PART II - CERTIFICATION

(4) Reopened (5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT CARMEL HOSPITAL (15-0157) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Officer or Administrator of Provider(s)

Title

Date

			Title	XVIII			
Cost Center Description		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	54, 726	85, 928	0	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	54, 726	85, 928	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.

Health Financial Systems ST. VINCENT CARMEL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0157 Peri od: Worksheet S-2 From 07/01/2016 Part I Date/Time Prepared: 06/30/2017 11/20/2017 12:48 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 13500 NORTH MERIDIAN STREET 1.00 1.00 PO Box: State: IN 2.00 City: CARMEL Zip Code: 46033 County: HAMILTON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal ST. VINCENT CARMEL 150157 26900 01/14/2004 N 0 3.00 HOSPI TAL Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2016 06/30/2017 20.00 Type of Control (see instructions) 21.00 21.00 1 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate Υ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Υ Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23 00 N 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method

_		used in the prior cost reporting period? In column 2	2, enter "Y	' for yes o	r "N" for r	10.			
			In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
			Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
			paid days	el i gi bl e	Medi cai d	Medi cai d		days	
				unpai d	paid days	eligible			
				days		unpai d			
			1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
2	24. 00	If this provider is an IPPS hospital, enter the	305	232	0	0	2, 579	0	24. 00
		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.							
- 2	25. 00	If this provider is an IRF, enter the in-state	o	0	0	0	0		25. 00
		Medicaid paid days in column 1, the in-state							
		Medicaid eligible unpaid days in column 2,							
		out-of-state Medicaid days in column 3, out-of-state							
		Medicaid eligible unpaid days in column 4, Medicaid							
		HMO paid and eligible but unpaid days in column 5.							
							'		
4		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. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	O	0	0	0	0		25

		RMEL HOSPITAL		In	Li eu	of Form	CMS-2	552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der CC		Period: From 07/01/2		Worksheet Part I		
				To 06/30/2		Date/Time 11/20/20	17 12:	
				Urban/Rura 1.00	I S	Date of G 2.00	eogr	
26.00 Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo			jinning of the		1			26. 00
27.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o	age) st	atus at the end			1			27. 00
enter the effective date of the geographic reclassif 35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35. 00
errect in the cost reporting perrou.				Begi nni ng	g:	Endi ng	:	
36.00 Enter applicable beginning and ending dates of SCH s	tatus	Subscript line	36 for number	1.00		2. 00		36. 00
of periods in excess of one and enter subsequent dat 37.00 If this is a Medicare dependent hospital (MDH), ente	es.	·			0			37. 00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f				N				37. 01
instructions) 38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o								38. 00
enter subsequent dates.				Y/N		Y/N		
				1. 00		2. 00		
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet the mileage re	i)? Ent quireme	er in column 1 nts in accordar	"Y" for yes nce with 42	e N		N		39. 00
CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes 40.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to 0cto	n adjus ber 1.	tment? Enter "Y Enter "Y" for y	" for yes or	. N		N		40. 00
no in column 2, for discharges on or after October 1	. (See	Instructions)			V		XI X	
Prospective Payment System (PPS)-Capital					1. 00	2.00	3. 00	
45.00 Does this facility qualify and receive Capital payme	nt for	di sproporti onat	e share in ac	cordance	N	Y	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46. 00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300 PPS cap 48.00 Is the facility electing full federal capital paymen					N N	N N		47. 00 48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in	approv	ed GME programs	? Enter "Y"	for yes	N			56. 00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is ""N", complete Wkst. D, Parts III & IV and D-2, Pt. I	r yes o th of t Y", com	r "N" for no ir his cost report plete Worksheet	n column 1. If ing period?	column 1 Enter "Y"				57. 00
58.00 If line 56 is yes, did this facility elect cost reim	burseme	nt for physicia	ıns' servi ces	as	N			58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If ye			Pt. I.		N			59. 00
60.00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"					N			60. 00
provider operated efficient under 3413.00: Effect	Y/N	IME	Direct GME	I ME		Direct (GME	
	1. 00	2. 00	3. 00	4.00		5. 00		
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0. 00			61. 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		0.00	0.0	00			•	61. 01
instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,		0.00	0.0	00				61. 02
and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care		0.00	0.0	00				61. 03
and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)								/1 0:
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.0	JU				61. 04
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		0.00	0.0	OO				61. 05
61.04 minus line 61.03). (see instructions)		I	I	1				

Health Financial Systems	ST. VINC	ENT CAR	MEL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DA	TΑ	Provi der CC		eriod: com 07/01/2016 o 06/30/2017	Worksheet S-2 Part I Date/Time Prep 11/20/2017 12:	pared:
		Y/N	I ME	Direct GME	IME	Direct GME	, 40 piii
61.06 Enter the amount of ACA §5503 awa used for cap relief and/or FTEs in	hat are nonprimary	1.00	2. 00	3. 00	4. 00	5. 00	61. 06
care or general surgery. (see ins	tructrons)	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, specif specialty, if any, and the number for each new program. (see instrucolumn 1, the program name, enter program code, enter in column 3, unweighted count and enter in col FTE unweighted count.	of FTE residents ctions) Enter in in column 2, the the IME FTE				0. 00	0. 00	61. 10
61.20 Of the FTEs in line 61.05, specific program specialty, if any, and the residents for each expanded progrinstructions) Enter in column 1, enter in column 2, the program column 2, the IME FTE unweighted count a 4, direct GME FTE unweighted count	e number of FTE am. (see the program name, de, enter in column nd enter in column				0. 00	0. 00	61. 20
						1. 00	
ACA Provisions Affecting the Heal							
62.00 Enter the number of FTE residents your hospital received HRSA PCRE	funding (see instruc	ctions)					62.00
62.01 Enter the number of FTE residents during in this cost reporting per Teaching Hospitals that Claim Res	iod of HRSA THC prog	gram. (s	<u>see instruction</u>		your nospi tai	0.00	62. 01
63.00 Has your facility trained residen "Y" for yes or "N" for no in colu	ts in nonprovider se	ettings	during this co		eriod? Enter	N	63. 00
	,			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				Si te 1. 00	2.00	3. 00	
Section 5504 of the ACA Base Year							
period that begins on or after Ju 64.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facilit er of unweighted nor ations occurring in number of unweighted r hospital. Enter ir	ty train n-primar all non d non-pr n column	ned residents by care provider imary care a 3 the ratio	0. 00	0. 00	0. 000000	64. 00
	Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
65.00 Enter in column 1, if line 63	1. 00		2. 00	3. 00 0. 00	4. 00 0. 00	5. 00 0. 000000	4E 00
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)				0.00	0.00	0. 300000	55.00

Health Financial Systems		ENT CARMEL HOSPITAL			u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENIIFICATION DA	TA Provider CC		eriod: rom 07/01/2016 o 06/30/2017	Worksheet S-2 Part I Date/Time Prep	
			Unwei ghted	Unwei ghted	11/20/2017 12: Ratio (col. 1/	48 pm
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovi der Si te	Hospi tal	2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Current		Nonprovider Setting				
beginning on or after July 1, 20 66.00 Enter in column 1 the number of		v care resident	0.00	0.00	0. 000000	66 00
FTEs attributable to rotations of			0.00	0.00	0.00000	00.00
Enter in column 2 the number of						
FTEs that trained in your hospit (column 1 divided by (column 1 divided						
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	noopi tui	.,,	
	1.00	2.00	3. 00	4.00	5. 00	
67.00 Enter in column 1, the program name associated with each of			0.00	0.00	0. 000000	67. 00
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						
<pre>divided by (column 3 + column 4)). (see instructions)</pre>						
(See Thistructions)						
	200			1. 00	2.00 3.00	
Inpatient Psychiatric Facility F		PE) or does it conta	ain an IPE subr	provi der? N		70. 00
Enter "Y" for yes or "N" for no		ii), or does it conte	arii aii iii subt	Novider: N		70.00
71.00 If line 70 yes: Column 1: Did th					0	71. 00
recent cost report filed on or but 42 CFR 412.424(d)(1)(iii)(c)) Co						
program in accordance with 42 CF	R 412.424 (d)(1)(iii)	(D)? Enter "Y" for ye	es or "N" for r	10.		
Column 3: If column 2 is Y, indi (see instructions)	cate which program ye	ar began during this	cost reporting	period.		
Inpatient Rehabilitation Facili	ty PPS					
75.00 Is this facility an Inpatient Re		(IRF), or does it co	ontain an IRF	N		75. 00
subprovider? Enter "Y" for yes 76.00 If line 75 yes: Column 1: Did th		proved GMF teaching p	orogram in the	most		76. 00
recent cost reporting period end	ling on or before Nove	mber 15, 2004? Enter	"Y" for yes or	"N" for		
no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente	train residents in a	new teaching program	in accordance	with 42		
indicate which program year bega						
					1.00	
Long Term Care Hospital PPS					1.00	
80.00 Is this a long term care hospita	al (LTCH)? Enter "Y"	for yes and "N" for r	no.		N	80. 00
81.00 Is this a LTCH co-located withir				peri od? Enter	N	81. 00
"Y" for yes and "N" for no. TEFRA Provi ders						
85.00 Is this a new hospital under 42			,		N	85. 00
86.00 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	ew Other subprovider (excluded unit) under	42 CFR Section	1		86. 00
87. 00 Is this hospital a "subclause (I		nder section 1886(d)	(1)(B)(iv)(II)?	PEnter "Y"	N	87. 00
for yes or "N" for no.	·				VI V	
				1. 00	XI X 2. 00	
Title V and XIX Services				1.00		
90.00 Does this facility have title V		hospital services? Er	nter "Y" for	N	Y	90. 00
yes or "N" for no in the applica 91.00 Is this hospital reimbursed for		rough the cost report	t either in	N	N	91. 00
full or in part? Enter "Y" for y	es or "N" for no in t	he applicable column.				
92.00 Are title XIX NF patients occupy instructions) Enter "Y" for yes			ion)? (see		N	92. 00
93.00 Does this facility operate an I			d XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the	applicable column.	•				
94.00 Does title V or XIX reduce capit applicable column.	aı cost? Enter "Y" fo	r yes, and "N" for no	o in the	N	N	94. 00
app. : 3351 0 001 dim 1.				1	ı l	

Health Financial Systems ST. VINCENT CARMEL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 1	15 O157 D	In Lie	u of Form CMS Worksheet S-	
TOUTHE AND HOST THE HEALTH CARE COMM LEX TRENTT FOR TOWN DATA		om 07/01/2016	Part I Date/Time Pr	epared:
		V 1. 00	11/20/2017 1 XI X 2. 00	2.46 piii
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in applicable column.	n the	0. 00 N	0. 00 N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. Rural Providers		0.00	0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (CAH)? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method for outpatient services? (see instructions)	of payment	N N		105. 00 106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement fo training programs? Enter "Y" for yes or "N" for no in column 1. (see instruct yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the programs reimbursed. If yes complete Wkst. D-2, Pt. II.	tions) If	N		107. 00
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108. 00
Physical Oc 1.00 109.00 If this hospital qualifies as a CAH or a cost provider, are	2.00 N	Speech 3.00 N	Respi ratory 4.00 N	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	IN .	N N	IN IN	109.00
110.00 Did this hospital participate in the Rural Community Hospital Demonstration p	aroi ect (410	A Demolfor	1. 00 N	110.00
the current cost reporting period? Enter "Y" for yes or "N" for no.		A Demoy For	"	110.00
Miscellaneous Cost Reporting Information		1.00	2.00 3.00)
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in co 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 c psychiatric, rehabilitation and long term hospitals providers) based on the d Pub. 15-1, chapter 22, §2208.1.	'E", enter i care (includ	n column es	0	115. 00
116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" fo 117.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for		N" for Y		116. 00 117. 00
118.00 is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the claim-made. Enter 2 if the policy is occurrence.	the policy i	s 1		118. 00
	Premi ums	Losses	Insurance	
110.01	1. 00	2.00	3.00	00110 01
118.01 List amounts of malpractice premiums and paid losses:	0			00 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost center other than Administrative and General? If yes, submit supporting schedule listing cost and amounts contained therein.		1. 00 N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" fo "N" for no. Is this a rural hospital with < 100 beds that qualifies for the OHOL Hold Harmless provision in ACA §3121 and applicable amendments? (see instruct	or yes or Outpatient	N	N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices chapatients? Enter "Y" for yes or "N" for no.	narged to	Υ		121. 00
122.00 Does the cost report contain state health or similar taxes? Enter "Y" for yes for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A linwhere these taxes are included.		Y	5. 00	122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for	r no If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter the certifica				126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 of this is a Medicare certified heart transplant center, enter the certificat				127. 00
in column 1 and termination date, if applicable, in column 2. 128.00 f this is a Medicare certified liver transplant center, enter the certificat	tion date			128. 00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certification	on date in			129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification.	cati on			130. 00
date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certidate in column 1 and termination date, if applicable, in column 2.	fi cati on			131. 00
132.00 If this is a Medicare certified islet transplant center, enter the certificat in column 1 and termination date, if applicable, in column 2.	tion date			132. 00

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLEX	ST. VINCENT CAR X IDENTIFICATION DATA	Provi der CCI	N: 15-0157		7/01/2016	u of Form CMS Worksheet S- Part I	-2
				To 0	6/30/2017 	Date/Time Pr 11/20/2017 1	
					1. 00	2.00	\dashv
33.00 If this is a Medicare certified ot			cation dat	е	1.00	2.00	133. 0
in column 1 and termination date, 34.00 If this is an organ procurement or and termination date, if applicabl	ganization (OPO), enter t		n column 1				134. 0
All Providers			D. L 1F 1		· · ·	240000	140.0
40.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. If	yes, and home	office cos	ts	Υ	269008	140. 0
1.00	2.0				3. 00		
If this facility is part of a chai home office and enter the home off				name and	d address	of the	
41.00 Name: ST. VINCENT HEALTH	Contractor's Name: WF			ctor's Nu	mber: 0810	1	141. (
42.00 Street: 10330 N. MERIDIAN STREET	PO Box:		7: n Co	do.	47.00	10	142. (
43.00 Ci ty: INDIANAPOLIS	State: IN		Zip Co	ue:	4629		143. (
						1.00	
44.00 Are provider based physicians' cos	ts included in Worksheet .	A?				Y	144. (
					1 00	2.00	-
45.00 f costs for renal services are cl	aimed on Wkst A line 74	are the costs	for		1. 00 N	2. 00 N	145. (
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no in Lude Medicare utilization	column 1. If co	olumn 1 is		IV.	, iv	143. (
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	y changed from the previous column 1. (See CMS Pub.			lf	N		146. (
						1.00	-
47.00 Was there a change in the statisti	cal basis? Enter "Y" for	yes or "N" for	no.			N N	147.
48.00 Was there a change in the order of	allocation? Enter "Y" fo	r yes or "N" fo	r no.			N	148. (
49.00 Was there a change to the simplifi	ed cost finding method? E					N	149.
		Part A 1.00	Part E 2.00		itle V 3.00	Title XIX 4.00	_
Does this facility contain a provi	der that qualifies for an			cation of			
or charges? Enter "Y" for yes or "	N" for no for each compon			S. (See 42			
55.00 Hospi tal		N N	N		N	N	155.
56.00 Subprovi der – IPF 57.00 Subprovi der – IRF		N N	N N		N N	N N	156. 157.
58. OO SUBPROVI DER		IN	IN		IN	IN IN	158.
59. 00 SNF		N I	N		N	N	159. (
60.00HOME HEALTH AGENCY		N	N		N	N	160. (
51.00 CMHC			N		N	N	161. (
						1.00	4
Mul ti campus						1.00	
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has on	e or more campu:	ses in dif	ferent CE		N	165. (
	Name	County		Zip Code	CBSA	FTE/Campus	
66.00 f ine 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5.00	00 166.
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						0. 0	100.
column 5 (see instructions)						1.00	
Health Information Tachnalogy (HIT) incentive in the Americ	an Recovery and	l Reinvestr	ent Act		1.00	
near the fill of matron reclinology (ner							167. (
57.00 s this provider a meaningful user 58.00 f this provider is a CAH (line 10 reasonable cost incurred for the H	5 is "Y") and is a meaning	gful user (line		"), enter	the	Y	0168.

