 193.00 193.01	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19100 RESEARCH 19200 PHYSI CIANS' PRI VATE OFFICES 19301 MARKETING/ PUBLIC RELATIONS 19302 NEW HORIZON OP	0 0 1, 564 8, 285	0 0 5, 626 12, 296	10 96	0 0 0 0 3 0 2 48, 940 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 2, 825 14, 083 0 535 0 0 0 0 0 0	88. 00 89. 00 90. 00 92. 00 118. 00 191. 00 192. 00 192. 00 193. 00 193. 01 193. 02
76.97 88.00 89.00 90.00 91.00 92.00 118.00 190.00 191.00 193.00 193.01 193.02 200.00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19100 RESEARCH 19200 PHYSI CIANS' PRIVATE OFFICES 19300 NONPAID WORKERS 19302 NEW HORIZON OP Cross Foot Adj ustments	0 0 1, 564 8, 285	0 0 5, 626 12, 296	10 96	0 0 0 0 0 0 3 0 2 48,940 0	0 0 2, 825 14, 083 0 0 535 0 0 0 0 0	88. 00 90. 00 91. 00 92. 00 118. 00 191. 00 192. 00 193. 00 193. 02 200. 00
76.97 88.00 89.00 90.00 91.00 92.00 118.00 191.00 192.00 193.00 193.01	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS 19301 MARKETING/ PUBLIC RELATIONS 19302 NEW HORIZON OP Cross Foot Adjustments Negative Cost Centers	0 0 1, 564 8, 285	0 0 5, 626 12, 296	10 96	0 0 0 0 0 0 3 0 2 48,940 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 2, 825 14, 083 0 0 535 0 0 0 0 0	88. 00 90. 00 91. 00 92. 00 118. 00 191. 00 192. 00 193. 00 193. 01 193. 02 200. 00 201. 00

	Financial Systems	ST VINCENT SALE			45 4044	In Lieu of Form CMS	-2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider (CCN:	F	Period: Worksheet B From 07/01/2018 Part II Fo 06/30/2019 Date/Time Pr 11/25/2019 6	
	Cost Center Description	Subtotal Re	Intern & esidents Cos & Post	t	Total		
			Stepdown				
		24.00	Adjustments 25.00		26.00	-	
	GENERAL SERVICE COST CENTERS	21.00	20.00		20.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFI TS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDI CAL RECORDS & LI BRARY						16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	I					
30.00	03000 ADULTS & PEDI ATRI CS	154, 792		0	154, 792	2	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	237, 862		0	237, 862	2	50.00
	05400 RADI OLOGY - DI AGNOSTI C	269, 754		0	269, 754	4	54.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	(58.00
	06000 LABORATORY	46, 235		0	46, 235	5	60.00
	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY			_			61.00
	06500 RESPI RATORY THERAPY	20, 991		0	20, 99		65.00
	06600 PHYSI CAL THERAPY	30, 569		0	30, 569		66.00
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	4, 982		0	4, 982	2	67.00 68.00
	06900 ELECTROCARDI OLOGY	57, 826			57, 826	5	69.00
	07000 ELECTROENCEPHALOGRAPHY	0,020		0	57, 020		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 759		0	4, 759		71.00
	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	2, 968		0	2, 968		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	63, 177		0	63, 177	7	73.00
	07400 RENAL DIALYSIS	0		0	(74.00
	07500 ASC (NON-DI STI NCT PART)	0		0	(75.00
	03950 SLEEP DI SORDER	15, 862		0	15, 862		75.01
	07501 ADULT MENTAL HEALTH	21, 482		0	21, 482		75.03
	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	16, 647		0	16, 64	/	76.97
	08800 RURAL HEALTH CLINIC	0		0	(88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		o			89.00
	09000 CLINIC	0		0			90.00
	09100 EMERGENCY	114, 511		õ	114, 51	1	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
	SPECIAL PURPOSE COST CENTERS	· · ·					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,062,417		0	1, 062, 41	7	118.00
	NONREIMBURSABLE COST CENTERS					_	
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0		0	(190.00
	19100 RESEARCH	0		0	(D	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	21, 877		0	21, 87	7	192.00
	19300 NONPALD WORKERS	0		0	(193.00
	19301 MARKETING/ PUBLIC RELATIONS	36		0	30		193.01
	19302 NEW HORIZON OP	2,030		0	2, 030		193.02
200.00 201.00		0		0	(200.00
2111 [1()	Negative Cost Centers	0		0	(201.00
201.00	TOTAL (sum lines 118 through 201)	1, 086, 360		0	1,086,360		202.00

ST AL	LOCAT	cial Systems TION - STATISTICAL BASIS	ST VINCENT SAI	Provider CC	CN: 15-1314	Peri od:	u of Form CMS- Worksheet B-1	
					1	From 07/01/2018 To 06/30/2019	Date/Time Pre	
			CAPITAL REL	LATED COSTS			11/25/2019 6:	<u>21 pr</u>
				LATED COSTS				
		Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	& GENERAL	
					DEPARTMENT (GROSS		(ACCUM. COST)	
			1.00	2.00	SALARI ES) 4. 00	5A	5.00	
(GENER	AL SERVICE COST CENTERS	1.00	2.00	4.00	5/	3.00	
		CAP REL COSTS-BLDG & FIXT	103, 359					1 1.
00	00200	CAP REL COSTS-MVBLE EQUIP		0				2.
00	00400	EMPLOYEE BENEFITS DEPARTMENT	1, 202	0	4, 682, 59	5		4
00	00500	ADMINISTRATIVE & GENERAL	11, 305	0	556, 579	9 -5, 771, 970	11, 259, 970	5
00	00700	OPERATION OF PLANT	16, 796	0	(0 0	1, 141, 601	7
		LAUNDRY & LINEN SERVICE	0	0	(0 0	66, 267	8
		HOUSEKEEPING	3, 153		(0 0	359, 883	
		DIETARY	9, 923	0	(0 0	40, 913	
		CAFETERIA	0		(0 0	259, 651	
		NURSING ADMINISTRATION	392		147, 889	9 0	202, 467	
		CENTRAL SERVICES & SUPPLY	0	-	(0 0	29, 106	
		PHARMACY	1,011				302, 082	
		MEDICAL RECORDS & LIBRARY	4, 810	0	(0 0	834	16
		I ENT ROUTI NE SERVI CE COST CENTERS	1	_		-		1
		ADULTS & PEDIATRICS	11, 424	0	737, 194	4 0	995, 813	30
		LARY SERVICE COST CENTERS	10.007		E74 054		1 050 407	
		OPERATING ROOM	10, 997				1, 059, 437	
		RADIOLOGY - DIAGNOSTIC	6, 671				1, 205, 168	
		MAGNETIC RESONANCE IMAGING (MRI)	0	-			0	
		LABORATORY	1, 926	0	(J 0	1, 163, 222	
		PBP CLINICAL LAB. SERVICE-PRGM. ONLY	1 114		150 100		214 520	61
		RESPI RATORY THERAPY	1, 114		159, 199		216, 528	
		PHYSICAL THERAPY	2,355		432, 818		555, 791	
		OCCUPATIONAL THERAPY	445		81, 84		105, 144	
		SPEECH PATHOLOGY	-	-			0	
		ELECTROCARDI OLOGY	2,866		133, 519	7 U	154, 481	
		ELECTROENCEPHALOGRAPHY	0	-	(0	125 054	
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-	(0	135, 854	
00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	(J 0	84, 707	72
00	07300	DRUGS CHARGED TO PATIENTS	0	0	(430, 764	73
		RENAL DIALYSIS	0	-			430, 704	
		ASC (NON-DISTINCT PART)	0	-	(0	
		SLEEP DI SORDER	2,905	-	67, 863	3 0	157, 952	
		ADULT MENTAL HEALTH	2, 389			0	399, 955	
		CARDI AC REHABI LI TATI ON	1, 347			5 0	145, 676	
		TIENT SERVICE COST CENTERS	1,017	<u> </u>	107,010		110,070	1 ' '
		RURAL HEALTH CLINIC	0	0	(0 0	0	88
		FEDERALLY QUALIFIED HEALTH CENTER	0		(0	
		CLINIC	0	-			0	
		EMERGENCY	4, 607	-	758, 02	7 0	1, 910, 319	
		OBSERVATION BEDS (NON-DISTINCT PART)	4,007		, 50, 02		1, 710, 517	92
		AL PURPOSE COST CENTERS	1	1				1 12
3. 00		SUBTOTALS (SUM OF LINES 1 through 117)	97, 638	0	4, 576, 87	5 -5, 771, 970	11, 123, 615	1118
		IMBURSABLE COST CENTERS	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		., 270, 370	-,,,,,,	.,,	1
		GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	(0 0	0	190
		RESEARCH	0			ว ดี		191
		PHYSICIANS' PRIVATE OFFICES	5, 053	-	105, 720	ว ดี	135, 139	
		NONPAI D WORKERS	0	Ó	(o o		193
		MARKETING/ PUBLIC RELATIONS	0	0	(o o	1, 104	
		NEW HORIZON OP	668	0	(o l		193
0. 00		Cross Foot Adjustments						200
. 00		Negative Cost Centers						201
2. 00		Cost to be allocated (per Wkst. B, Part I)	17, 386	0	1, 233, 200		5, 771, 970	202
3. 00		Unit cost multiplier (Wkst. B, Part I)	0. 168210	0. 000000	0. 263358	3	0. 512610	203
i. 00		Cost to be allocated (per Wkst. B,	0. 100210	0.000000	203330		372, 151	
r. UU		Part II)			20.	-	572, 131	204
5. 00		Unit cost multiplier (Wkst. B, Part			0.000043	3	0. 033051	205
					2. 30004	-	0.00001	[
5.00		NAHE adjustment amount to be allocated						206
I		(per Wkst. B-2)	1					1
7.00		NAHE unit cost multiplier (Wkst. D,						207.

	ancial Systems ATION - STATISTICAL BASIS	ST VINCENT SA	Provider C	N· 15-1314 □	eriod:	u of Form CMS-: Worksheet B-1	
SI ALLUU	ATTON - STATISTIONE DASIS			F	rom 07/01/2018		
				T	06/30/2019	Date/Time Pre 11/25/2019 6:	par
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	(HOURS)	
		(SQUARE FEET)	(POUNDS OF	SERVI CE)			
		7.00	LAUNDRY)	0.00	10.00	11 00	-
GENE	RAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	-
	DO CAP REL COSTS-BLDG & FIXT						1 1
	DO CAP REL COSTS-MVBLE EQUIP						2
0040	DO EMPLOYEE BENEFITS DEPARTMENT						4
0050	DO ADMI NI STRATI VE & GENERAL						5
0070	OO OPERATION OF PLANT	74,056					
00800	DO LAUNDRY & LINEN SERVICE	0	15, 018				8
0090	DO HOUSEKEEPI NG	3, 153	0	3, 002			9
00 0100	DO DI ETARY	9, 923	0	0	1, 770		10
00 0110	DO CAFETERIA	0	0	0	0	120, 322	11
00 0130	DO NURSING ADMINISTRATION	392	0	0	0	2,605	13
00 0140	DO CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14
00 0150	DO PHARMACY	1,011	0	0	0	4, 172	15
00 0160	DO MEDICAL RECORDS & LIBRARY	4, 810	0	0	0	0	16
	ATLENT ROUTINE SERVICE COST CENTERS						
00 0300	DO ADULTS & PEDIATRICS	11, 424	2, 397	539	1, 770	21, 723	30
ANCI	LLARY SERVICE COST CENTERS						
	DO OPERATING ROOM	10, 997		463		15, 399	
	DO RADI OLOGY – DI AGNOSTI C	6, 671	1, 680	349	0	19, 114	54
	DO MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58
00 0600	DO LABORATORY	1, 926	0	251	0	0	60
00 0610	DO PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61
00 0650	00 RESPI RATORY THERAPY	1, 114	. 0	0	0	4, 734	65
00 0660	DO PHYSI CAL THERAPY	2, 355	1, 799	151	0	12, 584	66
00 0670	00 OCCUPATIONAL THERAPY	445	0	0	0	2, 152	67
00 0680	DO SPEECH PATHOLOGY	0	0	0	0	0	68
00 0690	DO ELECTROCARDI OLOGY	2,866	532	198	0	5, 265	69
00 0700	DO ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70
. 00 0710	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71
	DO IMPLANTABLE DEVICES CHARGED TO	0	0	0	0	0	72
	PATIENTS						
. 00 0730	DO DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73
. 00 0740	DO RENAL DI ALYSI S	0	0	0	0	0	74
00 0750	DO ASC (NON-DISTINCT PART)	0	0	0	0	0	75
01 0395	50 SLEEP DI SORDER	2,905	289	136	0	2, 672	75
03 0750	D1 ADULT MENTAL HEALTH	2, 389	0	131	0	0	75
97 0769	7 CARDIAC REHABILITATION	1, 347	4	196	0	3, 804	76
OUTF	PATIENT SERVICE COST CENTERS						
00 0880	DO RURAL HEALTH CLINIC	0	0	0	0	0	88
	DO FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89
	DO CLINIC	0	0	0	0	0	
	DO EMERGENCY	4,607	5, 606	431	0	21, 940	91
	OO OBSERVATION BEDS (NON-DISTINCT PART)						92
SPEC	CLAL PURPOSE COST CENTERS	r			· · · · · · · · · · · · · · · · · · ·		
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	68, 335	14, 871	2, 845	1, 770	116, 164	118
	REIMBURSABLE COST CENTERS	T	, · · · · · · · · · · · · · · · · · · ·		, · · · ·		
	DO GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0			190
	DO RESEARCH	0	0	0			191
	DO PHYSICIANS' PRIVATE OFFICES	5, 053	147	157	0	4, 158	
	DO NONPAI D WORKERS	0	0	0	-		193
	01 MARKETING/ PUBLIC RELATIONS	0		0	-		193
	D2 NEW HORIZON OP	668	0	0	0	0	193
0.00	Cross Foot Adjustments						200
1.00	Negative Cost Centers						201
2.00	Cost to be allocated (per Wkst. B,	1, 726, 797	100, 236	617, 883	293, 264	392, 751	202
	Part I)						
3.00	Unit cost multiplier (Wkst. B, Part I)	23. 317449		205.823784		3. 264166	
4.00	Cost to be allocated (per Wkst. B,	212, 173	2, 190	23, 281	51, 543	8, 582	204
	Part II)						
	Unit cost multiplier (Wkst. B, Part	2.865035	0. 145825	7.755163	29. 120339	0.071325	205
5.00		1					
		1					
5.00 6.00	NAHE adjustment amount to be allocated						206
							208

