Health Financial Systems	ST. VINCENT WILLIAMSPORT HOSP			of Form CMS-2552-10
This report is required by law (42 USC 1395g; payments made since the beginning of the cost				FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST AND SETTLEMENT SUMMARY	REPORT CERTIFICATION Provider	CCN: 15-1307	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/25/2019 11:32 am
PART I - COST REPORT STATUS				
Provider 1. [X] Electronically filed co			Date: 11/25/20	019 Time: 11:32 am
use only 2. [] Manually submitted cost 3. [0] If this is an amended r 4. [F] Medicare Utilization. E	report eport enter the number of times nter "F" for full or "L" for low	the provider re /.	esubmitted this co	ost report
use only (1) As Submitted 7. (2) Settled without Audit 8.	Date Received: Contractor No. [N]Initial Report for this Pr [N]Final Report for this Prov	11. Covider CCN 12. [r Code: 4 lumn 1 is 4: Enter es reopened = 0-9.
PART II - CERTIFICATION				
MISREPRESENTATION OR FALSIFICATION OF ANY INFO ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMED PROVIDED OR PROCURED THROUGH THE PAYMENT DIREC ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMED	IT UNDER FEDERAL LAW. FURTHERMO CTLY OR INDIRECTLY OF A KICKBACK	RE, IF SERVICES	IDENTIFIED IN TH	IS REPORT WERE
CERTIFICATION BY CHIEF FINANCIAL OFFI	CER OR ADMINISTRATOR OF PROVIDER	?(S)		
I HEREBY CERTIFY that I have read the electronically filed or manually subm Expenses prepared by ST. VINCENT WILL 07/01/2018 and ending 06/30/2019 and correct, complete and prepared from t instructions, except as noted. I fur provision of health care services, an compliance with such laws and regulat	tted cost report and the Balance AMSPORT HOSPITAL (15-1307) for to the best of my knowledge and ne books and records of the prov ther certify that I am familiar d that the services identified i ons.	the Sheet and Sta or the cost repo- belief, this re rider in accorda with the laws a n this cost rep	tement of Revenue orting period begi port and statemen ince with applicab and regulations re port were provided	and nning t are true, le garding the in
[]I have read and agree with the a signature on this certification				
	(Si gned)			
	0f	ficer or Adminis	strator of Provide	er(s)
	Title			

			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	20, 374	126, 386	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	16, 093	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		59, 070		0	10.00
10.01	RURAL HEALTH CLINIC II	0		96, 062		0	10.01
200.00	Total	0	36, 467	281, 518	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.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi c	ler CCN: 1	15-1307	Period: From 07/01/ To 06/30/		Workshe Part I Date/Ti 11/25/2	me Pre	epare
	1.00	2.00		3.00		4	. 00			
~~	Hospital and Hospital Health Care Co									
00 00	Street: 412 NORTH MONROE City: WILLIAMSPORT	PO Box: State: IN	Zin Cod	e: 47993	Coup	ty: WARREN				1.
00	CITY. WILLIAWSFORT	Component Name	CCN	CBSA	Provi der		Payme	nt Syst	em (P	<u> </u>
			Number	Number	Type	Certi fi ed		, 0, or		
							V	XVIII		1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componen			1		I		1		
00	Hospi tal	ST. VINCENT WILLIAMSPORT HOSPITAL	151307	99915	1	07/01/1966	Ν	0	0	3.
00	Subprovider - IPF	WILLIAMSPORT HUSPITAL								4.
00	Subprovider - IRF									5.
00	Subprovider - (Other)									6
00	Swing Beds - SNF	ST. VINCENT	15Z307	99915		02/01/1988	Ν	0	N	7
		WILLIAMSPORT SWING BEDS								
00	Swing Beds - NF									8
00	Hospital-Based SNF									9
00	Hospital-Based NF									10
00 00	Hospi tal -Based OLTC Hospi tal -Based HHA									11
00	Separately Certified ASC									13
00	Hospi tal -Based Hospi ce									14
00		NORTH CLINIC	153993	99915		05/06/2001	Ν	0	N	15
01	Hospital-Based Health Clinic - RHC	SOUTH CLINIC	153994	99915		08/01/2001	Ν	0	N	15
	11									
00	Hospital-Based Health Clinic - FQHC									16
00	Hospital-Based (CMHC) I									17
00	Renal Dialysis									18
. 00	Other					Erom:		To	:	19
. 00	jotner					From: 1.00		To 		- 19
00	Cost Reporting Period (mm/dd/yyyy)					1.00 07/01/20	018		00	20
00	-					1.00	018	2. (00	20
00	Cost Reporting Period (mm/dd/yyyy)				1.00	1.00 07/01/20 1)18	2.(06/30/	00 /2019	20
00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)				1.00	1.00 07/01/20	018	2. (00 /2019	20
00 00	Cost Reporting Period (mm/dd/yyyy)	currently receiving pay	ments for		1.00 N	1.00 07/01/20 1)18	2.(06/30/	00 /2019	20 21
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00 00 00 01 02 03	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) Does this facility qualify and is it 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 Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft 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.	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column	th 42 CFF this ndment s for thi for no f October 1 of the c uctions) sated car "Y" for on or aff urban to stical ar "N" for r r 1. Ente e cost uctions) 9 beds (a 3, "Y" for	s for cost re is) yes .er yes .er o reas no er	N	1.00 07/01/20 1 2.00 N N	018	2.0 06/30, 3.0	00/2019	20 21 22 22 22 22 22
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SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA I	Provider CC	N: 15-1307	Period: From 07/C	1/2018	Worksh Part I	eet S-2	2
				To 06/3	0/2019	Date/T	ime Pre 2019 11	
	In-State Medicaid paid days	l n-State Medi cai d el i gi bl e unpai d days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medi ca HMO da	id C ys Mee)ther di cai d days	
00 L6 this growings is an LDDC baseled, onton the	1.00	2.00	3.00	4.00	5.00		6.00	
 .00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. .00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid 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 eligible unpaid days in column 4, Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. 	0	0	0	0		0) 24. C 25. C
				Urban/F	Rural S		f Geogr 00	-
0.00 Enter your standard geographic classification (not wa		at the beg	inning of t		2	۷.	00	26.0
 cost reporting period. Enter "1" for urban or "2" for 00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi 	ge) status "2" for r	ural. If ap		t	2			27.0
.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35.0
				Begi n		Endi 2	i ng: 00	
0.00 Enter applicable beginning and ending dates of SCH st		cript line	36 for numb		00	<u> </u>	00	36. (
of periods in excess of one and enter subsequent date .00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	s MDH statu	s	о			37.
.01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37.
instructions) 00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
				Y/ 1.			<u>/N</u>	-
						2		
2.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii)	, (ii), or he mileage	(iii)? Ent requiremen	er in colum ts in	ne N		2. N	N	39.
hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t	, (ii), or he mileage i)? Enter adjustmen er 1. Ente	(iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y	er in colum ts in "Y" for ye " for yes o	me M n s r M				39. 40.
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SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C		eriod: rom 07/01/2018	Worksheet S-2 Part I	
				Ť			
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	1
. 00	Are you claiming nursing and allied health education			N			60.
	any programs that meet the criteria under §413.85? (Y/N	structions) IME	Direct GME	I ME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.
. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.
. 02	Enter the current year total unweighted primary care						61.
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						
. 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						61.
. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.
. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.
. 06	61.04 minus line 61.03). (see instructions) 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.
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Direct GME FTE	-
			1.00	2.00	3.00	Count 4.00	1
. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME				0. 00	0. 00	0 61.
. 20	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. OC	0. 00	61.
						1.00	-
00	ACA Provisions Affecting the Health Resources and Ser						
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a	ti ons) Teachi	ng Health Cen	ter (THC) into		0.00	
. 00	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se	er Setti	i ngs	· ·	period? Enter	N	63
	"Y" for yes or "N" for no in column 1. If yes, comple					Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00	2.00 is your cost r	3.00 reporting	_
. 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 non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	<u>e June</u> y trair -primar all nor l non-pr	30, 2010. ned residents ry care nprovider rimary care	0. 00			64.

	EX IDENTIFICATION D	ATA Provider (riod: om 07/01/2018	Worksheet S-2 Part I	2
			Tc			
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
	5		FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
-	1 00	2.00	Si te 3. 00	4.00	F 00	-
00 Enter in column 1, if line 63	1.00	2.00	0.00	4.00	5.00 0.000000	65
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column						
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te	2.00	2.00	-
Section 5504 of the ACA Current	Vear FTF Residents i	n Nonnrovider Settin	1.00	2.00	3.00	
beginning on or after July 1, 20		n Nonprovider Settin	gsLitective to		ing perious	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column	3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00					
00 Entor in column 1 the preserve	11 00	2.00	3.00	4.00	5.00	47
00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		2.00	3.00 0.00	<u>4.00</u> 0.00		67.
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column		2.00		0.00	0. 000000	67.
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	PS		0.00	0.00	0. 000000	
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	PS ychiatric Facility (0.00	0.00	0. 000000	
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	PS ychiatric Facility (the facility have a ∋fore November 15, 2 umn 2: Did this fac ≷ 412.424 (d)(1)(iii cate which program y	IPF), or does it com n approved GME teach 004? Enter "Y" for y ility train resident)(D)? Enter "Y" for y	0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	0.00 1.0 1.0 rovi der? N he most b. (see i ng b.	0. 000000	70.
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	PS ychiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y y PPS nabilitation Facilit	IPF), or does it com n approved GME teachi 004? Enter "Y" for y ility train residents)(D)? Enter "Y" for y ear began during this	0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n s cost reporting	0.00 1.0 1.0 rovi der? N he most b. (see i ng b.	0.000000	70. 71. 75.

	Worksheet	S-2
/2018	Part I	

Perio		Worksheet S-2
From	07/01/2018	Part I
То	06/30/2019	Date/Time Prepared:
		11/25/2010 11:32 am

					11/25/2019 11	32 811
					1.00	-
	Long Term Care Hospital PPS				1.00	
	Is this a long term care hospital (LTCH)? Enter "Y" for yes				Ν	80.00
81.00	Is this a LTCH co-located within another hospital for part of	or all of the c	cost reporting	period? Enter	Ν	81.00
	"Y" for yes and "N" for no. TEFRA Provi ders					1
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)	TEFRA? Enter	"Y" for yes o	r "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (exclude	ed unit) under	42 CFR Section			86.00
07 00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					07.00
87.00	Is this hospital an extended neoplastic disease care hospita 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	I CLASSITIED L	inder section		Ν	87.00
				V	XI X	
				1.00	2.00	
~~ ~~	Title V and XIX Services		1 II)/II C	N		00.00
90.00	Does this facility have title V and/or XIX inpatient hospita yes or "N" for no in the applicable column.	al services? Er	iter 'Y' for	Ν	Y	90.00
91.00	is this hospital reimbursed for title V and/or XIX through 1	he cost report	either in	Ν	Ν	91.00
	full or in part? Enter "Y" for yes or "N" for no in the appl					
92.00	Are title XIX NF patients occupying title XVIII SNF beds (du		on)? (see		Y	92.00
03 00	instructions) Enter "Y" for yes or "N" for no in the applica Does this facility operate an ICF/IID facility for purposes		1 XIX2 Enter	Ν	N	93.00
75.00	"Y" for yes or "N" for no in the applicable column.				N.	/5.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for no	o in the	Ν	Ν	94.00
05 00	applicable column.			0.00	0.00	05.00
	If line 94 is "Y", enter the reduction percentage in the app Does title V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0. 00 N	95.00 96.00
90.00	applicable column.			IN	IN	90.00
97.00	If line 96 is "Y", enter the reduction percentage in the app	licable column	ı.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the ir			Ν	Y	98.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f	for yes or "N"	for no in			
98 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the re	porting of cha	arges on Wkst	Ν	Y	98.01
70.01	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti					/0.01
	title XIX.					
98.02	Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			Ν	Y	98. 02
	for title V, and in column 2 for title XIX.					
98.03	Does title V or XIX follow Medicare (title XVIII) for a crit	ical access ho	ospital (CAH)	Ν	Ν	98.03
	reimbursed 101% of inpatient services cost? Enter "Y" for ye	es or "N" for r	no in column 1			
98.04	for title V, and in column 2 for title XIX.	raimburgad 101	♥ of	Ν	N	98.04
90.04	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no ir			IN	IN	90.04
	in column 2 for title XIX.					
98.05	Does title V or XIX follow Medicare (title XVIII) and add ba			Ν	Y	98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c column 2 for title XIX.	column 1 for ti	tle V, and in			
98 06	Does title V or XIX follow Medicare (title XVIII) when cost	reimbursed for	-Wkst D	Ν	Y	98.06
/01/00	Pts. I through IV? Enter "Y" for yes or "N" for no in column					
	column 2 for title XIX.					
105 00	Rural Providers Does this hospital qualify as a CAH?			Y		105.00
	If this facility qualifies as a CAH, has it elected the all-	inclusive meth	nod of payment	N		105.00
	for outpatient services? (see instructions)					
107.00	If this facility qualifies as a CAH, is it eligible for cost			Ν		107.00
	training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.					
	reimbursed. If yes complete Wkst. D-2, Pt. II.	25 and the pr	ogram is cost			
108.00	Is this a rural hospital qualifying for an exception to the	CRNA fee sched	dulle? See 42	Ν		108.00
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
		Physi cal 1.00	Occupational 2.00	Speech 3.00	Respi ratory	-
109.00	If this hospital qualifies as a CAH or a cost provider, are	N	2.00 N	N	4.00 N	109.00
	therapy services provided by outside supplier? Enter "Y"					
	for yes or "N" for no for each therapy.					
					1.00	-
110.00	Did this hospital participate in the Rural Community Hospita	al Demonstratio	on project (\$41	AC	N	110.00
	Demonstration) for the current cost reporting period? Enter "	Y" for yes or	"N" for no. If	yes,		
	complete Worksheet E, Part A, lines 200 through 218, and Wor	rksheet E-2, li	nes 200 throug	h 215, as		
	appl i cabl e.					

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCM	F	Period: From 07/01/201 To 06/30/201	Worksheet S 8 Part I	repared:
		1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Cor Health Integration Project (FCHIP) demonstration for this cost reporting pe "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, er integration prong of the FCHIP demo in which this CAH is participating in of Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	eriod? Enter nter the column 2.	N		111.00
		1.	00 2.00 3.0	0
 Miscellaneous Cost Reporting Information 115.00 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 is 3 either "93" percent for short term hospital or "98" percent for long term psychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1. 11(001 e this chapter 22, §2208.1. 	s "E", enter i n care (includ e definition i	in column des in CMS		115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y"		"N" for Y		116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if claim-made. Enter 2 if the policy is occurrence.	the policy	is 1		118.00
cranii-liade. Enter 2 11 the portcy is occurrence.	Premiums	Losses	Insurance	
	1.00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:	93, 842	2	0	0 118. 01
110 colors as long at instance and as it because assessed in a cost control other at		1.00	2.00	110.00
118. 02 Are malpractice premiums and paid losses reported in a cost center other the Administrative and General? If yes, submit supporting schedule listing cost and amounts contained therein. 119. 00 D0 NOT USE THIS LINE		N		118. 02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instru- Enter in column 2, "Y" for yes or "N" for no.	for yes or e Outpatient	N	N	120. 00
121.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.	charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as defined in §1903(\ Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.		Y	5.00	122. 00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for yes and "N" t	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certifi	cation date			126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.	cation date			127.00
128.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.	cation date			128.00
129.00 If this is a Medicare certified lung transplant center, enter the certification of the contract of the certification of the cert	ation date in			129.00
130. 00 If this is a Medicare certified pancreas transplant center, enter the certified pancreas transplant center, enter the certified pancreas transplant center.	fi cati on			130. 00
131.00 If this is a Medicare certified intestinal transplant center, enter the cendate in column 1 and termination date, if applicable, in column 2.	tification			131.00
132.00 If this is a Medicare certified islet transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.	cation date			132.00
133.00 f this is a Medicare certified other transplant center, enter the certified in column 1 and termination date, if applicable, in column 2.	cation date			133.00
134.00 If this is an organ procurement organization (OPO), enter the OPO number in and termination date, if applicable, in column 2.	n column 1			134.00
All Providers 140.00Are there any related organization or home office costs as defined in CMS I	Pub 15-1	Y	15H046	140.00
The serves there any related organization of nome office costs as uctined in GWD f	office costs	1 '	101040	1.40.00

ealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			Provider CC		Peri oc		u of Form CMS- Worksheet S-2	
USPITAL AND NUSPITAL HEALTH CARE COMPLE	A IDENTIFICATION D			N. 13-1307	From ()7/01/2018)6/30/2019	Part I	epared
1.00		2.00				3.00	11/23/2017 1	1. 52 0
If this facility is part of a chai					name an	d address	of the	
home office and enter the home off 1.00 Name: ST. VINCENT HEALTH	<u>Contractor nar</u>				tor's N	umber: 0810	1	141. (
42.00 Street: 250 W. 96TH ST. SUITE 215	PO Box:	Name: wPS		Contrac				141.0
43. OO CI ty: INDI ANAPOLI S	State:	IN		Zip Cod	de:	4629	0	143. (
				· ·				
							1.00	-
44.00 Are provider based physicians' cos	sts included in Wor	rksheet A	?				Y	144. (
						1.00	2.00	-
 45.00 If costs for renal services are cliphic inpatient services only? Enter "Y" no, does the dialysis facility incomperiod? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in the cost allocation for the cost allocation for no in the cost allocation for no in the cost allocation for the cost allocation for no in the cost allocation for the cost allo	for yes or "N" fo clude Medicare util for no in column 2 gy changed from the n column 1. (See CM	or no in c lization 1 2. e previous MS Pub. 15	column 1. If c for this cost sly filed cost	column 1 is reporting : report?	lf	N		145. (
yes, enter the approval date (mm/c	d/yyyy) in column	2.						-
							1.00	-
47.00Was there a change in the statisti	cal basis? Enter "	"Y" for ye	es or "N" for	no.			N 11.00	147.
48.00 Was there a change in the order of	allocation? Enter	r "Y" for	yes or "N" fo	or no.			Ν	148.
49.00 Was there a change to the simplifi	ed cost finding me	ethod? Ent				T: +1 - \/	N Title XIX	149. (
		-	Part A 1.00	Part B 2.00		Title V 3.00	Title XIX 4.00	-
Does this facility contain a provi	der that qualifies	s for an e			cation o			
or charges? Enter "Y" for yes or '							. 13)	
55.00Hospi tal			N	N		N	N	155.
56.00 Subprovider - IPF 57.00 Subprovider - IRF			N N	N N		N N	N N	156. 157.
57. 00 Subprovider – TRF 58. 00 SUBPROVIDER			IN	IN IN		IN	N	157.
59. 00 SNF			Ν	N		N	N	159.
60.00 HOME HEALTH AGENCY			Ν	N		Ν	N	160.
61.00 CMHC				N		N	N	161. (
							1.00	-
Multicampus							1.00	
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that	t has one	or more campu	ises in dif	ferent C	BSAs?	N	165. (
Enter i for yes of in for no.	Name		County	State 2	Zip Code	CBSA	FTE/Campus	
	0		1.00	2.00	3.00	4.00	5.00	
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0. 0	0 166. (
							1.00	-
Health Information Technology (HI					ent Act			
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	05 is "Y") and is a	a meaningf	⁼ul user (line		'), ente	r the	Ν	167. 0168.
68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?	not a meaningful us ? Enter "Y" for yes	ser, does s or "N" f	this provider [≘] or no. (see i	nstruction	s)	·	Y	168.
69.00 If this provider is a meaningful u transition factor. (see instruction		ı) and I	S NUL A CAH (0169.
					Be	egi nni ng	Endi ng	-
70.00 Enter in columns 1 and 2 the EHR k period respectively (mm/dd/yyyy)	beginning date and	endi ng da	ate for the re	eporting	10	1.00 /01/2017	2.00 09/30/2018	170.
71.00 fline 167 is "Y", does this prov		· · ·	viduel =	Lod ! -		1.00	2.00	0174
					1	N		0171.

)SPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1307	Period: From 07/01/2018 To 06/30/2019	Worksheet S- Part II Date (Time Pr	
				10 06/30/2019	Date/Time Pr 11/25/2019 1	
				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	lfor all NO re	sponses. Ente	er all dates in t	he	
	Provider Organization and Operation Has the provider changed ownership immediately prior to the	boginning of	the cost	N		1 1.
00	reporting period? If yes, enter the date of the change in o					1.
	risporting portour in yes, ontor the date of the enange in t		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.	Program? If nn 3, "V" for	N			2.
00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or 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 der or its of the board	N			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,	N			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 Column 1: Are costs claimed for nursing school? Column 2:	lf vos is th	o providor i	s N		6.
00	the legal operator of the program?	TT yes, TS ti		5 11		0.
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		l during the	N N		7. 8.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	0	al education	Ν		9.
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of the statement of the		he current	N		10.
. 00	cost reporting period? If yes, see instructions. 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		11.
					Y/N 1.00	_
	Bad Debts				1.00	
. 00	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.
	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Ped Complement	ents waived? If	yes, see ins	structions.	Ν	14.
	Bed Complement Did total beds available change from the prior cost reporti				N	15
		Y/N	t A Date	Par Y/N	Date	
		1.00	2.00	3.00	4.00	
	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	Y	10/07/2019	Y	10/07/2019	16.
. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	N		N		17
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
. 00	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	N		Ν		18.
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.

Health Financial Systems

In Lieu of Form CMS-2552-10

Health Financial Systems	AMSPORT HOSPITA	AL.	In Lie	S-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE RI	EI MBURSEMENT QUESTI ONNAI RE	Provider C	F	Period: From 07/01/2018 Fo 06/30/2019	Date/Time P	repared:
		Descri	ption	Y/N	11/25/2019 Y/N	11:32 am
)	1.00	3.00	
20.00 If line 16 or 17 is yes, were Report data for Other? Descri				N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	01.00
21.00 Was the cost report prepared records? If yes, see instruct		N		N		21.00
					1.00	
COMPLETED BY COST REIMBURSED Capital Related Cost	AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)			
22.00 Have assets been relifed for	Medicare purposes? If yes, se	e instructions			N	22.00
23.00 Have changes occurred in the reporting period? If yes, see		e due to apprais	als made durir	ng the cost	N	23.00
24.00 Were new leases and/or amendm If yes, see instructions		red into during	orting period?	N	24.00	
25.00 Have there been new capitaliz	ed leases entered into during	the cost repor	ting period? I	f yes, see	N	25.00
26.00 Were assets subject to Sec. 23	14 of DEFRA acquired during t	he cost reporti	ng period? If	yes, see	N	26.00
27.00 Has the provider's capitaliza	tion policy changed during th	ne cost reportin	g period?lfy	/es, submit	N	27.00
Interest Expense						
28.00 Were new Loans, mortgage agree period? If yes, see instructi	ons.		0		N	28.00
29.00 Did the provider have a funde treated as a funded depreciat	ed depreciation account and/or ion account? If yes, see inst		bt Service Res	serve Fund)	N	29.00
30.00 Has existing debt been replac	ed prior to its scheduled mat	urity with new	debt? If yes,	see	N	30.00
31.00 Has debt been recalled before instructions.	e scheduled maturity without i	ssuance of new	debt? If yes,	see	Ν	31.00
Purchased Services32.00Have changes or new agreement	s occurred in patient care se	ervices furnishe	d through cont	ractual	N	32.00
arrangements with suppliers of 33.00 [If line 32 is yes, were the r	of services? If yes, see instr	uctions.	-			33.00
no, see instructions.						
Provider-Based Physicians34.00Are services furnished at the	provider facility under an a	rrangement with	provi der-base	ed physicians?	Y	34.00
If yes, see instructions. 35.00 If line 34 is yes, were there		-			N	35.00
physicians during the cost re				Y/N		
				1.00	Date 2.00	
Home Office Costs						
36.00 Were home office costs claime 37.00 If line 36 is yes, has a home		prepared by the	home office?	Y Y		36.00 37.00
If yes, see instructions. 38.00 If line 36 is yes, was the f		. ,		N		38.00
the provider? If yes, enter i 39.00 If line 36 is yes, did the pr	n column 2 the fiscal year er	nd of the home o	ffi ce.	N		39.00
40.00 If line 36 is yes, did the pr			5	N		40.00
instructions.				í N		40.00
		1.	00	2.	00	
41.00 Enter the first name, last na	me and the title/position	JILL		HILL		41.00
held by the cost report prepa respectively.						
42.00 Enter the employer/company na preparer.	me of the cost report	ASCENSI ON				42.00
43.00 Enter the telephone number ar report preparer in columns 1		3175833519		JI LL. HI LL1@ASC	ENSI ON. ORG	43.00

Heal th	Financial Systems	ST. VINCENT WILLIA	AMSPORT HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provider CCN: 15-1307	Peri od:	Worksheet S-2	
				From 07/01/2018 To 06/30/2019	Date/Time Pre	
					11/25/2019 11	:32 am
			2.00			
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the t	title∕position	REIMBURSEMENT MANAGER			41.00
	held by the cost report preparer in colur	nns 1, 2, and 3,				
	respecti vel y.					
42.00	Enter the employer/company name of the co	ost report				42.00
	preparer.					
43.00	Enter the telephone number and email addr	ress of the cost				43.00
	report preparer in columns 1 and 2, respe	ecti vel y.				