Health Financial Systems	ST. VINCENT CARME	EL HOSPITAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0157 For To				pared:		
				11/20/2017 12	:48 pm		
	Begi nni ng	Endi ng					
			1. 00	2.00			
170.00 Enter in columns 1 and 2 the EHR begineriod respectively (mm/dd/yyyy)	10/01/2016	12/31/2016	170. 00				
			1. 00	2.00			
171.00 If line 167 is "Y", does this provide section 1876 Medicare cost plans repo "Y" for yes and "N" for no in column 1876 Medicare days in column 2. (see	orted on Wkst. S-3, Pt. I, 1. If column 1 is yes, en	, line 2, col. 6? Enter	N n	0	171. 00		

	Financial Systems ST. VINCENT CAI	RMEL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI 7	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co		Peri od: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Pre 11/20/2017 12	epared:
				Y/N	Date	1. 40 piii
				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	r all dates in t	he	
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in o	column 2. (see	instructions)			
		•	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2.00	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.	nn 3, "V" for	N N			2.00
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provice officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)			3.00		
	Transfer (add that dott one)		Y/N	Type	Date	
			1.00	2.00	3. 00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4. 00
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit rec	onciliation.				
				Y/N 1. 00	Legal Oper.	
	Approved Educational Activities			1.00	2. 00	
6.00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	e provider is	N		6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	Ü	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	is.		N		9.00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	ne current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
					1. 00	
12. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	coo instruct	Long		Y	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	N	13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	tructions.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti		yes, see inst t A		Y t B	15. 00
		Y/N	Date	Y/N	Date	
	loos a	1.00	2. 00	3. 00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	10/09/2017	Y	10/09/2017	16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

HOSPI T	Financial Systems ST. VINCENT CA				eu of Form CMS			
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-0157	Peri od: From 07/01/2016 To 06/30/2017		repared:		
		Descri	pti on	Y/N	Y/N			
		()	1. 00	3.00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
	report data for other; beserred the other adjustments.	Y/N	Date	Y/N	Date			
		1.00	2. 00	3. 00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1.00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)					
	Capital Related Cost		•					
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	als made dur	ing the cost		23. 00		
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered If yes, see instructions.	ed into during	this cost re	eporting period?		24. 00		
25. 00	If yes, see instructions 5.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see							
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost renorti	na neriod2 L	f ves see		26. 00		
20.00	instructions.	no cost reporti	ng periou: I	1 yes, see		20.00		
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	yes, submit		27. 00		
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into dur	ing the cost	reporting		28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (Do	ht Sorvice F	Posorvo Fund)		29. 00		
29.00	treated as a funded depreciation account? If yes, see instr		bt Service R	teserve runu)		29.00		
30. 00	Has existing debt been replaced prior to its scheduled matu	urity with new	debt? If yes	s, see		30. 00		
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	s, see		31. 00		
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvicos furnisho	d through co	ntractual		32.00		
32.00	arrangements with suppliers of services? If yes, see instru	uctions.	_			32.00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app	plied pertainin	g to competi	tive bidding? If		33. 00		
	no, see instructions. Provider-Based Physicians							
34.00		rrangement with	provi der-ba	sed physi ci ans?		34.00		
25 00	If yes, see instructions.					25.00		
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ts with the	provi der-based		35. 00		
				Y/N	Date			
				Y/N 1. 00	Date 2.00			
	Home Office Costs			1. 00	 			
	Were home office costs claimed on the cost report?	repared by the	home office?	1. 00 Y	 	36.00		
		repared by the	home office?	1. 00 Y	 			
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi	fice different	from that of	1.00 Y Y	 			
37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other	fice different d of the home o	from that of ffice.	1.00 Y Y	 	37. 00 38. 00		
37. 00 38. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been provided in the provider? If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end if line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the	fice different d of the home o er chain compon	from that of ffice. ents? If yes	1.00 Y Y	 	37. 00 38. 00 39. 00		
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been put yes, see instructions. If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end if line 36 is yes, did the provider render services to other see instructions.	fice different d of the home o er chain compon	from that of ffice. ents? If yes	1.00 Y Y S, N	 	37. 00 38. 00 39. 00		
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been provided in the provider? If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end if line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the	fice different d of the home o er chain compon	from that of ffice. ents? If yes If yes, see	1.00 Y Y Y S N N N	 	37. 00 38. 00 39. 00		
37. 00 38. 00 39. 00 40. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been provided by the provider? If yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end if line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes If yes, see	1.00 Y Y S, N N	2.00	37. 00 38. 00 39. 00 40. 00		
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been provided by the provider? If yes, enter in column 2 the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end of the provider? If yes, enter in column 2 the fiscal year end of the provider? If yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions.	fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes If yes, see	1.00 Y Y Y S N N N	2.00	37. 00		
37. 00 38. 00 39. 00 40. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been provided by the provider? If yes, enter in column 2 the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end of the provider? If yes, enter in column 2 the fiscal year end of the provider? If yes, enter in column 2 the fiscal year end of the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes If yes, see	1.00 Y Y S, N N	2.00	37. 00 38. 00 39. 00 40. 00		
37. 00 38. 00 39. 00 40. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been provided by the provider? If yes, enter in column 2 the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end of the provider? If yes, enter in column 2 the fiscal year end of the provider? If yes, enter in column 2 the fiscal year end of the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes If yes, see	1.00 Y Y S, N N	2.00	37. 00 38. 00 39. 00 40. 00		

Heal th	Financial Systems S	ST. VINCENT	CARME	L HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE		Provider C	CCN: 15-0157	Peri Froi To	m 07/01/2016		epared:
				3	.00				
	Cost Report Preparer Contact Information								
41. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.	•		MBURSEMENT	MANAGER				41. 00
42. 00	Enter the employer/company name of the cost repreparer.	eport							42. 00
43. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective								43. 00

Health Financial Systems ST. VINC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0157

				To	06/30/2017	Date/Time Prep	
						I/P Days / 0/P	. 40 pili
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	· · · · ·	Line Number		Avai I abl e			
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	128	46, 720	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		128	46, 720	0.00	0	7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	31. 00	10	3, 650	0. 00	0	8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT					_	11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	35. 00		5, 475	0. 00		12. 00
13. 00	NURSERY	43. 00				0	13. 00
14. 00	Total (see instructions)		153	55, 845	0. 00		14. 00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE	20.00					24. 00
24. 10 25. 00	HOSPICE (non-distinct part)	30. 00					24. 10 25. 00
	CMHC - CMHC						26. 00
26. 00	RURAL HEALTH CLINIC	89. 00				0	26. 00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	89.00	153	,		U	26. 25
28. 00	Total (sum of lines 14-26) Observation Bed Days		103)		0	28.00
29. 00	Ambulance Trips					U	29.00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istruction)						31.00
32. 00	Labor & delivery days (see instructions)		c				32.00
32. 00	Total ancillary labor & delivery room			ή			32.00
32. UI	outpatient days (see instructions)						32.01
33 00	LTCH non-covered days						33. 00
55. 50	12.5 33voi od day3	I	ı	1	'		30.00

| Period: | Worksheet S-3 | From 07/01/2016 | Part | To 06/30/2017 | Date/Time Prepared: Health Financial Systems ST. VINC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0157

				T	o 06/30/2017	Date/Time Pre 11/20/2017 12	
		I/P Days / O/P Visits / Trips		Full Time Equivalents		, 10 p	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	3, 905	124	13, 175			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 407	2, 579				2. 00
3.00	HMO IPF Subprovider	1, 407	2, 3/9 N				3.00
4. 00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	Ö	0	ł			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	٩	0				6.00
7. 00	Total Adults and Peds. (exclude observation	3, 905	124				7. 00
	beds) (see instructions)	·		·			
8.00	INTENSIVE CARE UNIT	304	36	797			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	0	0				12. 00
13. 00	NURSERY		377				13. 00
14. 00	Total (see instructions)	4, 209	537		0.00	578. 27	14. 00
15. 00	CAH visits	0	0	0			15. 00
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY						18. 00 19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	o	0	0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	578. 27	27. 00
28. 00	Observation Bed Days		0	1, 756			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			930			30. 00
31. 00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	0				32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
22 00	outpatient days (see instructions)						22 00
აა. 00	LTCH non-covered days	0		I	I	I	33. 00

				To	06/30/2017	Date/Time Prep 11/20/2017 12:	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		(1, 169	121	6, 631	1. 00
2.00	HMO and other (see instructions)			353	686		2.00
3. 00 4. 00	HMO IPF Subprovider HMO IRF Subprovider				0		3. 00 4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				U		5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNI						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10. 00 11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	(1, 169	121	6, 631	14. 00
15. 00	CAH visits			.,		2, 22.	15. 00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						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 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)						22. 00 23. 00
24. 00	HOSPICE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27.00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00 32. 01
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. U I
33. 00	LTCH non-covered days						33. 00

| Period: | Worksheet S-3 | From 07/01/2016 | Part II | To 06/30/2017 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0157

					To	06/30/2017	Date/Time Pre	pared:
		Worksheet A	Amount	Recl assi fi cati	Adjusted	Pai d Hours	11/20/2017 12 Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Worksheet A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200.00	43, 177, 334	1 0	43, 177, 334	1, 203, 100. 84	35. 89	1.00
1.00	instructions)	200.00	43, 177, 334		43, 177, 334	1, 203, 100. 84	33. 69	1.00
2.00	Non-physician anesthetist Part		C	0	0	0.00	0.00	2. 00
3. 00	A Non-physician anesthetist Part		(0	0	0. 00	0. 00	3. 00
3.00	B			,		0.00	0.00	3.00
4.00	Physician-Part A -		417, 751	0	417, 751	2, 231. 02	187. 25	4. 00
4. 01	Administrative Physicians - Part A - Teaching		(0	0	0.00	0. 00	4. 01
5. 00	Physician and Non		3, 373, 536	1	_			
	Physician-Part B		004 4/		004.447	2 222 22	F7.0/	, ,,,,
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		224, 467	0	224, 467	3, 920. 00	57. 26	6. 00
	servi ces							
7. 00	Interns & residents (in an	21. 00	C	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and		C	0	0	0.00	0. 00	7. 01
	residents (in an approved							
8. 00	programs) Home office and/or related		4, 738, 124		4, 738, 124	195, 362. 62	24. 25	8. 00
6.00	organization personnel		4, 730, 124		4, 730, 124	195, 302. 02	24. 25	0.00
9.00	SNF	44. 00		0	-	0.00		
10. 00	Excluded area salaries (see instructions)		1, 248, 410	0	1, 248, 410	51, 115. 23	24. 42	10. 00
	OTHER WAGES & RELATED COSTS	L						
11. 00	Contract labor: Direct Patient		189, 484	0	189, 484	1, 973. 13	96. 03	11. 00
12. 00	Care Contract Labor: Top Level		C	0	0	0.00	0.00	12. 00
	management and other							
	management and administrative services							
13. 00	Contract Labor: Physician-Part		1, 566, 292	el o	1, 566, 292	20, 247. 28	77. 36	13. 00
	A - Administrative		_					
14. 00	Home office and/or related orgainzation salaries and		C	0	0	0. 00	0.00	14. 00
	wage-related costs							
14. 01	Home office salaries Related organization salaries		9, 090, 021	0	9, 090, 021	267, 058. 00 0. 00		14. 01 14. 02
14. 02 15. 00	Home office: Physician Part A		C		0	0.00		
	- Administrative							
16. 00	Home office and Contract Physicians Part A - Teaching		C	0	0	0. 00	0. 00	16. 00
	WAGE-RELATED COSTS	Į.						
17. 00	Wage-related costs (core) (see		10, 911, 164	0	10, 911, 164			17. 00
18. 00	instructions) Wage-related costs (other)		C	0	0			18. 00
	(see instructions)			_				
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		359, 284	0	359, 284			19. 00 20. 00
20.00	A							20.00
21. 00	Non-physician anesthetist Part		C	0	0			21. 00
22. 00	Physician Part A -		120, 226	0	120, 226			22. 00
	Administrative		_					
22. 01 23. 00	Physician Part A - Teaching Physician Part B		970, 882	0	970, 882			22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC)		64, 600	1	64, 600			24. 00
25. 00	Interns & residents (in an		C	0	0			25. 00
25. 50	approved program) Home office wage-related		2, 239, 174		2, 239, 174			25. 50
25. 51	Related orgainzation		,	O	0			25. 51
25. 52	wage-related Home office: Physician Part A		C		0			25. 52
20.02	- Administrative -							20.02
25 52	wage-related							25 52
25. 53	Home office & Contract Physicians Part A - Teaching -		C	,				25. 53
	wage-rel ated							1
24 00	OVERHEAD COSTS - DIRECT SALARIE		250 404		250 404	0.110.04	40.47	24 00
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	350, 106 6, 233, 550					26. 00 27. 00
	,	2. 00	,	,	,,	.,		

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 07/01/2016 | Part II | To 06/30/2017 | Date/Time Prepared: | 11/20/2017 | 12/40-----

							11/20/2017 12	48 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		1, 740, 283	0	1, 740, 283	11, 959. 37	145. 52	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	C	0	0	0.00		29. 00
30.00	Operation of Plant	7. 00	192, 562	. 0	192, 562	9, 876. 43	19. 50	30. 00
31. 00	Laundry & Linen Service	8. 00	C	0	0	0.00	0. 00	31. 00
32.00	Housekeepi ng	9. 00	C	0	0	0.00	0.00	32. 00
33.00	Housekeeping under contract		1, 482, 778	0	1, 482, 778	61, 368. 03	24. 16	33.00
	(see instructions)							
34.00	Di etary	10. 00	C	0	0	0.00	0.00	34.00
35.00	Di etary under contract (see		376, 956	0	376, 956	14, 048. 08	26. 83	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	C	0	0	0.00	0.00	36. 00
37.00	Maintenance of Personnel	12. 00	C	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	1, 300, 689	0	1, 300, 689	28, 425. 84	45. 76	38. 00
39.00	Central Services and Supply	14. 00	347, 839	0	347, 839	14, 771. 21	23. 55	39. 00
40.00	Pharmacy	15. 00	2, 026, 929	0	2, 026, 929	48, 611. 57	41. 70	40.00
41.00	Medical Records & Medical	16. 00	765, 674	. 0	765, 674	29, 740. 32	25. 75	41.00
	Records Library							
42.00	Social Service	17. 00	155, 644	. 0	155, 644	4, 463. 62	34. 87	42.00
43.00	Other General Service	18. 00	C	0	0	0.00	0. 00	43.00

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

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 15-0157 Peri od: From 07/01/2016 To 06/30/2017 11/20/2017 12:49 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col.2 ± col. col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 38, 441, 224 38, 441, 224 1, 067, 131. 19 1.00 36. 02 instructions) 2.00 Excluded area salaries (see 1, 248, 410 ol 1, 248, 410 51, 115. 23 2.00 24. 42 instructions) 3.00 Subtotal salaries (line 1 37, 192, 814 0 37, 192, 814 1, 016, 015. 96 36. 61 3.00 minus line 2) 4.00 Subtotal other wages & related 10, 845, 797 0 10, 845, 797 289, 278. 41 37.49 4.00 costs (see inst.) Subtotal wage-related costs 5.00 13, 270, 564 0 13, 270, 564 0.00 35. 68 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 61, 309, 175 0 61, 309, 175 1, 305, 294. 37 46 97

14, 973, 010

405, 344. 34

36.94

7.00

14, 973, 010

7.00

Total overhead cost (see

instructions)

Health Financial Systems	ST. VINCENT CARMEL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0157	Period: Worksheet S-3 From 07/01/2016 Part IV

	From 07/01/20 To 06/30/20		
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1. 00	401K Employer Contributions	1, 738, 231	1. 00
2. 00	Tax Sheltered Annuity (TSA) Employer Contribution	0	
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	348, 469	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
7. 00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8. 00	Health Insurance (Purchased or Self Funded)	6, 498, 481	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Heal th I nsurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10. 00	Dental, Hearing and Vision Plan	72, 415	
	Life Insurance (If employee is owner or beneficiary)	41, 756	1
	Accident Insurance (If employee is owner or beneficiary)	161	12. 00
	Disability Insurance (If employee is owner or beneficiary)	368, 194	•
	Long-Term Care Insurance (If employee is owner or beneficiary)	39, 836	
15. 00		235, 595	1
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	170	16. 00
	Non cumulative portion)		
47.00	TAXES	0.07/.0/0	4.7.00
	FICA-Employers Portion Only	2, 976, 069	•
	Medicare Taxes - Employers Portion Only	0	18. 00
	Unempl oyment Insurance	0	19.00
20. 00	State or Federal Unemployment Taxes	10, 854	20. 00
	OTHER	70.047	
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (s	ee 72, 247	21. 00
22. 00	instructions)) Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	23, 678	
24.00	Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost	12, 426, 156	24.00
25. 00		0	25. 00
25.00	IOTHER	1	25.00

Heal th	Financial Systems	ST. VINCENT CARMEL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	TAL CONTRACT LABOR AND BENEFIT COST		Peri od:	Worksheet S-3	
			From 07/01/2016	Part V	
			Γo 06/30/2017	Date/Time Prep 11/20/2017 12:	pared:
	Cook Cooker Doored at least		C+		48 pm
	Cost Center Description		Contract Labor		
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Ident	i fi cati on:			
1.00	Total facility's contract labor and benefit	t cost	189, 484	12, 426, 156	1.00
2.00	Hospi tal		189, 484	10, 667, 969	2. 00
3.00	Subprovi der - IPF				3. 00
4.00	Subprovi der - IRF				4.00
5.00	Subprovider - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
	lu i i b i aus				

8.00

9.00 10.00 11.00

12.00

13.00 14. 00 15.00 16.00 17.00

1, 758, 187 18. 00

Hospi tal -Based SNF

12.00 Separately Certified ASC

12.00 | Separately Certified ASC 13.00 | Hospital - Based Hospice 14.00 | Hospital - Based Health Clinic RHC 15.00 | Hospital - Based Health Clinic FQHC 16.00 | Hospital - Based - CMHC 17.00 | Renal Dialysis 18.00 | Other