	Financial Systems	ST VINCENT SAL				u of Form CMS-2552-1
COST AI	LLOCATION - STATISTICAL BASIS		Provider CC		Period: From 07/01/2018	Worksheet B-1
				-	Fo 06/30/2019	Date/Time Prepared: 11/25/2019 6:21 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY (COSTED	MEDI CAL RECORDS &	
		ADMINI STRATI ON	SUPPLY	REQUIS.)	LIBRARY	
		(DI RECT NURS.	(COSTED		(TIME SPENT)	
		HRS.) 13.00	REQUIS.) 14.00	15.00	16.00	
+	GENERAL SERVICE COST CENTERS				1	
	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP					1.0
	00400 EMPLOYEE BENEFITS DEPARTMENT					4.0
	00500 ADMI NI STRATI VE & GENERAL					5.0
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7.0
	00900 HOUSEKEEPING					9.0
10.00	01000 DI ETARY					10. 0
	01100 CAFETERIA	44 704				11.0
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	44, 706	486, 034			13. 0 14. 0
	01500 PHARMACY	0	0	100	D	15.0
	01600 MEDI CAL RECORDS & LI BRARY	0	0	(113, 545	16.0
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	10, 446	18, 128	(21, 723	30.0
	ANCI LLARY SERVICE COST CENTERS	10,440	10, 120		21,723	
	05000 OPERATING ROOM	11, 789	141, 469	(50.0
	05400 RADIOLOGY - DIAGNOSTIC	0	48, 076 0	(54.0
	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	0	0	(58. 0 60. 0
	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		-			61.0
	06500 RESPI RATORY THERAPY	0	0	(.,	65.0
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	5, 811	(66. 0 67. 0
	06800 SPEECH PATHOLOGY	0	0	(-	68.0
	06900 ELECTROCARDI OLOGY	176	0	(07200	69.0
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 135, 799	(-	70. 0 71. 0
	07200 IMPLANTABLE DEVICES CHARGED TO PATTENTS	0	84, 707	(-	71.0
	PATIENTS					
	07300 DRUGS CHARGED TO PATIENTS	0	0	100		73.0
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0	(-	74. 0 75. 0
	03950 SLEEP DI SORDER	0	0	(2,672	75.0
	07501 ADULT MENTAL HEALTH	0	0	(-	75.0
	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	1, 825	0	(3, 804	76.9
	08800 RURAL HEALTH CLINIC	0	0	(0 0	88.0
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(89.0
	09000 CLINIC 09100 EMERGENCY	0 20, 440	0 52, 044	(0 0 0 21, 940	90. 0 91. 0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	20, 440	52,044	(21, 940	92.0
	SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	44, 676	486, 034	100	0 109, 387	118. 0
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	(0 0	190. 0
191.00	19100 RESEARCH	0	0	(191. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	30	0	(4, 158	192.0
	19300 NONPALD WORKERS 19301 MARKETING/ PUBLIC RELATIONS	0	0	(193. 0 193. 0
	19302 NEW HORIZON OP	0	0	(193. 0
200.00	Cross Foot Adjustments					200. 0
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	323, 897	44 004	101 10	1 110 /10	201. 0 202. 0
202.00	Part I)	323, 097	44, 026	494, 124	113, 419	202.0
203.00	Unit cost multiplier (Wkst. B, Part I)	7. 245045	0. 090582	4, 941. 24000		203. 0
204.00	Cost to be allocated (per Wkst. B,	12, 304	962	48, 940	14, 618	204. 0
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 275220	0. 001979	489. 40000	0. 128742	205. 0
	11)		0.001777		0. 1207 12	
206.00	NAHE adjustment amount to be allocated					206. 0
	(per Wkst. B-2)					207.0
207.00	NAHE unit cost multiplier (Wkst. D,					

Health Fina	ancial Systems	ST VINCENT SA	LEM HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATI Of	N OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2018 To 06/30/2019		pared: 21 pm
			Titl€	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.		Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	TIENT ROUTINE SERVICE COST CENTERS					-	
	00 ADULTS & PEDIATRICS	2, 362, 789		2, 362, 7	89 0	0	30.00
	LLARY SERVICE COST CENTERS	0.405.000					
	00 OPERATING ROOM	2, 135, 220		2, 135, 2			
	00 RADIOLOGY - DIAGNOSTIC	2, 147, 385		2, 147, 3	85 0	-	54.00
	00 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
	00 LABORATORY	1, 856, 072		1, 856, 0	72 0	0	60.00
	00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0			0 0	0	61.00
	00 RESPI RATORY THERAPY	373, 680				0	65.00
	00 PHYSI CAL THERAPY	995, 016		995, 0		0	66.00
	00 OCCUPATIONAL THERAPY	176, 442	C	176, 4		0	67.00
	00 SPEECH PATHOLOGY	0	C)	0 0	0	68.00
	00 ELECTROCARDI OLOGY	368, 522		368, 5		0	69.00
	00 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	217, 795		217, 7		0	71.00
72.00 0720	00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	135, 802		135, 8	02 0	0	72.00
	DO DRUGS CHARGED TO PATIENTS	1, 145, 702		1, 145, 7	02 0	0	73.00
74.00 0740	DO RENAL DIALYSIS	0			0 0	0	74.00
	00 ASC (NON-DISTINCT PART)	0			0 0	0	
	50 SLEEP DI SORDER	347, 969		347, 9	69 0	0	75.01
	01 ADULT MENTAL HEALTH	687, 644		687,6		0	75.03
	P7 CARDI AC REHABI LI TATI ON	321, 567		321, 5	67 0	0	76.97
	ATIENT SERVICE COST CENTERS	-	-		T		
	00 RURAL HEALTH CLINIC	0			0 0		
	00 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
	DO CLINIC	0			0 0	0	90.00
	DO EMERGENCY	3, 369, 447		3, 369, 4		0	
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	992, 583		992, 5		0	
200.00	Subtotal (see instructions)	17, 633, 635					200. 00
201.00	Less Observation Beds	992, 583		992, 5			201.00
202.00	Total (see instructions)	16, 641, 052	C	16, 641, 0	52 0	0	202.00

Health Financial Systems	ST VINCENT SAL	EM HOSPITAL		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2018 To 06/30/2019		
			e XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient Ratio	
	6.00	7.00	8.00	9,00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	621, 697		621, 69	97		30.00
ANCI LLARY SERVICE COST CENTERS	021/07/		021/0			00100
50. 00 05000 OPERATI NG ROOM	517, 233	9, 884, 351	10, 401, 58	0. 205278	0.00000	50.00
54. 00 05400 RADIOLOGY - DIAGNOSTIC	84, 622	14, 186, 022				
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C		0 0.000000	0.000000	58.00
60. 00 06000 LABORATORY	176, 148	8, 020, 684	8, 196, 83	0. 226438	0.000000	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		0 0.000000	0.00000	61.00
65. 00 06500 RESPI RATORY THERAPY	25, 359	707, 324	732, 68	0. 510016	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	150, 560	2, 317, 046	2, 467, 60	0. 403231	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	30, 028	436, 601	466, 62	0. 378121	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0)	0 0.000000	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	8, 801	2, 100, 867	2, 109, 66	0. 174682	0.00000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C)	0 0.000000	0.00000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	132, 109	1, 335, 734	1, 467, 84	13 0. 148378	0.00000	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	108, 344	262, 936	371, 28	0. 365767	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	238, 506	4, 139, 678	4, 378, 18	0. 261684	0.00000	73.00
74.00 07400 RENAL DIALYSIS	0	C		0 0.000000		
75.00 07500 ASC (NON-DISTINCT PART)	0	C		0 0.000000		
75. 01 03950 SLEEP DI SORDER	0	946, 595			0. 000000	
75.03 07501 ADULT MENTAL HEALTH	0	1, 268, 784			0.00000	
76. 97 07697 CARDIAC REHABILITATION	0	344, 916	344, 91	0. 932305	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS	i i		1		1	-
88.00 08800 RURAL HEALTH CLINIC	0	C		0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89.00
90. 00 09000 CLINIC	0	0		0 0.00000		
91.00 09100 EMERGENCY	38, 445	10, 032, 962				
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	12, 630	376, 059			0.000000	
200.00 Subtotal (see instructions)	2, 144, 482	56, 360, 559	58, 505, 04	+ I		200.00
201.00 Less Observation Beds	2 144 400					201.00
202.00 Total (see instructions)	2, 144, 482	56, 360, 559	58, 505, 04	+ i	I	202.00

Health Financial Systems	ST VINCENT SALEM	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1314	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Pre 11/25/2019 6:	epared: 21 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
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 000000				54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000				58.00
60. 00 06000 LABORATORY	0. 000000				60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0. 000000				61.00
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 IMPLANTABLE DEVICES CHARGED TO	0.000000				72.00
PATIENTS	0.000000				12:00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
74.00 07400 RENAL DIALYSIS	0.000000				74.00
75.00 07500 ASC (NON-DI STINCT PART)	0.000000				75.00
75. 01 03950 SLEEP DI SORDER	0.000000				75.01
75.03 07501 ADULT MENTAL HEALTH	0.000000				75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000				76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89.00
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)	0.000000				200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00
	I I				1202.00

Heal th Financial Systems ST VINCENT SALEM H0SPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1314 Period: From 07/01/2018 To 06/30/2010 Part I Date/Time Prepared: 11/25/2019 6: 21 pm Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Total Costs RCE Disal I owance Total Costs RCE Disal I owance Total Costs 0
Cost Center Description Total Cost (From Wkst. B, Part I, col. 26) Therapy Limit Adj. Total Costs RCE Disal I owance Total Costs 30.00 ADULTS & PEDIATRICS 2,362,789 2,362,789 0 2,362,789 30.00 50.00 05000 [PERATI NG ROOM 2,135,220 2,135,220 0 2,135,220 50.00 50.00 50.00 05000 [PERATI NG ROOM 2,135,220 0 2,147,385 0 2,147,385 54.00 50.00 06000 LABORATORY 1,856,072 1,856,072 0 1,856,072 0 58.00 60.00 06000 LABORATORY 1,856,072 0 1,856,072 0 1,856,072 60.00 61.00 06100 PBP CLI NI CAL LAB, SERVI CE-PRGM. ONLY 0 0 0 0 65.00 65.00 065000 RESPI RATORY THERAPY 995,016 0 995,016 0 995,016 0 995,016 0 995,016 0 0 0 0 0 0 0 0 0 0 0 0 </td
Cost Center Description Total Cost (from Wist. B, Part I, col. 26) Therapy Limit Adj. Total Costs RCE Disal I owance Total Costs RCE Disal I owance Total Costs 30.00 ADULTS & PEDIATRI CS 2, 362, 789 2, 362, 789 0 2, 362, 789 30.00 30.00 OSD00 ADULTS & PEDIATRI CS 2, 362, 789 2, 362, 789 0 2, 362, 789 30.00 4NCI LLARY SERVICE COST CENTERS 2, 135, 220 2, 135, 220 0 2, 135, 220 50.00 54.00 O5000 OPERATI NG ROM 2, 135, 220 0 2, 135, 220 0 2, 135, 220 50.00 58.00 O5800 MACNETI C 2, 135, 220 0 2, 135, 220 0 6 0
Impart ENT ROUTINE SERVICE COST CENTERS Adj. Di sal I owance 30.00 ADULTS & PEDI ATRICS 2,362,789 2,362,789 0 2,362,789 30.00 30.00 OSOOO ADULTS & PEDI ATRICS 2,362,789 2,362,789 0 2,362,789 30.00 50.00 OSOOO OPERATI NG ROOM 2,135,220 2,135,220 0 2,135,220 50.00 54.00 O5400 RADI OLOGY - DI AGNOSTI C 2,147,385 2,147,385 0 2,147,385 50.00 58.00 O5800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 58.00 0 58.00 0 58.00 0 58.00 0 58.00 0 58.00 0
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 2, 362, 789 2, 362, 789 0 2, 362, 789 30. 00 ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 2, 135, 220 0 2, 135, 220 50. 00 2, 135, 220 0 2, 135, 220 50. 00 50. 00 2, 147, 385 0 2, 147, 385 0 2, 147, 385 54. 00 58. 00 0 0 0 0 0 0 58. 00 58. 00 0 0 0 0 0 58. 00 58. 00 0 <t< td=""></t<>
30. 00 03000 ADULTS & PEDIATRICS 2, 362, 789 2, 362, 789 0 2, 362, 789 30. 00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 2, 135, 220 0 2, 135, 220 50. 00 50. 00 54. 00 05400 RADI OLOGY - DI AGNOSTIC 2, 147, 385 0 2, 147, 385 0 2, 147, 385 54. 00 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 58. 00 60. 00 06000 LABORATORY 1, 856, 072 1, 856, 072 0 1, 856, 072 60. 00 61. 00 06100 PBP CLINI CAL LAB. SERVICE-PRGM. ONLY 0 0 0 0 61. 00 65. 00 06500 RESPI RATORY THERAPY 373, 680 0 373, 680 0 373, 680 65. 00 66. 00 06600 PHYSI CAL THERAPY 975, 016 0 995, 016 995, 016 0 995, 016 60. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 0 0 0 0 0 0 0<
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 135, 220 2, 135, 220 0 2, 135, 220 50.00 54.00 05400 RADIOLOGY - DIAGNOSTIC 2, 147, 385 2, 147, 385 0 2, 147, 385 54.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 60.00 06000 LABORATORY 1, 856, 072 0 1, 856, 072 0 61.00 61.00 61.00 0 <t< td=""></t<>
50.00 05000 OPERATING ROOM 2, 135, 220 2, 135, 220 0 2, 135, 220 50.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 2, 147, 385 2, 147, 385 0 2, 147, 385 54.00 58.00 05800 MACNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 58.00 60.00 06000 LABORATORY 1, 856, 072 1, 856, 072 0 1, 856, 072 60.00 61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY 0 0 0 0 61.00 65.00 06500 RESPI RATORY THERAPY 373, 680 0 373, 680 0 373, 680 0 373, 680 0 373, 680 0 373, 680 0 66.00 66.00 66.00 66.00 66.00 995, 016 0 995, 016 0 995, 016 0 995, 016 66.00 66.00 66.00 66.00 66.00 0 0 0 0 0 68.00 68.00
54.00 05400 RADIOLOGY - DIAGNOSTIC 2,147,385 2,147,385 0 2,147,385 54.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 60.00 06000 LABORATORY 1,856,072 1,856,072 0 1,856,072 60.00 61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY 0 0 0 61.00 65.00 06500 RASPI RATORY THERAPY 373,680 0 373,680 0 373,680 65.00 66.00 06600 PHYSI CAL THERAPY 995,016 0 995,016 0 995,016 0 995,016 66.00 67.00 06700 0CUPATIONAL THERAPY 176,442 0 176,442 0 176,442 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 368,522 368,522 368,522 0 368,522 69.00 0 0 0 0 0 0 <td< td=""></td<>
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 60.00 06000 LABORATORY 1,856,072 1,856,072 0 1,856,072 60.00 61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY 0 0 0 0 61.00 65.00 06500 RESPI RATORY THERAPY 373,680 0 373,680 0 373,680 65.00 66.00 06600 PHYSI CAL THERAPY 995,016 0 995,016 66.00 67.00 06700 OCUPATI ONAL THERAPY 176,442 0 176,442 0 176,442 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 368,522 368,522 368,522 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 71.00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 217,795 217,795 217,795 71.00 72.00 07200 IMPLANTABLE DEVI CES CHARGED
60.00 06000 LABORATORY 1,856,072 0 1,856,072 60.00 61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY 0 0 0 0 61.00 65.00 06500 RESPI RATORY THERAPY 373,680 0 373,680 0 373,680 0 373,680 65.00 66.00 06600 PHYSI CAL THERAPY 995,016 0 995,016 0 995,016 0 995,016 0 66.00 67.00 00 0 0 0 66.00 66.00 995,016 0 995,016 0
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY 0 0 61.00 65.00 06500 RESPI RATORY THERAPY 373, 680 0 373, 680 0 373, 680 65.00 66.00 06600 PHYSI CAL THERAPY 995, 016 0 995, 016 0 995, 016 0 995, 016 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 176, 442 0 176, 442 0 176, 442 67.00 68.00 0 0 0 0 68.00 69.00 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 368, 522 368, 522 0 368, 522 69.00 0
65.00 06500 RESPI RATORY THERAPY 373, 680 0 373, 680 0 373, 680 65.00 66.00 06600 PHYSI CAL THERAPY 995, 016 0 995, 016 0 995, 016 0 67.00 06700 OCCUPATI ONAL THERAPY 176, 442 0 176, 442 0 176, 442 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 368, 522 368, 522 0 368, 522 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 70.00 70.00 71.00 217, 795 217, 795 217, 795 71.00 72.00 72.00 135, 802 0 135, 802 72.00 135, 802 72.00 72.00 72.00 72.00 135, 802 135, 802 72.00 135, 802 72.00 72.00 135, 802 72.00 135, 802 72.00 135, 802 72.00 135, 802 72.00 135, 802 72.00 135, 802
66.00 06600 PHYSI CAL THERAPY 995, 016 0 995, 016 0 995, 016 60.00 67.00 06700 OCCUPATI ONAL THERAPY 176, 442 0 176, 442 0 176, 442 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 368, 522 368, 522 0 368, 522 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 217, 795 217, 795 0 217, 795 71.00 72.00 07200 IMPLANTABLE DEVI CES CHARGED TO 135, 802 135, 802 72.00 135, 802 72.00
67.00 06700 OCCUPATI ONAL THERAPY 176, 442 0 176, 442 0 176, 442 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 368, 522 368, 522 0 368, 522 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 217, 795 217, 795 0 217, 795 71.00 72.00 07200 IMPLANTABLE DEVI CES CHARGED TO 135, 802 135, 802 0 135, 802 72.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 368, 522 368, 522 0 368, 522 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 217, 795 0 217, 795 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 135, 802 135, 802 0 135, 802 72.00
69.00 06900 ELECTROCARDI OLOGY 368, 522 368, 522 0 368, 522 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 217, 795 217, 795 0 217, 795 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 135, 802 135, 802 0 135, 802 72.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 217,795 217,795 0 217,795 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 135,802 135,802 0 135,802 72.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 217, 795 217, 795 0 217, 795 71. 00 72. 00 07200 IMPLANTABLE DEVICES CHARGED TO 135, 802 135, 802 0 135, 802 72. 00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO 135, 802 135, 802 0 135, 802 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 145, 702 1, 145, 702 0 1, 145, 702 73. 00
74.00 07400 RENAL DIALYSIS 0 0 0 74.00
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00
75. 01 03950 SLEEP DI SORDER 347, 969 0 347, 969 0 347, 969 75. 01
75. 03 07501 ADULT MENTAL HEALTH 687, 644 687, 644 0 687, 644 75. 03
76. 97 07697 CARDI AC REHABI LI TATI ON 321, 567 0 321, 567 76. 97
OUTPATIENT SERVICE COST CENTERS
88.00 08800 RURAL HEALTH CLINIC 0 0 88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00
90. 00 09000 CLINIC 0 0 0 90. 00
91. 00 09100 EMERGENCY 3, 369, 447 0 3, 369, 447 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 992, 583 992, 583 992, 583 992, 583 992, 583
200.00 Subtotal (see instructions) 17, 633, 635 0 17, 633, 635 0 17, 633, 635 200.00
201.00 Less Observation Beds 992, 583 992, 583 992, 583 992, 583 201.00
202.00 Total (see instructions) 16, 641, 052 0 16, 641, 052 0 16, 641, 052 202.00