^{11/25/2019 11:32} am Y:\28950 - St. Vincent Williamsport Hospital\300 - Medicare Cost Report\20190630\HFS\20190630 Williamsport.mc

HOSPI T	Financial Systems ST. AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CO	CN: 15-1307	Peri od:	Worksheet S-3	
					From 07/01/2018 To 06/30/2019		narod
					10 00/30/2019	Date/Time Pre 11/25/2019 11	
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e		5.00	
1 00	Userital Adulta & Dada (aslumps F (7 and	1.00	2.00	3.00	4.00	5.00	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00	10	5, 8	40 36, 384. 00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation		16	5, 8	40 36, 384. 00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00 10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9.00 10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	
14.00	Total (see instructions)	101 00	16	5, 8	40 36, 384. 00		14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00 24.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23.00
24.00	HOSPICE HOSPICE (non-distinct part)	30, 00					24.00
25.00	CMHC - CMHC	30.00					25.0
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
27.00	Total (sum of lines 14-26)		16				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
22.00	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00 33.0
J. UI	LTCH site neutral days and discharges			1		1	1 33.

105PT 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-1307	Period: From 07/01/2018 To 06/30/2019		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00 2.00	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)	1, 109	31	1, 51	16		2.00
3.00	HMO I PF Subprovider	0	0				3.0
1.00	HMO IRF Subprovider	O	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	523	0		35		5.00
5.00	Hospital Adults & Peds. Swing Bed NF		0		22		6.0
7.00 3.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT	1, 632	31	2, 07	73		7.00
9.00 10.00 11.00 12.00 13.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY		0		0		9. 00 10. 00 11. 00 12. 00 13. 00
4.00	Total (see instructions)	1, 632	31	2,07	0	70.95	
5.00	CAH visits	25, 095	1, 155	63, 33			15.00
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF						17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
0. 00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23. C
4. 10	HOSPICE (non-distinct part)				0		24.0
5.00	CMHC - CMHC				0		25.0
6.00	RURAL HEALTH CLINIC	2, 695	202	13, 52	0.00	15.19	
6.01	RURAL HEALTH CLINIC II	5, 488	175	15, 06			
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
7.00	Total (sum of lines 14-26)				0.00	104.90	27.0
8.00	Observation Bed Days		0	72	22		28.0
9.00	Ambul ance Trips	512					29.0
0.00	Employee discount days (see instruction)				0		30.0
1. 00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	0	0		0		32.0
2. 01	Total ancillary labor & delivery room				0		32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0				1	33.0

	n Financial Systems ST. TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	<u>VINCENT WILLIAM</u> AL DATA	Provi der CC		Period: From 07/01/2018	u of Form CMS-: Worksheet S-3 Part I	
					To 06/30/2019	Date/Time Pre 11/25/2019 11	
		Full Time Equivalents		Di s	charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00			0	3	25 13 55 27 0 0	457	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
$\begin{array}{c} 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00 \end{array}$	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	0. 00	0	3	25 13	457	15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00
23.00 24.00 24.10 25.00 26.01 26.25 27.00 28.00 30.00 31.00 32.01 33.00 22.01	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC RURAL HEALTH CLINIC II 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. 00 0. 00 0. 00 0. 00			0 0		23.00 24.00 24.10 25.00 26.00 26.01 26.25 27.00 28.00 29.00 30.00 31.00 32.01 33.00 33.01

Heal th	Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1307	Peri od:	Worksheet S-8	
			Component	CCN: 15-3993	From 07/01/2018 To 06/30/2019		pared:
						11/25/2019 11	
					RHC I	Cost	
					1.	00	
	Clinic Address and Identification						
1.00	Street		Ci	ty	1731 RINGER LA State	NE ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		WI LLI AMSPORT			47993	2.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	r "D" for ruro	l or "II" for u	rhan		1.00	3.00
3.00	HOSPITAL-BASED FUNCS UNLT. DESIGNATION - EITE	R TOFTUIA		1	nt Award	Date	3.00
					1. 00	2.00	
	Source of Federal Funds			1			
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00 6.00	Migrant Health Center (Section 329(d), PHS Ac Health Services for the Homeless (Section 340						5.00 6.00
7.00	Appal achi an Regi onal Commi ssi on	(u), This Act)					7.00
8.00	Look-Alikes					ĺ	8.00
9.00	OTHER (SPECIFY)						9.00
9.01							9.01
9.02							9.02
9.03 9.04							9.03 9.04
9.05							9.05
9.06						ĺ	9.06
9.07							9.07
9.08							9.08
9.09 9.10							9.09 9.10
9.10							9.10
					1.00	2.00	
10. 00	Does this facility operate as other than a horyes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ite number of o	ther operation	s in column	N	0	10.00
		Sun	day	M	londay	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC			07:00	19:00	07: 00	11 00
11.00	CEINIC			07.00	19.00	07.00	11.00
					1.00	2.00	
	Have you received an approval for an exceptic		5		N		12.00
13.00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report. numbers below.	ımn 1. If yes,	enter in colum	in 2 the	N	0	13.00
					der name	CCN number	
14.00					1.00	2.00	14.00
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						

Health Financial Systems ST.	VINCENT WILLI	AMSPORT HOSPITA	AL	In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FOHC STATISTICAL DATA		Provider C	CN: 15-1307	Period:	Worksheet S-8	}
		Component	CCN: 15-3993	From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 11	epared: :32 am
				RHC I	Cost	
		Cou	inty			
		4.	00			
2.00 City, State, ZIP Code, County		WARREN				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)			_			
11.00 CLINIC	19: 00	07:00	19:00	07:00	19:00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	07:00	19:00				11.00

^{11/25/2019 11:32} am Y:\28950 - St. Vincent Williamsport Hospital\300 - Medicare Cost Report\20190630\HFS\20190630 Williamsport.mc

Heal th	Financial Systems ST.	VINCENT WILLI	AMSPORT HOSPITA	AL.	In Lie	eu of Form CMS-2	2552-10
HOSPI 1	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Peri od:	Worksheet S-8	
			Component	CCN: 15-3994	From 07/01/2018 To 06/30/2019	Date/Time Pre	nared
			component	CON. 13 3774	10 00/ 30/ 2017	11/25/2019 11	
				-	RHC I I	Cost	
					1	00	-
	Clinic Address and Identification				I.	00	
1.00	Street				440 W. SONGER	LANE	1.00
			Ci	ty	State	ZIP Code	
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		VEEDERSBURG		I N	47987	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for u	ırban		0	3.00
	· <u> </u>				nt Award	Date	
					1.00	2.00	
4 00	Source of Federal Funds	A - +)		1			1 4 00
4.00 5.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac						4.00 5.00
6.00	Heal th Services for the Homeless (Section 340						6.00
7.00	Appalachian Regional Commission	(-),					7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
9. 01 9. 02							9. 01 9. 02
9.02							9.02
9.04							9.04
9.05							9.05
9.06							9.06
9.07							9.07
9.08 9.09							9.08 9.09
9.09 9.10							9.10
7110				1			71.10
				-	1.00	2.00	
10.00	Does this facility operate as other than a ho yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ite number of a	other operation	ns in column	N	0	10.00
		Sur	iday	M	londay	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)		1	07.00	47.50	07.00	1
11.00	CLINIC			07:00	17: 50	07:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception	on to the produ	uctivity standa	ird?	N	2.00	12.00
13.00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report. numbers below.	lin CMS Pub. ´ mn 1. If yes,	100-04, chapter enter in colum	9, section n 2 the	N	0	13.00
				Provi	ider name	CCN number	
					1.00	2.00	
14.00	RHC/FQHC name, CCN number	X/ /N			<u> </u>		14.00
		Y/N 1.00	V 2.00	XVIII 3.00	4.00	Total Visits 5.00	
15.00	Have you provided all or substantially all	1.00	2.00	0.00	7.00	0.00	15.00
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						
			I	I	I	I	I

Health Financial Systems ST	. VINCENT WILLI	AMSPORT HOSPITA	AL	In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1307	Peri od:	Worksheet S-8	3
		Component	CCN: 15-3994	From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 11	epared:
				RHC II	Cost	. 32 811
		Cou	inty			
		4.	00			
2.00 City, State, ZIP Code, County		FOUNTAI N				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)						
11.00 CLINIC	17: 50	07: 00	17: 50	07:00	17: 50	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	07:00	17: 50				11.00

Heal th	Fi nanci al	Systems	

ST. VINCENT WILLIAMSPORT HOSPITAL

In Lieu of Form CMS-2552-10

HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN	I: 15-1307	Period: From 07/01/2018	Worksheet S-1	0
				To 06/30/2019		pared: :32 am
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi Medicaid (see instructions for each line)	ided by line	e 202 column	18)	0. 283782	1.00
2.00	Net revenue from Medicaid				1, 048, 721	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplementa			ai d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fro	om Medicaid			0	
6.00	Medi cai d charges				12, 857, 303	
7.00	Medicaid cost (line 1 times line 6)				3, 648, 671	
8.00	Difference between net revenue and costs for Medicaid program (I < zero then enter zero)	line 7 minus	s sum of lir	nes 2 and 5; if	2, 599, 950	8.00
	Children's Health Insurance Program (CHIP) (see instructions for	r each line))		1	
9.00	Net revenue from stand-alone CHIP				0	
	Stand-alone CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)			с н	0	
12.00	Difference between net revenue and costs for stand-alone CHIP (I enter zero)	line 11 mini	us line 9; i	f < zero then	0	12.00
	Other state or local government indigent care program (see instr					
	Net revenue from state or local indigent care program (Not inclu				0	
14.00	Charges for patients covered under state or local indigent care 10)	program (No	ot included	in lines 6 or	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14))			0	
16.00	Difference between net revenue and costs for state or local indi	igent care p	program (lir	ne 15 minus line	0	16.00
	13; if < zero then enter zero)		<i></i>			
	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)	and state	/local indig	jent care program	ns (see	
17.00	Private grants, donations, or endowment income restricted to fur	nding chari [.]	tv care		0	17.00
18.00	Government grants, appropriations or transfers for support of he				0	18.00
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent ca	are programs	s (sum of lines	2, 599, 950	19.00
			Uni nsured	Insured	Total (col. 1	
		-	patients 1.00	patients 2.00	+ col . 2) 3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20. 00	Charity care charges and uninsured discounts for the entire faci	ility	3, 055, 58	39 1, 011, 329	4, 066, 918	20.00
21.00	(see instructions) Cost of patients approved for charity care and uninsured discour	nts (see	867, 12	1, 011, 329	1, 878, 450	21.00
	instructions)					
22.00	Payments received from patients for amounts previously written of charity care	off as	69, 40	50 0	69, 460	22.00
23.00			797, 6	51 1, 011, 329	1, 808, 990	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patient	t days beyo	nd a length	of stay limit	N	24.00
05 00	imposed on patients covered by Medicaid or other indigent care p					05 00
25.00	If line 24 is yes, enter the charges for patient days beyond the stay limit	e indigent o	care program	's length of	0	25.00
26. 00	Total bad debt expense for the entire hospital complex (see inst	tructions)			1, 463, 866	26.00
	Medicare reimbursable bad debts for the entire hospital complex		uctions)		431, 618	
27.01	Medicare allowable bad debts for the entire hospital complex (se				664, 027	
28.00	Non-Medicare bad debt expense (see instructions)		-		799, 839	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (see i	nstructions)	1	459, 389	
	Cost of uncompensated care (line 23 column 3 plus line 29)				2, 268, 379	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus lir	ne 30)			4, 868, 329	31.00

Heal th	Financial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provider CO		eri od:	Worksheet A	
					rom 07/01/2018		
				T	o 06/30/2019		
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	11/25/2019 11 Recl assi fi ed	32 am
	cost center bescription	Sararres	other	+ col. 2)	ons (See A-6)	Trial Balance	
				+ (01. 2)	UIIS (SEE A-0)	(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		94, 136	94, 136	0	94, 136	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		617, 249	617, 249	0	617, 249	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS		017,217	017,217	0	017,217	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	12, 256	2, 366, 019	2, 378, 275	0	2, 378, 275	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	762, 763	5, 145, 091	5, 907, 854	0	5, 907, 854	5.00
7.00	00700 OPERATION OF PLANT	102, 703	694, 458	694, 458	0	694, 458	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0,4,430	074,430	0	0,14,430	8.00
9.00	00900 HOUSEKEEPING	0	364, 769	364, 769	0	364, 769	9.00
10.00	01000 DI ETARY	0	3, 336	3, 336	0	3, 336	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	142 704	25, 098	167, 802	0	167, 802	13.00
13.00	01400 CENTRAL SERVICES & SUPPLY	142, 704	25,098	6, 635	0		13.00
	01500 PHARMACY	172 001			0	6, 635	
15.00		173, 091	314, 956		0	488, 047	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	630	630	0	630	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	050 705	99, 914	1 050 (10	2 012	1 054 407	30.00
30.00 43.00	03000 ADULTS & PEDIATRICS 04300 NURSERY	959, 705 0	99, 914	1, 059, 619 0		1, 056, 607 0	43.00
43.00	ANCI LLARY SERVICE COST CENTERS	U	0	0	0	0	43.00
50.00	05000 OPERATING ROOM	468, 646	247, 434	716, 080	-16, 636	699, 444	50.00
53.00	05300 ANESTHESI OLOGY	400, 040	247, 434	10,080	- 10, 030	0,444	53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	532, 678	186, 871	719, 549	0	719, 549	54.00
60.00	06000 LABORATORY	36, 859	1, 435, 500	1, 472, 359	0	1, 472, 359	60.00
	06500 RESPIRATORY THERAPY				0		
65.00		21, 510	41, 217	62, 727	0	62, 727	65.00
66.00 68.00	06600 PHYSI CAL THERAPY	234, 419	8, 532	242, 951	0	242, 951	66.00 68.00
	06800 SPEECH PATHOLOGY	0	U 7 020	U 7 020	27 104	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	7, 930	7, 930	27, 104	35, 034	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	70, 211	70, 211	0	70, 211	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	1, 725	1, 725	0	1, 725	73.00
88.00	08800 RURAL HEALTH CLINIC	1,088,065	374, 031	1, 462, 096	0	1, 462, 096	88.00
88. 00 88. 01	08801 RURAL HEALTH CLINIC				0		88.00
91.00	09100 EMERGENCY	1, 445, 324	452, 318		-	1, 897, 642	
		862, 295	1, 508, 092	2, 370, 387	-7, 456	2, 362, 931	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	515, 369	39, 256	554, 625	0	554, 625	95.00
95.00	SPECIAL PURPOSE COST CENTERS	515, 309	39,230	554, 625	0	554, 625	95.00
118.00		7, 255, 684	14, 105, 408	21, 361, 092	0	21, 361, 092	110 00
110.00	NONREI MBURSABLE COST CENTERS	7,233,004	14, 105, 400	21, 301, 072	0	21, 301, 072	110.00
193 00	19300 NONPAID WORKERS		0	0	0	Λ	193.00
	19301 ORTHO CLINIC	319, 809	12, 230	332, 039	-	332, 039	
	19303 COMMUNITY MED CLINIC	017,007	43	43	0		193.02
	07950 MARKETING		43	445	0		193.02
200.00		7, 575, 493	14, 118, 126		-		
200.00		,,,,,,,,,,,,	11, 110, 120	21,070,017		21, 0, 0, 017	

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Heal th	Financial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	\L	In Lieu	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO	CN: 15-1307	Peri od:	Worksheet A	
					From 07/01/2018		
					To 06/30/2019	Date/Time Prep 11/25/2019 11:	
	Cost Center Description	Adjustments	Net Expenses			11/20/2017 11	
	'		For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	0	94, 136				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	617, 249				2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0				3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-38, 598	2, 339, 677				4.00
5.00	00500 ADMINI STRATI VE & GENERAL	118, 026	6, 025, 880				5.00
7.00	00700 OPERATION OF PLANT	0	694, 458				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	1			8.00
9.00	00900 HOUSEKEEPI NG	0	364, 769	1			9.00
10.00	01000 DI ETARY	-3, 336	0	1			10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-500	167, 302	1			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	6, 635	1			14.00
15.00	01500 PHARMACY	0	488, 047				15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	630				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDI ATRI CS	-2,000	1,054,607				30.00
43.00	04300 NURSERY	0	0				43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	-243, 464	455, 980				50.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-65, 365	654, 184				54.00
60.00	06000 LABORATORY	0	1, 472, 359				60.00
65.00	06500 RESPI RATORY THERAPY	0	62, 727				65.00
66.00	06600 PHYSI CAL THERAPY	0	242, 951				66.00
68.00	06800 SPEECH PATHOLOGY	0	0				68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35, 034				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	70, 211				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-1, 394	331				73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	1, 462, 096				88.00
88.01	08801 RURAL HEALTH CLINIC II	0	1, 897, 642				88.01
91.00	09100 EMERGENCY	0	2, 362, 931				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0	554, 625				95.00
	SPECIAL PURPOSE COST CENTERS	,,					
118.00		-236, 631	21, 124, 461				118.00
	NONREI MBURSABLE COST CENTERS	,,					
	19300 NONPAID WORKERS	0	0				193.00
	19301 ORTHO CLINIC	0	332, 039				193. 01
	19303 COMMUNITY MED CLINIC	0	43				193. 02
	07950 MARKETI NG	0	445				194.00
200.00	TOTAL (SUM OF LINES 118 through 199)	-236, 631	21, 456, 988				200. 00

Heal th	Financial Systems	ST.	VINCENT WILLI	AMSPORT HOSPIT	AL	In Lieu	u of Form CMS	-2552-10
RECLASSI FI CATI ONS			Provider (CCN: 15-1307	Period: From 07/01/2018	Worksheet A-	6	
						To 06/30/2019	Date/Time Pr 11/25/2019 1	epared: <u>1:32 am</u>
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	A – MEDICAL SUPPLIES							
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	27, 104				1.00
	PATI ENTS							
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
	TOTALS		0	27, 104				
500.00	Grand Total: Increases		0	27, 104	1			500.00
		•		•				•

Heal th	Financial Systems	ST. VINCENT WILLIAMSPORT HOSPITAL				In Lieu of Form CMS-2552-10		
RECLASSI FI CATI ONS				Provider (CCN: 15-1307	Period: From 07/01/2018	Worksheet A-	6
							Date/Time Pro 11/25/2019 1	epared: <u>1:32 am</u>
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	A - MEDICAL SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	3, 012		0		1.00
2.00	OPERATING ROOM	50.00	0	16, 636		0		2.00
3.00	EMERGENCY	91.00	0	7, 456		0		3.00
	TOTALS		0	27, 104		7		
500.00	Grand Total: Decreases		0	27, 104				500.00

In Lieu of Form CMS-2552-10 Worksheet A-7

					From 07/01/2018 To 06/30/2019		
				Acqui si ti on:	s		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE					-	
1.00	Land	174, 050	0		0 0	0	1.00
2.00	Land Improvements	159, 079	0		0 0	0	2.00
3.00	Buildings and Fixtures	8, 420, 526	254, 158		0 254, 158	8 0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	1, 676, 790	0		0 0	0	5.00
6.00	Movable Equipment	3, 827, 997	484, 802		0 484, 802	2 0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14, 258, 442	738, 960		0 738, 960	0	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	14, 258, 442	738, 960		0 738, 960	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	174, 050	0				1.00
2.00	Land Improvements	159, 079	0				2.00
3.00	Buildings and Fixtures	8, 674, 684	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	1, 676, 790	0				5.00
6.00	Movable Equipment	4, 312, 799	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	14, 997, 402	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	14, 997, 402	0				10.00

Heal th	Fi nanci al	Systems	
DECONIC			COCTO

RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1307		riod: om 07/01/2018 06/30/2019		pared:
	SUMMARY OF CAPITAL							
	Cost Center Description	Depreciation	Lease	Interest		nsurance (see instructions)	•	
		9.00	10.00	11.00		12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	21, 990	0		0	61, 014	11, 132	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	522, 166	95, 083		0	0	0	2.00
3.00	Total (sum of lines 1-2)	544, 156	95, 083		0	61, 014	11, 132	3.00
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum	I				
		Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	ind 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	94, 136	,				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	617, 249					2.00
3.00	Total (sum of lines 1-2)	0	711, 385					3.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	٨L	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	F	Period: From 07/01/2018 To 06/30/2019		pared: 32 am
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF		
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				-		
1.00 NEW CAP REL COSTS-BLDG & FIXT	10, 684, 603		10, 684, 603			1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	4, 312, 799		4, 312, 799			2.00
3.00 Total (sum of lines 1-2)	14, 997, 402		14, 997, 402			3.00
ALLOCATI ON OF OTHER CAPITAL SUMMARY OF 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 CE	INTERS	L	•			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	C	21, 990	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	C	522, 166	95, 083	2.00
3.00 Total (sum of lines 1-2)	0	0	C	544, 156	95, 083	3.00
		SL	JMMARY OF CAPIT	⊺AL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see instructions)	through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	61, 014	11, 132	2 0	94, 136	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	C	0 0	0177217	2.00
3.00 Total (sum of lines 1-2)	0	61, 014	11, 132	0	711, 385	3.00