9. 00 Hospi tal -Based NF 10. 00 Hospi tal -Based NF 11. 00 Hospi tal -Based HHA

8.00

	n Financial Systems ST. VINCENT CARMEL HOSPITAL TAL UNCOMPENSATED AND INDIGENT CARE DATA Provider C	CN: 15-0157	Peri od:	u of Form CMS-2 Worksheet S-10			
	THE UNCOME ENSATED AND THOUGHT GARE DATA	SIV. 13 0137	From 07/01/2016				
			To 06/30/2017	Date/Time Pre 11/20/2017 12	pared: 49 pm		
				1. 00			
	Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by Ii	ne 202 column	1 8)	0. 208548	1. 00		
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid			4, 691, 484	2. 0		
3. 00	Did you receive DSH or supplemental payments from Medicaid?			N 4, 671, 464	3. 0		
4. 00	If line 3 is yes, does line 2 include all DSH or supplemental payments fr	om Medicaid?			4. 0		
5. 00	If line 4 is no, then enter DSH or supplemental payments from Medicaid			0	5. 0		
6.00	Medi cai d charges			60, 650, 107	6. 00		
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (line 7 min	us sum of Lir	os 2 and 5: if	12, 648, 459 7, 956, 975	7. 00 8. 00		
0.00	<pre>< zero then enter zero)</pre>	ius suiii 01 111	ies 2 and 5, 11	7, 730, 773	0. 00		
	Children's Health Insurance Program (CHIP) (see instructions for each lin	e)					
9. 00	Net revenue from stand-alone CHIP			0	9. 00		
10.00				0	10.0		
11. 00 12. 00	,	nus line 0· i	f / zero then	0	11. 0 12. 0		
12.00	enter zero)	nus iine 7, i	1 \ Zero then		12.0		
	Other state or local government indigent care program (see instructions f				13. 0		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)						
14. 00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)						
15. 00				0	15. 0		
16. 00		program (lir	ne 15 minus line	0			
	13; if < zero then enter zero)						
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and statinstructions for each line)	e/local indig	jent care progran	ns (see			
17. 00	Private grants, donations, or endowment income restricted to funding char			0			
18.00			(6.1.	0	18. 0		
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent 8, 12 and 16)	care programs	s (Sull of Titles	7, 956, 975			
		1	1		17.0		
	0, 12 dia 10)	Uni nsured	Insured	Total (col. 1	17. 0.		
	o, 12 dia 10)	pati ents	pati ents	+ col . 2)	17. 0.		
					17. 0.		
20. 00	Uncompensated Care (see instructions for each line)	pati ents 1.00	pati ents 2.00	+ col . 2) 3.00			
20. 00	Uncompensated Care (see instructions for each line)	pati ents 1.00 5,402,82	pati ents 2.00 29 5,184,791	+ col . 2) 3. 00 10, 587, 620			
	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see	pati ents 1.00	pati ents 2.00 29 5,184,791	+ col . 2) 3. 00 10, 587, 620	20. 00		
21. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions)	pati ents 1.00 5, 402, 82 1, 126, 74	pati ents 2.00 29 5,184,791 5,184,791	+ col . 2) 3.00 10,587,620 6,311,540	20. 00		
21. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as	pati ents 1.00 5,402,82	pati ents 2.00 29 5,184,791 5,184,791	+ col . 2) 3.00 10,587,620 6,311,540	20. 00		
21. 00 22. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	pati ents 1.00 5, 402, 82 1, 126, 74	pati ents 2.00 29 5,184,791 5,184,791 25 218,828	+ col . 2) 3.00 10,587,620 6,311,540 308,653	20. 00 21. 00 22. 00		
21. 00 22. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	pati ents 1. 00 5, 402, 82 1, 126, 74 89, 82	pati ents 2.00 29 5,184,791 5,184,791 25 218,828	+ col . 2) 3.00 10,587,620 6,311,540 308,653 6,002,887	20. 00 21. 00 22. 00		
21. 00 22. 00 23. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)	pati ents 1.00 5,402,82 1,126,74 89,82 1,036,92	pati ents 2.00 29 5,184,791 49 5,184,791 25 218,828 24 4,965,963	+ col. 2) 3.00 10,587,620 6,311,540 308,653 6,002,887	20. 00 21. 00 22. 00 23. 00		
21. 00 22. 00 23. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient days beyon	pati ents 1.00 5,402,82 1,126,74 89,82 1,036,92	pati ents 2.00 29 5,184,791 49 5,184,791 25 218,828 24 4,965,963	+ col . 2) 3.00 10,587,620 6,311,540 308,653 6,002,887	20. 00 21. 00 22. 00		
21. 00 22. 00 23. 00 24. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)	patients 1.00 5,402,82 1,126,74 89,82 1,036,92 and a Length of	pati ents 2.00 29 5,184,791 49 5,184,791 25 218,828 4,965,963	+ col. 2) 3.00 10,587,620 6,311,540 308,653 6,002,887	20. 00 21. 00 22. 00 23. 00		
21. 00 22. 00 23. 00 24. 00 25. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient days beyo imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Total bad debt expense for the entire hospital complex (see instructions)	patients 1.00 5,402,82 1,126,74 89,82 1,036,92 and a Length of care program	pati ents 2.00 29 5,184,791 49 5,184,791 25 218,828 4,965,963	+ col. 2) 3.00 10, 587, 620 6, 311, 540 308, 653 6, 002, 887 1.00 N	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00		
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see instructions)	patients 1.00 5,402,82 1,126,74 89,82 1,036,92 and a Length of care program	pati ents 2.00 29 5,184,791 49 5,184,791 25 218,828 4,965,963	+ col. 2) 3.00 10, 587, 620 6, 311, 540 308, 653 6, 002, 887 1.00 N 0 2, 830, 713 135, 482	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00		
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see instructions) Medicare allowable bad debts for the entire hospital complex (see instructions)	patients 1.00 5,402,82 1,126,74 89,82 1,036,92 and a Length of care program	pati ents 2.00 29 5,184,791 49 5,184,791 25 218,828 4,965,963	+ col. 2) 3.00 10,587,620 6,311,540 308,653 6,002,887 1.00 N 0 2,830,713 135,482 208,434	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 00		
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient days beyo imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see instructions) Medicare allowable bad debts for the entire hospital complex (see instructions) Non-Medicare bad debt expense (line 26 minus line 27.01)	patients 1.00 5,402,82 1,126,74 89,82 1,036,92 and a Length of care program ructions)	patients 2.00 29 5,184,791 5,184,791 25 218,828 24 4,965,963 of stay limit o's length of	+ col. 2) 3.00 10, 587, 620 6, 311, 540 308, 653 6, 002, 887 1.00 N 0 2, 830, 713 135, 482 208, 434 2, 622, 279	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 28. 00		
20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 01 28. 00 29. 00 30. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see instructions) Medicare allowable bad debts for the entire hospital complex (see instructions) Medicare bad debt expense (line 26 minus line 27.01) Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see	patients 1.00 5,402,82 1,126,74 89,82 1,036,92 and a Length of care program ructions)	patients 2.00 29 5,184,791 5,184,791 25 218,828 24 4,965,963 of stay limit o's length of	+ col. 2) 3.00 10,587,620 6,311,540 308,653 6,002,887 1.00 N 0 2,830,713 135,482 208,434	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 00 28. 00 29. 00		

Health Financial Systems	ST. VINCENT CAR	MEL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CO		Peri od:	Worksheet A	
				From 07/01/2016	D-+- /T: D	
				Го 06/30/2017	Date/Time Pre 11/20/2017 12	
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	. 40 piii
		2 21.12.	+ col . 2)	ons (See A-6)	Trial Balance	
			,	, ,	(col. 3 +-	
					col . 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT		8, 314, 203			0,0.1,200	1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP		4, 192, 666			4, 192, 666	2. 00
4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT	350, 106	9, 244, 159			9, 594, 265	4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	6, 233, 550	14, 840, 633			21, 074, 183	5. 00
7. 00 00700 OPERATION OF PLANT	192, 562	5, 953, 692			6, 146, 254	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	613, 071	613, 07		613, 071	8. 00
9. 00 00900 HOUSEKEEPI NG	0	1, 997, 059			1, 997, 059	9. 00
10. 00 01000 DI ETARY	0	2, 101, 766	1		572, 895	1
11. 00 01100 CAFETERIA	1 200 (00	272 451	1 572 144	1,020,071	1, 528, 871	11.00
13.00 O1300 NURSI NG ADMINI STRATI ON 14.00 O1400 CENTRAL SERVI CES & SUPPLY	1, 300, 689	272, 451 42, 280	1, 573, 140 390, 119		1, 573, 140 390, 119	13. 00 14. 00
15. 00 01500 PHARMACY	347, 839 2, 026, 929	628, 431	2, 655, 360		2, 655, 360	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	765, 674	456, 957			1, 222, 631	1
17. 00 01700 SOCIAL SERVICE	155, 644	138, 614			294, 258	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	155, 044	130, 014	274, 230	5 0	274, 230	17.00
30. 00 03000 ADULTS & PEDIATRICS	10, 148, 255	3, 275, 049	13, 423, 304	4 -1, 156, 105	12, 267, 199	30.00
31. 00 03100 NTENSI VE CARE UNI T	1, 059, 956	684, 008			1, 743, 964	•
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	2, 762, 909	599, 805			3, 362, 714	35. 00
43. 00 04300 NURSERY	0	0 77, 000		1, 156, 105		43. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	J	,	1, 100, 100	1, 100, 100	10.00
50. 00 05000 OPERATI NG ROOM	3, 766, 801	5, 811, 877	9, 578, 678	3 0	9, 578, 678	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 163, 747	1, 453, 867			3, 617, 614	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 862, 453	857, 367	2, 719, 820		2, 719, 820	54.00
54. 01 03480 ONCOLOGY	O	0	, , , ,	0	0	54. 01
54. 02 05402 ULTRASOUND	202, 590	18, 904	221, 494	4 0	221, 494	54. 02
57. 00 05700 CT SCAN	523, 323	184, 903			708, 226	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	398, 562	232, 295	630, 85 ⁻	7 0	630, 857	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	O	0		0	0	59. 00
60. 00 06000 LABORATORY	o	2, 857, 249	2, 857, 249	9 0	2, 857, 249	60.00
65. 00 06500 RESPIRATORY THERAPY	959, 371	167, 760	1, 127, 13 ⁻	1 0	1, 127, 131	65. 00
66. 00 06600 PHYSI CAL THERAPY	386, 589	57, 442	444, 03	1 0	444, 031	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	17, 182	1, 658	18, 840	0	18, 840	68. 00
69. 00 06900 ELECTROCARDI OLOGY	91, 668	23, 557	115, 22!	5 0	115, 225	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	95, 700	15, 716			111, 416	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 705, 058		3 0	4, 705, 058	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 604, 667			5, 604, 667	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 504, 625			3, 504, 625	
75.00 07500 ASC (NON-DISTINCT PART)	2, 613, 659	6, 977, 987			9, 591, 646	
76. 00 03330 ENDOSCOPY	1, 592, 783	1, 423, 155	3, 015, 938	3 0	3, 015, 938	76. 00
OUTPATIENT SERVICE COST CENTERS				- 1		
91. 00 09100 EMERGENCY	1, 910, 383	816, 705	2, 727, 088	0	2, 727, 088	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
SPECIAL PURPOSE COST CENTERS	11 000 001	00.040.404	100 000 5/4		100 000 5/0	
118. 00 SUBTOTALS (SUM OF LINES 1-117)	41, 928, 924	88, 069, 636	129, 998, 560	0 0	129, 998, 560	1118.00
NONREI MBURSABLE COST CENTERS	100 003	200 575	F00 101	1 2	F00 400	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	102, 827	399, 575				
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	271, 235	61, 201	332, 436		,	
194.00 07950 MISSION EFFECTIVENESS	0	0		0 0		194. 00 194. 01
194. 01 07951 MARKETI NG	0	0				
194. 02 07952 JOI NT VENTURES 194. 04 07954 SCHOOL NURSE	492, 884	0 24 135	E20 000		529, 009	194. 02
194.06 07956 SPORTS MEDICINE & OB PHYS	381, 464	36, 125 312, 536			694, 000	
200.00 TOTAL (SUM OF LINES 118-199)	43, 177, 334	312, 536 88, 879, 073				
200.00 TOTAL (30M OF LINES 110 177)	1 45, 177, 554	00, 077, 073	102,000,40	,,	102,000,407	1200.00

Health FinancialSystemsST.VINCENTRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provi der CCN: 15-0157

Peri od: Worksheet A From 07/01/2016 To 06/30/2017 Date/Time Prepared:

				10 00/30	11/20/2017 12	2: 48 pm
	Cost Center Description	Adjustments	Net Expenses	•		
	'	(See A-8)	For Allocation			
		6. 00	7. 00			
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT	-1, 361, 387	6, 952, 816			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-4, 748	4, 187, 918			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-198, 835	9, 395, 430			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-432, 385	20, 641, 798			5. 00
7.00	00700 OPERATION OF PLANT	-86, 288	6, 059, 966			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	613, 071			8. 00
9. 00	00900 HOUSEKEEPI NG	0	1, 997, 059			9. 00
10. 00	01000 DI ETARY	-2, 005	570, 890			10.00
11. 00	01100 CAFETERI A	-490, 122	1, 038, 749			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-1, 521	1, 571, 619			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	390, 119			14. 00
15. 00	01500 PHARMACY	-2, 962	2, 652, 398			15. 00
16. 00	01600 MEDICAL RECORDS & LI BRARY		1, 222, 129			16.00
	01700 SOCIAL SERVICE	-502				•
17.00		-21, 027	273, 231			17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 222 220	10 000 071			1 20 00
30.00	03000 ADULTS & PEDI ATRI CS	-2, 233, 228	10, 033, 971			30.00
31. 00	03100 NTENSI VE CARE UNI T	0	1, 743, 964			31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	-1, 419, 732	1, 942, 982			35. 00
43. 00	04300 NURSERY	0	1, 156, 105			43. 00
	ANCILLARY SERVICE COST CENTERS		0.570.004			4
50. 00	05000 OPERATI NG ROOM	-5, 692	9, 572, 986			50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-1, 258, 071	2, 359, 543			52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-11, 252	2, 708, 568			54. 00
54. 01	03480 ONCOLOGY	0	0			54. 01
54. 02	05402 ULTRASOUND	0	221, 494			54. 02
57. 00	05700 CT SCAN	-23, 569	684, 657			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	630, 857			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0			59. 00
60.00	06000 LABORATORY	0	2, 857, 249			60. 00
65. 00	06500 RESPI RATORY THERAPY	-76	1, 127, 055			65. 00
66. 00	06600 PHYSI CAL THERAPY	0	444, 031			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0			67. 00
68.00	06800 SPEECH PATHOLOGY	0	18, 840			68. 00
69.00	06900 ELECTROCARDI OLOGY	0	115, 225			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	111, 416			70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 705, 058			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	5, 604, 667			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 504, 625			73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	77, 818	9, 669, 464			75. 00
76. 00	03330 ENDOSCOPY	13, 320	3, 029, 258			76. 00
	OUTPATIENT SERVICE COST CENTERS		5/ 52.// 255			1
91. 00	09100 EMERGENCY	-54, 399	2, 672, 689			91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		, , , , , ,			92.00
	SPECIAL PURPOSE COST CENTERS		l l			1
118.00		-7, 516, 663	122, 481, 897			118. 00
	NONREI MBURSABLE COST CENTERS	770.07000	122/101/07/			1.10.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	502, 402			190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	332, 436			192. 00
	07950 MI SSI ON EFFECTI VENESS	0	002, 100			194. 00
	07951 MARKETI NG	709, 868	709, 868			194. 01
	07952 JOINT VENTURES	0	707,000			194. 02
	07954 SCHOOL NURSE	0	529, 009			194. 02
	07956 SPORTS MEDICINE & OB PHYS		694, 000			194. 04
200.00	1 1	-6, 806, 795				200.00
200. UC	I TOTAL (SUM OF LINES 110-199)	-0, 000, 795	120, 249, 012			1200.00

Heal th	Financial Systems		ST. VINCENT CA	RMEL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLASS	SI FI CATI ONS			Provi der 0	CN: 15-0157	Peri od: From 07/01/2016	Worksheet A-0	5
						To 06/30/2017	Date/Time Pro 11/20/2017 12	epared: 2:49 pm
		Increases						
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5. 00				
	A - NURSERY							
1.00	NURSERY	43. 00	973, 809	182, 296				1. 00
	TOTALS		973, 809	182, 296				
	C - CAFETERIA							
1.00	CAFETERI A	11. 00	0	1, 528, 871				1. 00
	TOTALS		0	1, 528, 871				
500.00	Grand Total: Increases		973, 809	1, 711, 167				500. 00

Heal th	Financial Systems		ST. VINCENT CA	RMEL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLASSI FI CATI ONS				Provi der (CCN: 15-0157	Peri od: From 07/01/2016	Worksheet A-	5
						To 06/30/2017	Date/Time Pro	epared: 2:49 pm
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref			
	6. 00	7.00	8. 00	9. 00	10.00			
	A - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	973, 809	182, 296		0		1. 00
	TOTALS		973, 809	182, 296				
	C - CAFETERIA							
1.00	DI ETARY	10.00	0	1, 528, 871		0		1. 00
	TOTALS		0	1, 528, 871				
500.00	Grand Total: Decreases		973, 809	1, 711, 167				500.00

					To 06/30/2017		
				Acqui si ti ons		11/20/2017 12	40 piii
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES			_		
1.00	Land	2, 111, 746	0	(0	0	1.00
2.00	Land Improvements	2, 417, 235	13, 788	(13, 788		2.00
3.00	Buildings and Fixtures	54, 822, 280	185, 176	(185, 176	·	3.00
4.00	Building Improvements	38, 593, 961	17, 802, 181	(17, 802, 181	21, 564	4. 00
5.00	Fixed Equipment	2, 818, 804	14, 540	(14, 540	588	5. 00
6.00	Movable Equipment	43, 704, 870	2, 883, 454	(2, 883, 454	558, 854	6.00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	144, 468, 896	20, 899, 139	(20, 899, 139	704, 152	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	144, 468, 896	20, 899, 139	(20, 899, 139	704, 152	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	2, 111, 746	0				1. 00
2.00	Land Improvements	2, 431, 023	1, 877, 961				2. 00
3.00	Buildings and Fixtures	54, 884, 310	19, 321, 863				3. 00
4.00	Building Improvements	56, 374, 578	1, 281, 787				4. 00
5.00	Fixed Equipment	2, 832, 756	927, 614				5. 00
6.00	Movable Equipment	46, 029, 470	19, 261, 371				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	164, 663, 883	42, 670, 596				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	164, 663, 883	42, 670, 596				10.00

Heal th	Health Financial Systems ST. VINCENT CARMEL HOSPITAL In Lieu of Form CMS-2552-10						
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO		eri od:	Worksheet A-7	
					rom 07/01/2016		
				1	o 06/30/2017	Date/Time Pre 11/20/2017 12	
			SI	JMMARY OF CAPIT	ΔΙ	11/20/2017 12	. 40 piii
Sommun of On The				AL.			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	3, 420, 816	4, 058, 808	709, 796	64, 255	60, 528	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 597, 245	563, 732	0	2, 914	28, 775	2. 00
3.00	Total (sum of lines 1-2)	7, 018, 061	4, 622, 540	709, 796	67, 169	89, 303	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Relate					
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	8, 314, 203				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4, 192, 666				2. 00
3.00	Total (sum of lines 1-2)	0	12, 506, 869				3. 00