Health Financial Systems	ST VINCENT SAL	EM HOSPITAL		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2018 To 06/30/2019		
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	621, 697		621, 69	97		30.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	517, 233	9, 884, 351	10, 401, 58	0. 205278	0.00000	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	84, 622	14, 186, 022	14, 270, 64	0. 150476	0.000000	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C)	0 0.000000	0.000000	58.00
60. 00 06000 LABORATORY	176, 148	8, 020, 684	8, 196, 83	0. 226438	0.000000	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	C		0 0.000000	0.000000	61.00
65. 00 06500 RESPI RATORY THERAPY	25, 359	707, 324	732, 68	0. 510016	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	150, 560	2, 317, 046	2, 467, 60	0. 403231	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	30, 028	436, 601	466, 62	0. 378121	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0.000000	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	8, 801	2, 100, 867	2, 109, 60	0. 174682	0.00000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0.000000	0.00000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	132, 109	1, 335, 734	1, 467, 84	0. 148378	0.00000	71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	108, 344	262, 936	371, 28	0. 365767	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	238, 506	4, 139, 678	4, 378, 18	0. 261684	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	C)	0 0.000000	0.000000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C		0 0.000000		
75. 01 03950 SLEEP DI SORDER	0	946, 595	946, 59	0. 367601	0.000000	
75.03 07501 ADULT MENTAL HEALTH	0	1, 268, 784			0.000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	344, 916	344, 9	0. 932305	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C		0 0.000000		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0.000000		
90. 00 09000 CLINIC	0	C		0 0. 000000		
91. 00 09100 EMERGENCY	38, 445	10, 032, 962				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	12, 630	376, 059			0.000000	
200.00 Subtotal (see instructions)	2, 144, 482	56, 360, 559	58, 505, 04	11		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	2, 144, 482	56, 360, 559	58, 505, 04	11		202.00

Health Financial Systems	ST VINCENT SALEN	/ HOSPI TAL	In Lie	」 of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1314	Peri od: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared:
		Title XIX	Hospi tal	<u>11/25/2019 6:21 pm</u> Cost
Cost Center Description	PPS Inpatient		nospi tai	COST
oost oontor beschiption	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATI NG ROOM	0. 000000			50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 000000			54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
60. 00 06000 LABORATORY	0. 000000			60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0. 000000			61.00
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 PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
74.00 07400 RENAL DIALYSIS	0. 000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75.00
75. 01 03950 SLEEP DI SORDER	0. 000000			75.01
75.03 07501 ADULT MENTAL HEALTH	0. 000000			75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.00
90. 00 09000 CLI NI C	0.00000			90.00
91.00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000			92.00
200.00 Subtotal (see instructions)				200.00
201.00Less Observation Beds202.00Total (see instructions)				201.00 202.00
202.00 Total (see instructions)	1			202.00

Health Financial Systems	ST VINCENT SA	LEM HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 07/01/2018 To 06/30/2019		pared: 21 pm
		Title	e 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 ÷ co	. 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 OPERATI NG ROOM	237, 862	10, 401, 584	0. 0228	68 195, 101	4, 462	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	269, 754	14, 270, 644	0. 01890	03 9, 483	179	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000	0 00	0	58.00
60. 00 06000 LABORATORY	46, 235	8, 196, 832	0.0056	41 62, 846	355	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65. 00 06500 RESPI RATORY THERAPY	20, 991	732, 683	0. 0286	49 9, 305	267	65.00
66. 00 06600 PHYSI CAL THERAPY	30, 569	2, 467, 606	0.0123	88 20, 057	248	66.00
67.00 06700 OCCUPATI ONAL THERAPY	4, 982	466, 629	0. 0106	77 2, 712	29	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.0000			68.00
69. 00 06900 ELECTROCARDI OLOGY	57, 826	2, 109, 668	0. 0274	10 7, 468	205	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 759	1, 467, 843			141	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	2,968					72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	63, 177	4, 378, 184	0.0144	30 99, 583	1, 437	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.0000		0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000		0	75.00
75. 01 03950 SLEEP DI SORDER	15, 862	946, 595			0	75.01
75.03 07501 ADULT MENTAL HEALTH	21, 482				0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	16, 647				0	76.97
OUTPATIENT SERVICE COST CENTERS					-	
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000		0	89.00
90. 00 09000 CLINIC	0	0	0.0000		0	90.00
91. 00 09100 EMERGENCY	114, 511	10, 071, 407			0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	65,026				-	
200.00 Total (lines 50 through 199)	972, 651			490, 672		200.00
	,		•			

Health Financial Systems	ST VINCENT SAL	EM HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	VICE OTHER PASS	6 Provider C		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	
		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 RADIOLOGY - DIAGNOSTIC	0	C)	0 0	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
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	C)	0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	C)	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 PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	0	0		0 0	0	75.01
75.03 07501 ADULT MENTAL HEALTH	0	0		0 0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			1		-	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
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	U U		0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00
	-1	-		-	-	

Health Financial Systems	ST VINCENT SAU	_EM HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2018		
				To 06/30/2019	Date/Time Pre 11/25/2019 6:	pared: 21 nm
		Title	× XVIII	Hospi tal	Cost	21 piii
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	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	1		1		1	
50. 00 05000 OPERATI NG ROOM	0	0		0 10, 401, 584		1
54.00 05400 RADIOLOGY – DIAGNOSTIC	0	0		0 14, 270, 644		1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0. 000000	1
60. 00 06000 LABORATORY	0	0		0 8, 196, 832	0. 000000	
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 732, 683	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 467, 606		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 466, 629	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 2, 109, 668		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 467, 843	0. 000000	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 371, 280	0. 000000	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 4, 378, 184		
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0. 000000	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0. 000000	1
75. 01 03950 SLEEP DI SORDER	0	0		0 946, 595		
75.03 07501 ADULT MENTAL HEALTH	0	0		0 1, 268, 784		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 344, 916	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS					1	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0. 000000	1
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0. 000000	
90. 00 09000 CLINIC	0	0		0 0	0. 000000	
91.00 09100 EMERGENCY	0	0		0 10, 071, 407		1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 388, 689		1
200.00 Total (lines 50 through 199)	0	0		0 57, 883, 344		200.00

Health Financial Systems	ST VINCENT SALE	M HOSPI TAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider CO	CN: 15-1314		i od:	Worksheet D	
THROUGH COSTS					om 07/01/2018	Part IV	
				То	06/30/2019	Date/Time Pre	
		Title	XVIII		Hospi tal	11/25/2019 6: Cost	21 pm
Cost Center Description	Outpati ent	Inpati ent	I npati ent		Outpatient	Outpati ent	
	Ratio of Cost	Program	Program		Program	Program	
	to Charges	Charges	Pass-Throug	h	Charges	Pass-Through	
	(col. 6 ÷ col.	J	Costs (col.		J a J	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 OPERATING ROOM	0. 000000	195, 101		0	0	0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 000000	9, 483		0	0	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	0	58.00
60. 00 06000 LABORATORY	0. 000000	62, 846		0	0	0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY							61.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	9, 305		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	20, 057		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 712		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	7, 468		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	43, 473		0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 000000	40, 564		0	0	0	72.00
PATIENTS							
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	99, 583		0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	0	75.00
75. 01 03950 SLEEP DI SORDER	0. 000000	0		0	0	0	75.01
75.03 07501 ADULT MENTAL HEALTH	0. 000000	0		0	0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	0	89.00
90. 00 09000 CLINIC	0. 000000	0		0	0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	80		0	0	0	92.00
200.00 Total (lines 50 through 199)		490, 672		0	0	0	200. 00

Health Financial Systems	ST VINCENT SALE	EM HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider CO		Period: From 07/01/2018 To 06/30/2019	Worksheet D Part V Date/Time Pre 11/25/2019 6:	pared:
		Title	XVIII	Hospi tal	Cost	21 pili
		in the	Charges	10301 tui	Costs	
Cost Center Description	Cost to ChargeP	PS Reimbursed		Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(000 1100)	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	5		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 205278	0	2, 876, 58	8 0	0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 150476	0			0	54.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0.000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 226438	0	2, 557, 94	7 0	0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	-	_,, .	0 0	-	61.00
65. 00 06500 RESPIRATORY THERAPY	0. 510016	0	46, 58	9 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 403231	0	699, 66		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 378121	0	63, 84		0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 174682	0	1, 073, 47	°	0	69.00
70. 00 07000 ELECTROEARDFOLOGT	0. 000000	0		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 148378	0	376, 13	0	0	70.00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATTENTS	0. 365767	0	74, 87		0	72.00
PATIENTS	0. 305707	0	74, 07	/ 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 261684	0	1, 257, 95	1 83	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	0. 367601	0	356, 94	6 0	0	75.01
75.03 07501 ADULT MENTAL HEALTH	0. 541971	0	975, 98	7 0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 932305	0	159, 91	4 0	0	76.97
OUTPATIENT SERVICE COST CENTERS				-1		
88.00 08800 RURAL HEALTH CLINIC	0.000000				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 334556	0	2, 236, 55	7 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2. 553669	0	138, 35		0	92.00
200.00 Subtotal (see instructions)	2.00000/	0	17, 167, 78		-	200.00
201.00 Less PBP Clinic Lab. Services-Program		0		0 0		200.00
Only Charges				Ĭ		201.00
202.00 Net Charges (line 200 - line 201)		0	17, 167, 78	8 251	0	202. 00

Health Financial Systems	ST VINCENT SA			In Lie	u of Form CMS-2	552-1
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 Prep 11/25/2019 6:2	ared: 1 pm
			XVIII	Hospi tal	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coi ns.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS	500 500		1			
50. 00 05000 OPERATI NG ROOM	590, 500					50.00
54.00 05400 RADI OLOGY - DI AGNOSTI C	642, 978					54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	-				58.00
60. 00 06000 LABORATORY	579, 216					60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0					61. 0
65. 00 06500 RESPI RATORY THERAPY	23, 761	0				65.0
66. 00 06600 PHYSI CAL THERAPY	282, 125					66.00
67.00 06700 OCCUPATI ONAL THERAPY	24, 142	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.0
69. 00 06900 ELECTROCARDI OLOGY	187, 517	0				69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	-				70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	55, 810	0				71.0
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	27, 388	0				72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	329, 186	22				73.0
74.00 07400 RENAL DIALYSIS	0	0				74.0
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75.0
75. 01 03950 SLEEP DI SORDER	131, 214	0				75.0
75.03 07501 ADULT MENTAL HEALTH	528, 957	0				75.0
76. 97 07697 CARDI AC REHABI LI TATI ON	149,089	0				76.9
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88.0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	•			89.0
90. 00 09000 CLINIC	0	0				90.00
91. 00 09100 EMERGENCY	748, 254					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	353, 315					92.0
200.00 Subtotal (see instructions)	4, 653, 452					200.0
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201. 0
202.00 Net Charges (line 200 - line 201)	4, 653, 452	451			2	202. 00