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

ST. VINCENT WILLIAMSPORT HOSPITAL

	Financial Systems	ST.	VINCENT WILLIA	AMSPORT HOSPITAL		eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1307	Period: From 07/01/2018		
					To 06/30/2019	Date/Time Prep 11/25/2019 11:	
				Expense Classification o To/From Which the Amount is			
					to be Aujusteu		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
00	Investment income NEW CAD	1.00	2.00		4.00	5.00	1 00
. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-145, 226	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
00	2) Investment income - other (chapter 2)	В	-6, 522	ADMI NI STRATI VE & GENERAL	5.00	0	3.00
00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
00	Refunds and rebates of		0		0.00	0	5.00
. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
00	stations excluded) (chapter 21)		0		0.00		7.00
00	Television and radio service (chapter 21)		0		0.00		8.00
. 00 0. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	-88, 699		0.00	0	9. 00 10. 00
1.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
	Related organization transactions (chapter 10)	A-8-1	2, 021, 558			0	
3.00 4.00	Laundry and linen service Cafeteria-employees and guests		0		0.00		13.00 14.00
5. 00	Rental of quarters to employee and others		0		0.00		
5. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
7.00	Sale of drugs to other than		0		0.00	0	17.00
8. 00	patients Sale of medical records and abstracts		0		0.00	0	18.00
9. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
0. 00	books, etc.) Vending machines		0		0.00	0	20.00
1. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
2. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
4. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
5. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
b. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1.00	0	26.00
7.00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL		0	FIXT NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
3. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist			*** Cost Center Deleted ***			28.00
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	*** Cost Center Deleted ***	0.00 67.00		29. 00 30. 00
D. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
1. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						

Heal th	Financial Systems	ST.	VINCENT WILLIA	AMSPORT HOSPITAL	In Lieu of Form CMS-2552-10		
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					rom 07/01/2018 o 06/30/2019		nared
					0 00/ 30/ 2017	11/25/2019 11	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	CHARI TABLE CONTRI BUTI ONS	A		ADMI NI STRATI VE & GENERAL	5.00		00.00
33.01	PROMOTI ONAL	A	-450	ADMI NI STRATI VE & GENERAL	5.00	0	33.01
33.02	PHYSICIAN FUND	A	-212, 693	ADMI NI STRATI VE & GENERAL	5.00	0	33.02
33.03	MISSION POINT SAVINGS	В	-38, 598	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	REV OFFSET - ADMIN	В	-126, 267	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	REV OFFSET - FOOD SERVICES	В	-3, 336	DI ETARY	10.00	0	33.05
33.06	REV OFFSET - RADIOLOGY	В	-484	RADI OLOGY-DI AGNOSTI C	54.00	0	33.06
33.07	REV OFFSET - DRUGS	В	-1, 394	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08	REV OFFSET - NURSING ADMIN	В	-500	NURSING ADMINISTRATION	13.00	0	33.08
33.09	LOBBYI NG	А	-459	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PROVIDER TAX	А	-1, 411, 315	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MID LEVEL PROVIDERS - A&P	A	-2,000	ADULTS & PEDIATRICS	30.00	0	33.11
33.12	MID LEVEL PROVIDERS -	А	-219, 646	OPERATING ROOM	50.00	0	33. 12
	ANESTHESI OLOG						
50.00	TOTAL (sum of lines 1 thru 49)		-236, 631				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 WILL	AMSPORT HOSPITAL	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-1307	Peri od:	Worksheet A-8	3-1
OFFI CE	COSTS			From 07/01/2018 To 06/30/2019		narad
				10 00/30/2019	Date/Time Pre 11/25/2019 11	
	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	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		1	-		
1.00			Home Office - Capital	389, 092		1.00
2.00			Home Office - Interest	5, 483		2.00
3.00			Home Office - Other	5, 461, 620		
3.01			SVH Chargebacks	2, 496		
3.02			SVH Chargebacks	25, 571	25, 571	3. 02
3.03	30.00		SVH Chargebacks	44, 715	44, 715	3.03
3.04	54.00		SVH Chargebacks	25, 998	25, 998	3.04
3.05	65.00	RESPI RATORY THERAPY	SVH Chargebacks	35, 554	35, 554	3.05
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	Health Insurance	1, 434, 779	1, 434, 779	3.06
3.07	1.00	NEW CAP REL COSTS-BLDG & FIX	Interest Expense	145, 226	0	3.07
3.08	5.00	ADMINISTRATIVE & GENERAL	Interest Expense	1, 039	0	3.08
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			7, 571, 573	5, 550, 015	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.

has	not	been posted to Worksheet A,	columns 1 and/or 2, the amou	nt allowable sh	ould be indicated in column 4	of this part.	
					Related Organization(s) and/	or Home Office	
					o i i		
		Symbol (1)	Name	Percentage of	Name	Percentage of	
			Name	U U	Name	ý l	
				Ownershi p		Ownership	
		1.00	2.00	3.00	4.00	5.00	
		B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HC	ME 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	ST. VINCENT HEA	100.00 ST. VINCENT HEA	100.00	6.00
7.00	G	ASCENSI ON	100.00 ASCENSI ON	100.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	HOME OFFICE			100.00
	non-financial) specify:				

(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.

			11/25/2019 11	
	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 ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1.00	389, 092	0		1.00
2.00	5, 483	0		2.00
3.00	1, 480, 718	0		3.00
3.01	0	0		3. 01
3.02	0	0		3. 02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	145, 226	11		3.07
3.08	1,039	0		3.08
4.00	0	0		4.00
5.00	2, 021, 558			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.

1100			
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
-			

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

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

rerinbur	Sement under title Aviii.	
6.00	ADMI NI STRATI ON	6.00
7.00	ADMI NI STRATI ON	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.

Health Financial Systems

ST. VINCENT WILLIAMSPORT HOSPITAL

In Lieu of Form CMS-2552-10

	FINANCIAL SYSTE		. VINCLINI WILLI	ANSPORT HUSPIT			eu or Form CM3-	2002-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (1	Period: From 07/01/2018 To 06/30/2019	9 Date/Time Pre	epared:
							11/25/2019 11	1:32 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	1
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	23, 818	23, 818	0	0	0 0	1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	64, 881	64, 881	0	0	0	2.00
3.00		EMERGENCY	1, 376, 390		1, 376, 390	0	0	3.00
4.00	0.00		0	0	0	0	0	
5.00	0.00		0	0	0	0	0	
6.00	0.00		0	0	0	0		1
	0.00		0	0	0	0		
7.00			0	0	0	0	0	
8.00	0.00		0	0	0	0	0	0.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	
200.00			1, 465, 089		1, 376, 390		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0 0	1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	l o	0	0	o o	3.00
4.00	0,00		0	0	0	0	0	1
5.00	0.00		0	0	0	0	0	
6.00	0.00		0	0	0	0	0 0	1
7.00	0.00				0	0		
8.00	0.00		0		0			
	0.00		0	0	0	0	, en en en en en en en en en en en en en	
9.00			0	0	0	0	0	
10.00	0.00		0	0	0	0	0	
200.00			0	0	0	0	0 0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14				1	
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		OPERATING ROOM	0	0	0			1.00
2.00		RADI OLOGY-DI AGNOSTI C	0	0	0	64, 881		2.00
3.00	91.00	EMERGENCY	0	0	0	0)	3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	l o	0	0		5.00
6.00	0,00		0	0	0	0		6,00
7.00	0.00		0	n 0	0	0		7.00
8.00	0.00							8.00
9.00	0.00				0			9.00
	0.00							9.00
10.00	0.00		0	0	0			
200.00	I		0	0	0	88, 699	ļ	200.00

In Lieu of Form CMS-2552-10 Worksheet B

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2018 Fo 06/30/2019	Worksheet B Part I Date/Time Pre	pared:
					11/25/2019 11	32 am
		CAPI TAL REL	ATED COSTS			
Cast Contar Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
Cost Center Description	for Cost	FIXT	EQUIP	BENEFITS	Subtotal	
	Allocation	11.71	LUUIF	DEPARTMENT		
	(from Wkst A					
	col. 7)					
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	94, 136	94, 136				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	617, 249		617, 24	9		2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 339, 677	0	(2, 339, 677		4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	6, 025, 880	7, 685	50, 38	3 235, 960	6, 319, 913	5.00
7.00 00700 OPERATION OF PLANT	694, 458	13, 451	88, 202	2 0	796, 111	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	377	2, 47	5 0	2, 852	8.00
9. 00 00900 HOUSEKEEPI NG	364, 769	93	61	3 0	365, 475	9.00
10. 00 01000 DI ETARY	0	0	(0 0	0	10.00
13.00 01300 NURSING ADMINISTRATION	167, 302	1, 001	6, 56	5 44, 145	219, 013	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	6, 635	0	(0 0	6, 635	14.00
15. 00 01500 PHARMACY	488, 047	0	(53, 546	541, 593	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	630	3, 218	21, 09	3 0	24, 946	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1, 054, 607	11, 460	75, 14		1, 438, 092	30.00
43. 00 04300 NURSERY	0	0	(0 0	0	43.00
ANCILLARY SERVICE COST CENTERS	<u> </u>			1		
50.00 O5000 OPERATING ROOM	455, 980	7, 861	51, 54		660, 359	50.00
53. 00 05300 ANESTHESI OLOGY	0	0	(-	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	654, 184	6, 245	40, 94		866, 159	54.00
60. 00 06000 LABORATORY	1, 472, 359	2, 682	17, 58		1, 504, 029	60.00
65. 00 06500 RESPI RATORY THERAPY	62, 727	1, 625	10, 65		81, 661	65.00
66. 00 06600 PHYSI CAL THERAPY	242, 951	3, 548	23, 26		342, 283	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	(5	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1, 008	6, 61		42, 654	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	70, 211	0		0 0	70, 211	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	331	854	5, 59	9 0	6, 784	73.00
OUTPATIENT SERVICE COST CENTERS	1 1 1 0 001	0.010	50.00		1 0 (0 70 (
88.00 08800 RURAL HEALTH CLINIC	1, 462, 096	8, 219	53, 88		1, 860, 796	88.00
88.01 08801 RURAL HEALTH CLINIC II	1,897,642	11, 670	76, 52		2, 432, 939	88.01
91.00 09100 EMERGENCY	2, 362, 931	6, 976	45, 74	4 266, 750	2, 682, 401	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)					0	92.00
	FE4 (25	F 071	24 55	150,400	752.004	
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	554, 625	5, 271	34, 55	9 159, 429	753, 884	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 11	17) 21, 124, 461	93, 244	611, 403	3 2, 240, 744	21, 018, 790	110 00
NONREI MBURSABLE COST CENTERS	[/] 21,124,401	93, 244	011, 40	3 2, 240, 744	21,018,790	118.00
193. 00 19300 NONPAID WORKERS	0	0		0	0	193.00
193. 01 19301 ORTHO CLINIC	332, 039	892	5, 84	5	437, 710	
193. 02 19303 COMMUNITY MED CLINIC	332, 039		3, 64			193.01
193. 02 19303 COMMONTRY MED CETNIC 194. 00 07950 MARKETING	43	0				193.02
200.00 Cross Foot Adjustments	440	0	,			200.00
200.00 Regative Cost Centers		_				200.00
202.00 TOTAL (sum lines 118 through 201)	21, 456, 988	94, 136	617, 24	2, 339, 677	-	
	21,430,900	74, 130	017,24	2, 337, 077	21, 430, 900	202.00

	LOCATION - GENERAL SERVICE COSTS	VINCENT WILLIA	Provider C		eriod:	Worksheet B	2552-10
				F	rom 07/01/2018	Part I	
				T	0 06/30/2019	Date/Time Pre 11/25/2019 11	pared:
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	bost benter beschiption	& GENERAL	PLANT	LINEN SERVICE	HOUSEREEFING	DIEMM	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS		i		I		
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					1	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					1	4.00
5.00	00500 ADMINI STRATI VE & GENERAL	6, 319, 913				1	5.00
	00700 OPERATION OF PLANT	332, 386				1	7.00
	00800 LAUNDRY & LINEN SERVICE	1, 191	8, 021			1	8.00
9.00	00900 HOUSEKEEPI NG	152, 590	1, 986	0	520, 051		9.00
	01000 DI ETARY	0	0	0	0	0	10.00
	01300 NURSI NG ADMI NI STRATI ON	91, 441	21, 274	0	7, 179	0	
	01400 CENTRAL SERVICES & SUPPLY	2,770		0	0	0	
	01500 PHARMACY	226, 122		0	0	0	
	01600 MEDICAL RECORDS & LIBRARY	10, 415	68, 368	-	23, 072	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	10,110	00,000		20, 012		10.00
	03000 ADULTS & PEDI ATRI CS	600, 421	243, 491	5, 194	82, 168	0	30.00
	04300 NURSERY	0			02,100	0	
	ANCI LLARY SERVI CE COST CENTERS			, <u> </u>			101.00
	05000 OPERATING ROOM	275, 708	167, 025	1, 810	56, 364	0	50.00
	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	361, 632	132, 688		44, 777	0	
	06000 LABORATORY	627,950			19, 231	0	
	06500 RESPI RATORY THERAPY	34, 094			11, 652	0	
	06600 PHYSI CAL THERAPY	142, 907			25, 443	0	
	06800 SPEECH PATHOLOGY	0	0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17,809	21, 427	0	7, 231	0	
	07200 I MPL. DEV. CHARGED TO PATIENT	29, 314		0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	2,832			6, 122	0	
	OUTPATIENT SERVICE COST CENTERS	2,002	10,112		0,122		/ 01 00
	08800 RURAL HEALTH CLINIC	776, 905	0	274	58, 929	0	88.00
	08801 RURAL HEALTH CLINIC II	1, 015, 781		229		0	
	09100 EMERGENCY	1, 119, 936			50, 023	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	.,,		_,	,	-	92.00
	OTHER REIMBURSABLE COST CENTERS			1			
95.00	09500 AMBULANCE SERVI CES	314, 756	111, 987	362	37, 791	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	6, 136, 960	1, 109, 552	12,064	513, 658	0	118.00
	NONREI MBURSABLE COST CENTERS						1
	19300 NONPALD WORKERS	0	0	0	0	0	193.00
	19301 ORTHO CLINIC	182, 749	18, 945	0	6, 393		193.01
	19303 COMMUNITY MED CLINIC	18		0	0		193.02
	07950 MARKETI NG	186		0	0		194.00
200.00	Cross Foot Adjustments	1			-	-	200.00
201.00	Negative Cost Centers	0	0	0	О	0	201.00
202.00	TOTAL (sum lines 118 through 201)	6, 319, 913	1, 128, 497	12,064	520, 051		202.00
						-	

Heal th	Fi nanci al	Systems	
COCT A		CENEDAL	CED

In Lieu of Form CMS-2552-10

Hearth	Financial Systems SI.	VINCENT WILLIA	MSPURI HUSPITA	AL	In Lie	U OF FORM CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period:	Worksheet B	
					From 07/01/2018	Part I	
					To 06/30/2019	Date/Time Pre	
						11/25/2019 11	:32 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		13.00	14.00	15.00	16.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1 1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						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
13.00	01300 NURSING ADMINISTRATION	338, 907					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	9,405				14.00
15.00	01500 PHARMACY	0	0	767, 71	5		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 126, 801		16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U0	0		0 120,001		10.00
20.00	03000 ADULTS & PEDIATRICS	144 547	0		0 10 725	2 524 (40	20.00
30.00		144, 547	0		0 10, 735	2, 524, 648	
43.00	04300 NURSERY	0	0		0 0	0	43.00
	ANCILLARY SERVICE COST CENTERS	TT		1	T		-
50.00	05000 OPERATING ROOM	34, 156	0		0 9, 146	1, 204, 568	•
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 034	0		0 28, 345	1, 437, 159	54.00
60.00	06000 LABORATORY	0	0		0 24, 327	2, 232, 523	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 2, 988	164, 923	65.00
66.00	06600 PHYSI CAL THERAPY	940	0		0 3, 205	591, 140	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 131			92, 252	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	6, 274		0 0	105, 799	
72.00	07300 DRUGS CHARGED TO PATIENTS	0	0, 274			801, 595	
73.00	OUTPATIENT SERVICE COST CENTERS	U	0	767, 71	5 0	001, 393	/3.00
~~ ~~					al <u>(</u> 7 (al	0 704 /70	
88.00	08800 RURAL HEALTH CLINIC	0	0		0 4, 768	2, 701, 672	
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0 5, 858	3, 538, 483	
91.00	09100 EMERGENCY	155, 649	0		0 31, 811	4, 190, 758	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	581	0		0 5, 618	1, 224, 979	95.00
	SPECIAL PURPOSE COST CENTERS				·		1
118.00		338, 907	9, 405	767, 71	5 126, 801	20, 810, 499	1118 00
110.00	NONREI MBURSABLE COST CENTERS	000,707	7, 100	107,71	120,001	20,010,177	110.00
102 00	19300 NONPAID WORKERS	0	0		0 0	0	193.00
		0	0				
	19301 ORTHO CLINIC	0	0		0 0	645, 797	•
	2 19303 COMMUNITY MED CLINIC	0	0		0 0		193.02
	07950 MARKETI NG	0	0		0 0		194.00
200.00							200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00) TOTAL (sum lines 118 through 201)	338, 907	9, 405	767, 71	5 126, 801	21, 456, 988	202.00
				•			•

Health Financial Systems SI	. VINCENI WILLIAM	SPORT HOSPITAL		In Lieu	of Form CMS-2552-	-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN	: 15-1307		Vorksheet B Part I	
				To 06/30/2019 [Date/Time Prepared	
Cost Center Description	Intern &	Total		L	11/25/2019 11:32 a	am
cost center bescription	Residents Cost	IUtai				
	& Post					
	Stepdown					
	Adjustments	24.00				
GENERAL SERVICE COST CENTERS	25.00	26.00				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1	00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						00
5.00 00500 ADMINISTRATIVE & GENERAL						00
7.00 00700 OPERATION OF PLANT						00
8.00 00800 LAUNDRY & LINEN SERVICE						00
9.00 00900 HOUSEKEEPI NG						00
10. 00 01000 DI ETARY					10.	
13.00 01300 NURSING ADMINISTRATION					13.	
14.00 01400 CENTRAL SERVICES & SUPPLY					14.	00
15. 00 01500 PHARMACY					15.	00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.	00
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
30. 00 03000 ADULTS & PEDIATRICS	0	2, 524, 648			30.	00
43. 00 04300 NURSERY	0	0			43.	00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	1, 204, 568			50.	00
53.00 05300 ANESTHESI OLOGY	0	0			53.	00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 437, 159			54.	00
60. 00 06000 LABORATORY	0	2, 232, 523			60.	00
65. 00 06500 RESPI RATORY THERAPY	0	164, 923			65.	00
66. 00 06600 PHYSI CAL THERAPY	0	591, 140			66.	
68. 00 06800 SPEECH PATHOLOGY	0	0			68.	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	92, 252			71.	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	105, 799			72.	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	801, 595			73.	
OUTPATI ENT SERVICE COST CENTERS	<u> </u>	001,070			, 0.	00
88.00 08800 RURAL HEALTH CLINIC	0	2, 701, 672			88.	00
88.01 08801 RURAL HEALTH CLINIC II	0	3, 538, 483			88.	
91. 00 09100 EMERGENCY	0	4, 190, 758			91.	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 170, 700			92.	
OTHER REIMBURSABLE COST CENTERS	4					00
95. 00 09500 AMBULANCE SERVICES	0	1, 224, 979			95.	00
SPECIAL PURPOSE COST CENTERS		172217777			,,,,,	00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	20, 810, 499			118.	00
NONREI MBURSABLE COST CENTERS		20/010/1//				00
193. 00 19300 NONPAI D WORKERS	0	0			193.	00
193. 01 19301 ORTHO CLINIC	0	645, 797			193.	
193. 02 19303 COMMUNITY MED CLINIC	0	61			193.	
	0				193. 194.	
194.00 07950 MARKETING		631				
200.00 Cross Foot Adjustments	0	0			200.	
201.00 Negative Cost Centers	0	0			201.	
202.00 TOTAL (sum lines 118 through 201)	0	21, 456, 988			202.	00

	Idilci di Systellis 51.	VINCENT WILLIP					2552-10
ALLOCATION OF CAPITAL RELATED COSTS			Provider CO		eriod: rom 07/01/2018 o 06/30/2019	Worksheet B Part II Date/Time Pre	pared:
						11/25/2019 11	:32 am
			CAPI TAL REL	ATED COSTS			
	Cost Contor Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Cost Center Description	Directly Assigned New	FIXT	EQUI P	Subtotal	BENEFITS	
			FIAI	EQUIP		DEPARTMENT	
		Capital				DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS		0	1.00	2.00	ZA	4.00	
	100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
	500 ADMINISTRATIVE & GENERAL	389, 092	7,685	-	447, 165	0	5.00
	700 OPERATION OF PLANT	0	13, 451		101, 653	0	7.00
	BOO LAUNDRY & LINEN SERVICE	0	377		2, 852	0	8.00
	POO HOUSEKEEPI NG	0	93		706	0	9.00
	DOO DI ETARY	0	73	013	/00	0	10.00
		0	1 001	U (E (E	7 544	0	
	BOO NURSI NG ADMI NI STRATI ON	Ŭ	1, 001	6, 565	7, 566	-	13.00
	400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
	500 PHARMACY	0	0	0	0	0	15.00
16.00 016	500 MEDI CAL RECORDS & LI BRARY	0	3, 218	21, 098	24, 316	0	16.00
	PATIENT ROUTINE SERVICE COST CENTERS		44.440	75 444	04 404		0.00
	DOO ADULTS & PEDIATRICS	0	11, 460		86, 601	0	30.00
	300 NURSERY	0	0	0	0	0	43.00
	CILLARY SERVICE COST CENTERS		7.0/1	E1 E40	50.404	0	
	DOO OPERATING ROOM	0	7, 861	51, 543	59, 404	0	
	300 ANESTHESI OLOGY	0	0	-	0	0	53.00
	400 RADI OLOGY-DI AGNOSTI C	0	6, 245		47, 192	0	54.00
	DOO LABORATORY	0	2, 682		20, 268	0	60.00
	500 RESPI RATORY THERAPY	0	1, 625		12, 280	0	65.00
	500 PHYSI CAL THERAPY	0	3, 548		26, 815	0	66.00
	BOO SPEECH PATHOLOGY	0	0	0	0	0	68.00
	IOO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 008	6, 612	7, 620	0	71.00
	200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
	BOO DRUGS CHARGED TO PATIENTS	0	854	5, 599	6, 453	0	73.00
OUT	PATIENT SERVICE COST CENTERS						
	300 RURAL HEALTH CLINIC	0	8, 219		62, 108	0	88.00
	BO1 RURAL HEALTH CLINIC II	0	11, 670		88, 190	0	88.01
	IOO EMERGENCY	0	6, 976	45, 744	52, 720	0	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS							
	500 AMBULANCE SERVICES	0	5, 271	34, 559	39, 830	0	95.00
SPE	CIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	389, 092	93, 244	611, 403	1, 093, 739	0	118.00
NONRELMBURSABLE COST CENTERS							
	300 NONPAID WORKERS	0	0		0		193.00
	301 ORTHO CLINIC	0	892	5, 846	6, 738		193. 01
193.02 193	303 COMMUNITY MED CLINIC	0	0	0	0		193. 02
194.00079	950 MARKETI NG	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0		200. 00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	389, 092	94, 136	617, 249	1, 100, 477	0	202.00
	· · · · · · · · · · · · · · · · · · ·				•		