Heal th	n Financial Systems	ST. VINCENT CA	RMEL HOSPITAL		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 07/01/2016 To 06/30/2017		pared:	
		COM	PUTATION OF RAT	10S	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance		
			Leases	for Ratio	instructions)			
				(col. 1 - col. 2)	•			
		1. 00	2.00	3.00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	116, 522, 668				0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	46, 029, 469				0	2. 00	
3.00	Total (sum of lines 1-2)	162, 552, 137		162, 552, 13			3. 00	
		ALLOCATION OF OTHER CAPITAL			SUMMARY O	F CAPITAL		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
			Capi tal -Relate					
			d Costs	through 7)				
	DART LLL DESCRIPTION OF CARLEY COOTS	6.00	7. 00	8. 00	9. 00	10. 00		
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT	ENTERS	0		2 420 017	2 417 007	1 00	
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT	0	0		3, 420, 816 3, 597, 245		1. 00 2. 00	
3.00	Total (sum of lines 1-2)	0			7, 018, 061	3, 981, 539	3. 00	
3.00	Total (Sull of Titles 1-2)	0	SI SI	IYMMARY OF CAPI		3, 701, 337	3.00	
			30	MINIMARCI OI CALI	IAL			
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9		
					d Costs (see	through 14)		
					instructions)			
	DART III DECONOLILIATION OF CARLTAL COCTO OF	11. 00	12.00	13. 00	14. 00	15. 00		
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT	ENTERS 0	64, 255	60, 52	-10, 590	4 0E2 01/	1. 00	
2.00	CAP REL COSTS-BLDG & FIXT	0		· ·	· ·			
3.00	Total (sum of lines 1-2)							
3.00	Total (Sull of Titles 1-2)	1	07, 109	1 07, 30.	J ₁ -15, 550	11, 140, 734	3.00	

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: Worksheet A-From 07/01/2016 Provi der CCN: 15-0157

					o 06/30/2017	Date/Time Prep	
				Expense Classification on	Worksheet A	11/20/2017 12:	: 49 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1. 00 B	2. 00 -706, 014	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 11	1. 00
	COSTS-BLDG & FLXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	Investment income - other		0		0.00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7.00	Telephone services (pay stations excluded) (chapter 21)	А	-13, 573	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
8. 00	Tel evi si on and radi o servi ce (chapter 21)	A	-4, 946	OPERATION OF PLANT	7. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -4, 976, 838		0.00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	6, 393, 263			0	12. 00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	в В	0 -488 747	CAFETERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee		100,747	ON ETERTA	0.00	Ö	
16. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than	В	-486	PHARMACY	15. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines	В	-1, 375	CAFETERI A	11. 00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114.00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)		·				
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32. 00
33. 00	CAFETERIA REVENUE - IMAGING	В		RADI OLOGY-DI AGNOSTI C	54.00	0	
33. 01	CAFETERIA REVENUE - DIETARY	В	-1, 219	DI ETARY	10.00	0	33. 01

| Period: | Worksheet A-8 | From 07/01/2016 | To 06/30/2017 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 15-0157

				To	06/30/2017	Date/Time Prep 11/20/2017 12:	
				Expense Classification on		1172072017 12.	47 piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
33. 02	CAFETERIA REVENUE - FITNESS	1. 00 B	2.00	3.00 EMPLOYEE BENEFITS DEPARTMENT	4. 00	5. 00 0	33. 02
33. 02	CENTER	В	-1, 204	EMPLOTEE BENEFITS DEPARTMENT	4.00		33.02
33. 03	CAFETERI A REVENUE - PHARMACY	B B		PHARMACY	15.00	0	33. 03
34. 00 35. 00	OTHER MISC REVENUE - BENEFITS OTHER MISC REVENUE - ADMIN	В		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	34. 00 35. 00
36. 00	OTHER MISC REVENUE - MAINT	В		OPERATION OF PLANT	7. 00	0	36. 00
37. 00 38. 00	OTHER MISC REVENUE - OR OTHER MISC REVENUE - DIETARY	B B		OPERATING ROOM DIETARY	50. 00 10. 00	0 0	37. 00 38. 00
38. 01	OTHER MISC REVENUE - MED	В		MEDICAL RECORDS & LIBRARY	16. 00	0	38. 01
39. 00	RECORDS OTHER MISC REVENUE - ROUTINE	В	202	ADULTS & PEDIATRICS	30.00	0	39. 00
40. 00	OTHER MISC REVENUE - ROOTTNE	В		NEONATAL INTENSIVE CARE UNIT	35. 00	0	40. 00
41. 00	NEONATOLOGY	D	400	DADLOLOGY DLACNOSTIC	E4 00		41 00
41.00	OTHER MISC REVENUE - RADIOLOGY OTHER MISC REVENUE - ASC	B B		RADI OLOGY-DI AGNOSTI C ASC (NON-DI STI NCT PART)	54. 00 75. 00	0	41. 00 42. 00
42. 01	OTHER MISC REVENUE - ENDO	В	13, 320	ENDOSCOPY	76. 00	0	42. 01
43.00	PROPERTY RENTAL INCOME	В		CAP REL COSTS-BLDG & FIXT	1.00	10	
44. 00 44. 01	PROVIDER ASSESSMENT OFFSET LOSS ON SALE OF PPE	A A		ADMINISTRATIVE & GENERAL ASC (NON-DISTINCT PART)	5. 00 75. 00	0	44. 00 44. 01
45. 00	LOBBYI NG	A		ADMINISTRATIVE & GENERAL	5. 00	Ö	45. 00
46. 00	GAIN ON SALE OF PPE	В		CAP REL COSTS-MVBLE EQUIP	2. 00	14	
47. 00	CONSOLIDATING ENTRY	B B		ADMINISTRATIVE & GENERAL	5.00	0	47. 00
49. 00 49. 01	IFUE OPERATING COMFORT IMAGING ENTERTAINMENT EXP - HR	A A		CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT	1. 00 4. 00	14	49. 00 49. 01
49. 02	ENTERTALNMENT EXP - ADMIN	A		ADMINISTRATIVE & GENERAL	5. 00	Ö	49. 02
49. 03	ENTERTALNMENT EXP - NURS ADMIN	1	·	NURSING ADMINISTRATION	13. 00	0	49. 03
49. 04 49. 05	ENTERTALNMENT EXP - PHARMACY ENTERTALNMENT EXP - ROUTINE	A A		PHARMACY	15. 00 30. 00	0	49. 04 49. 05
49. 05	ENTERTALINMENT EXP - ROUTINE	A		ADULTS & PEDIATRICS OPERATING ROOM	50. 00 50. 00	0	49. 05
49. 07	ENTERTAL NMENT EXP - RADI OLOGY	A		RADI OLOGY-DI AGNOSTI C	54. 00	0	49. 07
49. 08	ENTERTAL NMENT EXP - RT	A		RESPIRATORY THERAPY	65.00	0	49. 08
49. 09 49. 10	ENTERTALNMENT EXP - ED CORP SPONSORSHIP - ADMIN	A A		EMERGENCY ADMINISTRATIVE & GENERAL	91. 00 5. 00	0	49. 09 49. 10
49. 11	MARKETING - ADMIN	A		ADMINISTRATIVE & GENERAL	5. 00	0	49. 11
49. 12	MARKETING - ROUTINE	A		ADULTS & PEDIATRICS	30. 00	0	49. 12
49. 13 49. 14	MARKETING - LABOR & DEL PROMOTIONAL ITEMS - ADMIN	A A		DELIVERY ROOM & LABOR ROOM ADMINISTRATIVE & GENERAL	52. 00 5. 00	0	49. 13 49. 14
49. 14	PROMOTIONAL ITEMS - ADMIN	A		DELIVERY ROOM & LABOR ROOM	52. 00 52. 00	0	49. 14
40.17	DEL DECMOTIONAL LITEMS FR		1 701	EMEDOENCY	01.00		40.17
49. 16 49. 17	PROMOTIONAL ITEMS - ED CHARITABLE EXP - ADMIN	A A	·	EMERGENCY ADMINISTRATIVE & GENERAL	91. 00 5. 00	0	49. 16 49. 17
49. 18	CHARITABLE EXP - PHARMACY	A	-368	PHARMACY	15. 00	Ö	49. 18
	CHARITABLE EXP - SOC SVC	A		SOCIAL SERVICE	17. 00	0	
49. 20 49. 21	INCENTIVE PYMT ADJ - SALARY INCENTIVE PYMT ADJ - BENEFITS	A A		ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMENT	5. 00 4. 00	0	49. 20 49. 21
49. 21	TELEPHONE OFFSET - DEPR	A		CAP REL COSTS-BLDG & FIXT	1. 00	-	
49. 23	DONATIONS MADE - A&G	A		ADMINISTRATIVE & GENERAL	5. 00		49. 23
49. 24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	49. 24
49. 25	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 25
49. 26	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 26
49. 27	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	49. 27
49. 28	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	
	(3)		0				
49. 29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	
49. 30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49. 30
49. 31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49. 31
49. 32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49. 32
49. 33	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49. 33
49. 34	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	49. 34
		1		, l	ı	'	I

Heal th	Financial Systems		ST. VINCENT CAF	RMEL HOSPITAL	In Li€	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Provider CCN: 15-0157	Peri od:	Worksheet A-8	
					From 07/01/2016 To 06/30/2017	Date/Time Pre 11/20/2017 12	
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
50.00	TOTAL (sum of lines 1 thru 49)		-6, 806, 795				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.

Worksheet A-8-1

OFFICE	COSTS			From 07/01/2016 To 06/30/2017		narod:
				10 00/30/2017	11/20/2017 12	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:		T		0	1 00
1.00	0.00	l .	H. O. COSTS	12 021 014	7 1/2 452	1.00
2.00 3.00			H.O. COSTS MARKETING	13, 031, 914	7, 163, 452 0	
3. 00			ISVH CHARGEBACK	709, 868		3. 00 3. 01
3.01			SVH CHARGEBACK	943, 605 4, 359, 709	943, 605 4, 359, 709	
3. 02			SVH CHARGEBACK	55, 193	4, 359, 709 55, 193	
3.03			SVH CHARGEBACK	-47, 020	-47, 020	3. 03
3. 04			SVH CHARGEBACK	1, 211, 762	1, 211, 762	
3.05		l .	SVH CHARGEBACK	226, 628	226, 628	
3.00			SVH CHARGEBACK	401, 496	401, 496	
3.07		NEONATAL INTENSIVE CARE UNIT		401, 490	401, 490 50	
3.00			SVH CHARGEBACK	450	450	
3. 10			SVH CHARGEBACK	100	100	
3. 10			SVH CHARGEBACK	163, 229	163, 229	
3. 12			SVH CHARGEBACK	350	350	
3. 12			SVH CHARGEBACK	36, 050	36, 050	_
4.00			SVH CHARGEBACK	544	544	4. 00
4. 01	•	l .	SVH CHARGEBACK	22, 917	22, 917	4. 01
4. 02			SVH CHARGEBACK	50	50	4. 02
4. 14	0.00			0	0	4. 14
4. 15	4. 00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	5, 586, 425	6, 381, 379	
4. 16			ASCENSION INTEREST	706, 014	709, 796	
4. 17		OPERATION OF PLANT	TRI MEDX	1, 899, 932	1, 913, 772	
4. 18	4. 00	EMPLOYEE BENEFITS DEPARTMENT	PENSI ON	1, 548, 796	921, 287	4. 18
4. 20	0.00			o	0	4. 20
	TOTALS (sum of lines 1-4).			30, 858, 062	24, 464, 799	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

The been posted to worksheet his cordinas i didnote si, the dimedite difference should be find edited in ordinar for this part.							
			Related Organization(s) and/	or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of	1		
		Ownershi p		Ownershi p			
1. 00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							
	Symbol (1) 1.00	Symbol (1) Name 1.00 2.00	Symbol (1) Name Percentage of Ownership 1.00 2.00 3.00	Related Organization(s) and/ Symbol (1) Name Percentage of Ownership 1.00 2.00 3.00 4.00	Related Organization(s) and/or Home Office		

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

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

6.00	G	ST. VINCENT HEA	100.00	ST. VINCENT HEA	100.00	6. 00
7.00	G	ASCENSI ON HEALT	100.00	ASCENSION HEALT	100.00	7.00
8.00	A	TRI MEDX	0.00	TRIMEDX	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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

0 0 3.03 3.04 0 3.04 0 3.05 0 3.05 0 0 3.06 3 06 0 3.07 3.07 3.08 0 3.08 0 0 3.09 3.09 0 0 3 10 3 10 3.11 0 3. 11 3.12 0 0 3. 12 0 0 3.13 3.13 0 4 00 4 00 4.01 0 4.01 0 0 4.02 4.02 0 4.14 0 4.14 -794, 954 4.15 4. 15 4.16 -3, 782 11 4. 16 0 4.17 -13,840 4.17 0 4.18 627, 509 4. 18 O 4 20 4 20 5.00 6, 393, 263 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.

Related Organization(s)		
and/or Home Office		
T 65 1		
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

i ei ilibui	erilibal sellent under title xviii.							
6.00	HOME OFFICE		6. 00					
7.00	HOME OFFICE		7.00					
8.00	TECHNOLOGY MGMT		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.

					-	To 06/30/2017	Date/Time Pre	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·			Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	C	l .	0 0		_	1.00
2.00	30. 00	ADULTS & PEDIATRICS	2, 524, 190		0 310, 100	211, 500	8, 286	2. 00
3.00	35. 00	NEONATAL INTENSIVE CARE UNIT	1, 419, 708	1, 419, 70		0	0	
4.00	50. 00	OPERATING ROOM	1, 052, 500		0 1, 052, 500	246, 400	10, 782	4. 00
5.00	52. 00	DELIVERY ROOM & LABOR ROOM	1, 257, 174	1, 257, 17	4 C	0	0	5. 00
6.00	54. 00	RADI OLOGY-DI AGNOSTI C	38, 162		0 38, 162	271, 900	218	6. 00
7.00	57. 00	CT SCAN	23, 569	23, 56	9 0	0	0	7. 00
8.00	91. 00	EMERGENCY	98, 796		0 98, 796	211, 500	454	8. 00
9. 00	0. 00		0)	0 0	0	0	9. 00
10.00	0. 00		0)	0 0	0	0	10.00
200.00			6, 414, 099	4, 914, 54	1 1, 499, 558		19, 740	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit		E Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14.00	
1.00		ADMINISTRATIVE & GENERAL	0		0	1	1	
2.00		ADULTS & PEDIATRICS	842, 543	42, 12		1	0	00
3.00		NEONATAL INTENSIVE CARE UNIT	0		0	0	0	
4.00		OPERATING ROOM	1, 277, 252	63, 86		0	0	
5. 00		DELIVERY ROOM & LABOR ROOM	0)	0	0	0	
6. 00		RADI OLOGY-DI AGNOSTI C	28, 497	1, 42	5 0	0	0	6. 00
7. 00		CT SCAN	0)	0	0	0	
8. 00		EMERGENCY	46, 164	2, 30	8 0	0	0	0.00
9. 00	0. 00		0	1	0	0	0	
10.00	0. 00		0	1	0 0	0	0	10. 00
200.00			2, 194, 456				0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	4.00		14	47.00	47.00	10.00		
1 00	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		4 00
1.00		ADMINISTRATIVE & GENERAL	0		0			1.00
2.00		ADULTS & PEDIATRICS	0	842, 54				2. 00
3. 00		NEONATAL INTENSIVE CARE UNIT	0	ــــــــــــــــــــــــــــــــــــــ	0 0	1, 1, 1, 1, 1, 00	1	3. 00
4.00		OPERATING ROOM	0	1, 277, 25	2 0	0		4. 00
5.00		DELIVERY ROOM & LABOR ROOM	0		0	1, 257, 174		5. 00
6. 00		RADI OLOGY-DI AGNOSTI C	0	28, 49	7 9, 665			6. 00
7. 00		CT SCAN	0	1	0	23, 569		7. 00
8. 00		EMERGENCY	0	46, 16	4 52, 632	1	1	8. 00
9. 00	0. 00		0	1	0	0	1	9. 00
10. 00	0. 00		0		0 0	1	1	10.00
200.00			0	2, 194, 45	62, 297	4, 976, 838	il .	200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0157 Peri od: Worksheet B From 07/01/2016 Part I Date/Time Prepared: 06/30/2017 11/20/2017 12:49 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 6, 952, 816 1 00 00100 CAP REL COSTS-BLDG & FLXT 6, 952, 816 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4, 187, 918 4, 187, 918 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 9, 395, 430 91, 497 9, 486, 927 4.00 00500 ADMINISTRATIVE & GENERAL 1, 380, 831 22, 998, 977 5 00 20, 641, 798 441, 750 534 598 5 00 7.00 00700 OPERATION OF PLANT 6,059,966 812, 089 47, 193 42,656 6, 961, 904 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 613,071 37, 740 650, 811 8.00 00900 HOUSEKEEPI NG 1, 997, 059 122, 901 3, 438 o 2, 123, 398 9.00 9.00 01000 DI ETARY 10.00 152, 714 570,890 3.313 0 726, 917 10 00 11.00 01100 CAFETERI A 1,038,749 178, 178 8, 842 0 1, 225, 769 11.00 01300 NURSING ADMINISTRATION 64, 296 288, 123 1, 927, 241 13.00 1, 571, 619 3, 203 13.00 01400 CENTRAL SERVICES & SUPPLY 390, 119 154, 888 26, 034 77, 052 14.00 648.093 14.00 01500 PHARMACY 121, 895 288, 740 448, 997 15.00 2, 652, 398 3, 512, 030 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 222, 129 7, 085 169, 609 1, 398, 823 16.00 0 01700 SOCIAL SERVICE 17.00 273, 231 16, 812 34, 478 324, 521 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 10, 033, 971 1,580,357 276, 967 2, 032, 297 13, 923, 592 30.00 161, 553 03100 INTENSIVE CARE UNIT 1, 743, 964 84, 919 234, 797 2, 225, 233 31.00 31.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 1, 942, 982 160, 804 27, 101 612, 029 2, 742, 916 35.00 <u>282,</u> 115 04300 NURSERY 215, 714 1, 156, 105 15,620 1, 669, 554 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 9, 572, 986 619, 928 1, 518, 956 834, 407 12, 546, 277 50.00 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 359, 543 329, 302 48, 746 479, 305 3, 216, 896 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 2, 708, 568 333, 487 246, 691 412, 563 3, 701, 309 54.00 54.01 03480 ONCOLOGY 0 54.01 05402 ULTRASOUND 221, 494 8, 792 44, 877 339, 720 54.02 64.557 54.02 57.00 05700 CT SCAN 684, 657 89, 042 118, 800 115, 924 1,008,423 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 630, 857 186, 315 78, 306 88, 288 983, 766 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 60.00 06000 LABORATORY 2, 857, 249 112, 869 4, 981 2, 975, 099 60.00 1, 458, 498 06500 RESPIRATORY THERAPY 1, 127, 055 53, 056 212, 516 65.00 65, 871 65.00 66.00 06600 PHYSI CAL THERAPY 444, 031 45, 854 0 85, 636 575, 521 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 67.00 06800 SPEECH PATHOLOGY 18,840 1, 941 3, 806 24, 587 68.00 68.00 0 06900 ELECTROCARDI OLOGY 4, 513 20, 306 15. 793 155, 837 69.00 115, 225 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 111, 416 4, 373 14,843 21, 199 151, 831 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 705, 058 4, 705, 058 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 604, 667 72 00 5 604 667 C 0 0 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 3,504,625 0 3, 504, 625 73.00 75.00 07500 ASC (NON-DISTINCT PART) 9, 669, 464 296, 425 152, 476 578, 967 10, 697, 332 75.00 03330 ENDOSCOPY 3, 873, 600 76.00 3, 029, 258 123, 018 368, 497 352, 827 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 2, 672, 689 318, 358 67, 046 423, 180 3, 481, 273 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 122, 481, 897 122, 064, 098 118. 00 118 00 6, 852, 854 4, 146, 624 9, 210, 384 NONREIMBURSABLE COST CENTERS 572, 017 190. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 502, 402 38, 675 8, 162 22, 778 192.00 19200 PHYSICIANS' PRIVATE OFFICES 60, 083 392, 519 192. 00 332, 436 0 194. 00 07950 MISSION EFFECTIVENESS 01194.00 C 0 0 194. 01 07951 MARKETI NG 709, 868 0 0 709, 868 194. 01 194. 02 07952 JOI NT VENTURES 0 0 194. 02 194.04 07954 SCHOOL NURSE 658, 885 194. 04 529,009 20, 694 109 182 0 194.06 07956 SPORTS MEDICINE & OB PHYS 694,000 40, 593 33, 132 84, 500 852, 225 194. 06 200.00 Cross Foot Adjustments 0 200. 00 0 201. 00 201.00 Negative Cost Centers 4, 187, 918 125, 249, 612 202. 00 TOTAL (sum lines 118-201) 125, 249, 612 6, 952, 816 9, 486, 927 202.00