Health Financial Systems	ST VINCENT SALE	M_HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
				From 07/01/2018	Part V	
		Component (CCN: 15-Z314	To 06/30/2019	Date/Time Pre 11/25/2019 6:	pared: 21 nm
		Title	XVIII	Swing Beds - SNF		21 μπ
			Charges		Costs	
Cost Center Description	Cost to Charge PF	PS Reimbursed	Cost	Cost	PPS Services	
	Ratio From S	ervices (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9	,	Subject To	Subject To		
			Ded. & Coi ns.	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 OPERATI NG ROOM	0. 205278	0		0 0	0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 150476	0		0 0	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 226438	0		0 0	0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0. 000000			0 0	-	61.00
65. 00 06500 RESPI RATORY THERAPY	0. 510016	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 403231	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 378121	0			0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 174682	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. 148378	0			0	71.00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATTENTS	1	0		0 0	0	
PATIENTS	0. 365767	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 261684	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	0. 367601	0		0 0	0	75.01
75.03 07501 ADULT MENTAL HEALTH	0. 541971	0		0 0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 932305	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 334556	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2. 553669	0		0 0	0	92.00
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
	· ·				1	

Health Financial Systems	ST VINCENT SA	LEM HOSPITAL		In Lie	u of Form CMS-2552	2-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1314	Peri od:	Worksheet D	
		Component	CCN: 15-Z314	From 07/01/2018 To 06/30/2019	Part V Date/Time Prepare	.ed.
		oomponent	00N. 10 2011	10 00/00/2017	11/25/2019 6: 21 p	pm
	1		XVIII	Swing Beds - SNF	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Services Subject To	Services Not Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	1			
ANCI LLARY SERVI CE COST CENTERS	0100	1.00	1			
50. 00 05000 OPERATI NG ROOM	0	C)		50	D. 00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	C			54	4.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C			58	B. 00
60. 00 06000 LABORATORY	0	C			60.	D. 00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0				61	1. 00
65. 00 06500 RESPI RATORY THERAPY	0	C			65	5.00
66. 00 06600 PHYSI CAL THERAPY	0	C			66	6.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C			67	7.00
68.00 06800 SPEECH PATHOLOGY	0	C				B. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C				9.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C				0. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C				1.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	C			72.	2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	c)		73	3.00
74.00 07400 RENAL DIALYSIS	0	C			74	4.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C			75	5.00
75. 01 03950 SLEEP DI SORDER	0	C			75	5. 01
75.03 07501 ADULT MENTAL HEALTH	0	C			75	5.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C			76	6. 97
OUTPATIENT SERVICE COST CENTERS	-					
88.00 08800 RURAL HEALTH CLINIC	0	C			88	B. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-	1		-	9.00
90. 00 09000 CLINIC	0	C				0. 00
91.00 09100 EMERGENCY	0	C	1			1.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	C				2.00
200.00 Subtotal (see instructions)	0	C				0.00
201.00 Less PBP Clinic Lab. Services-Program	0				201	1. 00
Only Charges 202.00 Net Charges (line 200 - line 201)	0	c			202	2. 00
202.00 Met charges (The 200 - The 201)	1 0	1 U	'		202	<u>.</u> . 00

11/25/2019 6:21 pm Y: \28800 - St. Vincent Salem\300 - Medicare Cost Report\20190630\HFS\20190630 Salem.mcrx

Health Financial Systems	ST VINCENT SA	LEM HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 07/01/2018 To 06/30/2019		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col.		(col. 1 - col	•		
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	154, 792	47, 746	107, 04	6 563	190.13	30.00
200.00 Total (lines 30 through 199)	154, 792		107, 04	6 563		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	2	380 380	•			30. 00 200. 00

APPORTLONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CON: 15-1314 Period: Form 07/01/2018 Period: Dest 11 Period: Dest 11 Period: Dest 11 Period: Dest 11 Worksheet D Part 11 Cost Center Description Capital Related Cost (from Wkst. B, Part 11, col. 26) Total Charges (col. 1 + col. 2) Ratio of Cost (column 4) Inpatient Cost (column 4) Cost (column 4) 50.00 05000 (PRDILORY - DI AGNOSTIC 00 05000 (PRDILORY - DI AGNOSTIC 56.00 237,862 (column 4) 10,401,584 (column 4) 0.022868 (column 4) 0 0 50.00 50.00 05000 (PRDILORY - DI AGNOSTIC 56.00 237,862 (column 4) 10,401,584 (column 4) 0.022868 (column 4) 0 0 0 50.00 (column 4) 58.00 (column 4) 66.00 06000 (PRDILORY - DI AGNOSTIC 56.00 20,991 (column 4) 14,270,644 (column 4) 0.022868 (column 4) 0 0 0 0 58.00 (column 4) 66.00 (column 4) 0 0 0 0 0 0 58.00 (column 4) 66.00 (column 4) 0 0 0 0 0 0 0 0 0 0 0 0 0	Health Financial Systems	ST VINCENT SAI	LEM HOSPITAL		In Lie	u of Form CMS-	2552-10
Cost Center Description Capital Related Cost (from Wkst. C, Dart I, col. 26) Total charges (col. 1 + col. 20) Inpatient (col. marges (col. 1 + col. 2) Capital Costs (col.mn 3 x 2) ANCILLARY SERVICE COST CENTERS 0 0 50.00 3.00 4.00 5.00 50.00 05000 (PERATI NG ROM 05000 (PERATI NG ROM 06000 (PENDICV - DI ACNOSTI C 58.00 237,862 10.401,584 0.022868 0 0 50.00 50.00 05000 (MAGNETI C RESONANCE IMAGI NG (MRI) 60.00 06000 (PBP CLINI CAL LAB. SERVICE-PRGM. ONLY 60.00 06000 (PBP CLINI CAL LAB. SERVICE-PRGM. ONLY 60.00 06000 (PBP CLINI CAL LAB. SERVICE-PRGM. ONLY 60.00 06000 (PBP CLINI CAL LAB. SERVICE-PRGM. ONLY 61.00 0 0.000000 0 58.00 60.00 06000 (PBP CLINI CAL LAB. SERVICE-PRGM. ONLY 60.00 06000 (PBP CLINI CAL LAB. SERVICE PRGM. ONLY 60.00 06000 (PECCUPATI ONAL THERAPY 9.0,569 2.467,606 0.028649 1.433 41 65.00 60.00 06000 SPEECH PATHOLOCY 7.00 07100 (ELCTROCARDI OLOGY 7.00 07300 (RUCS CHARGED TO PATIENTS 7.00 07300	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS			From 07/01/2018 To 06/30/2019	Part II Date/Time Pre	pared: 21 pm
Rel ated Cost (from Wkst. B, 26) Part II, col. 20 Program (col. 1 + col. 2) Col. umn 3 x col. umn 4) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 MODOQ OPERATI NG ROM 237, 862 10, 401, 584 0.022868 0 0 50.00 54.00 05400 RADI OLOCY - DI ACNOSTI C 269, 754 14, 270, 644 0.018903 1, 063 20 58.00 60.00 06000 LABORATORY 46, 235 8, 196, 832 0.005641 6, 387 36 60.00 66.00 61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY 46, 235 8, 196, 832 0.028649 1, 433 41 65.00 65.00 06500 RESPI RATORY THERAPY 20, 991 732, 683 0.028649 1, 433 41 65.00 66.00 00000 CUPATI ONAL THERAPY 4, 982 466, 629 0.010677 0 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 70.00 77.00 68.00 <td></td> <td></td> <td>Titl</td> <td>e XIX</td> <td>Hospi tal</td> <td>Cost</td> <td></td>			Titl	e XIX	Hospi tal	Cost	
ANCI LLARY SERVICE COST CENTERS Col.	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
Part II, col. 8) 2) 26) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS				to Charges	Program	(column 3 x	
26) 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 0PERATI NG ROM 237, 862 0.401, 584 0.022866 0 0 50.00 54.00 05400 RADI LOGY - DI AGNOSTI C 269, 754 14, 270, 644 0.018903 1, 063 20 54.00 56.00 06000 LABORATORY 0 0.000000 0 58.00 60.00 06000 LABORATORY 46, 235 8, 196, 832 0.005641 6, 387 36 60.00 65.00 06500 RESPI RATORY THERAPY 20, 991 732, 683 0.028649 1, 433 41 65.00 66.00 06600 PHYSI CAL THERAPY 30, 569 2, 467, 606 0.012388 0 0 66.00 66.70 0 66.70 0 66.70 0 66.70 0 66.70 0 66.70 0 66.70 0 66.70		(from Wkst. B,	Part I, col.	(col. 1 ÷ co	. Charges	column 4)	
ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 0.00000 00 5.00 05000 00ERATING ROM 237, 862 10, 401, 584 0.022868 0 0 50.00 54.00 05600 MAGNETI C RESONANCE I MAGING (MRI) 269, 754 14, 270, 644 0.018903 1, 063 20 54.00 58.00 06400 LABORATORY 46, 235 8, 196, 832 0.005641 6, 387 36 60.00 61.00 06500 RESPIRATORY THERAPY 20, 991 732, 683 0.028649 1, 433 41 65.00 65.00 06500 RESPIRATORY THERAPY 4, 982 466, 629 0.010677 0 67.00 68.00 64.00 0600 SPECH PATHOLOGY 0 0 0.000000 0 68.00 65.00 06500 ELECTROCARDI OLOGY 57, 826 2, 109, 668 0.027410 0 67.00 70.00 071000 ELECTROCARDI OLOGY 0		Part II, col.	8)	2)			
ANCI LLARY SERVICE COST CENTERS Image: Control of the service of the se							
50.00 05000 0PERATING ROOM 237,862 10,401,584 0.022868 0 0 50.00 54.00 05400 RADIOLOGY - DIAGNOSTI C 269,754 14,270,644 0.018903 1,063 20 54.00 65.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0 0.000000 0 0.58.00 60.00 06000 LABORATORY 46,235 8,196,832 0.005641 6,387 36 60.00 61.00 06500 RESPIRATORY THERAPY 20,991 732,683 0.028649 1,433 41 65.00 66.00 06600 PHYSI CAL THERAPY 30,569 2,467,606 0.012388 0 66.00 67.00 00 06000 SPECH PATHORY THERAPY 4,982 466,629 0.01677 0 67.00 68.00 69.00 06800 SPECH PATHOLOGY 57.826 2,109,668 0.027410 0 69.00 70.00 70.00 70.00 70.00 70.00 70.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00		1.00	2.00	3.00	4.00	5.00	
54.00 05400 RADI OLOGY - DI AGNOSTI C 269, 754 14, 270, 644 0.018903 1, 063 20 54.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0.000000 0 0 0 0.000000 0 0 58.00 60.00 06100 PBP CLI NI CAL LAB. SERVI CE-PRGM. ONLY 46, 235 8, 196, 832 0.028649 1, 433 41 65.00 65.00 06500 RESPI RATORY THERAPY 20, 991 732, 683 0.028649 1, 433 41 65.00 66.00 06500 RESPI CAL THERAPY 30, 569 2, 467, 606 0.01388 0 66.00 67.00 06700 0CUPATI ONAL THERAPY 4, 982 466, 629 0.010677 0 67.00 68.00 08600 SPEECH PATHOLOGY 0 0 0.000000 0 68.00 70.00 07100 REL CROCARDI LOGY 57, 826 2, 109, 668 0.027410 0 71.00 71.00 07100 MED CAL SUPPLIES CHARGED TO PATI ENTS 4, 759 1, 467, 843 0.003242 2, 750<							
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0.000000 0 58.00 60.00 06000 LABORATORY 46,235 8, 196,832 0.005641 6,387 36 60.00 61.00 06500 RESPI RATORY THERAPY 20,991 732,683 0.028649 1,433 41 65.00 66.00 06600 PHYSI CAL THERAPY 30,569 2,467,606 0.012388 0 0 66.00 67.00 0500 CCUPATI ONAL THERAPY 4,982 466,629 0.010677 0 67.00 68.00 68.00 6600 SPEECH PATHOLOGY 0 0 0.000000 0 68.00 69.00 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0 70.00 70.00 FLECTROENCE CHARGED TO PATI ENTS 4,759 1,467,843 0.003242 2,750 9 71.00 71.00 07300 DRUGS CHARGED TO PATI ENTS 63,177 4,378,184 0.014430 1,943 28 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0.		237, 862	10, 401, 584				
60.00 06000 LABORATORY 46, 235 8, 196, 832 0.005641 6, 387 36 60.00 61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY 20, 991 732, 683 0.028649 1, 433 41 65.00 65.00 06500 RESPIRATORY THERAPY 30, 569 2, 467, 606 0.012388 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 4, 982 466, 629 0.010677 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0.000000 0 68.00 69.00 0.000000 0 68.00 69.00 0 0.000000 0 68.00 69.00 0 0.000000 0 0 69.00 0 0.000000 0 0 70.00 71.00 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATI ENTS 4, 759 1, 467, 843 0.01430 1, 943 28 73.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATI ENTS 63, 177 4, 378, 184 0.014430 1, 943 28 73.00 74.00 </td <td>54.00 05400 RADIOLOGY – DIAGNOSTIC</td> <td>269, 754</td> <td>14, 270, 644</td> <td>0. 01890</td> <td>03 1, 063</td> <td>20</td> <td>54.00</td>	54.00 05400 RADIOLOGY – DIAGNOSTIC	269, 754	14, 270, 644	0. 01890	03 1, 063	20	54.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY 61.00 65.00 06500 RESPIRATORY THERAPY 20,991 732,683 0.028649 1,433 41 65.00 66.00 06500 RESPIRATORY THERAPY 30,569 2,467,606 0.012388 0 0 66.00 67.00 0CCUPATIONAL THERAPY 4,982 466,629 0.010677 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0.000000 0 68.00 69.00 0ECORDELECTROCARDIOLOGY 57,826 2,109,668 0.027410 0 69.00 70.00 OTOOD ELECTROENCEPHALOGRAPHY 0 0 0.000000 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4,759 1,467,843 0.003242 2,750 9 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 63,177 4,378,184 0.014430 1,943 28 73.00 74.00 OASOO ASC (NON-DISTINCT PART) 0 0 0.0000000 0 75.01 0	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000	0 00	0	58.00
65.00 06500 RESPI RATORY THERAPY 20,991 732,683 0.028649 1,433 41 65.00 66.00 06600 PHYSI CAL THERAPY 30,569 2,467,606 0.012388 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 4,982 466,629 0.010677 0 0 67.00 68.00 06800 SPECH PATHOLOGY 0 0.000000 0 68.00 69.00 06900 ELECTROCARDI OLOGY 57,826 2,109,668 0.027410 0 69.00 70.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 4,759 1,467,843 0.003242 2,750 9 71.00 72.00 O7200 IMPLANTABLE DEVI CES CHARGED TO 2,968 371,280 0.007994 0 72.00 72.00 73.00 ORUGS CHARGED TO PATI ENTS 63,177 4,378,184 0.014430 1,943 28 73.00 74.00 O7400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75.01 O3950 SLEEP DI SORDER 15,862 946,595	60. 00 06000 LABORATORY	46, 235	8, 196, 832	0.0056	41 6, 387	36	60.00
66.00 06600 PHYSI CAL THERAPY 30, 569 2, 467, 606 0.012388 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 4, 982 466, 629 0.010677 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0.000000 0 68.00 69.00 06900 ELECTROCARDI OLOGY 57, 826 2, 109, 668 0.027410 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 4, 759 1, 467, 843 0.003242 2, 750 9 71.00 72.00 07200 IMPLANTABLE DEVI CES CHARGED TO 2, 968 371, 280 0.007994 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 63, 177 4, 378, 184 0.014430 1, 943 28 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0 75.01 75.01 03950 SLEEP DI SORDER 15, 862	61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
67.00 06700 0CCUPATI ONAL THERAPY 4,982 466,629 0.010677 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0.000000 0 68.00 69.00 06900 ELECTROCARDI OLOGY 57,826 2,109,668 0.027410 0 0 69.00 70.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 4,759 1,467,843 0.003242 2,750 9 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 2,968 371,280 0.007994 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 63,177 4,378,184 0.014430 1,943 28 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75.01 03950 SLEEP DI SORDER 15,862 946,595 0.016757 0 75.01 75.01 76.97 CARDI AC REHABI LI TATI ON 16,647 344,916 0.048264 0 75.01 75.03 07501 ADULT MENTAL HEALTH 21,482 1,268,784 <td>65. 00 06500 RESPI RATORY THERAPY</td> <td>20, 991</td> <td>732, 683</td> <td>0. 0286</td> <td>49 1, 433</td> <td>41</td> <td>65.00</td>	65. 00 06500 RESPI RATORY THERAPY	20, 991	732, 683	0. 0286	49 1, 433	41	65.00
68.00 06800 SPEECH PATHOLOGY 0 0 0.00000 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 57,826 2,109,668 0.027410 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.00000 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 4,759 1,467,843 0.003242 2,750 9 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 2,968 371,280 0.007994 0 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 63,177 4,378,184 0.014430 1,943 28 73.00 74.00 74.00 REMAL DI ALYSI S 0 0 0.000000 0 75.00 75.01 03950 SLEEP DI SORDER 15,862 946,595 0.016757 0 0 75.03 76.97 CAGDI AC REHABI LI TATI ON 16,647 344,916 0.048264 0 0 75.03 76.97 CAGDI AC REHABI LI TATI ON	66. 00 06600 PHYSI CAL THERAPY	30, 569	2, 467, 606	0. 0123	38 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY 57, 826 2, 109, 668 0.027410 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 4, 759 1, 467, 843 0.003242 2, 750 9 71.00 72.00 07200 IMPLANTABLE DEVI CES CHARGED TO 2, 968 371, 280 0.007994 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 63, 177 4, 378, 184 0.014430 1, 943 28 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75.01 03950 SEEP DI SORDER 15, 862 946, 595 0.016757 0 75.01 75.03 07501 ADULT MENTAL HEALTH 15, 862 946, 595 0.016757 0 75.03 76.97 OAGPATI ENT SERVICE COST CENTERS 15, 647 344, 916 0.048264 0 0 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0.0	67.00 06700 OCCUPATI ONAL THERAPY	4, 982	466, 629	0. 0106	77 0	0	67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0.000000 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 4,759 1,467,843 0.003242 2,750 9 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 2,968 371,280 0.007994 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 63,177 4,378,184 0.014430 1,943 28 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.00 75.01 03950 SLEEP DI SORDER 15,862 946,595 0.016757 0 0 75.03 76.97 0.400 0 0.443.91 0 0 76.97 0017697 CARDI AC REHABILITATION 16,647 344,916 0.048264 0 76.97 0017697<	68.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0 00	0	68.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 4,759 1,467,843 0.003242 2,750 9 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 2,968 371,280 0.007994 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 63,177 4,378,184 0.014430 1,943 28 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.01 75.01 03950 SLEEP DI SORDER 15,862 946,595 0.016757 0 0 75.01 75.03 07501 ADULT MENTAL HEALTH 21,482 1,268,784 0.016931 0 0 75.03 76.97 OARDI AC REHABILITATION 16,647 344,916 0.48264 0 0 76.97 00 08900 RURAL HEALTH CLINIC 0 0 0.000000 0 88.00 94.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 99.	69.00 06900 ELECTROCARDI OLOGY	57, 826	2, 109, 668	0. 0274	10 0	0	69.00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO 2,968 371,280 0.007994 0 0 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 63,177 4,378,184 0.014430 1,943 28 73.00 74. 00 07400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.00 03950 SLEEP DI SORDER 15,862 946,595 0.016757 0 0 75.01 07607 CARDI AC REHABILI TATI ON 16,647 344,916 0.048264 0 0 76.97 00TPATI ENT SERVICE COST CENTERS 5 0 0 0.000000 0 76.97 000000 08900 RURAL HEALTH CLINIC 0 0 0.000000 0 88.00 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 89.00 90.00 09000 CLINIC	70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000	0 00	0	70.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO 2,968 371,280 0.007994 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 63,177 4,378,184 0.014430 1,943 28 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.00 03950 SLEEP DI SORDER 15,862 946,595 0.016757 0 0 75.01 75.01 03950 SLEEP DI SORDER 15,862 946,595 0.016757 0 0 75.03 76.97 07697 (CARDI AC REHABILI TATI ON 16,647 344,916 0.048264 0 0 76.97 0UTPATI ENT SERVICE COST CENTERS 9 0 0.000000 0 0 88.00 88.00 08900 FURAL HEALTH CLINIC 0 0 0.000000 0 89.00 90.00 09000 CLINIC <	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 759	1, 467, 843	0.0032	42 2, 750	9	71.00
PATI ENTS PATI ENTS PATI ENTS PATI ENTS PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 63, 177 4, 378, 184 0.014430 1, 943 28 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75.01 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.01 03950 SLEEP DI SORDER 15, 862 946, 595 0.016757 0 0 75.01 75.03 07501 ADULT MENTAL HEALTH 21, 482 1, 268, 784 0.016791 0 0 75.03 76.97 CARDI AC REHABI LI TATI ON 16, 647 344, 916 0.048264 0 0 76.97 OUTPATI ENT SERVICE COST CENTERS VUTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0 88.00 88.00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0.000000 0 89.00 90.00 09000 CLINI C	72.00 07200 IMPLANTABLE DEVICES CHARGED TO	2,968	371, 280	0.0079			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 63,177 4,378,184 0.014430 1,943 28 73.00 74.00 07400 RENAL DIALYSIS 0 0 0.000000 0 0 74.00 75.01 03950 SLEEP DI SORDER 15,862 946,595 0.016757 0 0 75.01 75.03 07501 ADULT MENTAL HEALTH 21,482 1,268,784 0.016757 0 0 75.03 76.97 07697 CARDIAC REHABILITATION 16,647 344,916 0.048264 0 0 76.97 0 08900 RURAL HEALTH CLINIC 0 0 0.000000 0 88.00 88.00 08900 RURAL HEALTH CLINIC 0 0 0.000000 0 88.00 90.00 09000 EDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 88.00 91.00 09000 CLINIC 0 0 0.000000 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.0							
75.00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.00 75.01 03950 SLEEP DI SORDER 15,862 946,595 0.016757 0 0 75.01 75.03 07501 ADULT MENTAL HEALTH 21,482 1,268,784 0.016931 0 0 75.03 76.97 07697 CARDI AC REHABILITATION 16,647 344,916 0.048264 0 0 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0 88.00 88.00 08900 FUBRALLY QUALI FIED HEALTH CENTER 0 0 0.000000 0 89.00 90.00 09000 CLINIC 0 0 0.000000 0 90.00 91.00 09100 EMERGENCY 114,511 10,071,407 0.011370 4,783 54 91.00 92.00 0B200 OBSERVATI ON BEDS (NON-DI STINCT PART) 65,026 388,689 0.167296 3,759 629 92.00	73.00 07300 DRUGS CHARGED TO PATIENTS	63, 177	4, 378, 184	0.0144	30 1, 943	28	73.00
75.01 03950 SLEEP DI SORDER 15,862 946,595 0.016757 0 0 75.01 75.03 07501 ADULT MENTAL HEALTH 21,482 1,268,784 0.016931 0 0 75.03 76.97 07697 CARDI AC REHABILI TATI ON 16,647 344,916 0.048264 0 0 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0 88.00 88.00 08900 RURAL HEALTH CLINIC 0 0.000000 0 88.00 99.00 09000 CLINIC 0 0 0.000000 0 90.00 91.00 09100 EMERGENCY 114,511 10,071,407 0.011370 4,783 54 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 65,026 388,689 0.167296 3,759 629 92.00	74.00 07400 RENAL DIALYSIS	0	0	0.0000	0 00	0	74.00
75.01 03950 SLEEP DI SORDER 15,862 946,595 0.016757 0 0 75.01 75.03 07501 ADULT MENTAL HEALTH 21,482 1,268,784 0.016931 0 0 75.03 76.97 07697 CARDI AC REHABILI TATI ON 16,647 344,916 0.048264 0 0 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0 88.00 88.00 08900 RURAL HEALTH CLINIC 0 0.000000 0 88.00 99.00 09000 CLINIC 0 0 0.000000 0 90.00 91.00 09100 EMERGENCY 114,511 10,071,407 0.011370 4,783 54 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 65,026 388,689 0.167296 3,759 629 92.00	75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	0 00	0	75.00
76. 97 07697 CARDI AC REHABILITATION 16, 647 344, 916 0.048264 0 0 76. 97 OUTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0 0 88.00 88.00 08900 RURAL HEALTH CLINIC 0 0 0.000000 0 88.00 90.00 09000 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 89.00 90.00 09000 CLINIC 0 0 0.000000 0 90.00 91.00 09100 EMERGENCY 114, 511 10, 071, 407 0.011370 4, 783 54 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 65, 026 388, 689 0.167296 3, 759 629 92.00		15, 862	946, 595	0. 0167	57 0	0	75.01
76. 97 07697 CARDI AC REHABILITATION 16, 647 344, 916 0.048264 0 0 76. 97 OUTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0 0 88.00 88.00 08900 RURAL HEALTH CLINIC 0 0 0.000000 0 89.00 90.00 09000 FLDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 89.00 90.00 09000 CLINIC 0 0 0.000000 0 90.00 91.00 09100 EMERGENCY 114, 511 10, 071, 407 0.011370 4, 783 54 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 65, 026 388, 689 0.167296 3, 759 629 92.00	75.03 07501 ADULT MENTAL HEALTH	21, 482	1, 268, 784	0. 01693	31 0	0	75.03
OUTPATI ENT_SERVICE_COST_CENTERS 88.00 08800 RURAL_HEALTH_CLINIC 0 0.000000 0 88.00 89.00 08900 FEDERALLY_QUALIFIED_HEALTH_CENTER 0 0 0.000000 0 89.00 90.00 09000 CLINIC 0 0 0.000000 0 90.00 91.00 09100 EMERGENCY 114, 511 10, 071, 407 0.011370 4, 783 54 91.00 92.00 09200 OBSERVATI ON_BEDS (NON-DI STINCT PART) 65, 026 388, 689 0.167296 3, 759 629 92.00	76. 97 07697 CARDI AC REHABI LI TATI ON				64 0	0	76.97
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0 00 89.00 90.00 09000 CLINIC 0 0 0.000000 0 90.00 90.00 91.00 09100 EMERGENCY 114,511 10,071,407 0.011370 4,783 54 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 65,026 388,689 0.167296 3,759 629 92.00							
90. 00 09000 CLINIC 0 0 0.00000 0 90. 00 90. 00 91. 00 09100 EMERGENCY 114, 511 10, 071, 407 0.011370 4, 783 54 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 65, 026 388, 689 0.167296 3, 759 629 92. 00	88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	88.00
91. 00 09100 EMERGENCY 114, 511 10, 071, 407 0. 011370 4, 783 54 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 65, 026 388, 689 0. 167296 3, 759 629 92. 00	89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	0.0000	0 00	0	89.00
91. 00 09100 EMERGENCY 114, 511 10, 071, 407 0. 011370 4, 783 54 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 65, 026 388, 689 0. 167296 3, 759 629 92. 00		0	0			0	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 65, 026 388, 689 0. 167296 3, 759 629 92. 00		114, 511	10, 071, 407			54	•
							•