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		CADI	TAI	DEL	ATED	

Heal th	n Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL .	In Lie	u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C		Peri od:	Worksheet B	
					From 07/01/2018		
					To 06/30/2019	Date/Time Pre 11/25/2019 11	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DIETARY	
	cost center bescription	& GENERAL	PLANT	LINEN SERVICE		DIETARI	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	447, 165					5.00
7.00	00700 OPERATION OF PLANT	23, 518	125, 171				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	84	890	3, 82	6		8.00
9.00	00900 HOUSEKEEPI NG	10, 796			0 11, 722		9.00
10.00	01000 DI ETARY	0	0		0 0	C	
13.00	01300 NURSI NG ADMI NI STRATI ON	6, 470	-		0 162	C C	
14.00	01400 CENTRAL SERVICES & SUPPLY	196	2,000		0 0	0	
15.00		15, 999	0		0 0	C	
16.00		737	7, 583		0 520	C C	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	131	7,303		0 320	0	10.00
30.00	03000 ADULTS & PEDIATRICS	42, 483	27,007	1, 64	8 1, 852	C	30.00
43.00		42,405			0 1,032	C C	
45.00	ANCI LLARY SERVICE COST CENTERS	0		1	0 0		45.00
50.00	05000 OPERATI NG ROOM	19, 508	18, 526	57	4 1, 270	C	50.00
53.00	05300 ANESTHESI OLOGY	0			0 0	C C	
54.00	05400 RADI OLOGY-DI AGNOSTI C	25, 587	14, 718		-	C C	
60.00	06000 LABORATORY	44, 431	6, 321		0 433	C C	
65.00	06500 RESPI RATORY THERAPY	2, 412	3, 830		0 263	0	
66.00	06600 PHYSI CAL THERAPY	10, 111	8, 363			C C	00.00
68.00	06800 SPEECH PATHOLOGY	0	0,000		0 0	C C	
71.00		1, 260			0 163	0	
72.00	07200 I MPL. DEV. CHARGED TO PATI ENT	2,074	2,0,7		0 0	C C	
73.00		200	2, 012		0 138	0	
70.00	OUTPATIENT SERVICE COST CENTERS	200	2,012	1	100		1 10.00
88.00		54, 970	0	8	7 1, 328	C	88.00
88.01	08801 RURAL HEALTH CLINIC II	71, 871	0	-		C C	
91.00	09100 EMERGENCY	79, 244	16, 442			0	
92.00					.,		92.00
72.00	OTHER REIMBURSABLE COST CENTERS	1	I	1		<u> </u>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
95.00		22, 270	12, 421	11	5 852	C	95.00
701.00	SPECIAL PURPOSE COST CENTERS	22,270	.2, .2.		002		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
118.00		434, 221	123, 070	3, 82	6 11, 578	C	118.00
	NONREI MBURSABLE COST CENTERS		,	-,	,	-	
193.00	19300 NONPAI D WORKERS	0	0		0 0	0	193.00
	1 19301 ORTHO CLINIC	12, 930	2, 101		0 144		193.01
	2 19303 COMMUNITY MED CLINIC	1	0		0 0		193.02
	DO7950 MARKETI NG	13	n		0 0		194.00
200.00			Ĭ			Ŭ	200.00
200.00	5	0	0		0 0	0	200.00
202.00	5	447, 165	125, 171	3, 82	6 11, 722		202.00
202.00		, 100		1 3, 62	-1, /22	, v	

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		OF	CADI	TAI	DEL	ATED	1

ALLOCATION OF CAPITAL RELAT		VINCENT WILLIA	Provi der C		Period: From 07/01/2018 To 06/30/2019	Worksheet B Part II Date/Time Pre 11/25/2019 11	epared:
Cost Center De	scription	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST							
1.00 00100 NEW CAP REL CO							1.00
2.00 00200 NEW CAP REL CO							2.00
4.00 00400 EMPLOYEE BENEF							4.00
5.00 00500 ADMI NI STRATI VE							5.00
7.00 00700 OPERATION OF P							7.00
8.00 00800 LAUNDRY & LINE	N SERVICE						8.00
9.00 00900 HOUSEKEEPI NG							9.00
10. 00 01000 DI ETARY							10.00
13.00 01300 NURSI NG ADMI NI 3		16, 558					13.00
14.00 01400 CENTRAL SERVIC	ES & SUPPLY	0	196				14.00
15.00 01500 PHARMACY		0	0		99		15.00
16.00 01600 MEDICAL RECORD	S & LI BRARY	0	0		0 33, 156		16.00
INPATIENT ROUTINE SE		1 1		1	1	-	
30.00 03000 ADULTS & PEDIA	TRI CS	7,062	0		0 2,805	169, 458	30.00
43.00 04300 NURSERY		0	0		0 0	0	43.00
ANCILLARY SERVICE CO	ST CENTERS	1 1		1			
50.00 05000 OPERATI NG ROOM		1, 669	0		0 2, 390	103, 341	•
53.00 05300 ANESTHESI OLOGY		0	0		0 0	0	
54.00 05400 RADI OLOGY-DI AG	NOSTIC	148	0		0 7,406		
60.00 06000 LABORATORY		0	0		0 6, 356		
65. 00 06500 RESPI RATORY TH		0	0		0 781	19, 566	65.00
66.00 06600 PHYSI CAL THERA		46	0		0 837	47, 051	
68.00 06800 SPEECH PATHOLO		0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLI	ES CHARGED TO PATIENTS	0	65		0 0	11, 485	71.00
72.00 07200 IMPL. DEV. CHA		0	131		0 0	2, 205	
73.00 07300 DRUGS CHARGED		0	0	15, 99	99 0	24, 802	73.00
OUTPATIENT SERVICE C					-		
88.00 08800 RURAL HEALTH C		0	0		0 1, 246		
88.01 08801 RURAL HEALTH C	LINIC II	0	0		0 1, 531	163, 551	
91.00 09100 EMERGENCY		7,605	0		0 8, 336	166, 333	
	DS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE C							
95.00 09500 AMBULANCE SERV		28	0		0 1, 468	76, 984	95.00
SPECIAL PURPOSE COST				1			
	OF LINES 1 through 117)	16, 558	196	15, 99	3 3, 156	1, 078, 550	118.00
NONREI MBURSABLE COST				1	-		
193.00 19300 NONPAID WORKER	ŝ	0	0		0 0		193.00
193.01 19301 ORTHO CLINIC		0	0		0 0		193.01
193. 02 19303 COMMUNI TY MED	CLINIC	0	0		0 0		193. 02
194. 00 07950 MARKETI NG		0	0		0 0		194.00
200.00 Cross Foot Adj							200. 00
201.00 Negative Cost		0	0		0 0		201.00
202.00 TOTAL (sum line	es 118 through 201)	16, 558	196	15, 99	33, 156	1, 100, 477	202.00

	TION OF CAPITAL RELATED COSTS	VINCENT WILLIF	Provider CC		Period: Worksheet	
ALLUCA	ITION OF CAPITAL RELATED COSTS		Provider CC	JN: 15-1307	From 07/01/2018 Part II To 06/30/2019 Date/Time 11/25/2019	Prepared:
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
		25.00	26.00			
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 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			1		10.00
13.00	01300 NURSING ADMINISTRATION					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	0	169, 458			30.00
43.00	04300 NURSERY	0	0			43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM	0	103, 341			50.00
53.00	05300 ANESTHESI OLOGY	0	0			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	96, 226			54.00
60.00	06000 LABORATORY	0	77, 809			60.00
65.00	06500 RESPI RATORY THERAPY	0	19, 566			65.00
66.00	06600 PHYSI CAL THERAPY	0	47, 051			66.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11, 485			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2, 205			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	24, 802			73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	119, 739			88.00
	08801 RURAL HEALTH CLINIC II	0	163, 551			88. 01
91.00	09100 EMERGENCY	0	166, 333			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	76, 984			95.00
	SPECIAL PURPOSE COST CENTERS					
118.00		0	1, 078, 550			118.00
	NONREI MBURSABLE COST CENTERS					
	19300 NONPAID WORKERS	0	0			193.00
	19301 ORTHO CLINIC	0	21, 913			193.01
	19303 COMMUNITY MED CLINIC	0	1			193.02
	07950 MARKETI NG	0	13			194.00
200.00	5	0	0			200.00
201.00	5	0	0			201.00
202.00	TOTAL (sum lines 118 through 201)	0	1, 100, 477			202.00

ST. VINCENT WILLIAMSPORT HOSPITAL

In Lieu of Form CMS-2552-10

Health Fina	ancial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der CO		eri od:	Worksheet B-1	
					rom 07/01/2018		
				T	o 06/30/2019	Date/Time Pre 11/25/2019 11	
		CAPI TAL REL	ATED COSTS			11/25/2019 11	. 32 am
		CAFITAL KLL	AILD COSIS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Peconciliation	ADMI NI STRATI VE	
	cost center bescription	FIXT	EQUI P	BENEFITS	Reconciliation	& GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
		1	ILLI)	SALARI ES)		0031)	
		1.00	2.00	4. 00	5A	5.00	
GENE	RAL SERVICE COST CENTERS	1.00	2.00	4.00	54	3.00	
	DO NEW CAP REL COSTS-BLDG & FIXT	52, 368					1.00
	DO NEW CAP REL COSTS MUBLE EQUIP	52, 500	52, 368				2.00
	DO EMPLOYEE BENEFITS DEPARTMENT	0	52, 500				4.00
	DO ADMINISTRATIVE & GENERAL	-				15, 137, 075	
		4, 275	4, 275		-6, 319, 913		
	OO OPERATION OF PLANT	7,483	7, 483		0	796, 111	
	DO LAUNDRY & LINEN SERVICE	210	210		0	2, 852	
	DO HOUSEKEEPI NG	52	52		0	365, 475	
	DO DI ETARY	0	0	-	0	0	
	DO NURSI NG ADMI NI STRATI ON	557	557	142, 704	0	219, 013	
	DO CENTRAL SERVICES & SUPPLY	0	0	-	0	6, 635	14.00
15.00 0150	DO PHARMACY	0	0		0	541, 593	15.00
16.00 0160	DO MEDICAL RECORDS & LIBRARY	1, 790	1, 790	0	0	24, 946	16.00
I NPA	ATIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	DO ADULTS & PEDIATRICS	6, 375	6, 375	959, 705	0	1, 438, 092	30.00
43.00 0430	DO NURSERY	0	0	0	0	0	43.00
ANCI	LLARY SERVICE COST CENTERS			_		_	
50.00 0500	DO OPERATING ROOM	4, 373	4, 373	468, 646	0	660, 359	50.00
53.00 0530	DO ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	3, 474	3, 474	532, 678	0	866, 159	54.00
	DOLABORATORY	1, 492	1, 492			1, 504, 029	60.00
	DO RESPIRATORY THERAPY	904	904			81, 661	
	DO PHYSI CAL THERAPY	1, 974	1, 974			342, 283	
	DO SPEECH PATHOLOGY	0	0		0	0	
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	561	561	0	0	42, 654	
	DO I MPL. DEV. CHARGED TO PATIENT	0	0	0	0		
	DO DRUGS CHARGED TO PATIENTS	475	475	-			
	PATIENT SERVICE COST CENTERS	475	+75	0	0	0,704	/ 3. 00
	DO RURAL HEALTH CLINIC	4, 572	4, 572	1, 088, 065	0	1, 860, 796	88.00
	DI RURAL HEALTH CLINIC II	6, 492	6, 492				
	DO EMERGENCY	3, 881	3, 881				
	DO OBSERVATION BEDS (NON-DISTINCT PART)	3,001	3, 001	002, 293	0	2,002,401	
							92.00
	ER REIMBURSABLE COST CENTERS	2,932	2, 932	515, 369	0	753, 884	95.00
	CIAL PURPOSE COST CENTERS	2,932	2, 932	515, 309	0	/55, 004	95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	51, 872	51, 872	7, 243, 428	-6, 319, 913	14, 698, 877	110 00
	REIMBURSABLE COST CENTERS	51,072	31, 072	7, 243, 420	-0, 319, 913	14, 090, 077	110.00
	DO NONPAI D WORKERS	o	0	0	0	0	193.00
	DI ORTHO CLINIC	496	496				
					0		
	OS COMMUNITY MED CLINIC	0	0	-	-		193.02
	50 MARKETING	0	0	0	0	445	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers			0 000 /			201.00
202.00	Cost to be allocated (per Wkst. B,	94, 136	617, 249	2, 339, 677		6, 319, 913	202.00
	Part I)	4 30355	44 30/355				000 00
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 797586	11. 786759	0. 309349		0. 417512	
204.00	Cost to be allocated (per Wkst. B,			0		447, 165	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part			0.00000		0. 029541	205.00
							001 00
206.00	NAHE adjustment amount to be allocated						206.00
207 00	(per Wkst. B-2)						207 00
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
I	Parts III and IV)	I I		I	I	I	I

Heal th Financial	Systems
COCT ALLOCATION	

ST. VINCENT WILLIAMSPORT HOSPITAL

In Lieu of Form CMS-2552-10

Cost Center Description OPERATION OF PLANT (SOUARE FEET) LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY) HOUSEKEEPING (SQUARE FEET) DIE COURT (M SERVICE (SQUARE FEET)	/01/2018 /30/2019 ETARY IEALS RVED) D. 00	Worksheet B-1 Date/Time Pre 11/25/2019 11 NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS) 13.00	
To 06. Cost Center Description OPERATION OF PLANT (SQUARE FEET) LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY) HOUSEKEEPING (SQUARE FEET) DIE (SQUARE FEET) 0 GENERAL SERVICE COST CENTERS 7.00 8.00 9.00 100 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 06	/30/2019 ETARY IEALS RVED)	11/25/2019 11 NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	
Cost Center Description OPERATION OF PLANT (SOUARE FEET) LAUNDRY & HOUSEKEEPING (SOUARE FEET) DIE (SOUARE FEET) Cost Center Description OPERATION OF PLANT (SOUARE FEET) LAUNDRY & HOUSEKEEPING (SOUARE FEET) DIE (SOUARE FEET) Cost Center Description OPERATION OF PLANT (SOUARE FEET) LAUNDRY) HOUSEKEEPING (SOUARE FEET) OI 7.00 8.00 9.00 10 Cost Centers 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP Image: Cost Center Ce	ETARY IEALS RVED)	11/25/2019 11 NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	
GENERAL SERVICE COST CENTERS PLANT (SQUARE FEET) LI NEN SERVICE (POUNDS OF LAUNDRY) (SQUARE FEET) (M FEET) 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL Image: Cost of the second s	IEALS RVED)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	32 811
GENERAL SERVICE COST CENTERS PLANT (SQUARE FEET) LI NEN SERVICE (POUNDS OF LAUNDRY) (SQUARE FEET) (M FEET) 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL Image: Cost of the second s	IEALS RVED)	ADMI NI STRATI ON (DI RECT NRSI NG HRS)	
GENERAL SERVICE COST CENTERS (SQUARE FEET) (POUNDS OF LAUNDRY) FEET) SEF 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 00100 00200 NEW CAP REL COSTS-MVBLE EQUIP 000200 NEW CAP REL COSTS-MVBLE EQUIP 000400 EMPLOYEE BENEFITS DEPARTMENT 000500 ADMINISTRATIVE & GENERAL 00500 00500 ADMINISTRATIVE & GENERAL 00000 00500	RVED)	(DI RECT NRSI NG HRS)	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 00100 COSTS-BLDG & FIXT 00100 COSTS-MVBLE C	,	NRSING HRS)	
GENERAL SERVICE COST CENTERS 7.00 8.00 9.00 10 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT <t< td=""><td>). 00</td><td>NRSING HRS)</td><td></td></t<>). 00	NRSING HRS)	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL). 00		
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL	0.00	13.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL			
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUI P 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL			
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL			1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL			2.00
5. 00 00500 ADMI NI STRATI VE & GENERAL			4.00
			5.00
			7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 210 93, 701			8.00
9.00 00900 HOUSEKEEPING 52 0 40,348			9.00
10. 00 0 0 0	100		10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 557 0 557	0	42, 557	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0	0	0	14.00
15.00 01500 PHARMACY 0 0 0	o	0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 1, 790 0 1, 790	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			10.00
30. 00 03000 ADULTS & PEDI ATRI CS 6, 375 40, 354 6, 375	100	18, 151	30.00
43. 00 04300 NURSERY 0 0 0	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS			
50. 00 05000 0PERATING ROOM 4, 373 14, 055 4, 373	0	4, 289	50.00
53. 00 05300 ANESTHESI OLOGY 0 0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 3, 474 4, 070 3, 474	0	381	54.00
60. 00 06000 LABORATORY 1, 492 0 1, 492	o	0	60.00
65. 00 06500 RESPI RATORY THERAPY 904 0 904	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY 1, 974 7, 500 1, 974	0	118	66.00
68. 00 06800 SPECH PATHOLOGY 0 0 0	0	0	68.00
	0	-	71.00
	-	0	
72.00 07200 I MPL DEV. CHARGED TO PATI ENT 0 0 0 0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 475 0 475	0	0	73.00
OUTPATI ENT_SERVICE_COST_CENTERS			
88.00 08800 RURAL HEALTH CLINIC 0 2,126 4,572	0	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II 0 1, 775 6, 492	0	0	88.01
91. 00 09100 EMERGENCY 3, 881 21, 010 3, 881	o	19, 545	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS			12100
95. 00 09500 AMBULANCE SERVICES 2, 932 2, 811 2, 932	0	73	95.00
	0	/3	95.00
SPECIAL PURPOSE COST CENTERS	100	10 553	
Subscription Subscription<	100	42, 557	118.00
NONREI MBURSABLE COST CENTERS			
193.00 19300 NONPAID WORKERS 0 0 0	0	0	193.00
193. 01 19301 ORTHO CLINIC 496 0 496	0	0	193.01
193. 02 19303 COMMUNITY MED CLINIC 0 0 0	0	0	193.02
194. 00 07950 MARKETING 0 0 0	0	0	194.00
200.00 Cross Foot Adjustments	-		200.00
			201.00
	0	220 007	
202.00 Cost to be allocated (per Wkst. B, 1, 128, 497 12, 064 520, 051	0	338, 907	202.00
Part I)			
	0.000000	7.963602	
204.00 Cost to be allocated (per Wkst. B, 125, 171 3, 826 11, 722	0	16, 558	204.00
Part II)			
205.00 Unit cost multiplier (Wkst. B, Part 4.236479 0.040832 0.290522	0.000000	0. 389078	205.00
206.00 NAHE adjustment amount to be allocated			206.00
(per Wkst. B-2)			
207.00 NAHE unit cost multiplier (Wkst. D,			207.00
Parts III and IV)			207.00
			I

Heal th Financial	Systems
MOLTADOLIA T200	

Health Financial System		VINCENI WILLIA			In Lieu of Form	
COST ALLOCATION - STATI	STICAL BASIS		Provider CC		eriod: Worksheet rom 07/01/2018	t B-1
					o 06/30/2019 Date/Time	e Prepared:
					11/25/201	19 11 32 am
Cost Center	Description	CENTRAL	PHARMACY	MEDI CAL		
		SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY		
		(DIRECT COSTS)		(GROSS		
		11.00	45.00	CHARGES)		
	COST CENTERS	14.00	15.00	16.00		
GENERAL SERVICE (I I				1 00
	COSTS-BLDG & FIXT					1.00
	COSTS-MVBLE EQUIP					
4. 00 00400 EMPLOYEE BE 5. 00 00500 ADMI NI STRAT	ENEFITS DEPARTMENT					4.00
7.00 00700 OPERATION 0						5.00
8.00 00800 LAUNDRY & L						7.00 8.00
9.00 00900 HOUSEKEEPIN						
	16					9.00
10.00 01000 DI ETARY						10.00
13.00 01300 NURSING ADM		105 245				13.00
14.00 01400 CENTRAL SEF 15.00 01500 PHARMACY	VICES & SUPPLY	105, 245	100			14.00
		0	100	40 101 402		15.00
16.00 01600 MEDI CAL REC		0	0	68, 181, 493		16.00
	E SERVICE COST CENTERS		0	E 771 (70		20.00
	DIATRICS	0	0			30.00
43.00 04300 NURSERY		0	0	0		43.00
ANCI LLARY SERVICE			0	4 017 000		F0.00
50.00 05000 OPERATING F		0	0	4, 917, 092		50.00
53. 00 05300 ANESTHESI OL		0	0	15 220 424		53.00
54. 00 05400 RADI OLOGY-E	JI AGNOSTI C	0	0	15, 239, 434		54.00
60. 00 06000 LABORATORY		0	0	13, 079, 107		60.00
65. 00 06500 RESPI RATORY		0	0	1, 606, 411		65.00
66.00 06600 PHYSI CAL TH 68.00 06800 SPEECH PATH		0	0	1, 722, 957 0		66.00
	PLIES CHARGED TO PATIENTS	-	0	0		68.00 71.00
	CHARGED TO PATIENTS	35, 034 70, 211	0	0		72.00
73.00 07300 DRUGS CHARG		70, 211	100	0		72.00
OUTPATIENT SERVI		U	100	0		/3.00
88.00 08800 RURAL HEALT		0	0	2, 563, 435		88.00
88. 01 08801 RURAL HEALT		0	0	3, 149, 716		88.01
91.00 09100 EMERGENCY	II CEINIC II	0	0	17, 111, 088		91.00
	I BEDS (NON-DISTINCT PART)	U	0	17, 111, 000		92.00
OTHER REI MBURSABI						92.00
95. 00 09500 AMBULANCE S		0	0	3, 020, 575		95.00
SPECIAL PURPOSE (0	0	3, 020, 373		/3.00
	SUM OF LINES 1 through 117)	105, 245	100	68, 181, 493		118.00
NONREI MBURSABLE		100,210	100	00, 101, 170		
193. 00 19300 NONPAI D WOF		0	0	0		193.00
193. 01 19301 ORTHO CLINI		0	0	0		193.00
193. 02 19303 COMMUNI TY N		0	0	0		193.02
194. 00 07950 MARKETI NG		0	0	0		194.00
1 1	Adjustments	U U	0	0		200.00
201.00 Negative Co	5					201.00
Ű	allocated (per Wkst. B,	9, 405	767, 715	126, 801		202.00
Part I)	Littation (por more b)	,, 103	, , , , , , , , , , , , , , , , , , , ,	120,001		202.00
	nultiplier (Wkst. B, Part I)	0. 089363	7, 677. 150000	0. 001860		203.00
1 1	allocated (per Wkst. B,	196	15, 999			204.00
Part II)			. = , , ,	22, 700		
	nultiplier (Wkst. B, Part	0. 001862	159. 990000	0. 000486		205.00
11)						
206.00 NAHE adjust	ment amount to be allocated					206.00
(per Wkst.	B-2)					
	cost multiplier (Wkst. D,					207.00
Parts III a	and IV)					

near th Financial Systems 51.	VINCENT WILLIA	AMSPORT HUSPITA	<u>۱</u>	III LIE		2002-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
				From 07/01/2018		
				To 06/30/2019		
					11/25/2019 11	:32 am
			XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 524, 648		2, 524, 64	8 0	0	30.00
43. 00 04300 NURSERY	0			0 0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 204, 568		1, 204, 56	8 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 437, 159		1, 437, 15	9 0	0	54.00
60. 00 06000 LABORATORY	2, 232, 523		2, 232, 52		0	60.00
65. 00 06500 RESPI RATORY THERAPY	164, 923		164, 92		0	65.00
66.00 06600 PHYSI CAL THERAPY	591, 140		591, 14		0	
68. 00 06800 SPEECH PATHOLOGY	0,1,110	0	0,1,11	0 0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	92, 252		92, 25	2 0	0	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	105, 799		105, 79		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	801, 595		801, 59		0	1
OUTPATIENT SERVICE COST CENTERS	001, 373		001, 37	5 0	. 0	/ 3.00
88. 00 08800 RURAL HEALTH CLINIC	2, 701, 672		2, 701, 67	2 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	3, 538, 483		3, 538, 48		0	
91. 00 09100 EMERGENCY	4, 190, 758		4, 190, 75		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	656, 601		656, 60		0	1
OTHER REIMBURSABLE COST CENTERS	050,001		050,00	1	0	92.00
	1 224 070	l	1 224 07	0 0	0	
95. 00 09500 AMBULANCE SERVICES	1, 224, 979		1, 224, 97			95.00
200.00 Subtotal (see instructions)	21, 467, 100		21, 467, 10			200.00
201.00 Less Observation Beds	656, 601		656, 60			201.00
202.00 Total (see instructions)	20, 810, 499	0	20, 810, 49	9 0	0	202.00