| Peri od: | Worksheet B | From 07/01/2016 | Part | | To 06/30/2017 | Date/Time Prepared: | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/40-2017 | 12/4

				T	o 06/30/2017	Date/Time Pre 11/20/2017 12	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	. 47 piii
	р	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT					I	1. 00
	00200 CAP REL COSTS-MVBLE EQUIP					I	2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT					I	4. 00
	00500 ADMINISTRATIVE & GENERAL	22, 998, 977				I	5. 00
7. 00	00700 OPERATION OF PLANT	1, 565, 920	8, 527, 824			I	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	146, 385	57, 395			I	8. 00
9. 00	00900 HOUSEKEEPI NG	477, 610	186, 907		2, 787, 915		9. 00
	01000 DI ETARY	163, 503	232, 246		78, 165	1, 200, 831	10.00
	01100 CAFETERI A	275, 709	270, 972		91, 199	0	11.00
	01300 NURSING ADMINISTRATION	433, 489	4, 872		1, 640	0	13. 00
	01400 CENTRAL SERVI CES & SUPPLY	145, 774	235, 553		79, 278	0	14. 00
	01500 PHARMACY	789, 950	185, 377		62, 391	0	15. 00
	01600 MEDICAL RECORDS & LIBRARY	314, 633	10, 775		3, 626	0	16. 00
17. 00	01700 SOCIAL SERVICE	72, 994	25, 568	0	8, 605	0	17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0 404 000	0.400.000	045 (00	000 000	4 004 070	00.00
	03000 ADULTS & PEDI ATRI CS	3, 131, 839	2, 403, 399		808, 893	1, 084, 979	1
	03100 INTENSI VE CARE UNI T	500, 515	245, 688		82, 689		31.00
	02060 NEONATAL INTENSIVE CARE UNIT	616, 956	244, 550		82, 306	0	
43. 00	04300 NURSERY	375, 528	429, 039	80, 418	144, 398	0	43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	2 021 007	040.702	101 500	217 204		FO 00
	05000 OPERATING ROOM	2, 821, 996	942, 783		317, 304	74 245	
	05200 DELIVERY ROOM & LABOR ROOM	723, 567	500, 800		168, 550	74, 245	
	05400 RADI OLOGY-DI AGNOSTI C 03480 ONCOLOGY	832, 524	507, 165 0		170, 692	0 0	54.00
	05402 ULTRASOUND	76, 412	_	_	4 500	_	
	05700 CT SCAN		13, 371	1, 469	4, 500	0 0	54. 02 57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	226, 822 221, 276	135, 415 283, 347		45, 575 95, 364	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	221,270	203, 347	07, 308	93, 304 0	0	59.00
	06000 LABORATORY	669, 180	171, 651	_	57, 771	0	60.00
	06500 RESPIRATORY THERAPY	328, 056	80, 687		27, 156	0	65. 00
	06600 PHYSI CAL THERAPY	129, 450	69, 734			1 0	66. 00
	06700 OCCUPATI ONAL THERAPY	127, 430	07, 734		23, 470	0	67. 00
	06800 SPEECH PATHOLOGY	5, 530	2, 952	_	993	0	68. 00
	06900 ELECTROCARDI OLOGY	35, 052	6, 863		2, 310	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	34, 151	6, 650		2, 238	. 0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 058, 295	0,000	, 0	2, 230	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 260, 641	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	788, 285	0		0	0	73. 00
	07500 ASC (NON-DISTINCT PART)	2, 406, 119	450, 802	45, 947	151, 723	Ö	75. 00
	03330 ENDOSCOPY	871, 277	187, 084		62, 965	ő	1
	OUTPATIENT SERVICE COST CENTERS	<u> </u>					
91. 00	09100 EMERGENCY	783, 032	484, 158	126, 453	162, 949	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				·	I	92.00
	SPECIAL PURPOSE COST CENTERS	'		'	'		
118. 00	SUBTOTALS (SUM OF LINES 1-117)	22, 282, 470	8, 375, 803	848, 594	2, 736, 750	1, 200, 831	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	128, 662	58, 817	0	19, 796	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	88, 288	0	0	0	0	192. 00
194. 00	07950 MISSION EFFECTIVENESS	0	0	0	0	0	194. 00
194. 01	07951 MARKETI NG	159, 668	0	0	0	0	194. 01
194. 02	07952 JOINT VENTURES	0	0	0	0	0	194. 02
	07954 SCH00L NURSE	148, 201	31, 471		10, 592		194. 04
	07956 SPORTS MEDICINE & OB PHYS	191, 688	61, 733	5, 997	20, 777	0	194. 06
200.00	, ,					I	200. 00
201. 00		0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118-201)	22, 998, 977	8, 527, 824	854, 591	2, 787, 915	1, 200, 831	202. 00

			То	06/30/2017	Date/Time Pre 11/20/2017 12	pared: · 49 nm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	. 47 piii
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						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 0/2 /40					10.00
11. 00 01100 CAFETERI A	1, 863, 649					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	53, 495		1 1/0 025			13.00
14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY	27, 798	1	1, 160, 935	4 (4((20		14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	91, 483	1	5, 408	4, 646, 639 0	1 702 025	15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	55, 968 8, 401	1	0	ol O	1, 783, 825 0	17. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	0, 401	<u> </u>	U	<u>U</u>	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	455, 394	911, 963	19, 659	0	184, 069	30.00
31. 00 03100 I NTENSI VE CARE UNI T	51, 133		5, 469	o	20, 698	31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	86, 720		5, 968	o	51, 179	35. 00
43. 00 04300 NURSERY	56, 086		2, 720	o	7, 557	43. 00
ANCILLARY SERVICE COST CENTERS	<u> </u>			'		
50.00 05000 OPERATING ROOM	207, 027	414, 589	243, 556	0	515, 747	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	106, 806	213, 888	12, 507	0	110, 834	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	117, 965	0	28, 550	0	82, 699	54.00
54. 01 03480 ONCOLOGY	0	0	0	0	0	54. 01
54. 02 05402 ULTRASOUND	7, 279	0	266	0	11, 547	54. 02
57.00 05700 CT SCAN	26, 066	1	4, 467	0	31, 477	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	24, 809	1	4, 788	0	13, 868	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	0	이	0	0	127, 633	60.00
65. 00 06500 RESPI RATORY THERAPY	55, 110	1	4, 766	0	13, 711	1
66. 00 06600 PHYSI CAL THERAPY	20, 648		678	0	8, 690	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	868	1	0	0	495	68. 00
69. 00 06900 ELECTROCARDI OLOGY	3, 754	1	1, 001	0	13, 145	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 176	1	463	0	8, 230	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	_	275, 433	0	0	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0		334, 025	4 4 4 4 0 5 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATLENTS 75. 00 07500 ASC (NON-DISTINCT PART)	173, 736		162, 393	4, 644, 850	0 293, 734	73. 00 75. 00
76. 00 07300 ASC (NON-DESTENCE PART) 76. 00 03330 ENDOSCOPY	78, 560		32, 782	0	128, 778	76.00
OUTPATIENT SERVICE COST CENTERS	70, 300	157, 524	32, 702	<u> </u>	120, 770	70.00
91. 00 09100 EMERGENCY	93, 454	187, 149	15, 386	0	159, 734	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	12, 12		,		,	92. 00
SPECIAL PURPOSE COST CENTERS		'		,		
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 806, 736	2, 273, 295	1, 160, 285	4, 644, 850	1, 783, 825	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10, 409		0	0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	12, 159	0	75	0		192. 00
194.00 07950 MISSION EFFECTIVENESS	0	0	0	0		194. 00
194. 01 07951 MARKETI NG	0	이	0	0		194. 01
194. 02 07952 JOI NT VENTURES	0	0	0	0		194. 02
194. 04 07954 SCHOOL NURSE	0.4.0.5	78, 664	0	0		194. 04
194. 06 07956 SPORTS MEDICINE & OB PHYS	34, 345	68, 778	575	1, 789	0	194. 06
200.00 Cross Foot Adjustments]			^	200.00
201.00 Negative Cost Centers	1 042 440	1	1 140 025	4 4 4 4 4 2 2 2		201.00
202.00 TOTAL (sum lines 118-201)	1, 863, 649	2, 420, 737	1, 160, 935	4, 646, 639	1, 783, 825	2U2. UU

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0157 Peri od: Worksheet B From 07/01/2016 Part I 06/30/2017 Date/Time Prepared: 11/20/2017 12:49 pm Cost Center Description SOCIAL SERVICE Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 440,089 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 98. 779 23, 238, 204 30.00 23, 238, 204 0 0 31.00 03100 INTENSIVE CARE UNIT 45, 162 3, 353, 875 3, 353, 875 31.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 73, 316 4, 077, 576 0 4, 077, 576 35.00 2, 877, 618 43.00 04300 NURSERY 2, 877, 618 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 8,646 18, 119, 433 0 18, 119, 433 50.00 05200 DELIVERY ROOM & LABOR ROOM 5, 269, 545 5, 269, 545 52.00 52.00 55, 676 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 5, 458, 938 5, 458, 938 54.00 0 03480 ONCOLOGY 0 54.01 0 54 01 0 54.02 05402 ULTRASOUND 454, 564 454, 564 54.02 05700 CT SCAN 1, 482, 941 1, 482, 941 57.00 00000000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 1, 694, 786 1, 694, 786 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 59.00 60.00 06000 LABORATORY 4,001,334 0 4, 001, 334 60.00 06500 RESPIRATORY THERAPY 1, 968, 770 1, 968, 770 65.00 65.00 829, 770 66.00 06600 PHYSI CAL THERAPY 829, 770 0 66.00 06700 OCCUPATIONAL THERAPY 0 67 00 67 00 35, 492 06800 SPEECH PATHOLOGY 35, 492 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 218, 041 218, 041 69.00 0 07000 ELECTROENCEPHALOGRAPHY 207, 817 207.817 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 6,038,786 6, 038, 786 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 7, 199, 333 0 7, 199, 333 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 8, 937, 760 0 8, 937, 760 73.00 07500 ASC (NON-DISTINCT PART) 0 14, 381, 786 0 75.00 14, 381, 786 75.00 76.00 03330 ENDOSCOPY 23,056 5, 456, 203 5, 456, 203 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 91.00 112, 366 5, 605, 954 0 5, 605, 954 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 417, 001 120, 908, 526 0 120, 908, 526 118.00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 789, 701 0 789, 701 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 23, 088 0 516, 129 516, 129 192.00 194. 00 07950 MISSION EFFECTIVENESS 0 194. 00 0 0 194. 01 07951 MARKETI NG 0 0 869, 536 869, 536 194.01 194. 02 07952 JOINT VENTURES 0 0 194.02 194.04 07954 SCHOOL NURSE 0 927, 813 0 927, 813 194.04 0 194. 06 07956 SPORTS MEDICINE & OB PHYS 0 1, 237, 907 194.06 1, 237, 907 0 200.00 Cross Foot Adjustments 200.00 0 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118-201) 440,089 125, 249, 612 125, 249, 612 202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2016 | Part II | To 06/30/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0157

					To	06/30/2017	Date/Time Pre	
				CAPLTAL REI	LATED COSTS		11/20/2017 12	48 pm
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New Capital				BENEFITS DEPARTMENT	
			Related Costs				DELYIKTIMENT	
	1		0	1. 00	2. 00	2A	4. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1. 00
2.00	1	CAP REL COSTS-BEDG & TTAT						2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	91, 497	О	91, 497	91, 497	4. 00
5.00		ADMINISTRATIVE & GENERAL	2, 505, 285	441, 750	534, 598	3, 481, 633	13, 315	5. 00
7. 00		OPERATION OF PLANT	0	812, 089		859, 282	411	7. 00
8.00	1	LAUNDRY & LINEN SERVICE	0	37, 740		37, 740	0	8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	0	122, 901 152, 714		126, 339 156, 027	0	9. 00 10. 00
11. 00	1	CAFETERIA	0	178, 178		187, 020	0	11. 00
13. 00		NURSING ADMINISTRATION	0	3, 203		67, 499	2, 778	13. 00
14.00		CENTRAL SERVICES & SUPPLY	o	154, 888	26, 034	180, 922	743	14. 00
15.00		PHARMACY	0	121, 895		410, 635	4, 330	15. 00
16.00		MEDICAL RECORDS & LIBRARY	0	7, 085		7, 085	1, 635	16.00
17. 00		SOCIAL SERVICE ENT ROUTINE SERVICE COST CENTERS	0	16, 812	0	16, 812	332	17. 00
30. 00		ADULTS & PEDIATRICS	0	1, 580, 357	276, 967	1, 857, 324	19, 614	30. 00
31. 00		INTENSIVE CARE UNIT	l o	161, 553		246, 472	2, 264	
35.00		NEONATAL INTENSIVE CARE UNIT	O	160, 804		187, 905	5, 902	35. 00
43.00		NURSERY	0	282, 115	15, 620	297, 735	2, 080	43. 00
F0 00		LARY SERVICE COST CENTERS		/40.000	4 540 054	0.400.004	0.047	F0 00
50. 00 52. 00		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0	619, 928		2, 138, 884 378, 048	8, 046 4, 622	50. 00 52. 00
54. 00		RADI OLOGY-DI AGNOSTI C	0	329, 302 333, 487		580, 178	3, 978	54. 00
54. 01	1	ONCOLOGY	l o	0		0	0, 770	54. 01
54. 02		ULTRASOUND	0	8, 792	64, 557	73, 349	433	54. 02
57. 00	1	CT SCAN	0	89, 042		207, 842	1, 118	57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	186, 315		264, 621	851	58. 00
59.00		CARDI AC CATHETERI ZATI ON LABORATORY	0	112.040	-	117.050	0	59. 00 60. 00
60. 00 65. 00	1	RESPI RATORY THERAPY	0	112, 869 53, 056		117, 850 118, 927	2, 049	65. 00
66. 00		PHYSI CAL THERAPY	0	45, 854		45, 854	826	66. 00
67. 00	1	OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68.00	06800	SPEECH PATHOLOGY	0	1, 941	0	1, 941	37	68. 00
69. 00		ELECTROCARDI OLOGY	0	4, 513		20, 306	196	69. 00
70.00	1	ELECTROENCEPHALOGRAPHY	0	4, 373		19, 216	204	70. 00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	- 1	0	0	71.00
73. 00		DRUGS CHARGED TO PATTENTS		0	0	0	0	72. 00 73. 00
75. 00		ASC (NON-DISTINCT PART)	l o	296, 425	152, 476	448, 901	5, 583	75. 00
76. 00		ENDOSCOPY	0	123, 018		491, 515	3, 402	76. 00
		TIENT SERVICE COST CENTERS						
91.00	1	EMERGENCY	0	318, 358	67, 046	385, 404	4, 081	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) AL PURPOSE COST CENTERS				0		92. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2, 505, 285	6, 852, 854	4, 146, 624	13, 504, 763	88, 830	118. 00
	NONRE	MBURSABLE COST CENTERS					·	
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38, 675	8, 162	46, 837		190. 00
		PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
		MISSION EFFECTIVENESS MARKETING	0	0	0	O O		194. 00 194. 01
	1	JOINT VENTURES		0		0		194. 01 194. 02
		SCHOOL NURSE		20, 694		20, 694		194. 04
	1	SPORTS MEDICINE & OB PHYS	0	40, 593		73, 725		194. 06
200.00		Cross Foot Adjustments				0		200. 00
201.00		Negative Cost Centers	0 505 055	0	0	0		201. 00
202.00	기	TOTAL (sum lines 118-201)	2, 505, 285	6, 952, 816	4, 187, 918	13, 646, 019	91, 497	202.00