Health Financial Systems	ST VINCENT SA	LEM HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COS			Period: From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 6:	
	_		e XIX	Hospi tal	Cost	
Cost Center Description			Allied Healt	h Allied Health	All Other	
	Post-Stepdown		Post-Stepdow	n Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	C	0)	0 0	0	30.00
200.00 Total (lines 30 through 199)	C	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpati ent	
	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C	0 0	56	3 0.00	2	30.00
200.00 Total (lines 30 through 199)		0	56	3	2	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	C					30.00
200.00 Total (lines 30 through 199)	C					200.00
	1	1				

Health Financial Systems	ST VINCENT SALE	EM HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	VICE OTHER PASS	Provider C		Period: From 07/01/2018 To 06/30/2019		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Non Physician N	lursi ng School	Nursing Schoo	Allied Health	Allied Health	
	Anesthetist I	Post-Stepdown	-	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	C		0 0	0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	C		0 0	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
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	C		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	C		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 PATI ENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
74. 00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	0	0		0 0	0	75.01
75. 03 07501 ADULT MENTAL HEALTH	0	0		0 0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			1	-		
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
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	0		0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	e e e e e e e e e e e e e e e e e e e	200.00
			1	-1 0	, v	0

Health Financial Systems	ST VINCENT SA	LEM HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C	CN: 15-1314	Period:	Worksheet D	
THROUGH COSTS				From 07/01/2018 To 06/30/2019		pared.
					11/25/2019 6:	21 pm
			e XIX	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
	4.00	5.00	and 4)	7.00	0.00	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	0	0		0 10 401 504	0,000000	
50. 00 05000 OPERATING ROOM	0			0 10, 401, 584		
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0		0 14, 270, 644		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	1
	0	0		0 8, 196, 832	0. 000000	1
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY					0.000000	61.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 732, 683		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 467, 606		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 466, 629		1
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	1
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 2, 109, 668		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.00000	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 467, 843		
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 371, 280	0. 000000	72.00
				0 4 270 104	0,000000	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 4, 378, 184		1
74.00 07400 RENAL DIALYSIS	0	0		0 0	0.00000	
75. 00 07500 ASC (NON-DI STI NCT PART) 75. 01 03950 SLEEP DI SORDER	0	0			0.00000	
	0	0		0 946, 595		1
75. 03 07501 ADULT MENTAL HEALTH 76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 1, 268, 784 0 344 916		1
	0	0	4	0 344, 916	0.00000	/0.9/
0UTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0.00000	88.00
89. 00 08800 FEDERALLY QUALIFIED HEALTH CENTER	0				0.000000	1
90. 00 099001 EDERALET GOALTTED HEALTT CENTER	0	0			0.000000	
91. 00 09100 EMERGENCY	0			0 10, 071, 407		1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 388, 689		
200.00 Total (lines 50 through 199)	0	0		0 57, 883, 344		200.00
	0	1 0	1	0 57,005,344	1	1200.00