Tiear th' Financial Systems 51.	VINCENT WILLIF					2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
				From 07/01/2018		
				To 06/30/2019		
		T: +1 -		11	11/25/2019 11	:32 am
			XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpatient	
	(00	7.00	0.00	0.00	Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS				_1		1
30. 00 03000 ADULTS & PEDI ATRI CS	4, 494, 095		4, 494, 09			30.00
43. 00 04300 NURSERY	0			0		43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	200, 626	4, 716, 466	4, 917, 09			
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	711, 001	14, 528, 433	15, 239, 43	4 0.094305	0.000000	54.00
60. 00 06000 LABORATORY	1, 059, 591	12, 019, 516	13, 079, 10	7 0. 170694	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	77, 832	1, 528, 579	1, 606, 41	1 0. 102666	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	196, 502	1, 526, 455	1, 722, 95	7 0.343096	0.000000	66.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	600, 293	829, 055	1, 429, 34	8 0.064541	0.000000	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	8, 942	239, 940	248, 88	2 0. 425097	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	943, 407	2, 529, 684	3, 473, 09	1 0.230802	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS			,			
88.00 08800 RURAL HEALTH CLINIC	0	2, 563, 435	2, 563, 43	5		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	3, 149, 716				88.01
91. 00 09100 EMERGENCY	263, 124	16, 847, 964			0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	60, 229	1, 217, 354				
OTHER REIMBURSABLE COST CENTERS	00,227	1,217,001	1,277,00	0.010710	0.000000	12.00
95. 00 09500 AMBULANCE SERVICES	0	3, 020, 575	3, 020, 57	5 0. 405545	0.000000	95.00
200.00 Subtotal (see instructions)	8, 615, 642	64, 717, 172			0.00000	200.00
201.00 Less Observation Beds	0,010,042	07,717,172	, 5, 552, 01	T		200.00
202.00 Total (see instructions)	8, 615, 642	64, 717, 172	73, 332, 81	4		201.00
	0,015,042	04, / 17, 172	13, 332, 01	-	I	1202.00

Health Financial Systems ST	. VINCENT WILLIAM	ISPORT HOSPITAL	u of Form CMS-2	<u>MS-2552-10</u>	
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1307	Period: From 07/01/2018 To 06/30/2019	Date/Time Prep 11/25/2019 11:	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
13. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS	1				
50. 00 05000 OPERATI NG ROOM	0. 000000				50.0
3. 00 05300 ANESTHESI OLOGY	0. 000000				53.0
4.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.C
0. 00 06000 LABORATORY	0. 000000				60. C
5.00 06500 RESPIRATORY THERAPY	0. 000000				65.C
6.00 06600 PHYSI CAL THERAPY	0. 000000				66. C
8.00 06800 SPEECH PATHOLOGY	0. 000000				68. C
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. C
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. C
OUTPATIENT SERVICE COST CENTERS	1 1				
8.00 08800 RURAL HEALTH CLINIC					88.0
88.01 08801 RURAL HEALTH CLINIC II	0.000000				88.0
91.00 09100 EMERGENCY	0. 000000				91.0
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000				92.0
OTHER REI MBURSABLE COST CENTERS	0.000000				
	0. 000000				95.0
200.00 Subtotal (see instructions)					200. C
201.00 Less Observation Beds					201.0
202.00 Total (see instructions)				I	202.0

	VINCENT WILLIN		<u>``</u> .			2002 10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 07/01/2018		
				To 06/30/2019	Date/Time Pre 11/25/2019 11	
		Ti +1	e XIX	Hospi tal	Cost	. 32 ani
		1111		Costs	CUST	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
COST Center Description	(from Wkst. B,	Adj.	TOTAL COSTS	Di sal l owance	TUTAL COSTS	
	Part I, col.	Auj.		DISALIOWALICE		
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS	2, 524, 648		2, 524, 64	0	2, 524, 648	30.00
43. 00 04300 NURSERY	2, 524, 040		2, 324, 04		2, 524, 048	
ANCI LLARY SERVICE COST CENTERS	0			0 0	0	43.00
50. 00 05000 OPERATI NG ROOM	1, 204, 568		1, 204, 56	8 0	1, 204, 568	50.00
53. 00 05300 ANESTHESI OLOGY	1, 204, 300		1, 204, 30		1, 204, 300	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 437, 159		1, 437, 15	0 0	1, 437, 159	
60. 00 06000 LABORATORY	2, 232, 523		2, 232, 52		2, 232, 523	
65. 00 06500 RESPIRATORY THERAPY	164, 923		164, 92		164, 923	•
66. 00 06600 PHYSI CAL THERAPY	591, 140		591, 14		591, 140	•
68. 00 06800 SPEECH PATHOLOGY	0,140		371, 14		0,140	•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	92, 252		92, 25	2 0	92, 252	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	105, 799		105, 79		105, 799	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	801, 595		801, 59		801, 595	
OUTPATIENT SERVICE COST CENTERS	001, 373		001, 37	5 0	001, 373	/ 5. 00
88. 00 08800 RURAL HEALTH CLINIC	2, 701, 672		2, 701, 67	2 0	2, 701, 672	88.00
88. 01 08801 RURAL HEALTH CLINIC II	3, 538, 483		3, 538, 48		3, 538, 483	•
91. 00 09100 EMERGENCY	4, 190, 758		4, 190, 75		4, 190, 758	•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	656, 601		656, 60		656,601	92.00
OTHER REIMBURSABLE COST CENTERS	000,001	I	000,00	·	000,001	12.00
95. 00 09500 AMBULANCE SERVICES	1, 224, 979		1, 224, 97	9 0	1, 224, 979	95 00
200.00 Subtotal (see instructions)	21, 467, 100		21, 467, 10		21, 467, 100	
201.00 Less Observation Beds	656, 601		656, 60		656, 601	
202.00 Total (see instructions)	20, 810, 499				20, 810, 499	
	1 20,010,477		20,010,47	1 0	20,010,477	1-02.00

	VINCENT WILLIF	WJFORT HUJFTTF				2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	Provider CCN: 15-1307		Worksheet C	
				From 07/01/2018		nored.
				To 06/30/2019	Date/Time Pre 11/25/2019 11	
		Titl	e XIX	Hospi tal	Cost	. 52 am
		Charges	1			
Cost Center Description	I npati ent	Outpati ent	Total (col. (6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	4, 494, 095		4, 494, 09	5		30.00
43.00 04300 NURSERY	0			0		43.00
ANCILLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATI NG ROOM	200, 626	4, 716, 466	4, 917, 09	2 0. 244976	0.00000	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0.000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	711,001	14, 528, 433	15, 239, 43	4 0.094305	0.000000	54.00
60. 00 06000 LABORATORY	1, 059, 591	12, 019, 516	13, 079, 10	0. 170694	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	77, 832	1, 528, 579	1, 606, 41	1 0. 102666	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	196, 502	1, 526, 455	1, 722, 95	7 0.343096	0.00000	66.00
68.00 06800 SPEECH PATHOLOGY	0	0		0.000000	0.00000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	600, 293	829, 055	1, 429, 34	8 0.064541	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	8, 942	239, 940	248, 88	2 0. 425097	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	943, 407	2, 529, 684	3, 473, 09	1 0. 230802	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	2, 563, 435	2, 563, 43	5 1.053926	0.000000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	3, 149, 716	3, 149, 71	6 1.123429	0.000000	88.01
91. 00 09100 EMERGENCY	263, 124	16, 847, 964	17, 111, 08	8 0. 244915	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	60, 229	1, 217, 354	1, 277, 58	3 0. 513940	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	3, 020, 575	3, 020, 57	5 0. 405545	0.00000	95.00
200.00 Subtotal (see instructions)	8, 615, 642	64, 717, 172	73, 332, 81	4		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	8, 615, 642	64, 717, 172	73, 332, 81	4		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1307	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared 11/25/2019 11:32 a
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.
43. 00 04300 NURSERY				43.
ANCI LLARY SERVI CE COST CENTERS				
50.00 05000 OPERATING ROOM	0.000000			50.
53. 00 05300 ANESTHESI OLOGY	0.000000			53.
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.
60. 00 06000 LABORATORY	0.000000			60.
65. 00 06500 RESPI RATORY THERAPY	0.000000			65.
66. 00 06600 PHYSI CAL THERAPY	0.000000			66.
68.00 06800 SPEECH PATHOLOGY	0.000000			68.
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000			73.
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0.000000			88.
88.01 08801 RURAL HEALTH CLINIC II	0.000000			88.
91.00 09100 EMERGENCY	0.000000			91.
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0.000000			95.
200.00 Subtotal (see instructions)				200.
201.00 Less Observation Beds				201.
202.00 Total (see instructions)				202.

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider CO		Period: From 07/01/2018 To 06/30/2019		pared: :32 am
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	103, 341	4, 917, 092				
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	96, 226					1
60. 00 06000 LABORATORY	77, 809					60.00
65. 00 06500 RESPI RATORY THERAPY	19, 566					
66. 00 06600 PHYSI CAL THERAPY	47, 051					
68.00 06800 SPEECH PATHOLOGY	0	Ŭ	0.0000		0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 485					1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 205					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	24, 802	3, 473, 091	0.00714	1 519, 829	3, 712	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	119, 739			-	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	163, 551				0	88. 01
91.00 09100 EMERGENCY	166, 333			-	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	44,072	1, 277, 583	0.03449	6, 842	236	92.00
OTHER REIMBURSABLE COST CENTERS	1	1				
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	876, 180	65, 818, 144		1, 989, 087	17, 163	200.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2018 To 06/30/2019		narod
				10 00/30/2019	11/25/2019 11	
		Title	XVIII	Hospi tal	Cost	<u>- 02 um</u>
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	I Allied Health	Allied Health	
	Anesthetist	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	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88. 01
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1	I	1	-T		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C	Provider CCN: 15-1307		Worksheet D	
THROUGH COSTS				From 07/01/2018 To 06/30/2019	Part IV Date/Time Pre	norod.
				10 06/30/2019	11/25/2019 11	· 32 am
		Title	XVIII	Hospi tal	Cost	<u>102 am</u>
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1	-		1	-	
50.00 05000 OPERATI NG ROOM	0	0		0 4, 917, 092		
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 15, 239, 434		
60. 00 06000 LABORATORY	0	0		0 13, 079, 107		•
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 606, 411		•
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 722, 957		
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 429, 348		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 248, 882		•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 473, 091	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS				1		
88.00 08800 RURAL HEALTH CLINIC	0	0		0 2, 563, 435		•
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 3, 149, 716	0. 000000	88. 01
91.00 09100 EMERGENCY	0	0		0 17, 111, 088		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 277, 583	0.00000	92.00
OTHER REI MBURSABLE COST CENTERS				1		
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	0		0 65, 818, 144		200.00

Health Financial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	AL.	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-1307	Period: From 07/01/2018 To 06/30/2019		pared: :32 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1 1					
50.00 05000 OPERATI NG ROOM	0. 000000	124, 805		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	344, 604		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	547, 442		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	35, 192		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	74, 094		0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	329, 856		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	6, 423		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	519, 829		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			-		-	
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.01
91.00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	6, 842		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)		1, 989, 087		0 0	0	200. 00

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Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Period: From 07/01/2018 To 06/30/2019		
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		-				
50.00 05000 OPERATING ROOM	0. 244976	0	2, 132, 28	5 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 094305	0	5, 535, 69	3 0	0	54.00
60. 00 06000 LABORATORY	0. 170694	0	5, 084, 93	0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 102666	0	734, 78	5 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 343096	0	621, 36	3 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 064541	0	433, 25	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 425097	0	80, 67		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 230802	0	1, 013, 02	2, 936	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				0	88.01
91. 00 09100 EMERGENCY	0. 244915	0	4, 924, 72	5 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 513940	0	622, 81	5 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 405545			0		95.00
200.00 Subtotal (see instructions)		0	21, 183, 54	2 2, 936	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	21, 183, 54	2 2, 936	0	202.00

Heal th	Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	L	In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC		Period: From 07/01/2018 To 06/30/2019	Worksheet D Part V Date/Time Pre 11/25/2019 11	
			Title	XVIII	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCILLARY SERVICE COST CENTERS	1					_
	05000 OPERATING ROOM	522, 359	0				50.00
	05300 ANESTHESI OLOGY	0	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	522, 044	0				54.00
	06000 LABORATORY	867, 967					60.00
	06500 RESPI RATORY THERAPY	75, 437	0				65.00
	06600 PHYSI CAL THERAPY	213, 187	0				66.00
	06800 SPEECH PATHOLOGY	0	0				68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 962					71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	34, 294					72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	233, 808	678				73.00
	OUTPATIENT SERVICE COST CENTERS	1					
	08800 RURAL HEALTH CLINIC	0	0				88.00
	08801 RURAL HEALTH CLINIC II	0	0				88.01
	09100 EMERGENCY	1, 206, 139					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	320, 090	0				92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0					95.00
200.00		4, 023, 287	678				200.00
201.00		0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	4, 023, 287	678				202.00

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Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2018 To 06/30/2019		pared:
		componionie	2007		11/25/2019 11	
		Title	XVIII S	Swing Beds - SNF	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(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. 244976			0 0	0	50.00
53.00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 094305			0 0	0	0 11 00
60. 00 06000 LABORATORY	0. 170694			0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 102666			0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 343096			0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 064541	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 425097			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 230802	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS				-		
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				0	88. 01
91.00 09100 EMERGENCY	0. 244915			0 0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 513940	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	0.1055.15	I	1	- -	[
95. 00 09500 AMBULANCE SERVICES	0. 405545	_			~	95.00
200.00 Subtotal (see instructions)		0		0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges					0	202.00
202.00 Net Charges (line 200 - line 201)	ļ	0	1	0 0	0	202.00

Heal th	Financial Systems ST.	VINCENT WILLI	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1307	Peri od:	Worksheet D	
			Component	CCN: 15-Z307	From 07/01/2018 To 06/30/2019	Part V Date/Time Pre	narod
			component	CCN. 15-2307	10 00/30/2019	11/25/2019 11	l:32 am
			Title	e XVIII	Swing Beds - SNF		
		Co	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	-			
		6.00	7.00				
	ANCI LLARY SERVI CE COST CENTERS			1			1 50 00
	05000 OPERATING ROOM						50.00
	05300 ANESTHESI OLOGY						53.00
	05400 RADI OLOGY-DI AGNOSTI C						54.00
							60.00
	06500 RESPI RATORY THERAPY						65.00
	06600 PHYSI CAL THERAPY						66.00
	06800 SPEECH PATHOLOGY						68.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS						71.00
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS						72.00
73.00	OUTPATIENT SERVICE COST CENTERS		<u> </u>	1			/3.00
88.00	08800 RURAL HEALTH CLINIC						88.00
	08801 RURAL HEALTH CLINIC II						88.01
	09100 EMERGENCY						91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
72.00	OTHER REIMBURSABLE COST CENTERS		, U	1			72.00
95.00	09500 AMBULANCE SERVICES	0					95.00
200.00							200.00
200.00							200.00
201.00	Only Charges						
202.00		c	o				202.00

Health Financial Systems ST	. VINCENT WILLIA	AMSPORT HOSPITA	AL .	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COS			Period: From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 11	
			e XIX	Hospi tal	Cost	
Cost Center Description	Nursing School	Nursing School	Allied Healt	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 & PEDI ATRI CS	0	C)	0 0	0	30.00
43. 00 04300 NURSERY	0	l o		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	l a		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,				
		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	0	C	2,23	8 0.00	31	30.00
43. 00 04300 NURSERY		l a		0 0.00	0	43.00
200.00 Total (lines 30 through 199)			2, 23	8	31	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 & PEDI ATRI CS	0					30.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	1 0	I				1200.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2018 To 06/30/2019		narod
				10 00/ 30/ 2019	11/25/2019 11	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	I Allied Health	Allied Health	
	Anestheti st	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
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	r	1		1		
88.00 08800 RURAL HEALTH CLINIC	0	C		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	C		0 0	0	88. 01
91. 00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1	1	1	1		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	C		0 0	0	200.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL .	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2018 To 06/30/2019	Part IV Date/Time Pre	norod.
				10 06/30/2019	11/25/2019 11	· 32 am
		Ti tl	e XIX	Hospi tal	Cost	<u>102 am</u>
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1		1	-1		-
50.00 05000 OPERATI NG ROOM	0	0		0 4, 917, 092		•
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 15, 239, 434		
60. 00 06000 LABORATORY	0	0		0 13, 079, 107		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 606, 411		•
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 722, 957		
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 429, 348		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 248, 882		•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 473, 091	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 2, 563, 435		
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 3, 149, 716		
91. 00 09100 EMERGENCY	0	0		0 17, 111, 088		•
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	0		0 1, 277, 583	0.00000	92.00
OTHER REI MBURSABLE COST CENTERS			1	-		
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	0	1	0 65, 818, 144		200.00

Health Financial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-1307	Period: From 07/01/2018 To 06/30/2019		pared:
		Titl	e XIX	Hospi tal	Cost	. 52 am
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 000000	13, 207		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	49, 916		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	43, 263		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 206		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	812		0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	5, 274		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	35, 609		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.01
91.00 09100 EMERGENCY	0. 000000	53, 209		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)		202, 496	1	0 0	0	200. 00

11/25/2019 11:32 am Y:\28950 - St. Vincent Williamsport Hospital\300 - Medicare Cost Report\20190630\HFS\20190630 Williamsport.mc

	Financial Systems ST. VINCENT WILLIAM: ATION OF INPATIENT OPERATING COST	SPORT HOSPITAL Provider CCN: 15-1307	In Lie Period:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 11	
		Title XVIII	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	INPATIENT DAYS			0.705	1 1 00
1.00 2.00 3.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day and exclusion bed days)	-bed and newborn days)	rivate room days,	2, 795 2, 238 0	1.00 2.00 3.00
4.00 5.00	do not complete this line. Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	1, 516 278	4.00 5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	257	6.00
7.00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through December	31 of the cost	11	7.00
8.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	11	8.00
9.00	Total inpatient days including private room days applicable t newborn days)	to the Program (excluding	g swing-bed and	1, 109	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	251	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e	only (including private r enter 0 on this line)	5 ,	272	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	<u> </u>	5 -	0	
	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y	year, enter 0 on this lir	ne)	0	
14.00 15.00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
17 00	SWING BED ADJUSTMENT	and the such Desember 21	£ +b +		17.00
17.00 18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period Medicare rate for swing-bed SNF services applicable to servic	Ũ			17.00
	reporting period			100 14	
	Medicaid rate for swing-bed NF services applicable to service reporting period Medicaid rate for swing-bed NF services applicable to service	C C		129. 14 129. 14	
20.00	reporting period Total general inpatient routine service cost (see instruction		the cost	2, 524, 648	
22.00	Swing-bed cost applicable to SNF type services through Decemb 5×1 ine 17)		ing period (line	2, 324, 040	
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost reporti	ng period (line	1, 421	24.00
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	1, 421	25.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		489, 376 2, 035, 272	
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ad and obconvetion het -		0	20 00
28.00 29.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	eu anu unservatron ned Cr	iai yes)	0	28.00 29.00
30.00	Semi -private room charges (excluding swing bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		ations)	0.00	
34.00 35.00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		.11005)	0.00 0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0.00	36.00
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	2, 035, 272	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
00.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				00.07
	Adjusted general inpatient routine service cost per diem (see	-		909.41	
39.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		1, 008, 536 0	39.00 40.00
40.00					

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Health Financial Systems	ST. VINCENT WILLIA	AMSPORT HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1307	Period: From 07/01/2018 To 06/30/2019		
		Ti †l (e XVIII	Hospi tal	Cost	. JZ dill
Cost Center Description	Total Inpatient Cost	Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
	1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
42.00 NURSERY (title V & XIX only)	0					42.00
Intensive Care Type Inpatient Hospital Un			<u> </u>			12.00
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
cost center bescription					1.00	
48.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3	, line 200)			333, 064	48. OC
49.00 Total Program inpatient costs (sum of lin	es 41 through 48)(see instructio	ons)		1, 341, 600	49.00
PASS THROUGH COST ADJUSTMENTS			willing the Design	ef Dente I and		
50.00 Pass through costs applicable to Program	Inpatient routine	Services (Tro	n wkst. D, Sum	or Parts I and	0	50.00
51.00 Pass through costs applicable to Program and IV)	inpatient ancillar	y services (fi	rom Wkst. D, s	um of Parts II	0	51.00
52.00 Total Program excludable cost (sum of lin	es 50 and 51)				0	52.00
53.00 Total Program inpatient operating cost ex		lated, non-ph	ysician anesth	etist, and	0	
medical education costs (line 49 minus li	ne 52)					
TARGET AMOUNT AND LIMIT COMPUTATION						-
54.00 Program di scharges					0	
55.00 Target amount per discharge 56.00 Target amount (line 54 x line 55)					0.00	
57.00 Difference between adjusted inpatient ope	rating cost and ta	raet amount (l	ine 56 minus	line 53)	0	
58.00 Bonus payment (see instructions)				Title 33)	0	
59.00 Lesser of lines 53/54 or 55 from the cost	reporting period	endi ng 1996, u	updated and co	mpounded by the	0.00	
market basket						
60.00 Lesser of lines 53/54 or 55 from prior ye				the emount by	0.00	
61.00 If line 53/54 is less than the lower of l which operating costs (line 53) are less					0	61.00
amount (line 56), otherwise enter zero (s		5 (11165 01 x		the target		
62.00 Relief payment (see instructions)	,				0	62.00
63.00 Allowable Inpatient cost plus incentive p	ayment (see instru	ictions)			0	63.00
64.00 PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine	costs through Dece	mber 31 of the	e cost reporti	na period (See	228, 262	64.00
instructions) (title XVIII only)						
65.00 Medicare swing-bed SNF inpatient routine	costs after Decemb	er 31 of the o	cost reporting	period (See	247, 360	65. OC
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient ro	utino costs (lino	64 plus lipo /	45) (+i +l o - V)/I I	Lonly) For	475, 622	66.00
CAH (see instructions)		04 prus rifle (r onry). ror	475, 022	00.00
67.00 Title V or XIX swing-bed NF inpatient rou	tine costs through	December 31 d	of the cost re	porting period	0	67.00
(line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient rou	tine costs after D	ecember 31 of	the cost repo	orting period	0	68.00
(line 13 x line 20)				3 1 2		
69.00 Total title V or XIX swing-bed NF inpatie PART III - SKILLED NURSING FACILITY, OTHE					0	69. OC
70.00 Skilled nursing facility/other nursing fa	5		,			70.00
71.00 Adjusted general inpatient routine servic		ine 70 ÷ line	2)			71.00
72.00 Program routine service cost (line 9 x li		(lim- 14)	no 25)			72.00
73.00 Medically necessary private room cost app 74.00 Total Program general inpatient routine s						73.00 74.00
75.00 Capital-related cost allocated to inpatie				Part II, column		75.00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷	line 2)					76.00
77.00 Program capital -related costs (line 9 x l						77.00
78.00 Inpatient routine service cost (line 74 m						78.00
79.00 Aggregate charges to beneficiaries for ex	cess costs (from p	rovider record	ds)			79.00
30.00 Total Program routine service costs for c	•	ost limitation	n (line 78 min	us line 79)		80. 0
31.00 Inpatient routine service cost per diem I		`				81.00
32.00 Inpatient routine service cost limitation	•					82.00
 33.00 Reasonable inpatient routine service cost 34.00 Program inpatient ancillary services (see 	•	13)				83.00 84.00
85.00 Utilization review - physician compensati		ins)				85.00
86.00 Total Program inpatient operating costs (86.00
PART IV - COMPUTATION OF OBSERVATION BED	PASS THROUGH COST					[
87.00 Total observation bed days (see instructi					722	
88.00 Adjusted general inpatient routine cost p89.00 Observation bed cost (line 87 x line 88)					909.42 656,601	
	(SEE THELTULE)				000,001	1 U7.UL