Provider CCN: 15-0157

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 07/01/2016 | Part II |
| To 06/30/2017 | Date/Time Prepared: | 11/20/2017 | 12:48 pm

				'	0 00/30/2017	11/20/2017 12	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS			ı			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	3, 494, 948					5. 00
7. 00	00700 OPERATION OF PLANT	237, 958	1, 097, 651				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	22, 245	7, 388				8. 00
9. 00	00900 HOUSEKEEPI NG	72, 578	24, 058				9. 00
10. 00	01000 DI ETARY	24, 846	29, 893		-,	217, 018	10. 00
11. 00	01100 CAFETERI A	41, 897	34, 878		7, 294	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	65, 873	627		131	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	22, 152	30, 319	· ·	6, 341	0	14. 00
15. 00	01500 PHARMACY	120, 041	23, 861	0	4, 990	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	47, 812	1, 387	1	290	0	16. 00
17. 00	01700 SOCIAL SERVICE	11, 092	3, 291	0	688	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00	03000 ADULTS & PEDIATRICS	475, 927	309, 349		· · ·	196, 081	30. 00
31. 00	03100 INTENSIVE CARE UNIT	76, 058	31, 624			7, 519	31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	93, 753	31, 477		-,	0	35. 00
43. 00	04300 NURSERY	57, 065	55, 223	6, 340	11, 549	0	43. 00
	ANCILLARY SERVICE COST CENTERS	100 000	404.040		05.070		
50.00	05000 OPERATING ROOM	428, 832	121, 349		· · · · · · · · · · · · · · · · · · ·	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	109, 954	64, 460			13, 418	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	126, 511	65, 279		l	0	54.00
54. 01	03480 ONCOLOGY	0	0	0	· ·	0	54. 01
54. 02	05402 ULTRASOUND	11, 612	1, 721	116	l .	0	54. 02
57. 00	05700 CT SCAN	34, 468	17, 430			0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	33, 625	36, 471	5, 327	l	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	· ·	0	59. 00
60.00	06000 LABORATORY	101, 689	22, 094		4, 620	0	60.00
65. 00	06500 RESPI RATORY THERAPY	49, 851	10, 386		· · ·	0	65. 00
66.00	06600 PHYSI CAL THERAPY	19, 671	8, 976			0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	_		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	840	380			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	5, 327	883		185	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	5, 190	856	6	179	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	160, 819	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	191, 568	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	119, 788	0	0	0	0	73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	365, 635	58, 025			0	75. 00
76. 00	03330 ENDOSCOPY	132, 400	24, 080	3, 215	5, 036	0	76. 00
04.00	OUTPATIENT SERVICE COST CENTERS	110.000	(0.040	0.040	40.000		04 00
91.00	09100 EMERGENCY	118, 990	62, 318	9, 969	13, 033	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
110 00	SPECIAL PURPOSE COST CENTERS	3, 386, 067	1 070 002	44 000	210 002	217 010	110 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	3, 380, 007	1, 078, 083	66, 900	218, 883	217, 018	118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 552	7, 571	0	1, 583	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	13, 416	7, 571	0	l		190.00
	07950 MISSION EFFECTIVENESS	13,410	0	0	· ·		194. 00
	07951 MARKETI NG	1 "	0	0	-		194. 00
	207952 JOINT VENTURES	24, 263	0	0			194. 01
	107954 SCHOOL NURSE	22, 521	4, 051		847		194. 02
	07954 SCHOOL NORSE	29, 129	7, 946		l .		194. 04
200.00		27, 129	7, 940	4/3	1,002	U	200. 00
200.00		0	^	_		Ō	200.00
201.00		3, 494, 948	1, 097, 651	67, 373	222, 975	217, 018	
202.00	101AL (Suil 111163 110-201)] 3,474,740	1,077,001	1 07,373	222, 7/3	217,010	1202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2016 | Part II | To 06/30/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0157

COST CENTER DESCRIPTION					To	06/30/2017	Date/Time Pre	
CHINEMAL SERVICE COST. CHINES 1.100 13.00 14.00 15.00 16.0		Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY		. 46 pili
STREAM SERVICE COST CENTERS		'		ADMI NI STRATI ON	SERVICES &			
GENERAL SERVICE COST CENTERS			44.00	10.00		45.00		
1.00 1.00		GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
2.00	1 00							1 00
0.0400 EMPLOYEE REKEPLIS DEPARTMENT								1
0.0700 OPERATION OF PLANT		1 1						4. 00
B. DO	5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
0.000 0.0000 HOUSEKEPENK		1 1						1
10.00 01000 DIETARY								1
11.00 01100 CAFETERIA 271,089								1
13.00 01300 NURSIN & ADMIN ISTRATION 7, 781 144, 689 246, 447 14.00 1010 CENTRAL SERVICES & SUPPLY 4.043 0 246, 447 15.00 15.00 15.00 01500 PHARMACY 13, 307 0 1, 148 578, 312 15.00 15.00 10.00 10.00 15.00 15.00 10.00 10.00 15.00 10.00			271 089					1
14. 00 01400 CENTRAL SERVICES & SUPPLY 13, 307 0 1, 148 578, 312 15, 00 16. 00 01600 MEDICAL RECORDS & LIBRARY 13, 307 0 1, 148 578, 312 15, 00 16. 00 1000 MEDICAL RECORDS & LIBRARY 13, 307 0 0 0 0 0 0 0 0 17, 00 170				1				1
15.00 01500 PHARMACY 13.307		1 1	1	1	246, 447			
17. 00 01700 SOCIAL SERVICE 1,222 0 0 0 0 17. 00	15.00	1 1	1	1		578, 312		15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	16.00	01600 MEDICAL RECORDS & LIBRARY	8, 141	0	0	0	66, 350	16. 00
30.00 03000 03000 03000 03000 03000 03000 0300 03000	17. 00		1, 222	0	0	0	0	17. 00
31 0 03100 INTENSIVE CARE UNIT			1					
35. 00			1	1				
A3. 00 04300 NURSERY A5. 00 A			1					
ANCILLARY SERVICE COST CENTERS				1				
SOLIC OSDOO OPERATI NG ROOM 30, 114 24, 780 51, 703 0 19, 229 50. 00	10.00		0,100	0, 710	377	<u> </u>	201	10.00
52.00 05200 05200 05200 05200 05	50.00		30, 114	24, 780	51, 703	0	19, 229	50.00
S4. 01 03480 ONCOLOGY 0 0 0 0 0 54. 01	52.00		15, 536	12, 784	2, 655	0	4, 119	52. 00
54 02 05402 ULTRASQUIND			17, 159	1		-1	3, 073	
57.00 05700 CT SCAN 3,792 0 948 0 1,170 57.00				1	- 1	٩		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 3,609 0 1,016 0 515 58.00				1		9		1
59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 59.00				1		٩		
60. 00 06000 LABORATORY 0 0 0 0 4, 743 60. 00 65. 00 06500 RSPI RATORY THERAPY 8, 016 0 1, 012 0 509 65. 00 66. 00 06600 PHYSI CAL THERAPY 3, 004 0 144 0 323 66. 00 67. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0		1 1		1		-1		1
65. 00 06500 RESPI RATORY THERAPY 8, 016 0 1, 012 0 509 65. 00 66. 00 06600 06600 PHYSI CAL THERAPY 3, 004 0 144 0 323 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 126 0 0 0 0 18 68. 00 69. 00 06900 ELECTROCARDI OLOGY 546 0 213 0 488 69. 00 70. 00 07000 ELECTROCNCEPHALOGRAPHY 607 0 98 0 306 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 58, 470 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 58, 470 0 0 71. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 578, 089 0 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 25, 272 0 34, 474 0 10, 915 76. 00 0330 ENDOSCOPY 11, 427 9, 403 6, 959 0 4, 785 76. 00 09100 EMERGENCY 13, 594 11, 186 3, 266 0 5, 936 79. 00 09100 EMERGENCY 13, 594 11, 186 3, 266 0 5, 936 79. 00 09100 EMERGENCY 13, 594 11, 186 3, 266 0 5, 936 79. 00 09100 EMERGENCY 13, 594 11, 186 3, 266 0 5, 936 79. 00 09100 EMERGENCY 13, 594 11, 186 3, 266 0 5, 936 79. 00 09100 EMERGENCY 13, 594 11, 186 3, 266 0 5, 936 79. 00 09100 EMERGENCY 13, 594 11, 186 3, 266 0 5, 936 79. 00 09100 EMERGENCY 13, 594 11, 186 3, 266 0 5, 936 79. 00 09100 EMERGENCY 13, 594 11, 186 3, 266 0 0 0 79. 00 09100 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 514 0 0 0 0 79. 00 09100 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 514 0 0 0 0 79. 00 0900 0900 0900 0900 0900 0900 0900 0900 79. 00 0900 0900 0900 0900 0900 0900 0900 79. 00 0900 0900 0900 0900 0900 0900 0900 79. 00 0900 0900 0900 0900 0900 0900 0900 79. 00 0900 0900 0900 0900 0900 0900 0900 79. 00 0900 0900 0900 0900 0900 0900 0900 79. 00 0900 0900 0900		1 1				-		1
67. 00 06700 0CCUPATIONAL THERAPY 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 126 0 0 0 0 18 68. 00 69. 00 06900 ELECTROCARDIOLOGY 546 0 213 0 488 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 607 0 98 0 306 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 58, 470 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 58, 470 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 578, 089 0 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 25, 272 0 34, 474 0 10, 915 76. 00 03330 ENDOSCOPY 11, 427 9, 403 6, 959 0 4, 785 76. 00 03330 ENDOSCOPY 11, 427 9, 403 6, 959 0 4, 785 76. 00 09200 DRUGS CHARGED TO PATIENTS 13, 594 11, 186 3, 266 0 5, 936 76. 00 09200 DRUGS CHARGED TO PATIENTS 13, 594 11, 186 3, 266 0 5, 936 77. 00 09200 DRUGS CHARGED TO PATIENTS 13, 594 11, 186 3, 266 0 5, 936 78. 00 09200 DRUGS CHARGED TO PATIENTS 13, 594 11, 186 3, 266 0 5, 936 79. 00 09200 DRUGS CHARGED TO PATIENTS 13, 594 11, 186 3, 266 0 5, 936 79. 00 09200 DRUGS CHARGED TO PATIENTS 13, 594 11, 186 3, 266 0 5, 936 79. 00 09200 DRUGS CHARGED TO PATIENTS 262, 810 135, 876 246, 309 578, 089 66, 350 79. 00 09200 DRUGS CHARGED TO PATIENTS 262, 810 135, 876 246, 309 578, 089 66, 350 79. 00 09200 DRUGS CHARGED TO PATIENTS 262, 810 135, 876 246, 309 578, 089 66, 350 79. 00 09200 DRUGS CHARGED TO PATIENTS 262, 810 135, 876 246, 309 578, 089 66, 350 79. 00 09200 DRUGS CHARGED TO PATIENTS 262, 810 135, 876 246, 309 578, 089 66, 350 79. 00 09200 DRUGS CHARGED TO PATIENTS 262, 810 135, 876 246, 309 578, 089 66, 350 79. 00 09200 DRUGS CHARGED TO PATIENTS 262, 810 135, 876 246, 309 578, 089 66, 350 79. 00 09200 DRUGS CHARGED TO PATIENTS 262, 810		1 1	8, 016	o	- 1	Ö		1
68. 00 06800 SPEECH PATHOLOGY 126 0 0 0 18 68. 00 69. 00 06900 ELECTROCARDI OLOGY 546 0 213 0 488 69. 00 70. 00 07000 ELECTROCARDI PALLOGRAPHY 607 0 98 0 306 70. 00 71. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 58, 470 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 70, 907 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 578, 089 0 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 25, 272 0 34, 474 0 10, 915 76. 00 03330 ENDOSCOPY 11, 427 9, 403 6, 959 0 4, 785 76. 00 09100 EMERGENCY 13, 594 11, 186 3, 266 0 5, 936 79. 00 09100 EMERGENCY 13, 594 11, 186 3, 266 0 5, 936 79. 00 O9200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 SUBTOTALS (SUM OF LINES 1-117) 262, 810 135, 876 246, 309 578, 089 66, 350 79. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 514 0 0 0 0 0 79. 00 194. 00 07950 MISSI ON EFFECTI VENESS 0 0 0 0 0 79. 00 194. 00 07950 MISSI ON EFFECTI VENESS 0 0 0 0 0 79. 00 194. 00 07952 JOI NT VENTURES 0 0 0 0 79. 00 07952 JOI NT VENTURES 0 0 0 0 79. 00 0 0 0 0 79. 00 0 0 0 79. 00 0 0 0 79. 00 0 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 79. 00 0 0 79. 00 0 79	66.00	06600 PHYSI CAL THERAPY	3, 004	o	144	0	323	66. 00
69. 00 06900 ELECTROCARDI OLOGY 546 0 213 0 488 69. 00 70. 00 70000 ELECTROCARDI OLOGY 607 0 98 0 306 70. 00 71. 00 70100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 58, 470 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 70, 907 0 0 72. 00 73. 00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 578, 089 0 73. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 25, 272 0 34, 474 0 10, 915 75. 00 07500 DRUGS CHARGED TO PATI ENTS 70. 00 70. 00 3330 ENDOSCOPY 11, 427 9, 403 6, 959 0 4, 785 76. 00 76. 00 00 DSERVATI ON BEDS (NON-DI STI NCT PART) 70. 00 00 DSERVATI ON BEDS (NON-DI STI NCT PART) 70. 00 00 DRUGS CHARGED TO PATI ENTS 70. 00 00 00 00 00 00 00	67. 00	06700 OCCUPATI ONAL THERAPY	C	O	0	0	0	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 607 0 98 0 306 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 58, 470 0 0 71. 00 72. 00 07200 MPU. DEV. CHARGED TO PATIENTS 0 0 0 70, 907 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 578, 089 0 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 25, 272 0 34, 474 0 10, 915 75. 00 76. 00 03330 ENDOSCOPY 11, 427 9, 403 6, 959 0 4, 785 91. 00 09100 EMERGENCY 13, 594 11, 186 3, 266 0 5, 936 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 92. 00 OSSERVATI ON BEDS (NON-DISTINCT PART) 262, 810 135, 876 246, 309 578, 089 66, 350 18. 00 SUBTOTALS (SUM OF LINES 1-117) 262, 810 135, 876 246, 309 578, 089 66, 350 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 514 0 0 0 0 0 192. 00 19200 PHYSI CI ANS* PRI VATE OFFI CES 1, 769 0 16 0 0 0 194. 00 07950 MI SSI ON EFFECTI VENESS 0 0 0 0 0 194. 01 07951 MARKETI NG 0 0 0 0 0 194. 02 07952 JOINT VENTURES 0 0 0 0 0 194. 04 07954 SCHOOL NURSE 0 4, 702 0 0 0 194. 04 07954 SCHOOL NURSE 0 4, 702 0 0 0 194. 06 07956 SPORTS MEDI CINE & 0B PHYS 4, 996 4, 111 122 223 0 194. 06 200. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 202. 00 0 0 0 202. 00 0 0 0 203. 00 0 0 0 203			1	1	- 1	0		1
71. 00			1	1		0		1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 70, 907 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 578, 089 0 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 25, 272 0 34, 474 0 10, 915 75. 00 76. 00 03330 ENDOSCOPY 11, 427 9, 403 6, 959 0 4, 785 76. 00 OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 13, 594 11, 186 3, 266 0 5, 936 91. 00 92. 00 09200 DRSERVATION BEDS (NON-DISTINCT PART) 92. 00 SUBTOTALS (SUM OF LINES 1-117) 262, 810 135, 876 246, 309 578, 089 66, 350 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 769 0 16 0 0 192. 00 194. 00 107951 MARKETING 0 0 0 0 0 194. 00 194. 01 07955 MARKETING 0 0 0 0 0 194. 01 194. 02 07952 JOINT VENTURES 0 0 0 0 0 0 194. 01 194. 04 07954 SCHOOL NURSE 0 0 4, 702 0 0 0 194. 01 194. 06 07956 SPORTS MEDICINE & 0B PHYS 4, 996 4, 111 122 223 0 194. 04 194. 06 07956 SPORTS MEDICINE & 0B PHYS 4, 996 4, 111 122 223 0 194. 04 194. 06 07956 SPORTS MEDICINE & 0B PHYS 4, 996 4, 111 122 223 0 194. 04 194. 06 07956 SPORTS MEDICINE & 0B PHYS 4, 996 4, 111 122 223 0 194. 06 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	607	0		0		
73. 00		1 1				-1		
75. 00		1 1		1		~I		
76. 00 03330 ENDOSCOPY			25, 272	1			-	
91. 00	76.00	O3330 ENDOSCOPY	1	1		0		
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 92. 00 SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) 262,810 135,876 246,309 578,089 66,350 118. 00 NONREI MBURSABLE COST CENTERS 1190.00 190			1					
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 262,810 135,876 246,309 578,089 66,350 118.00			13, 594	11, 186	3, 266	0	5, 936	
118. 00 SUBTOTALS (SUM OF LINES 1-117) 262, 810 135, 876 246, 309 578, 089 66, 350 118. 00	92. 00							92. 00
NONRE MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,514 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1,769 0 16 0 0 192.00 194.00 07950 MI SSI ON EFFECTI VENESS 0 0 0 0 0 0 194.01 07951 MARKETI NG 0 0 0 0 0 194.02 07952 JOI NT VENTURES 0 0 0 0 0 194.02 07954 SCHOOL NURSE 0 4,702 0 0 194.04 07954 SCHOOL NURSE 0 4,702 0 0 194.06 07955 SPORTS MEDICI NE & OB PHYS 4,996 4,111 122 223 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00 Negative Cost Centers 0 0 0 0 190.00 0 0 0 0 190.00 0 0 0 0 190.00 0 0 0 190.00 0 0 0 190.00 0 0 0 190.00 0 0 0 190.00 0 0 0 190.00 0 0 0 190.00 0 0 0 190.00 0 0 190.00 0 0 0 190.00 0 0 190.00 0 0 0 190.00 0 190.00 0 0 190.00 0 190.00 0 190.00 0 0 190.00	110 00		242 010	125 074	244 200	E70 000	44 250	110 00
190. 00	110.00	,	202,010	1 133, 670	240, 309	370,009	00, 330	1116.00
192. 00	190.00		1.514	0	0	0	0	190. 00
194. 01 07951 MARKETING 0 0 0 0 0 194. 01 194. 01 194. 02 07952 JOINT VENTURES 0 0 0 0 0 0 194. 02 194. 04 07954 SCHOOL NURSE 0 4, 702 0 0 0 194. 04 194. 06 07956 SPORTS MEDICINE & OB PHYS 4, 996 4, 111 122 223 0 194. 06 1					16	0		
194. 02 07952 JOINT VENTURES 0 0 0 0 0 0 194. 02 194. 04 07954 SCHOOL NURSE 0 4, 702 0 0 0 194. 04 194. 06 07956 SPORTS MEDICINE & OB PHYS 4, 996 4, 111 122 223 0 194. 06 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194.00	07950 MISSION EFFECTIVENESS	C	o	0	0		
194. 04 07954 SCHOOL NURSE 0 4, 702 0 0 194. 04 194. 06 07956 SPORTS MEDICINE & OB PHYS 4, 996 4, 111 122 223 0 194. 06 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00			C		- 1	0		
194.06 07956 SPORTS MEDICINE & OB PHYS 4,996 4,111 122 223 0 194.06 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 0 0 0 201.00		l l	C	1		0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			4 000		-	-1		
201.00 Negative Cost Centers 0 0 0 0 201.00		1 1	4, 996	4, 111	122	223	0	
					0	0	Ω	
			271, 089		- 1	578, 312		