Health Financial Systems	ST VINCENT SALE	M HOSPITAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider CO	CN: 15-1314		ri od:	Worksheet D	
THROUGH COSTS					om 07/01/2018	Part IV	
				То	06/30/2019	Date/Time Pre	
		Ti †I	e XIX		Hospi tal	11/25/2019 6: Cost	21 piii
Cost Center Description	Outpati ent	Inpatient	I npati ent		Outpatient	Outpati ent	
	Ratio of Cost	Program	Program		Program	Program	
	to Charges	Charges	Pass-Throug	h	Charges	Pass-Through	
	(col. 6 ÷ col.	J	Costs (col.		J	Costs (col. 9	
	7)		x col. 10)			x col. 12)	
	9.00	10.00	11.00		12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0. 000000	0		0	0	0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 000000	1, 063		0	0	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	0	58.00
60. 00 06000 LABORATORY	0. 000000	6, 387		0	0	0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY							61.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 433		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	2, 750		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	1, 943		0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0		0	0	0	75.00
75. 01 03950 SLEEP DI SORDER	0. 000000	0		0	0	0	75.01
75.03 07501 ADULT MENTAL HEALTH	0. 000000	0		0	0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	0	88.00
89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0.000000	0		0	0	0	89.00
90. 00 09000 CLINIC	0.000000	0		0	0	0	90.00
91.00 09100 EMERGENCY	0.000000	4, 783		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	3, 759		0	0	0	92.00
200.00 Total (lines 50 through 199)		22, 118		0	0	0	200. 00

	Financial Systems ST VINCENT SALEM ATION OF INPATIENT OPERATING COST	HOSPITAL Provider CCN: 15-1314		u of Form CMS-2 Worksheet D-1	
COMPUT	ATTON OF INPATIENT OPERATING COST	Provider CCN: 15-1314	Period: From 07/01/2018 To 06/30/2019		pared:
		Title XVIII	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	c oveluding newborn)		838	1.00
2.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			563	•
3.00	Private room days (excluding swing-bed and observation bed da		ivate room days,	0	3.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		221	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	125	•
(00	reporting period	am dava) aftar Daaambar	21 of the east	105	6 00
6.00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	un days) arter December	31 OF THE COST	125	6.00
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	13	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	1 of the cost	12	8.00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	swing-bed and	117	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	103	10.00
11 00	through December 31 of the cost reporting period (see instruc			100	11 00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		oom days) arter	102	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XL	X only (including privat	e room days)	0	12.00
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including privat	e room davs)	0	13.00
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lir	ne)		
14.00 15.00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	
16.00	Nursery days (title V or XIX only)			0	•
17 00	SWING BED ADJUSTMENT	an through December 21 a	f the east		17.00
17.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through becember 31 c	n the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost		18.00
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	the cost	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	129.14	20.00
21.00	reporting period Total general inpatient routine service cost (see instruction	s)		2, 362, 789	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	1 679	24.00
	7 x line 19)		51 (
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	1, 550	25.00
26.00	Total swing-bed cost (see instructions)			728, 802	
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		1, 633, 987	27.00
28.00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	· Lipo 28)		0 0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	÷ 111e 28)		0.000000	
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 mi		ctions)	0.00	
35.00 36.00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	1
36.00 37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	1, 633, 987	•
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PART IT - HUSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJI	USTMENTS			1
				2 002 20	38.00
38.00	Adjusted general inpatient routine service cost per diem (see			2, 902. 29	
38.00 39.00 40.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	38)		2, 902. 29 339, 568 0	39.00

MPUTATION OF TW	PATIENT OPERATING COST		Provider C	CN: 15-1314	Peri od:	Worksheet D-1	2552 1
					From 07/01/2018 To 06/30/2019		
			Titl∈	XVIII	Hospi tal	Cost	p
Cost	Center Description	Total Inpatient Costl	Total Inpatient Days			Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4)	+
.00 NURSERY (t	tle V & XIX only)						42.
	Care Type Inpatient Hospital	Uni ts		1			
00 I NTENSI VE							43
. 00 CORONARY C	ARE UNIT SIVE CARE UNIT						44
	VTENSIVE CARE UNIT						40
	AL CARE (SPECIFY)						47
Cost	Center Description			•			
00 Drogram in	ationt and llong convice cos	t (Wkat D 2 and 2	Line 200)			1.00	10
	patient ancillary service cos ram inpatient costs (sum of l			ns)		118, 422 457, 990	
	H COST ADJUSTMENTS			113)		437,770	<u> </u>
	gh costs applicable to Progra	m inpatient routine s	services (from	Wkst. D, su	m of Parts I and	0	50
)						-	
	gh costs applicable to Progra	m inpatient ancillary	y services (fr	om Wkst. D,	sum of Parts II	0	51
and IV) .00 Total Prog	ram excludable cost (sum of I	ines 50 and 51)				0	52
	ram inpatient operating cost		lated, non-phy	sician anest	hetist, and	0	
	ucation costs (line 49 minus	line 52)				L	
	INT AND LIMIT COMPUTATION						
.00 Program dis .00 Target amo	scnarges unt per discharge					0. 00	
5	unt (line 54 x line 55)					0.00	
U U	between adjusted inpatient c	perating cost and ta	rget amount (I	ine 56 minus	line 53)	0	
	ent (see instructions)					0	
	ines 53/54 or 55 from the co	st reporting period of	endi ng 1996, ι	pdated and c	ompounded by the	0.00	59
.00 Lesser of	ket ines 53/54 or 55 from prior	vear cost report up	dated by the m	arkat haskat		0.00	60
	/54 is less than the lower of				the amount by	0.00	
	ating costs (line 53) are les				2		
	ne 56), otherwise enter zero	(see instructions)			-		
	nent (see instructions)	novment (and instru	ati ana)			0	
	npatient cost plus incentive PATIENT ROUTINE SWING BED COS					0	1 03
	wing-bed SNF inpatient routin		mber 31 of the	cost report	ing period (See	298, 936	64
	ns)(title XVIII only)						
	wing-bed SNF inpatient routin	e costs after Decembe	er 31 of the c	ost reportin	g period (See	296, 034	65
	ns)(title XVIII only) care swing-bed SNF inpatient	routine costs (line (64 nlus line 6	5)(title XVI	ll only) For	594, 970	66
	nstructions)			0)((1110),(11	in only). Tor	0,1,,,,0	
	XIX swing-bed NF inpatient r	outine costs through	December 31 c	f the cost r	eporting period	0	67
(line 12 x							
1.00 Title V or (line 13 x	XIX swing-bed NF inpatient r	outine costs atter De	ecember 31 or	the cost rep	orting period	0	68
	e V or XIX swing-bed NF inpat	ient routine costs (I	line 67 + line	68)		0	69
	SKILLED NURSING FACILITY, OT						
	rsing facility/other nursing	5)		70
, , , , , , , , , , , , , , , , , , , ,	eneral inpatient routine serv		ıne 70 ÷ line	2)		l	71
Ű	utine service cost (line 9 x necessary private room cost a		(line 14 v li	ne 35)		1	72
, , , , , , , , , , , , , , , , , , , ,	ram general inpatient routine						74
9	ated cost allocated to inpat		,		Part II, column	l	75
26, line 4							_
	apital-related costs (line 75 pital-related costs (line 9 x					l	76
0	routine service cost (line 74					1	78
· ·	charges to beneficiaries for		rovider record	s)		1	79
	ram routine service costs for				nus line 79)		80
	routine service cost per diem		、 、				81
	routine service cost limitati					l	82
	inpatient routine service co patient ancillary services (s	•	5)			1	83
5	review - physician compensa		ns)			1	85
	ram inpatient operating costs					<u> </u>	86
PART IV - 0	COMPUTATION OF OBSERVATION BE	D PASS THROUGH COST					
	rvation bed days (see instruc	tions)				342	
	eneral inpatient routine cost	non diam (11 07	Line 2			2, 902. 29	88

Health Financial Systems	ST VINCENT S	ALEM	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provider CC		Peri od:	Worksheet D-1	
					From 07/01/2018 To 06/30/2019		
		_	Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Rc	outine Cost	column 1 ÷	Total	Observati on	
		(fr	rom 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	154, 79	2	2, 362, 789	0.0655	2 992, 583	65, 026	90.00
91.00 Nursing School cost		0	2, 362, 789	0.0000	992, 583	0	91.00
92.00 Allied health cost		0	2, 362, 789	0.0000	992, 583	0	92.00
93.00 All other Medical Education		0	2, 362, 789	0.0000	992, 583	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1314	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Pre 11/25/2019 6:3	
		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			838	1.0
. 00	Inpatient days (including private room days, excluding swing-			563	2.0
. 00	Private room days (excluding swing-bed and observation bed day	ys). If you nave only pr	rivate room days,	0	3.0
. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ad davis)		221	4.0
. 00	Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	125	4. C
. 00	reporting period	ull days) thi ough becenbe	er st of the cost	120	5.0
. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	125	6.0
. 00	reporting period (if calendar year, enter 0 on this line)	on days) arter becenber	ST OF the cost	125	
. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	13	7.0
	reporting period				
. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	12	8.0
	reporting period (if calendar year, enter 0 on this line)	5.			
. 00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	2	9.
	newborn days)		-		
0.00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days)	0	10.
	through December 31 of the cost reporting period (see instruc				
1.00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days) after	0	11.
	December 31 of the cost reporting period (if calendar year, en			-	
2.00	Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including privat	te room days)	0	12.
	through December 31 of the cost reporting period				10
3.00	Swing-bed NF type inpatient days applicable to titles V or XI.			0	13.
4.00	after December 31 of the cost reporting period (if calendar yo Medically necessary private room days applicable to the Progra			0	14.
4.00 5.00	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	
6.00	Nursery days (title V or XIX only)			0	
0.00	SWING BED ADJUSTMENT			0	10.
7.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 (of the cost		17.
/. 00	reporting period	es thi ough becomber of t			
8.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18.
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	f the cost	129.14	19.
	reporting period	-			
0.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of 1	the cost	129.14	20.
	reporting period				
1.00	Total general inpatient routine service cost (see instruction			2, 362, 789	
2.00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ting period (line	0	22.
	5 x line 17)				
3.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.0
4 00	x line 18)	- 21 -6 +6++		1 (70	24
4.00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	i si or the cost reporti	ng period (line	1, 679	24.
5.00		21 of the cost reporting	n poriod (line 9	1, 550	25.
5.00	Swing-bed cost applicable to NF type services after December : x line 20)	si or the cost reporting		1, 550	∠⊃.
	Total swing-bed cost (see instructions)			728, 802	26.
6.00					

	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	1, 633, 987	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 902. 29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5, 805	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)	5, 805	41.00

	Financial Systems FATION OF INPATIENT OPERATING COST	ST VINCENT SAL		CCN: 15-1314	Period:	u of Form CMS- Worksheet D-1	
COMPUT	ATTON OF INPATIENT OPERATING COST		Provider C	UN: 15-1314	From 07/01/2018 To 06/30/2019		epared:
					Hospi tal	Cost	1
	Cost Center Description	Total Inpatient Cost	Total Inpatient 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	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Unit:	S I		1			1
43.00	INTENSIVE CARE UNIT						43.00
44.00 45.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.00
45.00	SURGICAL INTENSIVE CARE UNIT						45.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
49.00	Program inpatient ancillary service cost (W	ket D 2 col 2	Line 200)			1.00 14,452	2 48.00
48.00 49.00	Total Program inpatient costs (sum of lines			nns)		20, 257	
17.00	PASS THROUGH COST ADJUSTMENTS			5113)		20,207	
50.00	Pass through costs applicable to Program in	patient routine :	services (fro	n Wkst. D, sun	n of Parts I and	C	50.00
						_	
51.00	Pass through costs applicable to Program in and IV)	patient ancillar	y services (fi	rom Wkst. D, s	sum of Parts II	C	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				C	52.00
53.00	Total Program inpatient operating cost excl		lated, non-ph	ysician anesth	netist, and	0	
	medical education costs (line 49 minus line	52)					
F 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 55.00	Program discharges Target amount per discharge					0. 00	
56.00	Target amount (line 54 x line 55)					0.00	
57.00	Difference between adjusted inpatient opera	ting cost and ta	rget amount (line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	-	-			C	
59.00	Lesser of lines 53/54 or 55 from the cost r	eporting period	endi ng 1996, i	updated and co	ompounded by the	0.00	59.0
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report up	dated by the	market hasket		0.00	60.00
61.00	If line 53/54 is less than the lower of lin				the amount by	0.00	
	which operating costs (line 53) are less th						
	amount (line 56), otherwise enter zero (see	instructions)					
62.00	Relief payment (see instructions)		-+:)			0	
63.00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	ctions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine co	sts through Dece	mber 31 of the	e cost reporti	ng period (See	C	64.00
	instructions)(title XVIII only)	0			0 1 1		
65.00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the o	cost reportino	g period (See	C	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ing costs (ling)	64 nlus line	65)(+i+l_o_XVII	Lonly) For	C	66.00
00.00	CAH (see instructions)				i oniy). Toi		00.00
67.00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	of the cost re	eporting period	C	67.00
	(line 12 x line 19)					_	
68.00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after D	ecember 31 of	the cost repo	orting period	C	68.00
69.00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		C	69.00
07100	PART III - SKILLED NURSING FACILITY, OTHER			,			
70.00	Skilled nursing facility/other nursing faci	2		• •)		70.00
71.00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71.00
72.00 73.00	Program routine service cost (line 9 x line	,	(lipo 14 v li	1 DO 2E)			72.00
74.00	Medically necessary private room cost appli Total Program general inpatient routine ser						74.00
75.00	Capital -related cost allocated to inpatient				Part II, column		75.00
	26, line 45)						1
76.00	Per diem capital-related costs (line 75 ÷ l						76.00
77.00 78.00	Program capital -related costs (line 9 x lin						77.0
78.00	Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce		rovi der i record	ds)			78.0
80.00	Total Program routine service costs for com				nus line 79)		80. 0
81. 00	Inpatient routine service cost per diem lim	•		-			81.0
82.00	Inpatient routine service cost limitation (82.0
83.00	Reasonable inpatient routine service costs	•	s)				83.00
84.00 85.00	Program inpatient ancillary services (see i		ns)				84. 0 85. 0
85.00	Utilization review - physician compensation Total Program inpatient operating costs (su						85.00
55.00	PART IV - COMPUTATION OF OBSERVATION BED PA		. sagn 00)				- 55. 00
87.00	Total observation bed days (see instruction	s)				342	
88.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (s	•	line 2)			2, 902. 29 992, 583	
89.00							

Health Financial Systems	ST VINCENT	SALEN	1 HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provider CC		Period: From 07/01/2018	Worksheet D-1	
					To 06/30/2019	Date/Time Pre 11/25/2019 6:	
			Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	R	outine Cost	column 1 ÷	Total	Observati on	
		(fi	rom 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	154, 7	'92	2, 362, 789	0. 06551	2 992, 583	65, 026	90.00
91.00 Nursing School cost		0	2, 362, 789	0.0000	992, 583	0	91.00
92.00 Allied health cost		0	2, 362, 789	0.0000	992, 583	0	92.00
93.00 All other Medical Education		0	2, 362, 789	0.00000	992, 583	0	93.00

^{11/25/2019 6:21} pm Y: \28800 - St. Vincent Salem\300 - Medicare Cost Report\20190630\HFS\20190630 Salem.mcrx