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	L	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		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	169, 458	2, 524, 648	0.06712	1 656, 601	44, 072	90.00
91.00 Nursing School cost	0	2, 524, 648	0.00000	0 656, 601	0	91.00
92.00 Allied health cost	0	2, 524, 648	0.00000	0 656, 601	0	92.00
93.00 All other Medical Education	0	2, 524, 648	0.00000	0 656, 601	0	93.00

	Financial Systems ST. VINCENT WILLIAM ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1307	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2018 To 06/30/2019	Date/Time Prep 11/25/2019 11	
	Cost Contor Description	Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				-
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs. excluding newborn)		2, 795	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed da do not complete this line.	-bed and newborn days)	ivate room days,	2, 238 0	2.00 3.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation H Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	1, 516 278	4.00 5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	257	6. 00
7.00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through December	31 of the cost	11	7.00
8.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	11	8.00
9.00	Total inpatient days including private room days applicable newborn days)	0		31	9.00
10.00 11.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of	ctions)	5,	0	
12.00	December 31 of the cost reporting period (if calendar year, of Swing-bed NF type inpatient days applicable to titles V or XI	enter 0 on this line)	5 ,	0	
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendary Medically necessary private room days applicable to the Progr			0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0 0	
17.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31 c	of the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost		18.00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	f the cost	129. 14	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of 1	he cost	129. 14	20.00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)		ing period (line	2, 524, 648 0	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)			1, 421	
	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8		25.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		489, 376 2, 035, 272	
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)		-	0	29.00
30.00 31.00	Semi-private room charges (excluding swing-bed charges)	· lino 20)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- 1111111111111111111111111111111111111		0. 000000 0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room per drem charge (inne 30 - inne 4) Average per diem private room charge differential (line 32 mi	inus line 33)(see instruc	ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li			0.00	
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 27 minus line 36)	and private room cost di	fferential (line	2, 035, 272	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IUSTMENTS			-
38.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see			909.41	38.00
38.00	Program general inpatient routine service cost per diem (see	-		909.41 28, 192	
40.00	Medically necessary private room cost applicable to the Prog	ram (line 14 x line 35)	1	0	40.00

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42. 00 43. 00 44. 00	ATION OF INPATIENT OPERATING COST Cost Center Description		Provi der	CCN: 15-1307	Period: From 07/01/2018 To 06/30/2019		
43. 00 44. 00	Cost Center Description						narod
43. 00 44. 00	Cost Center Description				10 06/30/2019	Date/lime Pre	nared
43. 00 44. 00	Cost Center Description					11/25/2019 11	
43. 00 44. 00	Cost Center Description		Ti	tle XIX	Hospi tal	Cost	. JZ dill
43. 00 44. 00	oust center bescription	Total	Total	Average Per		Program Cost	
43. 00 44. 00				sDiem (col. 1		$(col \cdot 3 \times col \cdot$	
43. 00 44. 00		inpatront ocot	inputiont buj	col . 2)		4)	
43. 00 44. 00		1.00	2.00	3.00	4.00	5.00	
44.00	NURSERY (title V & XIX only)	0		0 0.	00 0	0	42.00
44.00	Intensive Care Type Inpatient Hospital Units						
	INTENSIVE CARE UNIT						43.00
15 00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGI CAL INTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						<u> </u>
10.00						1.00	10.00
	Program inpatient ancillary service cost (Wks			>		37, 321	
49.00	Total Program inpatient costs (sum of lines 4	41 through 48)(see Instruct	ons)		65, 513	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	ationt routing	convious (fr	om Wkst D su	m of Darte L and	0	50.00
50.00	(111)		Services (III	JIII WKSL. D, SUI	I UI PAILS I ANU	0	50.00
51.00	Pass through costs applicable to Program inpa	atient ancillar	v services (from Wkst D	sum of Parts II	0	51.00
01.00	and IV)		y services (Tom more b,		Ŭ	
52.00	Total Program excludable cost (sum of lines !	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclude		lated, non-pl	nysi ci an anest	netist, and	0	
	medical education costs (line 49 minus line 5	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
	Target amount (line 54 x line 55)					0	
57.00	Difference between adjusted inpatient operati	ing cost and ta	irget amount	(line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)					0	
59.00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	59.00
(0.00	market basket					0.00	
60.00	Lesser of lines 53/54 or 55 from prior year of lines				the emount by	0.00	
61.00	If line 53/54 is less than the lower of lines				2	0	61.00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		S (TTHES 54 .	(00), 01 1% 0	the target		
62.00	Relief payment (see instructions)	nisti ucti ons)				0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)			0	
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of t	ne cost report	ng period (See	0	64.00
	instructions)(title XVIII only)	0		•	0.		
65.00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the	cost reporting	j period (See	0	65.00
	instructions)(title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVI	l only). For	0	66.00
	CAH (see instructions)					_	
67.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31	of the cost re	eporting period	0	67.00
(0.00	(line 12 x line 19)	a anata aftam D	locombor 21 o	f the east rep	arting pariod	0	68.00
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs arter b	ecember 31 0	the cost repo	orting period	0	08.00
69.00	Total title V or XIX swing-bed NF inpatient i	routine costs (line 67 ± lii	ne 68)		0	69.00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NU						1 07.00
70.00	Skilled nursing facility/other nursing facili)		70.00
71.00	Adjusted general inpatient routine service of						71.00
72.00	Program routine service cost (line 9 x line]			-			72.00
73.00	Medically necessary private room cost applica	able to Program	n (line 14 x	ine 35)			73.00
74.00	Total Program general inpatient routine servi	ce costs (line	e 72 + line 73	3)			74.00
75.00	Capital-related cost allocated to inpatient i	routine service	e costs (from	Worksheet B, M	°art II, column		75.00
	26, line 45)						
76.00	Per diem capital-related costs (line 75 ÷ lin						76.00
77.00	Program capital -related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minus						78.00
79.00	Aggregate charges to beneficiaries for excess						79.00
80.00	Total Program routine service costs for compa		JUST IIMITATIO	JI (IINE /8 MII	ius i i ne 79)		80.00
81.00	Inpatient routine service cost per diem limit)				81.00
82.00 83.00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		* .				82.00
83.00	Program inpatient ancillary services (see ins		<i>)</i>				83.00
85.00	Utilization review - physician compensation		ns)				85.00
	Total Program inpatient operating costs (sum	•					86.00
20.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					1	1 30.00
	Total observation bed days (see instructions)					722	87.00
87.00	Adjusted general inpatient routine cost per o		line 2)			909.42	
87.00 88.00		e instructions)					89.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	L	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		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	169, 458	2, 524, 648	0.06712	1 656, 601	44, 072	90.00
91.00 Nursing School cost	0	2, 524, 648	0.00000	0 656, 601	0	91.00
92.00 Allied health cost	0	2, 524, 648	0.00000	0 656, 601	0	92.00
93.00 All other Medical Education	0	2, 524, 648	0.00000	0 656, 601	0	93.00

^{11/25/2019 11:32} am Y:\28950 - St. Vincent Williamsport Hospital\300 - Medicare Cost Report\20190630\HFS\20190630 Williamsport.mc

Health Financial Systems ST. VINCENT WILLIAMS	PORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1307	Period:	Worksheet D-3	
			From 07/01/2018 To 06/30/2019	Date/Time Pre	nared
			10 00/ 30/ 2017	11/25/2019 11	:32 am
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
		1.00	2.00	3.00	
30. 00 ADULTS & PEDIATRICS			2 547 207		30,00
43. 00 04300 NURSERY			2, 547, 397		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM		0. 2449	76 124, 805	30, 574	50.00
53. 00 05300 ANESTHESI OLOGY		0.0000		00,071	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 09430			
60. 00 06000 LABORATORY		0. 1706			
65. 00 06500 RESPI RATORY THERAPY		0. 1026			
66. 00 06600 PHYSI CAL THERAPY		0. 3430	74, 094	25, 421	66.00
68.00 06800 SPEECH PATHOLOGY		0.0000	0 00	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0645	41 329, 856	21, 289	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 4250			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2308	519, 829	119, 978	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000		0	
88.01 08801 RURAL HEALTH CLINIC II		0.0000		0	00101
91. 00 09100 EMERGENCY		0. 2449		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5139	40 6, 842	3, 516	92.00
OTHER REI MBURSABLE COST CENTERS					1 05 00
95.00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(1) (1)		1, 989, 087	333, 064	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(IINe 61)		1 000 007		201.00
202.00 Net charges (line 200 minus line 201)		I	1, 989, 087		202.00

Health Financial Systems ST. VINCENT WI	LI AMSPORT HOSPI TA	AL.	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	;
	Component		From 07/01/2018 To 06/30/2019	Date/Time Pre	narod
	component	JUN. 15-2307	10 00/30/2019	11/25/2019 11	
	Title	XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			0		30, 00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM		0. 24497	6 0	0	50.00
53. 00 05300 ANESTHESI OLOGY		0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 09430		4, 084	
60. 00 06000 LABORATORY		0. 17069			
65. 00 06500 RESPI RATORY THERAPY		0. 10266	6 12, 324		
66. 00 06600 PHYSI CAL THERAPY		0. 34309	6 99, 738	34, 220	66.00
68.00 06800 SPEECH PATHOLOGY		0. 00000	0 0	0	68.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0.06454	1 133, 095	8, 590	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 42509		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 23080	2 156, 790	36, 187	73.00
OUTPATIENT SERVICE COST CENTERS			_		
88.00 08800 RURAL HEALTH CLINIC		0.00000		0	
88. 01 08801 RURAL HEALTH CLINIC II		0.00000		0	
91.00 09100 EMERGENCY		0. 24491		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 51394	0 1, 546	795	92.00
0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES					05.00
	2)		502,400	110 011	95.00
200.00 Total (sum of lines 50 through 94 and 96 through 9 201.00 Less PBP Clinic Laboratory Services-Program only cl			592, 499	110, 011	200.00
201.00 [Less PBP cliffic Laboratory Services-Program only cl 202.00 [Net charges (line 200 minus line 201)	larges (The of)		592, 499		201.00
202.00 Inter charges (The 200 minus the 201)		I	572, 499		1202.00

Health Financial Systems ST. VINCENT WILLIAMSPORT HOSI	PI TAL	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provide	^ CCN: 15-1307	Period:	Worksheet D-3	
		From 07/01/2018 To 06/30/2019	Date/Time Pre	pared.
			11/25/2019 11	
	itle XIX	Hospi tal	Cost	
Cost Center Description	Ratio of Cos		Inpati ent	
	To Charges		Program Costs	
		Charges	(col. 1 x col.	
	1.00		2)	
	1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS		74 055		30,00
43. 00 04300 NURSERY		76, 055		43.00
ANCI LLARY SERVICE COST CENTERS		0		43.00
50, 00 05000 OPERATI NG ROOM	0. 2449	76 13, 207	3, 235	50.00
53. 00 05300 ANESTHESI OLOGY	0.0000		0,235	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.0943		4. 707	
60. 00 06000 LABORATORY	0. 1706		7, 385	
65. 00 06500 RESPI RATORY THERAPY	0. 1026		124	
66.00 06600 PHYSI CAL THERAPY	0. 3430		279	
68.00 06800 SPEECH PATHOLOGY	0.0000		0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.0645	41 5, 274	340	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 4250	97 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 2308	02 35, 609	8, 219	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	1.0539	26 0	0	
88.01 08801 RURAL HEALTH CLINIC II	1. 1234		0	
91. 00 09100 EMERGENCY	0. 2449	15 53, 209	13, 032	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 5139	40 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		- 1		
95. 00 09500 AMBULANCE SERVI CES				95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		202, 496	37, 321	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 6	1)	0		201.00
202.00 Net charges (line 200 minus line 201)		202, 496		202.00

In Lieu of Form CMS-2552-10

Heal th	Financial Systems ST. VINCENT WILLIAM	ASPORT HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1307	Period: From 07/01/2018 To 06/30/2019		
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	unti ana)		4, 023, 965	
2.00 3.00	Medical and other services reimbursed under OPPS (see instru OPPS payments	ictions)		0	
4.00	Outlier payment (see instructions)			0	
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instr	ructions)		0.000	
6.00	Line 2 times line 5			0	
7.00 8.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4, 023, 965	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
12.00	Reasonable charges Ancillary service charges			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)	-		0	14.00
	Customary charges				1 45 00
	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable f			0	
10.00	had such payment been made in accordance with 42 CFR §413.13		ni a charyebasis	0	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
	Total customary charges (see instructions)			0	
19.00	Excess of customary charges over reasonable cost (complete o	only if line 18 exceeds li	ne 11) (see	0	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete o	nlvifline 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)		10) (300	0	20.00
21.00	Lesser of cost or charges (see instructions)			4, 064, 205	21.00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see ins Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	-		0	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructio	ns)		35, 361	25.00
	Deductibles and Coinsurance amounts relating to amount on li			3, 172, 070	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 22	2 and 23] (see	856, 774	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4,	line 50)		0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36			0	
	Subtotal (sum of lines 27 through 29)			856, 774	
	Primary payer payments			905	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	(LCES)		855, 869	32.00
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			649, 215	34.00
	Adjusted reimbursable bad debts (see instructions)			421, 990	1
	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (see instructions)	structions)		597, 407 1, 277, 859	
	MSP-LCC reconciliation amount from PS&R			1, 277, 859	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
39.50	Pioneer ACO demonstration payment adjustment (see instructio	ons)			39.50
	Demonstration payment adjustment amount before sequestration			0	
	Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instruc	ctions)	0	
	Subtotal (see instructions)			1, 277, 859	
40.01	Sequestration adjustment (see instructions)			25, 557	
40.02	Demonstration payment adjustment amount after sequestration			0	
	Interim payments			1, 125, 916	
42.00 43.00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 126, 386	
	Protested amounts (nonallowable cost report items) in accord	lance with CMS Pub. 15-2	chapter 1.	120, 380	
	§115. 2				
00.5-	TO BE COMPLETED BY CONTRACTOR				0.0.7.7
	Original outlier amount (see instructions)				90.00
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91.00 92.00
	Time Value of Money (see instructions)			0.00	
					94.00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 07/01/2018 To 06/30/2019		pared
		Title	XVIII	Hospi tal	Cost	
		Inpatien		Par	T B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		1, 013, 57	'3	1, 125, 916	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.
00	amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3
04				0	0	3
05	Den dela de Den man			0	0	3
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
50 51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 013, 57	'3	1, 125, 916	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					-
	write "NONE" or enter a zero. (1)					
	Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5
02 03				0	0	5
55	Provider to Program			0	0	5
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
20	5. 50-5. 98)					,
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		20, 37	4	126, 386	6
02	SETTLEMENT TO PROVIDER		20, 37	0	120, 380	6
02	Total Medicare program liability (see instructions)		1, 033, 94	0	1, 252, 302	7
			.,,	Contractor	NPR Date	,
				Number	(Mo/Day/Yr)	
)	1.00	2.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider C		Period: From 07/01/20		
		Component (CCN: 15-Z307	To 06/30/20	9 Date/Time Pre 11/25/2019 11	
		Title	XVIII	Swing Beds - S		
		I npati en	t Part A	Р	art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		557, 2	90	C) 1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.
00	amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	-				
01	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
03				0	0	
04 05				0		
05	Provider to Program			0) 3
50	ADJUSTMENTS TO PROGRAM			0	C	3
51				0		
52				0	0	
53				0	0	3 3
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0) 3
00	3.50-3.98)		EE7 0	00	0	4
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		557, 2	90		' ⁴
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after] 5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					-
01	Program to Provider TENTATIVE TO PROVIDER			0	C	5
02				0		
03				0	0	
	Provider to Program					
50	TENTATIVE TO PROGRAM			0	0	
51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	C	5
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					1
01	SETTLEMENT TO PROVIDER		16, 0	93	0	-
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		573, 3		0) 7
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1, 00	2.00	
00	Name of Contractor			1.00	2.00	8

Heal th	Financial Systems ST. VINCENT WILLIAMS	PORT HOSPI TAL	In Lie	u of Form CMS-	2552-10			
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1307	Peri od:	Worksheet E-1				
			From 07/01/2018					
			To 06/30/2019	Date/Time Pre 11/25/2019 11				
		Title XVIII	Hospi tal	Cost	. 52 am			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS							
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION							
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14							
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00			
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00			
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	-12			4.00			
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li				6.00			
7.00	CAH only - The reasonable cost incurred for the purchase of co	ertified HIT technology	Wkst. S-2, Pt. I		7.00			
	line 168							
8.00	Calculation of the HIT incentive payment (see instructions)				8.00			
9.00	Sequestration adjustment amount (see instructions)	· · · · · ·			9.00			
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00			
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH							
	Initial/interim HIT payment adjustment (see instructions)				30.00 31.00			
	31.00 Other Adjustment (specify)							
32.00	Balance due provider (line 8 (or line 10) minus line 30 and li	ine 31) (see instruction	s)		32.00			

LCULA	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1307 Component CCN: 15-Z307	Period: From 07/01/2018 To 06/30/2019	Worksheet E-2 Date/Time Pre 11/25/2019 11	parec
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
	Inpatient routine services - swing bed-SNF (see instructions)		480, 378	0	1.0
	Inpatient routine services - swing bed-NF (see instructions)				2.0
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		111, 111	0	3.0
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins				
00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4.
00	instructions) Program days		523	0	5.
00	Interns and residents not in approved teaching program (see in	etructions)	523	0	
00	Utilization review - physician compensation - SNF optional met		0	0	7.
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	nou on y	591, 489	0	
00	Primary payer payments (see instructions)		0,1,407	0	
	Subtotal (line 8 minus line 9)		591, 489	0	
	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	
	professional services)				
. 00	Subtotal (line 10 minus line 11)		591, 489	0	12.
. 00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	6, 404	0	13.
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	585, 085	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions	-			16.
. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16.
~~	adjustment (see instructions)			0	11
	Demonstration payment adjustment amount before sequestration		0	0	
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	suctions)	0	0	
	Total (see instructions)		585, 085	0	
	Sequestration adjustment (see instructions)		11, 702	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
	Interim payments		557, 290	0	1
	Tentative settlement (for contractor use only)		0	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, a	ind 21)	16, 093	0	
	Protested amounts (nonallowable cost report items) in accordan	-	0	0	
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) Adjustment			
	Is this the first year of the current 5-year demonstration per	iod under the 21st			200.
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				1004
1.00	Medicare swing-bed SNF inpatient routine service costs (from W	KST. D-I, PT. II, IIne			201.
2 00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from	What D 2 col 2 lir			202.
	200 (title XVIII swing-bed SNF))	TWKSL D-3, COL 3, TH	le		202.
	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	first year of the curre	ent 5-vear demonst		
	period)	,	, ,		
5.00	Medicare swing-bed SNF target amount				205.
o. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see instr				207.
3. 00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	, col. 1, sum of lines	1		208.
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209.
	Reserved for future use				210.
	Comparision of PPS versus Cost Reimbursement				1
00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	vy plus line 210) (see			215

ALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1307	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part V Date/Time Pre 11/25/2019 11	pare
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MED	ICARE PART A SERVICES - COST	REIMBURSEMENT		
00	Inpatient services			1, 341, 600	
00	Nursing and Allied Health Managed Care payment (see inst	ructions)		0	
00	Organ acqui si ti on			0	-
00	Subtotal (sum of lines 1 through 3)			1, 341, 600	
00	Primary payer payments	``````````````````````````````````````		0	
00	Total cost (line 4 less line 5). For CAH (see instructio	ons)		1, 355, 016	6
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable charges			0	7
00 00	Routine service charges Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
00	Total reasonable charges			0	
. 00	Customary charges			0	1 10
. 00	Aggregate amount actually collected from patients liable	for navment for services on	a charge basis	0	1 11
2.00	Amounts that would have been realized from patients liab	1 5	ų	0	
. 00	had such payment been made in accordance with 42 CFR 413		in a charge basis	0	'2
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	. 10(0)		0.000000	13
. 00	Total customary charges (see instructions)			0	
5.00	5 6 1	ete onlvifline 14 exceeds li	ne 6) (see	0	
	instructions)	, , , , , , , , , , , , , , , , , , ,			
6. 00	Excess of reasonable cost over customary charges (comple	ete only if line 6 exceeds lin	e 14) (see	0	16
	instructions)				
. 00	Cost of physicians' services in a teaching hospital (see	e instructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00		et E-4, line 49)		0	
	Cost of covered services (sum of lines 6, 17 and 18)			1, 355, 016	
. 00				309, 596	
. 00				0	
	Subtotal (line 19 minus line 20 and 21)			1, 045, 420	
. 00				0	1
. 00				1,045,420	
. 00		services) (see Instructions)		14,812	
. 00	· j · · · · · · · · · · · · · · · · · · ·	instructions)		9, 628	
. 00	Allowable bad debts for dual eligible beneficiaries (see Subtotal (sum of lines 24 and 25, or line 26)	: THSTFUCTIONS)		1 055 049	
00 0.00				1, 055, 048 0	
. 00 . 50		uctions)		0	
. 50	Pioneer ACO demonstration payment adjustment (see instru Demonstration payment adjustment amount before sequestra			0	
. 99				1, 055, 048	
. 00	Sequestration adjustment (see instructions)			21, 101	
	Demonstration payment adjustment amount after sequestrat	ion		21, 101	
. 02	1,5,5,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1			1, 013, 573	
2.00				1, 013, 573	
3.00		30 02 31 and 32)		20, 374	
4.00	Protested amounts (nonallowable cost report items) in ac		chanter 1	20, 374	
	§115. 2		onapton n		ľ