Health Financial Systems	ST. VINCENT CARM	MEL HOSPITAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-0157 Pe Fr To	eriod: com 07/01/2016 o 06/30/2017	Worksheet B
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
OFWERN OFRWAR AREA OFWERN	17. 00	24. 00	25. 00	26. 00	
GENERAL SERVICE COST CENTERS	33, 437				1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00 16. 00 17. 00
30. 00 03000 ADULTS & PEDIATRICS	7, 505	3, 079, 261	l ol	3, 079, 261	30.00
31.00 03100 INTENSIVE CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT 43.00 04300 NURSERY	3, 431 5, 570 0	392, 093 357, 353 445, 721	0	392, 093 357, 353 445, 721	31. 00 35. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	657	2, 856, 975	l ol	2, 856, 975	50. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03480 ONCOLOGY 54. 02 05402 ULTRASOUND 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05600 CADUAC CATUATEDI ZATI ON 05600 CADUAC 05600	4, 230 0 0 0 0	630, 068 817, 313 0 89, 136 270, 783 353, 662	0 0 0 0	630, 068 817, 313 0 89, 136 270, 783 353, 662	52. 00 54. 00 54. 01 54. 02 57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	250, 996	1	250, 996	59. 00 60. 00
65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATIONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDIOLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0 0 0 0	192, 984 80, 800 0 3, 426 28, 150	0 0 0 0 0	192, 984 80, 800 0 3, 426 28, 150	65. 00 66. 00 67. 00 68. 00 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26, 662 219, 289	1	26, 662 219, 289	70. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS 75.00 07500 ASC (NON-DISTINCT PART) 76.00 03330 ENDOSCOPY	0 0 0 1, 752	262, 475 697, 877 964, 562 693, 974	0 0 0	262, 475 697, 877 964, 562 693, 974	72. 00 73. 00 75. 00 76. 00
OUTPATIENT SERVICE COST CENTERS	0 520	/ 2/ 21E		/2/ 215	01.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	8, 538	636, 315	0	636, 315	92. 00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	31, 683	13, 349, 875	0	13, 349, 875	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 194. 00 07950 MISSION EFFECTIVENESS 194. 01 07951 MARKETING 194. 02 07952 JOINT VENTURES	0 1,754 0 0	77, 277 17, 534 0 24, 263 0	0	77, 277 17, 534 0 24, 263 0	190. 00 192. 00 194. 00 194. 01 194. 02
194.0407954 SCHOOL NURSE 194.0607956 SPORTS MEDICINE & OB PHYS 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	0 0 0 33,437	53, 868 123, 202 0 0 13, 646, 019	0 0 0	53, 868 123, 202 0 0 13, 646, 019	194. 04 194. 06 200. 00 201. 00 202. 00
1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	, 25, 37	-, -, -, -, -	,	., , ,	1===.00

			SI. VINCENI CA				u or Form Cws-	
COSTA	LLOCA	TION - STATISTICAL BASIS		Provi der C	CN: 15-0157	Peri od:	Worksheet B-1	
						From 07/01/2016	Doto/Time Dro	norod.
						To 06/30/2017		
			CADITAL DE	LATED COSTS			11/20/2017 12	. 40 pili
			CAPITAL RE	LATED COSTS				
			DI DO A FINT					
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation		
			(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		& GENERAL	
					DEPARTMENT		(ACCUM. COST)	
					(GROSS		, , , , , , , , , , , , , , , , , , ,	
					SALARI ES)			
			1.00	2.00	4.00	5A	5. 00	
	CENED	AL CEDVICE COST CENTERS	1.00	2.00	4.00	JA	5.00	
4 00		AL SERVICE COST CENTERS	007.04/	.1				1
1.00	1	CAP REL COSTS-BLDG & FIXT	297, 346	•				1. 00
2.00		CAP REL COSTS-MVBLE EQUIP		4, 015, 707				2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3, 913	3 0	42, 827, 22	8		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18, 892	512, 615	6, 233, 55	-22, 998, 977	102, 250, 635	5.00
7.00	1	OPERATION OF PLANT	34, 730				6, 961, 904	1
8. 00	1	LAUNDRY & LINEN SERVICE	1, 614		1	0 0	650, 811	1
					1			1
9.00		HOUSEKEEPI NG	5, 256		1	0	2, 123, 398	
10.00		DI ETARY	6, 531	I 3, 177	1	0	726, 917	10.00
11. 00	01100	CAFETERI A	7, 620	8, 478		0	1, 225, 769	11.00
13.00	01300	NURSING ADMINISTRATION	137	61, 652	1, 300, 68	9 0	1, 927, 241	13.00
14.00		CENTRAL SERVICES & SUPPLY	6, 624				648, 093	1
15. 00		PHARMACY			1		3, 512, 030	1
			5, 213					
		MEDICAL RECORDS & LIBRARY	303		765, 67			
17. 00		SOCIAL SERVICE	719	9 0	155, 64	4 0	324, 521	17. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67, 586	265, 578	9, 174, 44	6 0	13, 923, 592	30.00
31.00		INTENSIVE CARE UNIT	6, 909					
		NEONATAL INTENSIVE CARE UNIT						1
35. 00			6, 877					
43.00		NURSERY	12, 065	14, 978	973, 80	9 0	1, 669, 554	43.00
		LARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26, 512	1, 456, 494	3, 766, 80	1 0	12, 546, 277	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14, 083	46, 742	2, 163, 74	7 0	3, 216, 896	52.00
54.00		RADI OLOGY-DI AGNOSTI C	14, 262				3, 701, 309	
		ONCOLOGY	14, 202	•		0		
54. 01					1			
54. 02	1	ULTRASOUND	376				339, 720	
57.00	05700	CT SCAN	3, 808	113, 915	523, 32	3 0		
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7, 968	75, 086	398, 56	2 0	983, 766	58.00
59.00	05900	CARDI AC CATHETERI ZATI ON	C	ol o		0	0	
60.00		LABORATORY	4, 827	4, 776	1	0		
					1			1
65. 00	1	RESPI RATORY THERAPY	2, 269				1, 458, 498	1
66. 00		PHYSI CAL THERAPY	1, 961	1	386, 58			1
67. 00		OCCUPATI ONAL THERAPY	C	0 0)	0	0	
68.00	06800	SPEECH PATHOLOGY	83	3 0	17, 18	2 0	24, 587	68.00
69.00	06900	ELECTROCARDI OLOGY	193	15, 144	91, 66	8 0	155, 837	69.00
		ELECTROENCEPHALOGRAPHY	187	1				1
		MEDICAL SUPPLIES CHARGED TO PATIENTS			1	0	4, 705, 058	1
					1			1
		IMPL. DEV. CHARGED TO PATIENTS			'	0	5, 604, 667	1
	1	DRUGS CHARGED TO PATIENTS	C	0 0	1	0	3, 504, 625	73. 00
75.00	07500	ASC (NON-DISTINCT PART)	12, 677	146, 206	2, 613, 65	9 0	10, 697, 332	75.00
76.00	03330	ENDOSCOPY	5, 261	353, 344	1, 592, 78	3 0	3, 873, 600	76.00
		TIENT SERVICE COST CENTERS				*		1
91.00		EMERGENCY	13, 615	64, 289	1, 910, 38	3 0	3, 481, 273	91.00
			13,013	04, 207	1, 710, 30	3	3, 401, 273	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
		AL PURPOSE COST CENTERS						4
118.00		SUBTOTALS (SUM OF LINES 1-117)	293, 071	3, 976, 111	41, 578, 81	8 -22, 998, 977	99, 065, 121	 118. 00
	NONRE	IMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 654	7, 826	102, 82	7 0	572, 017	190.00
		PHYSICIANS' PRIVATE OFFICES	C		271, 23			
		MISSION EFFECTIVENESS				0 0		194. 00
	1			1	l .			
		MARKETI NG	C		'	0		
194. 02	07952	JOINT VENTURES	C	0 0	1	0		194. 02
194.04	07954	SCHOOL NURSE	885	5 0	492, 88	4 0	658, 885	194.04
		SPORTS MEDICINE & OB PHYS	1, 736				852, 225	
200.00	1	Cross Foot Adjustments]]			200.00
					1			1
201.00	1	Negative Cost Centers	/ 050 0::	4 407 0:-		_	20 000 0	201. 00
202.00	<u>'</u>	Cost to be allocated (per Wkst. B,	6, 952, 816	4, 187, 918	9, 486, 92	'	22, 998, 977	202.00
		Part I)		.		.]		
203.00		Unit cost multiplier (Wkst. B, Part I)	23. 382914	1. 042884	0. 22151	6	0. 224927	
204.00)	Cost to be allocated (per Wkst. B,			91, 49	7	3, 494, 948	204.00
		Part II)			1			
205.00		Unit cost multiplier (Wkst. B, Part			0.00213	6	0. 034180	205 00
_55.00		II)			0.00213	-	3. 334 100	
	1	1117	I	1	I	T	ı	1

OST AI	LLOCATION - STATISTICAL BASIS		Provi der Co	CN: 15-0157 P	'eri od:	Worksheet B-1	
					rom 07/01/2016	WOLKSHOOL D	
					o 06/30/2017	Date/Time_Pre	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	11/20/2017 12 CAFETERI A	2:48 p
	cost center bescription	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(HOURS OF	
		(SQUARE FEET)	(POUNDS OF	(,	()	SERVICE)	
			LAUNDRY)				
	CENEDAL CEDVICE COCT CENTEDS	7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. (
	00200 CAP REL COSTS-BEDG & TTXT						2. (
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. (
	00500 ADMINISTRATIVE & GENERAL						5. (
	00700 OPERATION OF PLANT	239, 811					7. (
. 00	00800 LAUNDRY & LINEN SERVICE	1, 614	494, 597				8.
	00900 HOUSEKEEPI NG	5, 256	0	232, 941	I I		9.
	01000 DI ETARY	6, 531	0	6, 531		000 000	10.
1	01100 CAFETERIA	7, 620	0	7, 620	I I	990, 298	
1	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	137 6, 624	14, 144	137 6, 624	1	28, 426 14, 771	1
	01500 PHARMACY	5, 213	14, 144	5, 213	l l	48, 612	1
	01600 MEDICAL RECORDS & LIBRARY	303	0	303	I I	29, 740	
	01700 SOCIAL SERVICE	719	Ō	719	1	4, 464	
Ī	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	67, 586	124, 801	67, 586	41, 619	241, 985	30.
	03100 INTENSIVE CARE UNIT	6, 909	19, 262	6, 909		27, 171	1
	02060 NEONATAL INTENSIVE CARE UNIT	6, 877	0	6, 877	l l	46, 081	1
	04300 NURSERY	12, 065	46, 542	12, 065	0	29, 803	43.
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	24 512	E0 740	26, 512	ار	110, 009	50.
	05200 DELIVERY ROOM & LABOR ROOM	26, 512 14, 083	58, 748 49, 643			56, 754	1
	05400 RADI OLOGY-DI AGNOSTI C	14, 063	10, 437	14, 063		62, 684	
	03480 ONCOLOGY	14, 202	10, 437	14, 202	1	02,004	1
	05402 ULTRASOUND	376	850	376	- 1	3, 868	
7. 00	05700 CT SCAN	3, 808	2, 718	3, 808	o	13, 851	
8. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	7, 968	39, 105	7, 968	o	13, 183	58.
	05900 CARDI AC CATHETERI ZATI ON	0	0	C	1	0	
	06000 LABORATORY	4, 827	0	4, 827	I I	0	
	06500 RESPI RATORY THERAPY	2, 269	455	2, 269	1	29, 284	
	06600 PHYSI CAL THERAPY	1, 961	914 0	1, 961	1	10, 972	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0 83	39	0 83	1	0 461	1
	06900 ELECTROCARDI OLOGY	193	46	193	l l	1, 995	1
	07000 ELECTROENCEPHALOGRAPHY	187	45	187	1	2, 219	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	1	. 0	
2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72.
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	
	07500 ASC (NON-DISTINCT PART)	12, 677	26, 592		1	92, 319	
	03330 ENDOSCOPY	5, 261	23, 600	5, 261	0	41, 745	76.
	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	10 (15	70 105	12 /15	ol	40 (50	01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	13, 615	73, 185	13, 615	٩	49, 659	91
	SPECIAL PURPOSE COST CENTERS						92
8. 00	SUBTOTALS (SUM OF LINES 1-117)	235, 536	491, 126	228, 666	46, 063	960, 056	1118
	NONREI MBURSABLE COST CENTERS	200,000	171,120	220,000	10,000	700, 000	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 654	0	1, 654	0	5, 531	190
2.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0	6, 461	
4. 00	07950 MISSION EFFECTIVENESS	0	0	C	0		194
	07951 MARKETI NG	0	0	C	0		194
	07952 JOINT VENTURES	0	0	0	0		194
	07954 SCHOOL NURSE	885	0	885	l l		194
74. 06 00. 00	07956 SPORTS MEDICINE & OB PHYS	1, 736	3, 471	1, 736	o o	18, 250	
	Cross Foot Adjustments						200
)1. 00)2. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	8, 527, 824	854, 591	2, 787, 915	1, 200, 831	1, 863, 649	1 .
,2.00	Part I)	0, 327, 024	004, 071	2, 707, 913	1, 200, 031	1, 003, 049	202.
03.00	Unit cost multiplier (Wkst. B, Part I)	35. 560604	1. 727853	11. 968331	26. 069318	1. 881907	203.
	Cost to be allocated (per Wkst. B,	1, 097, 651	67, 373		l l	271, 089	
04.00		1		l '	1 1		1
	Part II) Unit cost multiplier (Wkst. B, Part					0. 273745	1