Health Financial Systems ST VINCENT SAL	EM HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1314	Peri od:	Worksheet D-3	
			From 07/01/2018		nonod.
			To 06/30/2019	11/25/2019 6:	
	Title	e XVIII	Hospi tal	Cost	21 pm
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		1	1	1	
30. 00 03000 ADULTS & PEDI ATRI CS			122, 321		30.00
ANCI LLARY SERVI CE COST CENTERS		0.0050		10.050	
50.00 OSOOO OPERATING ROOM		0. 2052			
54.00 O5400 RADIOLOGY - DIAGNOSTIC		0. 1504			1
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000		, s	
		0. 2264			
61.00 O6100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0.5100			
66. 00 06600 PHYSI CAL THERAPY		0.4032			66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 3781			1
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0.0000		0	
70. 00 07000 ELECTROCARDI OLOGY		0. 1746 0. 0000		1, 305 0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1483		-	
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 1483			
73. 00 07200 DRUGS CHARGED TO PATIENTS		0. 2616			
74. 00 07400 RENAL DIALYSIS		0. 2010		20, 039	•
75. 00 07500 ASC (NON-DI STI NCT PART)		0.0000		0	•
75. 01 03950 SLEEP DI SORDER		0.3676		0	•
75. 03 07501 ADULT MENTAL HEALTH		0. 5419		0	•
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 9323		, o	
OUTPATIENT SERVICE COST CENTERS		0.7020	50 0	<u> </u>	10.77
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90. 00 09000 CLINIC		0.0000		0	
91. 00 09100 EMERGENCY		0. 3345		0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2. 5536		204	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			490, 672	118, 422	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)	,		490, 672		202.00
-					

Health Financial Systems	ST VINCENT SALEM HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
	Component	CCN: 15-Z314	From 07/01/2018 To 06/30/2019		narod
	component	CCN. 15-2514	10 00/30/2019	11/25/2019 6:	
	Titl	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
ANCI LLARY SERVICE COST CENTERS					00.00
50. 00 05000 OPERATI NG ROOM		0. 2052	78 0	0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC		0. 1504	6 8, 700	1, 309	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000	0 0	0	58.00
60. 00 06000 LABORATORY		0. 22643		6, 451	
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0.0000		0	61.00
65. 00 06500 RESPI RATORY THERAPY		0.51001			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 40323			
67.00 06700 OCCUPATI ONAL THERAPY		0. 37812			
68.00 06800 SPEECH PATHOLOGY		0.0000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 17468			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0.1483			
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 36576		0 9,649	
74. 00 07400 RENAL DIALYSIS		0. 20100		9, 849	
75. 00 07500 ASC (NON-DI STINCT PART)		0.00000		0	
75. 01 03950 SLEEP DI SORDER		0.36760		0	75.00
75. 03 07501 ADULT MENTAL HEALTH		0. 54197		0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 93230		-	76.97
OUTPATIENT SERVICE COST CENTERS			-		
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00	0	89.00
90. 00 09000 CLINIC		0.0000	0 0	0	90.00
91. 00 09100 EMERGENCY		0. 33455		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2. 55366		0	92.00
200.00 Total (sum of lines 50 through 94 and 96			189, 877	60, 899	200.00
201.00 Less PBP Clinic Laboratory Services-Prog	gram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		I	189, 877	I	202.00

Health Financial Systems ST	VINCENT SALEM HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1314	Period:	Worksheet D-3	
			From 07/01/2018 To 06/30/2019		narad
			10 00/ 30/ 2019	11/25/2019 6:	
	Ti tl	e XIX	Hospi tal	Cost	<u> </u>
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		1	1	I	
30. 00 03000 ADULTS & PEDI ATRI CS			22, 729		30.00
ANCI LLARY SERVI CE COST CENTERS				-	
50.00 05000 OPERATING ROOM		0. 2052		-	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 1504			•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	
60.00 06000 LABORATORY		0. 2264		1, 446	
61. 00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0.5100			
66. 00 06600 PHYSI CAL THERAPY		0.4032		0	
67.00 06700 OCCUPATIONAL THERAPY		0. 3781		0	071.00
68. 00 06800 SPEECH PATHOLOGY		0.0000		0	00.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1746		0	
70.00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.1483			
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3657 0. 2616		0 508	
74.00 07400 RENAL DIALYSIS		0.2010			
75. 00 07500 ASC (NON-DI STINCT PART)		0.0000		0	
75. 01 03950 SLEEP DI SORDER		0. 3676			
75. 03 07501 ADULT MENTAL HEALTH		0. 5419			
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 9323		Ű	
OUTPATIENT SERVICE COST CENTERS		0.9323	00	0	/0.9/
88. 00 08800 RURAL HEALTH CLINIC		0.0000	0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90. 00 09000 CLINIC		0.0000		0	
91. 00 09100 EMERGENCY		0. 3345			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2. 5536			92.00
200.00 Total (sum of lines 50 through 94 and 96 t	hrough 98)	2.0000	22, 118		200.00
201.00 Less PBP Clinic Laboratory Services-Progra			0		201.00
202.00 Net charges (line 200 minus line 201)			22, 118		202.00
······································		I.		I	

	Financial Systems ST VINCENT SALEM ATION OF REIMBURSEMENT SETTLEMENT	/ HOSPITAL Provider CCN: 15-1314	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
CALCUL	ATTON OF REIMBORSEMENT SETTLEMENT	Provider CCN. 15-1314	From 07/01/2018	Part B	narodi
			To 06/30/2019	Date/Time Pre 11/25/2019 6:	
		Title XVIII	Hospi tal	Cost	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			4, 653, 903	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		0	2.00
3.00	OPPS payments			0	3.00
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 instru	uctions)		0.000	4.01 5.00
6.00	Line 2 times line 5			0.000	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)	1)/ apl 12 Line 200		0	8.00
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	TV, COL. 13, TTHE 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4, 653, 903	
	COMPUTATION OF LESSER OF COST OR CHARGES				1
12.00	Reasonable charges Ancillary service charges			0	12.00
12.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	12.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	
	Customary charges				1
15.00	Aggregate amount actually collected from patients liable for		0	0	15.00
16.00	Amounts that would have been realized from patients liable fo 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	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete on	lyifline 18 exceeds li	ne 11) (see	0	19.00
20. 00	instructions) Excess of reasonable cost over customary charges (complete on	lvifline 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)			, i i i i i i i i i i i i i i i i i i i	20.00
21.00	Lesser of cost or charges (see instructions)			4, 700, 442	
22.00 23.00	Interns and residents (see instructions)	ructions)		0	22.00 23.00
23.00	Cost of physicians' services in a teaching hospital (see inst Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructions)			23.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	
25.00	Deductibles and coinsurance amounts (for CAH, see instruction			49, 085	25.00
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on lin Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	-		2, 958, 277 1, 693, 080	26.00 27.00
27.00	instructions)	prus the suit of Triles 22		1, 093, 000	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, I			0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 693, 080 804	
	Subtotal (line 30 minus line 31)			1, 692, 276	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			877, 210 570, 187	34.00 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		804, 134	
37.00	Subtotal (see instructions)			2, 262, 463	
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00 39.01	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00 39.01
39.50	Pioneer ACO demonstration payment adjustment (see instruction	is)			39.50
39. 97	Demonstration payment adjustment amount before sequestration	-		0	39.97
39.98				0	39.98
39.99 40.00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 2, 262, 463	39.99 40.00
40.01	Sequestration adjustment (see instructions)			45, 249	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
	Interim payments			2, 417, 310	1
42.00 43.00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			-200, 096	42.00 43.00
44.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR			0	
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90.00 91.00
92.00	The rate used to calculate the Time Value of Money				92.00
93.00				0	
	Total (sum of lines 91 and 93)			ı 0	94.00

 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 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 ADJUSTMENTS TO PROVIDER 		XVIII t Part A Amount 2.00 321,13	mm/dd/yyyy 3.00	Cost t B 4.00 2,235,510 0	1. 0 2. 0 3. 0
 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 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 ADJUSTMENTS TO PROVIDER 	mm/dd/yyyy	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00 2,235,510	2.0
 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 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 ADJUSTMENTS TO PROVIDER 		2.00	3. 00	4.00 2,235,510	2.0
 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 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 ADJUSTMENTS TO PROVIDER 	1.00		3. 00	2, 235, 510	2.0
 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 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 ADJUSTMENTS TO PROVIDER 		321, 13			2.0
for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER					
ADJUSTMENTS TO PROVIDER					
3			0 01/18/2019	181, 800	3.0
			0	0	3.0
			0	0	3. 0 3. 0
5			0	0	3.0
			0	0	3.4
Provider to Program					
ADJUSTMENTS TO PROGRAM			0	0	3.5
2			0	0	3.5 3.5
3			0	0	3.5
1			0	0	3.5
9 Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	181, 800	3. 9
3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		321, 13	32	2, 417, 310	4.0
appropriate) TO BE COMPLETED BY CONTRACTOR					
 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 					5.0
Program to Provider			_		
TENTATI VE TO PROVIDER			0	0	5. (5. (
3			0	0	5.0
Provider to Program					
D TENTATIVE TO PROGRAM			0	0	5.5
			0	0	5. ! 5. !
Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.9
5.50-5.98) Determined net settlement amount (balance due) based on					6.
the cost report. (1) SETTLEMENT TO PROVIDER		04 / 4	0	0	
I SETTLEMENT TO PROVIDER 2 SETTLEMENT TO PROGRAM		94, 61	0	200, 096	6. 6.
) Total Medicare program liability (see instructions)		415, 75	50	2, 217, 214	7.
)	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Conception	CN: 15-1314 CCN: 15-Z314	Period: From 07/01/2018 To 06/30/2019	Date/Time Pre	pared
		Title	e XVIII	Swing Beds - SN	11/25/2019 6: F Cost	21 pm
			it Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
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 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		543, 6		000	1. (2. (3. (
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01 02 03 04 05 49	ADJUSTMENTS TO PROVIDER			0 0 0 0 0		3. (3. (3. (3. (3. (3. (3. (
49	Provider to Program			0	0	3.4
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51 52 53 54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0 0 0 0		3. 3. 3. 3. 3.
99 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		E42 6	0	0	3. 4.
00	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		543, 6	50	0	4.
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.
01	TENTATI VE TO PROVIDER			0	0	5.
02 03				0	0	5. 5.
	Provider to Program					
50 51 52 99	TENTATIVE TO PROGRAM			0 0 0	0 0 0 0 0	5. 5. 5. 5.
99 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on					5. 6.
DU D1	the cost report. (1) SETTLEMENT TO PROVIDER		105, 5 ⁻	10	0	0. 6.
51 52 50	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		649, 1	0	0	6. 7.
			•	Contractor Number	NPR Date (Mo/Day/Yr)	,.
	Name of Contractor	(2	1.00	2.00	8.

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1314	Period: From 07/01/2018	Worksheet E-2	
		Component CCN: 15-Z314	To 06/30/2019	Date/Time Pre 11/25/2019 6:	pare 21 n
		Title XVIII	Swing Beds - SNF	Cost	- p
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient routine services - swing bed-SNF (see instructions)		600, 920	0	
00	Inpatient routine services - swing bed-NF (see instructions)		(1.500	0	2.
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins		61, 508	0	3.
00	Per diem cost for interns and residents not in approved teaching			0.00	4
00	instructions)			0.00	
00	Program days		205	0	5
00	Interns and residents not in approved teaching program (see ins	structions)		0	6
00	Utilization review - physician compensation - SNF optional meth	hod only	0		7
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		662, 428	0	8
00	Primary payer payments (see instructions)		0	0	9
00	Subtotal (line 8 minus line 9)		662, 428	0	
00	Deductibles billed to program patients (exclude amounts application	able to physician	0	0	11
00	professional services)			-	1
. 00	Subtotal (line 10 minus line 11)		662, 428	0	
. 00	Coinsurance billed to program patients (from provider records) for physician professional services)	(exclude collisurance	0	0	13
. 00	80% of Part B costs (line 12 x 80%)			0	14
. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 14	4)	662, 428	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	.,	002, 120	0	
50	Pioneer ACO demonstration payment adjustment (see instructions))		-	16
. 55	Rural community hospital demonstration project (§410A Demonstra		0		16
	adjustment (see instructions)				
. 99	Demonstration payment adjustment amount before sequestration		0	0	16
. 00	Allowable bad debts (see instructions)		0	0	
01	Adjusted reimbursable bad debts (see instructions)		0	0	
00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)	0	0	
00	Total (see instructions)		662, 428	0	
01	Sequestration adjustment (see instructions)		13, 249	0	
02	Demonstration payment adjustment amount after sequestration)		E 42 ((0	0	
00	Interim payments		543, 660	0	
. 00 . 00	Tentative settlement (for contractor use only) Balance due provider/program (line 19 minus lines 19.01, 20, au	nd 21)	105, 519	0	
00	Protested amounts (nonallowable cost report items) in accordance	-	105, 519	0	
. 00	chapter 1, §115.2		Ŭ	0	20
	Rural Community Hospital Demonstration Project (§410A Demonstra	ation) Adjustment			
0. 00	Is this the first year of the current 5-year demonstration peri				200
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
1.00	Medicare swing-bed SNF inpatient routine service costs (from W	kst. D-1, Pt. II, line			201
2 00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from	What D 2 col 2 lin	0		202
2.00	200 (title XVIII swing-bed SNF))	WKST. D-3, COL. 3, TTH	e		202
3 00	Total (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)				204
	Computation of Demonstration Target Amount Limitation (N/A in 1	first year of the curre	nt 5-year demonst	ration	
	peri od)				
	Medicare swing-bed SNF target amount				205
5.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 tin				206
1 00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse		1		1207
	Program reimbursement under the §410A Demonstration (see instru Medicare swing hed SNE inpatient service costs (from West E 2		1		207
J. UU	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, and 3)	, cor. r, sum or rines			208
9 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209
	Reserved for future use				210
	Comparision of PPS versus Cost Reimbursement				1
	Total adjustment to Medicare swing-bed SNF PPS payment (line 20				215

	Financial Systems ST VINCENT SA ATION OF REIMBURSEMENT SETTLEMENT	ALEM HOSPITAL Provider CCN: 15-1314	Peri od:	u of Form CMS-2 Worksheet E-3	
ALCOL			From 07/01/2018 To 06/30/2019	Part V Date/Time Pre 11/25/2019 6:	pare
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIC			1.00	
. 00	Inpatient services	ARE FART A SERVICES - COST	KLIWDUKJEWENI	457, 990	1 1.
. 00	Nursing and Allied Health Managed Care payment (see instru	ictions)		437, 770	
. 00	Organ acqui si ti on			0	1
. 00	Subtotal (sum of lines 1 through 3)			457, 990	4.
. 00	Primary payer payments			0	5.
. 00	Total cost (line 4 less line 5). For CAH (see instructions	5)		462, 570	6.
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.0	Reasonable charges				
. 00	Routine service charges			0	
. 00 . 00	Ancillary service charges Organ acquisition charges, net of revenue			0	
0.00	Total reasonable charges			0	
0.00	Customary charges			0	1 10.
1.00	Aggregate amount actually collected from patients liable f	for payment for services on	a charge basis	0	1 11.
2.00	Amounts that would have been realized from patients liable			0	12.
	had such payment been made in accordance with 42 CFR 413.1		0		
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	
4.00	Total customary charges (see instructions)			0	
5.00	Excess of customary charges over reasonable cost (complete	e only if line 14 exceeds li	ne 6) (see	0	15
< 00	instructions)	anly if line (avagada lir	14) (222	0	14
6.00	Excess of reasonable cost over customary charges (complete instructions)	only if the 6 exceeds iff	le 14) (see	0	16.
7.00	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	17.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	1
8.00	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	18.
9.00	Cost of covered services (sum of lines 6, 17 and 18)			462, 570	19.
0. 00	Deductibles (exclude professional component)			39, 206	
1.00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			423, 364	
3.00 4.00	Coinsurance			0	
4.00 5.00	Subtotal (line 22 minus line 23) Allowable bad debts (exclude bad debts for professional se	rvicos) (soo instructions)		423, 364 1, 340	
5.00 6.00	Adjusted reimbursable bad debts (see instructions)			871	
7.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		1, 340	
B. 00	Subtotal (sum of lines 24 and 25, or line 26)			424, 235	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see instruct	i ons)		0	
9. 99	Demonstration payment adjustment amount before sequestrati	on		0	29
0. 00	Subtotal (see instructions)			424, 235	
D. 01	Sequestration adjustment (see instructions)			8, 485	
0. 02		on		0	
1.00	Interim payments			321, 132	
2.00	Tentative settlement (for contractor use only)			0	32
3.00	Balance due provider/program (line 30 minus lines 30.01, 3		abantan 1	94, 618	
4.00	Protested amounts (nonallowable cost report items) in accc §115.2	pruance with CMS Pub. 15-2,	chapter I,	0	34