Heal th	Fi nan	ci a	I Systems		
CALCUL	ATLON	0F	RELMBURSEMENT	SETTI	FMF

In Lieu of Form CMS-2552-10

Hearth	Financial Systems ST. VINCENT WILLIAMS	PORT HOSPITAL	In Lie	u of Form CMS-2	2552-10
	TION OF REIMBURSEMENT SETTLEMENT		Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VII Date/Time Pre	pared:
		Title XIX	Hospi tal	11/25/2019 11 Cost	: 32 811
		пцехих	Inpatient	Outpati ent	
			1.00	2.00	
F	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
	Inpatient hospital/SNF/NF services		65, 513		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)		65, 513	0	4.00
	Inpatient primary payer payments		0		5.00
1	Outpatient primary payer payments			0	
	Subtotal (line 4 less sum of lines 5 and 6)		65, 513	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
	Reasonable Charges		74 055		0.00
	Routine service charges		76, 055	0	8.00
	Ancillary service charges Organ acquisition charges, net of revenue		202, 496	0	9.00
	Incentive from target amount computation		0		11.00
	Total reasonable charges (sum of lines 8 through 11)		278, 551	0	1
	CUSTOMARY CHARGES		270, 331	0	12.00
	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.00
	basi s	i services on a charge	Ŭ	0	10.00
	Amounts that would have been realized from patients liable for	r payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 4				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	15.00
16.00	Total customary charges (see instructions)		278, 551	0	16.00
	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	213, 038	0	17.00
1	line 4) (see instructions)				
	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds line	0	0	18.00
	16) (see instructions)			0	10.00
	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
1	Cost of physicialis services that teaching hospital (see fish)		65, 513	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.00
	Other than outlier payments		0	0	22.00
	Outlier payments		0	0	
	Program capital payments		0	-	24.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		65, 513	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1		
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	65, 513	0	
	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review Subtotal (sum oflines 31, 34 and 35 minus sum oflines 32 and	d 33)	65, 513	0	35.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	u 33)	03, 313	0	1
	Subtotal (line 36 ± 1 ine 37)		65, 513	0	
	Direct graduate medical education payments (from Wkst. E-4)		03, 313	0	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		65, 513	0	
	Interim payments		65, 513	0	
	Balance due provider/program (line 40 minus line 41)		03, 313	0	1
	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	0	0	1
43.00					

	Financial Systems ST. VINCENT WILLIA E SHEET (If you are nonproprietary and do not maintain	Provider C	CN: 15-1307 P	eriod:	<u>u of Form CMS-</u> Worksheet G	
d-t	ype accounting records, complete the General Fund column		F	rom 07/01/2018 o 06/30/2019	Date/Time Pre	pare
y)					11/25/2019 11	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
0	Cash on hand in banks	176, 013		-	0	
0	Temporary investments	0	-	-	0	
0	Notes receivable	0	,	-	0	
0 0	Accounts receivable Other receivable	6, 191, 576 111, 099		-	0 0	
10	Allowances for uncollectible notes and accounts receivable	-3, 662, 328			0	
0	Inventory	228, 719	-	-	0	-
0	Prepaid expenses	125,000		-	0	
0	Other current assets	1, 398, 033	0	0	0	9
00	Due from other funds	3, 358, 763	0	0	0	10
00	Total current assets (sum of lines 1-10)	7, 926, 875	0	0	0	11
	FIXED ASSETS		1	1		
00	Land	174,050		-	0	
00	Land improvements	159, 079			0	
00 00	Accumulated depreciation	-112, 734		-	0	
00	Buildings Accumulated depreciation	8, 674, 684 -5, 124, 909		-	0	
	Leasehold improvements	5, 124, 709 N	0		0	
	Accumulated depreciation	0	0	-	0	
	Fi xed equi pment	1, 676, 790		-	0	
00	Accumulated depreciation	-966, 537	0	0	0	20
00	Automobiles and trucks	51, 450	0	0	0	21
	Accumulated depreciation	-51, 450			0	
	Major movable equipment	4, 261, 349			0	
	Accumulated depreciation	-3, 365, 298			0	
	Minor equipment depreciable	0	0		0	
	Accumulated depreciation HIT designated Assets	0	0	-	0	
	Accumul ated depreciation	0	0	-	0	
	Mi nor equi pment-nondepreci abl e	0	0	-	0	
	Total fixed assets (sum of lines 12-29)	5, 376, 474			0	
	OTHER ASSETS					1
00	Investments	251, 935	0	0	0	31
00	Deposits on Leases	0	-		0	
00	Due from owners/officers	0	0	-	0	
	Other assets	0	234, 891	0	0	
00	Total other assets (sum of lines 31-34)	251, 935 13, 555, 284		0	0	
00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	13, 555, 284	234, 891	0	0	36
00	Accounts payable	446, 852	0	0	0	37
00	Salaries, wages, and fees payable	912, 966		-	0	
00	Payroll taxes payable	0			0	
00	Notes and Loans payable (short term)	65, 985	0	0	0	40
	Deferred income	0	0	0	0	41
00	Accelerated payments	0				42
00	Due to other funds	6, 414, 555			0	
	Other current liabilities	946, 958			0	
00	Total current liabilities (sum of lines 37 thru 44)	8, 787, 316	0	0	0	45
00	LONG TERM LIABILITIES Mortgage payable	0	0	0	0	46
00	Notes payable	0	0		0	
00	Unsecured Loans	3, 761, 193			0	
00	Other long term liabilities	0	0	0	0	
00	Total long term liabilities (sum of lines 46 thru 49)	3, 761, 193	0	0	0	
00	Total liabilities (sum of lines 45 and 50)	12, 548, 509	0	0	0	51
0.2	CAPITAL ACCOUNTS					
00	General fund balance	1, 006, 775				52
00	Specific purpose fund		234, 891			53
00 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54 55
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant			0	0	
00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	55
		1,006,775	234, 891		0	59
00	Total fund balances (sum of lines 52 thru 58)	1,000,773	201,071	9	0	

Heal th	Financial Systems ST.	VINCENT WILLIAM	ISPORT HOSPITA	L	In Lie	eu of Form CMS-2	2552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC	N: 15-1307	Period: From 07/01/2018 To 06/30/2019		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 1 1 0 0 0 0 0	1, 778, 458 -1, 041, 393 737, 065 1 737, 066		234, 89 ⁻ 234, 89 ⁻ 0 0 0 0 0 0 234, 89 ⁻ 0 0 0 0 0 0 0 0 0 0 0 0 0		1.00 2.00 3.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
16.00 17.00 18.00 19.00	Released Capital Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	-269, 709 0	-269, 709 1, 006, 775		0 0 234, 89	0	16.00 17.00 18.00 19.00
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		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	Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Released Capital	0 0	0 0 0 0 0 0 0		0		8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
17.00 17.00 18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0		0 0		17.00 18.00 19.00

Cost Center Description Input ent Outpatient Total Center Language 1.00 2.00 3.00 Center Language 5.793,969 5.793,969 2.0 1.00 SUBPROVIDER - IFF 5.793,969 2.0 3.00 SUBPROVIDER - IFF 0 0 6.0 3.00 Support 0 0 0 6.0 3.00 Support 1.00 2.0 3.00 4.0 3.00 Support 1.00 2.0 3.00 4.0 3.00 Support 1.00 0 0 6.0 3.00 Support 0 0 0 6.0 5.00 3.00 Support 5.793,969 5.793,969 5.793,969 10.0 1.00 Total general inpatient care services (sum of lines 1-9) 5.793,969 10.0 10.0 1.00 Intersitive Care type inpatient hospital services 3.708,266 37,030,818 40,829,064 11.0 1.00 Other Special Care type inpati		Financial Systems ST. VINCENT WILLIAMS ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCI			riod: om 07/01/2018 06/30/2019	u of Form CMS- Worksheet G-2 Parts I & II Date/Time Pre 11/25/2019 11	pared:
PART I - PATI I PATI NUT REVENUES General Inpatient Routine Services 1.00 Mospi tal 0.00 SUPROVIDER - IFF 3.00 SUPROVIDER - IFF 0.00 0.00 SWIND EACH 0.00 0.01 0.02 0.03 0.05 0.05 0.05 0.06 0.07 0.08 0.00 0.01 <td< td=""><td></td><td>Cost Center Description</td><td></td><td>Inpati ent</td><td></td><td>Outpati ent</td><td></td><td>. <u>52 am</u></td></td<>		Cost Center Description		Inpati ent		Outpati ent		. <u>52 am</u>
General Inpatient Routine Services 1.00 Hospital 5, 793, 969 5, 793, 969 1, 0 2.00 SUBPROVIDER - IFF 0 3, 0 3, 0 3.00 SUBPROVIDER - IFF 0 0 0, 0 0 0, 0 0 0, 0 0, 0 0, 0 0, 0 0, 0 0, 0 0, 0 0, 0 0, 0 0, 0 0, 0 0, 0 0, 0				1.00		2.00	3.00	
1:00 Hospital 5, 793, 969 5, 793, 969 2, 0 2:00 SUPPROVIDER - IFF 0 0 2, 0 3:00 SUPPROVIDER - IFF 0 0 0 5, 793, 969 1, 0 0:00 SuppROVIDER - IFF 0 0 0 5, 793, 969 1, 0 0:00 Skiller Ning Bed - SN 0 0 0, 0 5, 793, 969 1, 0 0:00 Skiller Ning Bed - NF 0 0 0, 0 5, 793, 969 1, 0 0:00 Total general inpatient care services (sum of lines 1-9) 5, 793, 969 5, 793, 969 10, 0 1:00 Intensive Care Type Inpatient Hospital Services 1, 0 1, 0 1, 0 1, 0 1:00 Intensive Care Type Inpatient hospital services (sum of lines 1, 9, 9, 969 5, 793, 969 1, 0 1, 0 1:00 Total intensive care type inpatient hospital services (sum of lines 1, 2, 2, 50, 3, 16, 56, 329 16, 33, 792, 964 17, 0 1:00 Total intensive care type inpatient hospital services (sum of lines 1, 2, 2, 56, 37, 030, 818 40, 829, 964 16, 0 1:00 Total intensive carestype inpatient hospital								-
2.00 SUBPROVIDER - IPF 2.0 3.00 SUBPROVIDER 187 5.00 Swing bed - SNF 0 0 5.00 Swing bed - SNF 0 0 5.00 Swing bed - SNF 0 6.00 6.00 Swing bed - SNF 0 6.00 7.00 SKLLED RURSING FACILITY 0 6.00 8.00 NURSING FACILITY 0 7.93,969 5.793,969 10.00 Total general inpatient Hospital Services 11.0 12.00 6.00,700,784 7.93,969 10.0 11.00 INTENSIVE CARE UNIT 11.0 12.00 13.00 11.01 13.00 11.01 13.00 11.01 Intensive Care type inpatient hospital services (sum of lines 10 and 16) 5.793,969 5.793,969 15.793,969 11.01 Intensive care type inpatient hospital services 3.798,266 37,030,818 40,829,084 18.0 10.00 Ottal intensive care type inpatient hospital services 3.798,266 37,030,818,482,10 10.0 14.0 14.0 14.0 14.0 14.0 14.0 14.0 14.0 14	1 00			F 702 0	(0)		E 702 0(0	1 1 00
3.00 SUBPROVIDER - IRF 3.0 4.00 SUBPROVIDER 0 4.0 5.00 Swing bed - SWF 0 0 5.0 6.00 Swing bed - SWF 0 0 6.0 0.00 SKILLED NURSING FACILITY 0 7.0 7.0 0.00 OTHER LONG TERM CARE 0 5.793,969 5.793,969 9.0 1.00 Intensive Care Type Inpatient Hospital Services 10.0 11.0 <t< td=""><td></td><td></td><td></td><td>5, 793, 90</td><td>09</td><td></td><td>5, 793, 909</td><td></td></t<>				5, 793, 90	09		5, 793, 909	
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27.01 Other Patient Service Revenue - NRCCs 0 393,689 393,689 27.0 27.02 OTHER (SPECIFY) 0 0 0 27.0 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 9,915,588 64,218,195 74,133,783 28.0 29.00 PART 11 - OPERATING EXPENSES 0 0 30.0 30.0 30.0 31.00 ADD (SPECIFY) 0 0 31.0 32.0 33.0 32.0 35.0 35.0 35.0 35.0 35.0								26.00
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G-3, line 1) PART 11 - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 21,693,619 29.00 30.00 ADD (SPECIFY) 0 30.0 31.00 31.00 0 0 31.00 32.00 33.00 33.00 34.00 35.00 35.00 35.00 35.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 37.00 38.00 38.00 37.00 38.00 37.00 38.00 38.00 37.00 38.00 38.00 37.00 38.00 38.00 37.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 39.00 38.00 39.00 38.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.			+- 111+	0 015 5	-	-		
PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 21,693,619 29.0 30.0 <td>28.00</td> <td></td> <td>to wkst.</td> <td>9, 915, 56</td> <td>88</td> <td>04, 218, 195</td> <td>74, 133, 783</td> <td>28.00</td>	28.00		to wkst.	9, 915, 56	88	04, 218, 195	74, 133, 783	28.00
29.00 Operating expenses (per Wkst. A, column 3, line 200) 21,693,619 29.0 30.00 ADD (SPECLEY) 0 30.0 31.00 0 0 31.0 32.00 0 0 33.0 34.00 0 0 33.0 35.00 0 0 34.0 36.00 Total additions (sum of lines 30-35) 0 35.0 37.00 DEDUCT (SPECLEY) 0 38.0 39.00 0 0 39.0 40.00 0 0 40.0			I					
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					õ			40.00
					0			41.00
42.00 Total deductions (sum of lines 37-41) 0 42.0		Total deductions (sum of lines 37-41)			-	о		42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 21, 693, 619 43.0		Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer			21, 693, 619		43.00
to Wkst. G-3, line 4)		to Wkst. G-3, line 4)						

Health Financial Systems

In Lieu of Form CMS-2552-10

Heal th	Financial Systems ST. VINCENT WILLIAMS	SPORT HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1307	Peri od:	Worksheet G-3	
			From 07/01/2018		
			To 06/30/2019		
	· · · · · · · · · · · · · · · · · · ·			11/25/2019 11	32 811
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	o 28)		74, 133, 783	1.00
2.00	Less contractual allowances and discounts on patients' account				2.00
2.00		15		54, 348, 923 19, 784, 860	
3.00 4.00	Net patient revenues (line 1 minus line 2)	42)			
4.00 5.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		21, 693, 619 -1, 908, 759	4.00 5.00
5.00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			-1, 900, 739	5.00
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			937	7.00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		,37	
9.00	Revenue from television and radio service	361 11 663		0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	· ·			0	12.00
	Parking lot receipts			0	12.00
13.00 14.00	Revenue from laundry and linen service			0	13.00
	Revenue from meals sold to employees and guests			0	
15.00	Revenue from rental of living quarters	han nationta		-	15.00
16.00 17.00	Revenue from sale of medical and surgical supplies to other t	nan patrents		0	16.00
17.00	Revenue from sale of drugs to other than patients			8, 175	17.00 18.00
	Revenue from sale of medical records and abstracts				
19.00 20.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00 20.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	
21.00	Rental of vending machines			-	21.00
22.00	Rental of hospital space			0	
23.00	Governmental appropriations			0	23.00
24.00	OTHER (SPECIFY)			-	24.00
24.01	Other - Credentialing			70, 958	
24.02	Other - Pharmacy Services			1, 394	
24.04	Rental Income - ENT Clinic			143, 430	
24.14	Other - Food Services			12, 350	
24.15	Other - State Program Revenue			34,000	
24.19	Other - South Clinic			18, 477	
24.23	Other - Phys Fund Rev IC			212, 693	
24.24	Other - Unclaimed Property Exemptions			6, 491	
24.25	Other - Contract Services Revenue			323, 079	
24.26	Other - Late Penal ty Fees			241	
24.27	Other - Medical Staff Dues Revenue			500	
24.28	Other - Shared Savings Payments			34, 641	24.28
25.00	Total other income (sum of lines 6-24)			867, 366	
26.00	Total (line 5 plus line 25)			-1, 041, 393	
27.00	OTHER EXPENSES (SPECIFY)			0	
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-1, 041, 393	29.00

Heal th	Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	eu of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1307	Peri od:	Worksheet M-1	
					From 07/01/2018		
			Component (CCN: 15-3993	To 06/30/2019		
					RHC I	11/25/2019 11	:32 am
		Company at 1 an		Tatal (asl	RHC I I Reclassi fi cati	Cost Reclassified	
		Compensati on	Other Costs			Trial Balance	
				+ col. 2)	ons	(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	5.00	4.00	5.00	
1.00	Physi ci an	316, 370	0	316, 37	0 0	316, 370	1.00
2.00	Physician Assistant	510, 570	0	310, 37		0	2.00
3.00	Nurse Practitioner	369, 101	0	369, 10	0	369, 101	3.00
4.00	Visiting Nurse	0,101		307,10		0	4.00
5.00	Other Nurse	207, 915	0	207, 91	5 0	207, 915	
6.00	Clinical Psychologist	207, 715		207,71		207, 713	6.00
7.00	Clinical Social Worker	0				0	7.00
8.00	Laboratory Techni ci an	0				0	8.00
9.00	Other Facility Health Care Staff Costs	194,679		194, 67		194, 679	
10.00	Subtotal (sum of lines 1 through 9)	1, 088, 065	0	1, 088, 06		1, 088, 065	
11.00	Physician Services Under Agreement	1,000,000	0	1,000,00	0 0	1,000,000	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
12.00	Other Costs Under Agreement	0	0		0 0	0	12.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
14.00	Medical Supplies	0	5,073	5, 07	2 0	5,073	
16.00	Transportation (Health Care Staff)	0	5,073	5,07	0 0	0	
17.00	Depreciation-Medical Equipment	0	0			0	17.00
18.00	Professional Liability Insurance	0				0	18.00
19.00	Other Health Care Costs	0	368, 958	368, 95	8 0	368, 958	
20.00	Allowable GME Costs	0	500, 750	500, 75	0	300, 930	20.00
20.00	Subtotal (sum of lines 15 through 20)	0	374, 031	374, 03	1 0	374, 031	20.00
21.00	Total Cost of Health Care Services (sum of	1,088,065	374,031				
22.00	lines 10, 14, and 21)	1,000,003	574,051	1,402,05	0	1, 402, 070	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES		<u> </u>				
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0		0 0	0	25.01
25.02	Chronic Care Management	0	0		0 0	0	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		o o	0	28.00
	through 27)	-			-		
	FACILITY OVERHEAD					•	
29.00	Facility Costs	0	0		0 0	0	29.00
30.00	Administrative Costs	0	0		0 0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	0		0 0	0	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	1, 088, 065	374, 031	1, 462, 09	6 0	1, 462, 096	32.00
	and 31)						

Heal th	Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPIT	AL	In Lie	u of Form CMS-	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1307	Peri od:	Worksheet M-1	1
					From 07/01/2018		
			Component	CCN: 15-3993	To 06/30/2019	Date/Time Pre	
					RHC I	11/25/2019 1	1:32 am
			Nat European		KHC I	Cost	
		Adjustments	Net Expenses				
			for Allocation	ו			
			(col. 5 + col.				
		(00	6)	-			
		6.00	7.00				
1.00	FACILITY HEALTH CARE STAFF COSTS	0	214 270				1.00
2.00	Physician	0	316, 370				2.00
2.00	Physician Assistant Nurse Practitioner	0	369, 101				3.00
		0	309, 10				
4.00	Visiting Nurse	0					4.00
5.00	Other Nurse	0	207, 915				5.00
6.00	Clinical Psychologist	0					6.00
7.00	Clinical Social Worker	0	(7.00
8.00	Laboratory Techni ci an	0	(8.00
9.00	Other Facility Health Care Staff Costs	0	194, 679	1			9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 088, 065				10.00
11.00	Physician Services Under Agreement	0	() 			11.00
12.00	Physician Supervision Under Agreement	0	(12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	Medical Supplies	0	5, 073	3			15.00
16.00	Transportation (Health Care Staff)	0	(16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0	(18.00
19.00	Other Health Care Costs	0	368, 958	3			19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	374, 031				21.00
22.00	Total Cost of Health Care Services (sum of	0	1, 462, 096				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	()			23.00
24.00	Dental	0	(24.00
25.00	Optometry	0	(25.00
25.01	Tel eheal th	0	(25.01
25.02	Chronic Care Management	0	0				25.02
26.00	All other nonreimbursable costs	0	(26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	(28.00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	(29.00
30.00	Administrative Costs	0	(30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	(31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	1, 462, 096				32.00
	and 31)						

Heal th	Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	L	In Lie	eu of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C		Peri od:	Worksheet M-1	
			Component (From 07/01/2018 To 06/30/2019		narod
			component	JUN. 15-3994	10 00/30/2019	11/25/2019 11	
					RHC II	Cost	
		Compensation	Other Costs		1 Recl assi fi cati		
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	0.00			4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	FACILITY HEALTH CARE STAFF COSTS Physician	638, 316	0	638, 31	6 0	638, 316	1.00
2.00	Physician Assistant	030, 310	0	030, 31		030, 310	2.00
3.00	Nurse Practitioner	238, 526	0	238, 52		238, 526	3.00
4.00	Visiting Nurse	230, 320	0	230, 32	0 0	230, 320	4.00
4.00 5.00	Other Nurse	347,042	0	347, 04	2 0	347,042	5.00
6.00	Clinical Psychologist	0,042	0	347,04	0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	221, 439	0	221, 43	0	221, 439	9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 445, 323	0	1, 445, 32			
11.00	Physician Services Under Agreement	0	0	1, 110, 02	0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	5, 210	5, 21	0 0	5, 210	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	447, 109	447, 10	9 0	447, 109	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	452, 319	452, 31	9 0	452, 319	21.00
22.00	Total Cost of Health Care Services (sum of	1, 445, 323	452, 319	1, 897, 64	2 0	1, 897, 642	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES					1	
23.00	Pharmacy	0	0		0 0	-	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0		0 0	0	25.01
25.02	Chronic Care Management	0	0		0 0	0	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
	through 27) FACILITY OVERHEAD						
20.00		0	0		0 0	0	29.00
29.00 30.00	Facility Costs Administrative Costs	0	0		0 0	-	29.00 30.00
30.00	Total Facility Overhead (sum of lines 29 and	0	0			0	30.00
51.00	30)	0	0		0		31.00
32.00	Total facility costs (sum of lines 22, 28	1, 445, 323	452, 319	1, 897, 64	.2 0	1, 897, 642	32.00
02.00	and 31)	1, 110, 020	±52, 517	1,077,04	-	1,077,042	02.00
		ı I	1	1	I .	1	

Heal th	Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPIT	AL	In Lie	u of Form CMS-	-2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS			CN: 15-1307	Peri od:	Worksheet M-	1
					From 07/01/2018		
			Component	CCN: 15-3994	To 06/30/2019	Date/Time Pro	
					500.00	11/25/2019 1	1:32 am
					RHC II	Cost	
		Adjustments	Net Expenses				
			for Allocatior				
			(col. 5 + col.				
			6)	4			
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	638, 316	5			1.00
2.00	Physician Assistant	0	(2.00
3.00	Nurse Practitioner	0	238, 526	5			3.00
4.00	Visiting Nurse	0	(4.00
5.00	Other Nurse	0	347,042				5.00
6.00	Clinical Psychologist	0	(6.00
7.00	Clinical Social Worker	0	(7.00
8.00	Laboratory Techni ci an	0					8.00
9.00	3	0	221, 439				9.00
9.00 10.00	Other Facility Health Care Staff Costs	0					10.00
	Subtotal (sum of lines 1 through 9)	0	1, 445, 323				
11.00	Physician Services Under Agreement	0	(11.00
12.00	Physician Supervision Under Agreement	0	(12.00
13.00	Other Costs Under Agreement	0	(13.00
14.00	Subtotal (sum of lines 11 through 13)	0	(14.00
15.00	Medical Supplies	0	5, 210	D			15.00
16.00	Transportation (Health Care Staff)	0	(16.00
17.00	Depreciation-Medical Equipment	0	(17.00
18.00	Professional Liability Insurance	0	(18.00
19.00	Other Health Care Costs	0	447, 109				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	452, 319				21.00
22.00	Total Cost of Health Care Services (sum of	0	1, 897, 642				22.00
22.00	lines 10, 14, and 21)	Ũ	1,0,,,01				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
23.00	Pharmacy	0	(23.00
24.00	Dental	0	(24.00
25.00	Optometry	0	(25.00
25.00	Tel eheal th	0					25.00
25.01	Chronic Care Management	0	(25.01
	0	0	(
26.00	All other nonreimbursable costs	0	l (1			26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	(28.00
	through 27)						
	FACILITY OVERHEAD			1			
29.00	Facility Costs	0	(29.00
30.00	Administrative Costs	0	(30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	(0			31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	1, 897, 642	2			32.00
	and 31)						

Interview Interview <t< th=""><th></th><th><u>Financial Systems</u>ST ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC</th><th>SERVI CES</th><th>Provider C</th><th></th><th>Period:</th><th>Worksheet M-2</th><th></th></t<>		<u>Financial Systems</u> ST ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Period:	Worksheet M-2	
Number of FTE PersonnelTotal VisitsProductivity Standard (1)Minimum Visits (col. 1 x col. col. 2 or of 				Component (Date/Time Prep 11/25/2019 11:	
Personnel Standard (1) (col. 1 x col. 3) col. 2 or of 4 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Positions 1.00 2.00 3.00 4.00 5.00 2.00 Physician Assistant 1.71 4,006 4,200 7,182 0 2.00 Physician Assistant 0.00 0 2,100 0 0 3.00 Nurse Practitioner 4.30 9,516 2,100 9,030 0 4.00 Subtotal (sum of lines 1 through 3) 6.01 13,522 16,212 16, 5.00 Visiting Nurse 0.00 0 0 0 0 7.00 Clinical Social Worker 0.00 0 0 0 0 7.01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 0 0 8.00 Total FTEs and Visits (sum of lines 4 6.01 13,522 16, 1.00 9.00 Physician Services Under Agreements 0							Cost	
VISITS AND PRODUCTIVITY 3) 4 Positions 1.00 2.00 3.00 4.00 5.00 Positions 1.00 2.00 3.00 4.00 5.00 Physician 1.71 4.006 4.200 7.182 0 2.00 Physician Assistant 0.00 0 2.100 0 3.00 Nurse Practitioner 4.30 9.516 2.100 9.030 4.00 Subtotal (sum of lines 1 through 3) 6.01 13,522 16,212 16, 5.00 Visiting Nurse 0.00 0				Total Visits				
I.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Positions 1.00 2.00 3.00 4.00 5.00 Physician 1.71 4,006 4.200 7,182 0.00 0 2,100 0 0 3.00 4.00 5.00 0 2,100 0 0 2,00 7,182 0.00 0 0.00 0 2,100 0 0 0.00 0			Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
VISITS AND PRODUCTIVITY Positions 1.00 Physician 1.71 4,006 4,200 7,182 2.00 Physician Assistant 0.00 0 2,100 0 3.00 Nurse Practitioner 4.30 9,516 2,100 9,030 4.00 Subtotal (sum of lines 1 through 3) 6.01 13,522 16,212 16, 5.00 Visiting Nurse 0.00 0 0 0 0 16,212 16, 7.00 Clinical Social Worker 0.00 0							4	
Positions 1.00 Physician 1.71 4,006 4,200 7,182 2.00 Physician Assistant 0.00 0 2,100 0 3.00 Nurse Practitioner 4.30 9,516 2,100 9,030 4.00 Subtotal (sum of lines 1 through 3) 6.01 13,522 16,212 16, 5.00 Visiting Nurse 0.00 0 0 0 16,212 16, 7.00 Clinical Psychologist 0.00 0 0 0 16,212 16, 7.01 Medical Nutrition Therapist (FQHC only) 0.00 0 0 0 0 7.02 Diabetes Self Management Training (FQHC 0.00 0 0 0 0 16, </td <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td>			1.00	2.00	3.00	4.00	5.00	
1.00 Physician 1.71 4,006 4,200 7,182 2.00 Physician Assistant 0.00 0 2,100 0 3.00 Nurse Practitioner 4.30 9,516 2,100 9,030 4.00 Subtotal (sum of lines 1 through 3) 6.01 13,522 16,212 16, 5.00 Visiting Nurse 0.00 0 0 0 16,212 16, 5.00 Clinical Psychologist 0.00 0 0 0 16,212 16, 7.00 Clinical Social Worker 0.00 0 0 0 0 0 7.02 Diabetes Self Management Training (FQHC only) 0.00 0 0 0 0 7.02 Diabetes Sulf Management Training (FQHC only) 0.00 0 0 0 16, 9.00 Physician Services Under Agreements 0 0 13, 522 16, 1.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1.00 1.00 1.00								
2.00 Physician Assistant 0.00 0 2,100 0 3.00 Nurse Practitioner 4.30 9,516 2,100 9,030 4.00 Subtotal (sum of lines 1 through 3) 6.01 13,522 16,212 16, 5.00 Visiting Nurse 0.00 0 0 0 0 16,212 16, 5.00 Clinical Psychologist 0.00 0 0 0 0 0 16,212 16, 7.00 Clinical Social Worker 0.00 0<								
3.00 Nurse Practitioner 4.30 9,516 2,100 9,030 4.00 Subtotal (sum of Lines 1 through 3) 6.01 13,522 16,212 16, 5.00 Visiting Nurse 0.00 0 0 0 16,212 16, 5.00 Clinical Psychologist 0.00 0 0 0 0 16,212 16, 7.00 Clinical Social Worker 0.00 0 0 0 0 0 0 0 7.01 Medical Nutrition Therapist (FOHC only) 0.00 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1.00</td>								1.00
4.00 Subtotal (sum of lines 1 through 3) 6.01 13,522 16,212 16, 5.00 Visiting Nurse 0.00 0 0 0 0 6.00 Clinical Psychologist 0.00 0 0 0 0 7.00 Clinical Social Worker 0.00 0 0 0 0 7.01 Medical Nutrition Therapist (FQHC only) 0.00 0 0 0 0 7.02 Diabetes Self Management Training (FQHC 0.00 0 0 0 0 8.00 Total FTEs and Visits (sum of lines 4 6.01 13,522 16, 16, 9.00 Physician Services Under Agreements 0 0 0 16, 16, 9.00 Physician Services Under Agreements 0 0 16, 16, 16, 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1.00 1,462, 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 1,462,								2.00
5.00 Visiting Nurse 0.00 0 6.00 Clinical Psychologist 0.00 0 7.00 Clinical Social Worker 0.00 0 7.01 Medical Nutrition Therapist (FOHC only) 0.00 0 7.02 Diabetes Self Management Training (FOHC 0.00 0 7.02 Diabetes Self Management Training (FOHC 0.00 0 8.00 Total FTEs and Visits (sum of lines 4 6.01 13, 522 16, 1.00 Physician Services Under Agreements 0 0 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,462, 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 1,462,								3.00
6.00 Clinical Psychologist 0.00 0 7.00 Clinical Social Worker 0.00 0 7.01 Medical Nutrition Therapist (FOHC only) 0.00 0 7.02 Diabetes Self Management Training (FOHC 0.00 0 7.02 Diabetes Self Management Training (FOHC 0.00 0 8.00 Total FTEs and Visits (sum of lines 4 6.01 13,522 16, 1.00 Physician Services Under Agreements 0 0 10,00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,462, 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 1,462,						16, 212	16, 212	4.00
7.00 Clinical Social Worker 0.00 0 7.01 Medical Nutrition Therapist (FOHC only) 0.00 0 7.02 Diabetes Self Management Training (FOHC only) 0.00 0 0.19 0.00 0 0 8.00 Total FTEs and Visits (sum of lines 4 through 7) 6.01 13,522 16, 9.00 Physician Services Under Agreements 0 0 16, DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 1,462,	5.00						0	5.00
7.01 Medical Nutrition Therapist (FOHC only) 0.00 0 7.02 Diabetes Self Management Training (FOHC 0.00 0 0.1 y) 0.00 0 0 8.00 Total FTEs and Visits (sum of lines 4 6.01 13,522 16, 9.00 Physician Services Under Agreements 0 0 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,462, 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 1,462,	6.00			0			0	6.00
7.02 Diabetes Self Management Training (FOHC 0.00 0 onlyy 8.00 Total FTEs and Visits (sum of lines 4 6.01 13,522 16, 9.00 Physician Services Under Agreements 0 0 10,00 10,00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,462, 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 1,462,	7.00	Clinical Social Worker	0.00	0			0	7.OC
a. 00 onl y) Total FTEs and Visits (sum of lines 4 through 7) 6. 01 13, 522 16, 16, 10, 00 9.00 Physician Services Under Agreements 0 0 16, 10, 00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,462, 1,462, 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 1,462,	7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
9.00 through 7) Physician Services Under Agreements 0 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	7.02		0.00	0			0	7. 02
DETERMI NATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	8.00		6. 01	13, 522			16, 212	8.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,462, 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 1,462,	9.00	Physician Services Under Agreements		0			0	9.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,462, 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 1,462,								
10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,462, 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 1,462,							1.00	
11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					VICES			
							1, 462, 096	
12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,462,							0	11.00
	12.00	Cost of all services (excluding overhead) (sum of lines 10	and 11)			1, 462, 096	12.00

13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12)
14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)
15.00 Parent provider overhead allocated to facility (see instructions)
16.00 Total overhead (sum of lines 14 and 15)

17.00 Allowable GME overhead (see instructions)

18.00 Enter the amount from line 16

19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)

20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

11/25/2019 11:32 am Y:\28950 - St. Vincent Williamsport Hospital\300 - Medicare Cost Report\20190630\HFS\20190630 Williamsport.mc

1.000000

1, 239, 576

1, 239, 576

0 14.00

1, 239, 576 18.00

1, 239, 576 19.00

2, 701, 672 20.00

13.00

15.00

16.00

0 17.00

	2	VINCENT WILLIA				eu of Form CMS-2	
ALLOC	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVICES	Provider CO		Period: From 07/01/2018	Worksheet M-2	
			Component (To 06/30/2019		pared:
						11/25/2019 11	
					RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		1.00	2.00	2.00	3)	4	
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	5.00	
	Positions						
1.00	Physi ci an	3.06	9, 811	4, 20	0 12, 852		1.00
2.00	Physician Assistant	0, 00		2, 10			2.00
3.00	Nurse Practitioner	2.59	5, 253				3.00
4.00	Subtotal (sum of lines 1 through 3)	5.65	15,064		18, 291		4.00
5.00	Visiting Nurse	0.00	10,001		10, 271	0,2,1	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7.02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	5.65	15, 064			18, 291	8.00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	0 HOSPI TAL-BASE	D RHC/FQHC SER	VICES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	, line 22)			1, 897, 642	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	8)			0	
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			1, 897, 642	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. M	I-1, col. 7, li	ne 31)		0	14.00
15.00			tions)			1, 640, 841	
16 00	Total overhead (sum of lines 14 and 15)					1 640 941	16 00

16.00 Total overhead (sum of lines 14 and 15)

17.00 Allowable GME overhead (see instructions)

18.00Enter the amount from line 1619.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)

20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

16.00

17.00 0

18.00

1, 640, 841

1, 640, 841 1, 640, 841 19. 00

3, 538, 483 20.00

	Provider CCN: 15-1307	Period:	Worksheet M-3	
RVI CES	Component CCN: 15-3993	From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 11	
	Title XVIII	RHC I	Cost	
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			0 704 (70	
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from			2, 701, 672	
00 Cost of vaccines and their administration (from Wkst. M-4, lin 00 Total allowable cost excluding vaccine (line 1 minus line 2)	ie 15)		116, 143 2, 585, 529	
00 Total allowable cost excluding vaccine (line 1 minus line 2) 00 Total Visits (from Wkst. M-2, column 5, line 8)			2, 585, 529	
00 Physicians visits under agreement (from Wkst. M-2, column 5, 1	ino (l)		10, 212	
00 Total adjusted visits (line 4 plus line 5)	The 9)		16, 212	
00 Adjusted cost per visit (line 3 divided by line 6)			159.48	
Wighted cost per visit (time 5 drivided by time 0)		Cal cul ati on o		<u> </u>
		Prior to Jan.	On or After	
			Jan. 1 (Rate	
		1)	Period 2)	<u> </u>
00 Der visit reverst Linit (fran CNC Dub 100 04 sharter 0, 500		1.00	2.00	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20. 00 Rate for Program covered visits (see instructions)	6 or your contractor)	83.45 159.48	84.70	8
CALCULATION OF SETTLEMENT		139.40	159.48	9
00 Program covered visits excluding mental health services (from	contractor records)	1, 334	1, 361	1 10
.00 Program cost excluding costs for mental health services (line		212, 746	217, 052	
. 00 Program covered visits for mental health services (from contra		212, 740	217,032	
.00 Program covered cost from mental health services (line 9 x lin		0	0	13
.00 Limit adjustment for mental health services (see instructions)	-	0	0	
.00 Graduate Medical Education Pass Through Cost (see instructions			-	15
.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	429, 798	16
.01 Total program charges (see instructions)(from contractor's rec	ords)		512, 058	16
. 02 Total program preventive charges (see instructions) (from provi	der's records)		115, 381	16
.03 Total program preventive costs ((line 16.02/line 16.01) times	line 16)		96, 846	16
.04 Total Program non-preventive costs ((line 16 minus lines 16.03	and 18) times .80)		226, 585	16
(Titles V and XIX see instructions.)				
. 05 Total program cost (see instructions)		0	323, 431	16
.00 Primary payer amounts			231	
Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		49, 721	18
records) 00 Beneficiary coinsurance for RHC/FQHC services (see instruction	c) (from contractor		69, 391	19
records)			07, 371	17
00 Net Medicare cost excluding vaccines (see instructions)			323, 200	20
.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		48, 403	
.00 Total reimbursable Program cost (line 20 plus line 21)			371, 603	22
.00 Allowable bad debts (see instructions)			0	23
.01 Adjusted reimbursable bad debts (see instructions)			0	23
.00 Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	24
. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25
.50 Pioneer ACO demonstration payment adjustment (see instructions	5)		0	25
. 99 Demonstration payment adjustment amount before sequestration			0	
00 Net reimbursable amount (see instructions)			371, 603	
01 Sequestration adjustment (see instructions)			7, 432	
. 02 Demonstration payment adjustment amount after sequestration			0	26
.00 Interim payments			305, 101	
.00 Tentative settlement (for contractor use only) .00 Balance due component/program (line 26 minus lines 26.01, 26.0	12 27 and 29)		0 50.070	28
 .00 Balance due component/program (line 26 minus lines 26.01, 26.0 .00 Protested amounts (nonallowable cost report items) in accordant 			59, 070 0	29 30
	ICE WILLI UWO PUD. ID-II,	1	0	1 30

LCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC RVICES	Provider CCN: 15-1307	Period: From 07/01/2018	Worksheet M-3	
NT CL3	Component CCN: 15-3994	To 06/30/2019	Date/Time Pre 11/25/2019 11	
	Title XVIII	RHC II	Cost	
		-	1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from			3, 538, 483	
00 Cost of vaccines and their administration (from Wkst. M-4, lin	ne 15)		123, 182	
00 Total allowable cost excluding vaccine (line 1 minus line 2)			3, 415, 301	
00 Total Visits (from Wkst. M-2, column 5, line 8) 00 Physicians visits under agreement (from Wkst. M-2, column 5, l			18, 291 0	
00 Total adjusted visits (line 4 plus line 5)	inne 9)		18, 291	
00 Adjusted cost per visit (line 3 divided by line 6)			186.72	
Augusted cost per visit (inne 5 divided by inne 0)		Calculation of		- '
		Prior to Jan.	On or After	
			Jan. 1 (Rate	
		1)	Peri od 2)	-
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	1.00	2.00	8
00 Rate for Program covered visits (see instructions)		186. 72	186.72	
CALCULATION OF SETTLEMENT		100.72	100.72	ſ
.00 Program covered visits excluding mental health services (from	contractor records)	2, 568	2, 920	1 10
.00 Program cost excluding costs for mental health services (line	9 x line 10)	479, 497	545, 222	11
.00 Program covered visits for mental health services (from contra	actor records)	0	0	12
.00 Program covered cost from mental health services (line 9 x lin		0	0	
.00 Limit adjustment for mental health services (see instructions)		0	0	
.00 Graduate Medical Education Pass Through Cost (see instructions				15
.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	1,024,719	
.01 Total program charges (see instructions)(from contractor's red .02 Total program preventive charges (see instructions)(from provi			900, 734	
. 03 Total program preventive costs ((line 16.02/line 16.01) times			54, 322 61, 800	
.04 Total Program non-preventive costs ((line 16.02/11)e 10.07) times			700, 761	
(Titles V and XIX see instructions.)			,, ,	
.05 Total program cost (see instructions)		0	762, 561	16
.00 Primary payer amounts			0	17
.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		86, 968	18
records)				
.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		151, 889	19
.00 Net Medicare cost excluding vaccines (see instructions)			762, 561	20
.00 Program cost of vaccines and their administration (from Wkst.	M_{-4} line 16)		63, 990	
.00 Total reimbursable Program cost (line 20 plus line 21)	M=4, 111e 10)		826, 551	
. 00 Allowable bad debts (see instructions)			020,001	
.01 Adjusted reimbursable bad debts (see instructions)			0	
.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24
. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0	25
.50 Pioneer ACO demonstration payment adjustment (see instructions	s)		0	1
. 99 Demonstration payment adjustment amount before sequestration			0	
.00 Net reimbursable amount (see instructions)			826, 551	
. 01 Sequestration adjustment (see instructions)			16, 531	26
.02 Demonstration payment adjustment amount after sequestration .00 Interim payments			0 713, 958	
.00 Tentative settlement (for contractor use only)			/13, 958	
.00 Balance due component/program (line 26 minus lines 26.01, 26.0	02. 27. and 28)		96,062	
.00 Protested amounts (nonallowable cost report items) in accorda			0,002	
				1

Heal th	Financial Systems ST. VINCENT WILLIAMS	PORT HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1307	Period:	Worksheet M-4	
VACCI N	E COST	Component CCN: 15-3993	From 07/01/2018 To 06/30/2019	Date/Time Prep 11/25/2019 11:	
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1, 088, 065	1, 088, 065	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota				2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lin	2	532	1, 057	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi	5	43, 568		4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	,	44, 100		5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshe	eet M-1, col. 7, line 22)			6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 239, 576		7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 030162	0. 012827	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l		37, 388		
10. 00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	81, 488	34, 655	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	329	653	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10	D/line 11)	247.68	53.07	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini beneficiaries	stered to Program	138	268	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (th (line 12 x line 13)	neir) administration	34, 180	14, 223	14.00
15.00				116, 143	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and i administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	ts (their)		48, 403	16.00

Heal th	Financial Systems ST. VINCENT WILLIAMS	PORT HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1307	Period:	Worksheet M-4	
VACCIN	E COST	Component CCN: 15-3994	From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 11	
		Title XVIII	RHC II	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1, 445, 323	1, 445, 323	
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota				
3.00	Pneumococcal and influenza vaccine health care staff cost (lir	2	530	692	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	5	50, 280		
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	,	50, 810		5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshe	eet M-1, col. 7, line 22)	1, 897, 642	1, 897, 642	
7.00	Total overhead (from Wkst. M-2, line 19)		1, 640, 841	1, 640, 841	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot	tal direct cost (line 5	0. 026775	0. 008037	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l		43, 934		
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	94, 744	28, 438	10. 00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	348	454	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10	D/line 11)	272.25	62.64	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini beneficiaries	stered to Program	172	274	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (th (line 12 x line 13)	neir) administration	46, 827	17, 163	14.00
15.00				123, 182	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and i administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	ts (their)		63, 990	16. 00

Health Fir	nancial Systems ST. VINCENT WILLI	AMSPORT HOSPITAL	In Lie	u of Form CMS-2	2552-10
	OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR	Provider CCN: 15-1307	Peri od:	Worksheet M-5	
	RENDERED TO PROGRAM BENEFICIARIES		From 07/01/2018		
		Component CCN: 15-3993	To 06/30/2019	Date/Time Prep	
			RHC I	11/25/2019 11: Cost	32 alli
				t B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00 Tot	tal interim payments paid to hospital-based RHC/FQHC			305, 101	1.00
	terim payments payable on individual bills, either submit	tted or to be submitted to		0	2.00
	e contractor for services rendered in the cost reporting			-	
	ONE" or enter a zero				
3.00 Lis	st separately each retroactive lump sum adjustment amount	t based on subsequent			3.00
rev	vision of the interim rate for the cost reporting period.	Also show date of each			
pay	yment. If none, write "NONE" or enter a zero. (1)				
Pro	ogram to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	ovider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
	btotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	2		0	3.99
	tal interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		305, 101	4.00
27)					
	BE COMPLETED BY CONTRACTOR st separately each tentative settlement payment after des	k raviaw. Alaa ahaw data a	e		5.00
	ch payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date of			5.00
	pgram to Provider				
5.01				0	5. 01
5.02				0	5.02
5.02				0	5.02
	ovider to Program			0	5.05
5.50				0	5.50
5.51				0	5.50
5.52				0	5.52
	btotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.	98)		0	5.99
	termined net settlement amount (balance due) based on the	2		Ű	6,00
	TTLEMENT TO PROVIDER	······································		59, 070	6.01
	TTLEMENT TO PROGRAM			0	6. 02
	tal Medicare program liability (see instructions)			364, 171	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1 00	0.00	
		0	1.00	2.00	

Health Financial Systems ST. VINCENT WILLI	AMSPORT HOSPITAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1307	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-3994	From 07/01/2018 To 06/30/2019	Date/Time Prep 11/25/2019 11:	
		RHC II	Cost	. <u>52 am</u>
			t B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC			676, 058	1.00
2.00 Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero			0	2.00
3.00 List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider				
3.01		01/18/2019	37, 900	3.01
3. 02			0	3. 02
3. 03			0	3.03
3.04			0	3.04
3. 05			0	3.05
Provider to Program				
3. 50			0	3.50
3. 51			0	3.51
3. 52			0	3.52
3. 53 3. 54			0	3. 53 3. 54
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	08)		37, 900	3.54 3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)			713, 958	3.99 4.00
TO BE COMPLETED BY CONTRACTOR		- 1		
5.00 List separately each tentative settlement payment after des	sk review. Also show date o	f		5.00
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				F 04
5. 01 5. 02			0	5. 01 5. 02
5. 02			0	5.02 5.03
Provider to Program			0	5.03
5. 50			0	5.50
5. 51			0	5.50
5. 52			0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	. 98)		Ő	5.99
6.00 Determined net settlement amount (balance due) based on the			Ű	6.00
6.01 SETTLEMENT TO PROVIDER			96, 062	6.01
6.02 SETTLEMENT TO PROGRAM			0	6. 02
7.00 Total Medicare program liability (see instructions)			810, 020	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
	0	1.00	2.00	
8.00 Name of Contractor				8.00