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1314	Peri od:	Worksheet E-3	2552-10	
			From 07/01/2018 To 06/30/2019		pared: 21 pm	
		Title XIX	Hospi tal	Cost		
			Inpati ent	Outpatient		
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	DVICES FOR TITLES V OR Y		2.00		
	COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR A	IN SERVICES		-	
1.00	Inpatient hospital/SNF/NF services		20, 257		1 1.00	
2.00	Medical and other services			0	2.00	
3.00	Organ acquisition (certified transplant centers only)		0		3.00	
4.00	Subtotal (sum of lines 1, 2 and 3)		20, 257	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)		20, 257	0		
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		20, 237	0	7.00	
	Reasonable Charges					
8.00	Routi ne servi ce charges		22, 729		8.00	
9.00	Ancillary service charges		22, 118	0	9.00	
10.00	Organ acquisition charges, net of revenue		0		10.00	
11.00	Incentive from target amount computation		0		11.00	
12.00	Total reasonable charges (sum of lines 8 through 11)		44, 847	0	12.00	
13.00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment fo	r sorvicos on a chargo	0	0	13.00	
13.00	basis	i services on a charge	0	0	13.00	
14.00	Amounts that would have been realized from patients liable fo	r payment for services o	n 0	0	14.00	
	a charge basis had such payment been made in accordance with					
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00	
16.00	Total customary charges (see instructions)		44, 847	0		
17.00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	24, 590	0	17.00	
18.00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds lin		0	18.00	
18.00	16) (see instructions)	i y 11 11ne 4 exceeds 11n	e 0	0	10.00	
19.00	Interns and Residents (see instructions)		0	0	19.00	
20.00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	1	
21.00	Cost of covered services (enter the lesser of line 4 or line		20, 257	0	21.00	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi				
22.00	Other than outlier payments		0	0		
23.00	Outlier payments		0	0		
24.00 25.00	Program capital payments Capital exception payments (see instructions)		0		24.00	
26.00	Routine and Ancillary service other pass through costs		0	0		
27.00	Subtotal (sum of lines 22 through 26)		0	0	1	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	1	
29.00	Titles V or XIX (sum of lines 21 and 27)		20, 257	0	29.00	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	、	0	0		
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	20, 257	0		
32.00	Deducti bl es Coi nsurance		0	0		
	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 an	20, 257	0	1		
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00		
38.00	Subtotal (line 36 ± line 37)		20, 257	0		
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)		20, 257	0		
41.00	Interim payments Balance due provider/program (line 40 minus line 41)		20, 257	0		
10 00		0	0	42.00		
42.00 43.00						

nd-t				Peri od:	Worksheet G	
ly)	ype accounting records, complete the General Fund column			From 07/01/2018 To 06/30/2019		
		General Fund	Specific Purpose Func		Plant Fund	
		1.00	2.00	3.00	4.00	-
00	Cash on hand in banks	19, 333		0 0	0	1.
00	Temporary investments	0		0 0	0	
00	Notes receivable	0		0 0	0	3
00	Accounts receivable	5, 832, 691		0 0	0) 4
00	Other receivable	954, 107		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	-3, 434, 721		0 0	0	
00	Inventory	341, 101		0 0	0	
00	Prepaid expenses	153, 134		0 0	0	
00	Other current assets Due from other funds	32, 798		0 0	0	
00	Total current assets (sum of lines 1-10)	3, 898, 443		0 0		
00	FIXED ASSETS	5, 070, 445		0 0	0	
00	Land	180, 000		0 0	0	12
00	Land improvements	0		0 0	0	13
00	Accumulated depreciation	0		0 0	0	14
	Bui I di ngs	1, 975, 974		0 0	0	
	Accumulated depreciation	-509, 579		0 0	0	
00	Leasehold improvements	859, 079		0 0	0	
	Accumulated depreciation	-858, 243		0 0	0	
	Fixed equipment Accumulated depreciation	1, 869, 764 -635, 117		0 0	0	
	Automobiles and trucks	-035, 117		0 0	0	
-	Accumulated depreciation	0		0 0	0	
	Major movable equipment	2, 551, 062		0 0	0	
	Accumulated depreciation	-1, 658, 718		0 0	0	
00	Minor equipment depreciable	0		0 0	0	25
00	Accumulated depreciation	0		0 0	0	
	HIT designated Assets	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Minor equipment-nondepreciable	0		0 0		
00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	3, 774, 222		0 0	0	30
00	Investments	0		0 0	0	31
00	Deposits on Leases	0		0 0	0	
00	Due from owners/officers	0		0 0	0	33
00	Other assets	0		0 0	0	34
. 00	Total other assets (sum of lines 31-34)	0		0 0	0	35
00	Total assets (sum of lines 11, 30, and 35)	7, 672, 665		0 0	0	36
	CURRENT LI ABI LI TI ES			-	-	
	Accounts payable	504, 719		0 0	-	
00 00	Salaries, wages, and fees payable Payroll taxes payable	227, 463 0		0 0	0	
	Notes and Loans payable (short term)	0			0	
	Deferred income	0		0 0	0	
	Accelerated payments	0				42
. 00	Due to other funds	1, 360, 564		0 0	0	43
. 00	Other current liabilities	1, 442, 348		0 0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	3, 535, 094		0 0	0	45
	LONG TERM LIABILITIES		1			.
	Mortgage payable	0		0 0	-	
00 00	Notes payable Unsecured Loans	0		0 0	0	
	Other long term liabilities	0			0	
	Total long term liabilities (sum of lines 46 thru 49)	0		0 0	0	
	Total liabilities (sum of lines 45 and 50)	3, 535, 094		0 0		
	CAPI TAL ACCOUNTS					1
00	General fund balance	4, 137, 571				52
	Specific purpose fund			0	l	53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0	1	55
	Governing body created - endowment fund balance			0	-	56
00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
		4, 137, 571		0 0	0	59
. 00	Total fund balances (sum of lines 52 thru 58)					

	Financial Systems	ST VINCENT SALE			In Lie	u of Form CMS-2	2552-10
STATEN	STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1314	Period: From 07/01/2018 To 06/30/2019	Worksheet G-1 Date/Time Pre 11/25/2019 6:	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		3, 495, 661		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2, 541, 747				2.00
3.00 4.00	Total (sum of line 1 and line 2)	0	6, 037, 408		0	0	3.00 4.00
	Additions (credit adjustments) (specify)	12, 870			0	0	
5.00 6.00	Rel eased capital Donation	7,434			0	0	5.00 6.00
7.00	Grant revenue	9,000			0	0	7.00
7.00 8.00	ROUNDING	7,000			0	0	8.00
9.00		0			0	0	
10.00	Total additions (sum of line 4-9)	0	29, 306		0	-	10.00
11.00	Subtotal (line 3 plus line 10)		6,066,714		0		11.00
12.00	Transfer from Affiliates	1, 846, 416	0,000,714		0	0	12.00
13.00		1, 040, 410			0	0	13.00
14.00	Released Capital	12, 870			0	o o	
15.00	Released Operating	69, 857			0	0	
16.00		0			0	0	
17.00	Rounding	0			0	0	17. OC
18.00	Total deductions (sum of lines 12-17)		1, 929, 143		0		18.00
19.00	Fund balance at end of period per balance		4, 137, 571		0		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	Additions (credit adjustments) (specify)				0		
4.00			0		0		4.00
5.00	Rel eased capi tal		0		0		5.00
5.00 6.00	Released capital Donation		0		0		5.00 6.00
5.00 6.00 7.00	Released capital Donation Grant revenue		0 0 0				5.00 6.00 7.00
5.00 6.00 7.00 8.00	Released capital Donation		0				5.00 6.00 7.00 8.00
5.00 6.00 7.00 8.00 9.00	Released capital Donation Grant revenue ROUNDING		0 0 0				5.00 6.00 7.00 8.00 9.00
5.00 6.00 7.00 8.00 9.00 10.00	Released capital Donation Grant revenue ROUNDING Total additions (sum of line 4-9)	0	0 0 0		0		5.00 6.00 7.00 8.00 9.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00	Released capital Donation Grant revenue ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0	0 0 0 0				5.00 6.00 7.00 8.00 9.00 10.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Released capital Donation Grant revenue ROUNDING Total additions (sum of line 4-9)	0 0	0 0 0 0 0		0		5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Released capital Donation Grant revenue ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer from Affiliates	0 0	0 0 0 0 0 0 0		0		4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	Released capital Donation Grant revenue ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer from Affiliates Released Capital	0 0			0		5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	Released capital Donation Grant revenue ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer from Affiliates	0 0			0		5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Released capital Donation Grant revenue ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer from Affiliates Released Capital Released Operating	0 0			0		5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Released capital Donation Grant revenue ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer from Affiliates Released Capital Released Operating Rounding	0 0			0 0		5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Released capital Donation Grant revenue ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer from Affiliates Released Capital Released Operating	0 0			0		5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00

	Financial Systems	-		HOSPI TAL		1 1 1 1 1 1 1		_
STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES)		Provi de	r cur	N: 15-1314		e
								0
							1.	Č
	Cost Center Description					Inpatient	t	Γ
	·					1.00		Г
	PART I – PATIENT REVENUES							
	General Inpatient Routine Services							
1.00	Hospi tal					2, 570,	746	,
2.00	SUBPROVIDER - IPF							
3.00	SUBPROVIDER - IRF							
4.00	SUBPROVI DER							
5.00	Swing bed - SNF						С	1
6.00	Swing bed - NF						С	1
7.00	SKILLED NURSING FACILITY							
8.00	NURSING FACILITY							
								1

	General Inpatient Routine Services			
1.00	Hospi tal	2, 570, 746	2, 570, 746	1.00
2.00	SUBPROVIDER - IPF			2.00
3.00	SUBPROVIDER - IRF			3.00
4.00	SUBPROVI DER			4.00
5.00	Swing bed - SNF	0	0	5.00
6.00	Swing bed - NF	0	0	6.00
7.00	SKILLED NURSING FACILITY			7.00
8.00	NURSING FACILITY			8.00
9.00	OTHER LONG TERM CARE			9,00
10.00	Total general inpatient care services (sum of lines 1-9)	2, 570, 746	2, 570, 746	
10.00	Intensive Care Type Inpatient Hospital Services	2, 370, 740	2, 370, 740	10.00
11.00	INTENSIVE CARE UNIT			11.00
12.00	CORONARY CARE UNIT			12.00
12.00	BURN INTENSIVE CARE UNIT			13.00
13.00	SURGICAL INTENSIVE CARE UNIT			13.00
15.00	OTHER SPECIAL CARE (SPECIFY)			15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	0	0	16.00
17 00	11-15)	2 570 744	0 570 744	17 00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2, 570, 746	2, 570, 746	
18.00	Ancillary services	1, 467, 094 44, 042, 3		18.00
19.00	Outpatient services	51, 075 10, 390, 1		
20.00	RURAL HEALTH CLINIC	0	0 0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0 0	21.00
22.00	HOME HEALTH AGENCY			22.00
23.00	AMBULANCE SERVICES			23.00
24.00	СМНС			24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)			25.00
26.00	HOSPICE			26.00
27.00	OTHER (SPECIFY)	0	0 0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	4, 088, 915 54, 432, 4	58, 521, 332	28.00
	G-3, line 1)			
	PART II - OPERATING EXPENSES			
29.00	Operating expenses (per Wkst. A, column 3, line 200)	17, 163, 9	51	29.00
30.00	ADD (SPECIFY)	0		30.00
31.00		0		31.00
32.00		0		32.00
33.00		0		33.00
34.00		0		34.00
35.00		0		35.00
36.00	Total additions (sum of lines 30-35)		0	36.00
37.00	DEDUCT (SPECIFY)	0	Ŭ	37.00
38.00		0		38.00
39.00		0		39.00
40.00		0		40.00
40.00		0		40.00
	Total deductions (sum of lines 27 41)			41.00
42.00	Total deductions (sum of lines 37-41)	17 1/2 0	1	
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	17, 163, 9		43.00
	to Wkst. G-3, line 4)	I I	I	I

In Lieu of Form CMS-2552-10 Worksheet G-2 Parts I & II Date/Time Prepared: 11/25/2019 6:21 pm

Total

3.00

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

Outpatient 2.00

Heal th	Financial Systems	ST VINCENT SALEM	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES Provide			Provider CCN:	15-1314	Period: From 07/01/2018 To 06/30/2019	Worksheet G-3 Date/Time Pre 11/25/2019 6:	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	58, 521, 332	1.00				
2.00	Less contractual allowances and discounts on patients' accounts						2.00
3.00	Net patient revenues (line 1 minus line 2)		39, 284, 493 19, 236, 839	3.00			
4.00	Less total operating expenses (from Wkst. G-	-2, Part II, line 4	43)			17, 163, 951	4.00
5.00	Net income from service to patients (line 3	minus line 4)	,			2, 072, 888	5.00
	OTHER INCOME						
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					926	7.00
8.00	Revenues from telephone and other miscellane	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	1.00 Rebates and refunds of expenses						
12.00	Parking lot receipts					0	12.00
13.00	Revenue from Laundry and Linen service					0	13.00
14.00	Revenue from meals sold to employees and gue	ests				54, 607	14.00
15.00	Revenue from rental of living quarters					0	15.00
	Revenue from sale of medical and surgical su		nan patients			0	16.00
	Revenue from sale of drugs to other than pat					0	17.00
18.00	Revenue from sale of medical records and abs					19, 604	
	Tuition (fees, sale of textbooks, uniforms,					0	19.00
	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					324, 014	
23.00	Governmental appropriations					0	23.00
24.00	OTHER (SPECIFY)					0	24.00
24.02	Net Assets Released from Restriction					69, 857	
	Grant Revenue					9, 469	
	Unclaimed Property Exemptions					-9, 618	
	. ,					468, 859	
	Total (line 5 plus line 25)					2, 541, 747	26.00
27.00	OTHER EXPENSES (SPECIFY)					0	27.00
	Total other expenses (sum of line 27 and sub					0	28.00
29.00	Net income (or loss) for the period (line 20	5 minus line 28)			ļ	2, 541, 747	29.00