	Financial Systems	ST. VINCENT CAR				u of Form CMS-2	
COST A	NLLOCATION - STATISTICAL BASIS		Provi der CC		eriod: rom 07/01/2016 o 06/30/2017	Worksheet B-1 Date/Time Pre 11/20/2017 12	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCIAL SERVICE	
			SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DI RECT NURS. HRS.)	(COSTED REQUIS.)		(PATI ENT REVENUE)		
	OFNEDAL CEDIUSE COCT OFNEDO	13.00	14. 00	15. 00	16. 00	17. 00	
1.00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	OO400	1					4. 00 5. 00
7.00	00700 OPERATION OF PLANT]					7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	(40,000					11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	642, 330 0	19, 479, 230				13. 00 14. 00
15. 00	01500 PHARMACY	0	90, 746	3, 505, 975			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0	0	490, 945, 789	12 004	16.00
17. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	j Uj	U _I	U	<u> </u>	13, 896	17. 00
30. 00	03000 ADULTS & PEDIATRICS	241, 985	329, 849	0	50, 665, 747	3, 119	
31. 00 35. 00	03100 INTENSI VE CARE UNIT 02060 NEONATAL INTENSI VE CARE UNIT	27, 171 46, 081	91, 756 100, 132	0	5, 697, 110 14, 087, 261	1, 426 2, 315	1
43. 00	04300 NURSERY	29, 803	45, 643	0	2, 080, 127	2, 313	
F0 00	ANCILLARY SERVICE COST CENTERS	110 000	4 004 570		4.44 004 550	070	
50. 00 52. 00	O5000 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM	110, 009 56, 754	4, 086, 579 209, 852	0	141, 901, 552 30, 507, 609	273 1, 758	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	479, 031	0	22, 763, 217	0	54.00
54. 01	03480 ONCOLOGY 05402 ULTRASOUND	0	0	0	2 179 245	0	
54. 02 57. 00	05700 CT SCAN	0	4, 469 74, 953	0	3, 178, 245 8, 664, 315	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	80, 342	0	3, 817, 140	0	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	0	0 35, 131, 591	0	
65. 00	06500 RESPI RATORY THERAPY	0	79, 971	0	3, 773, 987	0	
66.00	06600 PHYSI CAL THERAPY	0	11, 384	0	2, 391, 930	0	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	136, 198	0	
69. 00	06900 ELECTROCARDI OLOGY	0	16, 798	0	3, 618, 349	0	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7, 771 4, 621, 442	0	2, 265, 440	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	5, 604, 667	0	ő	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	3, 504, 625	0	0	
75. 00 76. 00	O7500 ASC (NON-DISTINCT PART) O3330 ENDOSCOPY	0 41, 745	2, 724, 756 550, 035	0	80, 851, 659 35, 446, 832	0 728	
70.00	OUTPATIENT SERVICE COST CENTERS	11,710	000, 000		00, 110, 002	720	70.00
	09100 EMERGENCY	49, 659	258, 163	0	43, 967, 480	3, 548	91.00
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS				l		92.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	603, 207	19, 468, 339	3, 504, 625	490, 945, 789	13, 167	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ام	0	ol	0] 190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	1, 251	0	Ö		192. 00
	07950 MI SSI ON EFFECTI VENESS	0	0	0	o		194. 00
	07951 MARKETI NG 07952 JOI NT VENTURES	0	O O	0	0		194. 01 194. 02
	07954 SCHOOL NURSE	20, 873	o	0	ő		194. 04
	07956 SPORTS MEDICINE & OB PHYS	18, 250	9, 640	1, 350	0	0	194. 06
200. 00 201. 00	, ,						200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	2, 420, 737	1, 160, 935	4, 646, 639	1, 783, 825	440, 089	
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	3. 768681	0. 059599	1. 325349	0. 003633	31. 670193	203 00
204.00		144, 689	246, 447	578, 312	66, 350		204. 00
	Part II)						1
205.00		0. 225256	0. 012652	0. 164950	0. 000135	2. 406232	205 20

Health Financial Systems	ST. VINCENT CAF	RMEL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Pre 11/20/2017 12	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

						11/20/2017 12	. 40 piii
			litle	XVIII	Hospi tal	PPS	
					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 & PEDIATRICS	23, 238, 204		23, 238, 204	0	23, 238, 204	30.00
31.00	03100 INTENSIVE CARE UNIT	3, 353, 875		3, 353, 875	o	3, 353, 875	
35.00	02060 NEONATAL INTENSIVE CARE UNIT	4, 077, 576		4, 077, 576		4, 077, 576	
43.00	04300 NURSERY	2, 877, 618	ł .	2, 877, 618		2, 877, 618	1
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG ROOM	18, 119, 433		18, 119, 433	0	18, 119, 433	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 269, 545		5, 269, 545		5, 269, 545	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 458, 938		5, 458, 938			1
54. 01	03480 ONCOLOGY	0		0	0	0	1
54. 02	05402 ULTRASOUND	454, 564		454, 564	0	454, 564	1
57. 00	05700 CT SCAN	1, 482, 941		1, 482, 941	0	1, 482, 941	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 694, 786		1, 694, 786		1, 694, 786	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	
60.00	06000 LABORATORY	4, 001, 334		4, 001, 334	0	4, 001, 334	1
65. 00	06500 RESPI RATORY THERAPY	1, 968, 770		1, 968, 770	0	1, 968, 770	1
66. 00	06600 PHYSI CAL THERAPY	829, 770		829, 770		829, 770	1
67. 00	06700 OCCUPATI ONAL THERAPY	027,770	0	027,770	0	027,770	1
68. 00	06800 SPEECH PATHOLOGY	35, 492	0	35, 492	0	35, 492	
69. 00	06900 ELECTROCARDI OLOGY	218, 041		218, 041	0	218, 041	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	207, 817		207, 817	0	207, 817	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 038, 786		6, 038, 786		6, 038, 786	1
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7, 199, 333		7, 199, 333		7, 199, 333	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 937, 760		8, 937, 760		8, 937, 760	
	07500 ASC (NON-DISTINCT PART)	14, 381, 786		14, 381, 786		14, 381, 786	
76. 00	03330 ENDOSCOPY	5, 456, 203		5, 456, 203		5, 456, 203	1
76.00	OUTPATIENT SERVICE COST CENTERS	3, 430, 203		3, 430, 203	U	5, 450, 205	76.00
91. 00	09100 EMERGENCY	5, 605, 954		5, 605, 954	52, 632	5, 658, 586	01 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						
		2, 732, 986		2, 732, 986		2, 732, 986	
200.00	1 1	123, 641, 512					1
201.00	1	2, 732, 986		2, 732, 986		2, 732, 986	
202.00	Total (see instructions)	120, 908, 526	0	120, 908, 526	62, 297	120, 970, 823	1202. UU

Health Financial Systems	ST. VINCENT CARMEL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Period: Worksheet C From 07/01/2016 Part I
		To 06/30/2017 Date/Time Prepared:

					To 06/30/2017	Date/Time Pre 11/20/2017 12	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	42, 912, 516		42, 912, 51			30. 00
31. 00	03100 INTENSIVE CARE UNIT	5, 697, 110		5, 697, 11			31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	14, 087, 261		14, 087, 26			35. 00
43.00	04300 NURSERY	2, 080, 127		2, 080, 12	7		43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	57, 693, 172	84, 208, 380			0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	29, 759, 645	747, 964			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 211, 033	20, 552, 184	22, 763, 21		0. 000000	
54. 01	03480 ONCOLOGY	0	0	l .	0. 000000	0. 000000	
54. 02	05402 ULTRASOUND	436, 171	2, 742, 074			0. 000000	
57.00	05700 CT SCAN	1, 420, 205	7, 244, 110			0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	204, 547	3, 612, 593	3, 817, 14		0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0. 000000	0.000000	
60.00	06000 LABORATORY	14, 340, 910	20, 790, 681			0. 000000	
65.00	06500 RESPI RATORY THERAPY	2, 744, 185	1, 029, 802			0.000000	
66. 00	06600 PHYSI CAL THERAPY	1, 249, 406	1, 142, 524	2, 391, 93		0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0. 000000	0.000000	
68. 00	06800 SPEECH PATHOLOGY	98, 116	38, 082			0.000000	
69. 00	06900 ELECTROCARDI OLOGY	987, 171	2, 631, 178			0.000000	
	07000 ELECTROENCEPHALOGRAPHY	1, 715, 438	550, 002	2, 265, 44		0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 874, 360	24, 613, 103			0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	16, 598, 788	4, 511, 653	21, 110, 44	0. 341032	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	17, 333, 542	10, 886, 581	28, 220, 12	3 0. 316716	0.000000	73. 00
75.00	07500 ASC (NON-DISTINCT PART)	1, 233, 494	79, 618, 165	80, 851, 65	9 0. 177879	0.000000	75. 00
76.00	03330 ENDOSCOPY	2, 076, 480	33, 370, 352	35, 446, 83	2 0. 153926	0.000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	6, 282, 099	37, 685, 381	43, 967, 48	0. 127502	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	972, 704	6, 780, 527	7, 753, 23	0. 352496	0. 000000	92. 00
200.00	Subtotal (see instructions)	237, 008, 480	342, 755, 336	579, 763, 81	6		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	237, 008, 480	342, 755, 336	579, 763, 81	6		202. 00

Health Financial Systems	ST. VINCENT CARME	L HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0157	Peri od: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/20/2017 12:48 pm

					11/20/2017 12	2:48 pm_
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 INTENSIVE CARE UNIT					31. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT					35. 00
43.00	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 127690				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 172729				52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 240239				54.00
54.01	03480 ONCOLOGY	0. 000000				54. 01
54.02	05402 ULTRASOUND	0. 143024				54. 02
57.00	05700 CT SCAN	0. 171155				57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 443994				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. 00
60.00	06000 LABORATORY	0. 113896				60.00
65.00	06500 RESPI RATORY THERAPY	0. 521668				65. 00
66.00	06600 PHYSI CAL THERAPY	0. 346904				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68.00	06800 SPEECH PATHOLOGY	0. 260591				68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 060260				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 091734				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 152929				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 341032				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 316716				73. 00
75.00	07500 ASC (NON-DISTINCT PART)	0. 177879				75. 00
76.00	03330 ENDOSCOPY	0. 153926				76.00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>				
91.00	09100 EMERGENCY	0. 128699				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 352496				92.00
200.00						200.00
201.00						201.00
202.00	Total (see instructions)					202. 00

Health Financial Systems	ST. VINCENT CA	RMEL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Pre 11/20/2017 12	
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE Di sal Lowanso	Total Costs	

						11/20/2017 12:	:48 pm_
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	•				
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	23, 238, 204		23, 238, 204	0	23, 238, 204	30. 00
31.00	03100 INTENSIVE CARE UNIT	3, 353, 875		3, 353, 875	0	3, 353, 875	31. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	4, 077, 576		4, 077, 576		4, 077, 576	35. 00
43.00	04300 NURSERY	2, 877, 618		2, 877, 618		2, 877, 618	
	ANCILLARY SERVICE COST CENTERS	, , , , , ,		, , , , , , , , , , , , , , , , , , , ,	-1		
50.00	05000 OPERATI NG ROOM	18, 119, 433		18, 119, 433	0	18, 119, 433	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	5, 269, 545		5, 269, 545		5, 269, 545	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 458, 938		5, 458, 938		5, 468, 603	
54. 01	03480 ONCOLOGY	0		,,	0	0	54. 01
54. 02	05402 ULTRASOUND	454, 564		454, 564	0	454, 564	
57. 00	05700 CT SCAN	1, 482, 941		1, 482, 941		1, 482, 941	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 694, 786		1, 694, 786		1, 694, 786	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		., 0, ., , 00		0	59. 00
60.00	06000 LABORATORY	4, 001, 334		4, 001, 334	-	4, 001, 334	
65. 00	06500 RESPI RATORY THERAPY	1, 968, 770	0			1, 968, 770	
66. 00	06600 PHYSI CAL THERAPY	829, 770	n	829, 770		829, 770	
67. 00	06700 OCCUPATI ONAL THERAPY	027,770	0	027,770		027,770	67. 00
68. 00	06800 SPEECH PATHOLOGY	35, 492	n	35, 492	0	35, 492	68. 00
69. 00	06900 ELECTROCARDI OLOGY	218, 041	Ŭ	218, 041		218, 041	
70.00	07000 ELECTROENCEPHALOGRAPHY	207, 817		207, 817		207, 817	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 038, 786		6, 038, 786		6, 038, 786	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7, 199, 333		7, 199, 333		7, 199, 333	
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 937, 760		8, 937, 760		8, 937, 760	
75. 00	07500 ASC (NON-DISTINCT PART)	14, 381, 786		14, 381, 786		14, 381, 786	
76. 00	03330 ENDOSCOPY	5, 456, 203		5, 456, 203		5, 456, 203	
70.00	OUTPATIENT SERVICE COST CENTERS	5, 450, 203		5, 450, 203	ı o	5, 450, 203	70.00
91. 00	09100 EMERGENCY	5, 605, 954		5, 605, 954	52, 632	5, 658, 586	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 732, 986		2, 732, 986		2, 732, 986	
200.00		123, 641, 512	0				
	1 /		U			2, 732, 986	
201. 00 202. 00		2, 732, 986	0	2, 732, 986			
202.00	Total (see instructions)	120, 908, 526	0	120, 908, 526	62, 297	120, 970, 823	J2U2. UU

ST. VINCENT CARMEL HOSPITAL	In Lieu of Form CMS-2552-10
Provi der CCN: 15-0157	Peri od: Worksheet C
	From 07/01/2016 Part

					rom 07/01/2016 o 06/30/2017	Part I Date/Time Prep 11/20/2017 12:	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
1	03000 ADULTS & PEDIATRICS	42, 912, 516		42, 912, 516	,		30. 00
31.00	03100 INTENSIVE CARE UNIT	5, 697, 110		5, 697, 110			31. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	14, 087, 261		14, 087, 261			35. 00
43.00	04300 NURSERY	2, 080, 127		2, 080, 127	1		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	57, 693, 172	84, 208, 380	141, 901, 552	0. 127690	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	29, 759, 645	747, 964	30, 507, 609	0. 172729	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 211, 033	20, 552, 184	22, 763, 217	0. 239814	0.000000	54.00
54. 01	03480 ONCOLOGY	0	0	C	0.000000	0.000000	54. 01
54. 02	05402 ULTRASOUND	436, 171	2, 742, 074	3, 178, 245	0. 143024	0. 000000	54. 02
57.00	05700 CT SCAN	1, 420, 205	7, 244, 110	8, 664, 315	0. 171155	0. 000000	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	204, 547	3, 612, 593	3, 817, 140	0. 443994	0. 000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0	c	0. 000000	0. 000000	59.00
60.00	06000 LABORATORY	14, 340, 910	20, 790, 681	35, 131, 591	0. 113896	0. 000000	60.00
65. 00	06500 RESPI RATORY THERAPY	2, 744, 185	1, 029, 802	3, 773, 987	0. 521668	0. 000000	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 249, 406	1, 142, 524	2, 391, 930	0. 346904	0. 000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	0. 000000	0. 000000	67. 00
68.00	06800 SPEECH PATHOLOGY	98, 116	38, 082	136, 198	0. 260591	0. 000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	987, 171	2, 631, 178	3, 618, 349	0. 060260	0. 000000	69. 00
	07000 ELECTROENCEPHALOGRAPHY	1, 715, 438	550, 002	2, 265, 440		0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 874, 360	24, 613, 103	39, 487, 463	0. 152929	0. 000000	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	16, 598, 788	4, 511, 653			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	17, 333, 542	10, 886, 581	28, 220, 123		0.000000	1
	07500 ASC (NON-DISTINCT PART)	1, 233, 494	79, 618, 165			0. 000000	
	03330 ENDOSCOPY	2, 076, 480	33, 370, 352	35, 446, 832		0. 000000	l
	OUTPATIENT SERVICE COST CENTERS		0070.07000	227			
	09100 EMERGENCY	6, 282, 099	37, 685, 381	43, 967, 480	0. 127502	0.000000	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	972, 704	6, 780, 527	7, 753, 231		0. 000000	
200.00	Subtotal (see instructions)	237, 008, 480	342, 755, 336				200.00
201.00	Less Observation Beds	_5.,555,100	2.2, .33, 000	3,			201. 00
202.00	Total (see instructions)	237, 008, 480	342, 755, 336	579, 763, 816			202.00
202.00	Total (300 That detroils)	207, 300, 400	5 12, 755, 550	077,700,010	1 1	'	1202.00

Health Financial Systems	ST. VINCENT CARM	EL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0157	Peri od: From 07/01/2016	Worksheet C	pared:
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INDATIENT POLITINE SERVICE COST CENTERS					

		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30. 00
31.00 03100 INTENSIVE CARE UNIT				31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT				35. 00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01 03480 ONCOLOGY	0. 000000			54. 01
54. 02 05402 ULTRASOUND	0. 000000			54. 02
57. 00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 00 03330 ENDOSCOPY	0. 000000			76. 00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>			
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	1			

Health Financial Systems	ST. VINCENT CAI	RMEL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 07/01/2016 To 06/30/2017		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capi tal Rel ated Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3, 079, 261	0	3, 079, 26			30.00
31.00 INTENSIVE CARE UNIT	392, 093		392, 09			
35.00 NEONATAL INTENSIVE CARE UNIT	357, 353		357, 35			
43. 00 NURSERY	445, 721	l .	445, 72			
200.00 Total (lines 30-199)	4, 274, 428		4, 274, 42	8 21, 105		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col. 6)				
	6. 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	3, 905	805, 328				30.00
31. 00 INTENSIVE CARE UNIT	304					31.00
35. 00 NEONATAL INTENSIVE CARE UNIT	0	1 177,000	,			35. 00
43. 00 NURSERY	0	d	,			43. 00
200.00 Total (lines 30-199)	4, 209	954, 884				200. 00

Health Financial Systems	ST. VINCENT CAI	DMEL HOSDITAL		In lie	u of Form CMS-2	0552_10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CN: 15-0157	Peri od:	Worksheet D	2002 10
7.11.01.11.01.11.11.11.11.11.11.11.11.11.	000.0	1.101.40.		From 07/01/2016	Part II	
				To 06/30/2017	Date/Time Pre	
		T: +1 a	e XVIII	Heeni tel	11/20/2017 12 PPS	:49 pm
Cost Center Description	Capi tal	Total Charges		Hospital Inpatient	Capi tal Costs	
cost center bescription		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col		column 4)	
	Part II, col.	8)	2)	. Charges	COT unit 4)	
	26)	0)	2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50. 00 05000 OPERATING ROOM	2, 856, 975	141, 901, 552	0. 02013	4 17, 046, 246	343, 209	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	630, 068		1			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	817, 313		1	· ·		
54. 01 03480 0NCOLOGY	0	0	0.00000	· ·	0	54. 01
54. 02 05402 ULTRASOUND	89, 136	3, 178, 245			4, 179	54. 02
57. 00 05700 CT SCAN	270, 783		1	· ·	·	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	353, 662			· ·		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	· ·	0	59. 00
60. 00 06000 LABORATORY	250, 996	35, 131, 591	1		30, 329	60.00
65. 00 06500 RESPIRATORY THERAPY	192, 984	3, 773, 987	0. 05113	5 1, 009, 045	51, 598	65. 00
66. 00 06600 PHYSI CAL THERAPY	80, 800	2, 391, 930	0. 03378	0 562, 452	19, 000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	O	0.00000	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	3, 426	136, 198	0. 02515	54, 011	1, 359	68. 00
69. 00 06900 ELECTROCARDI OLOGY	28, 150	3, 618, 349	0. 00778	0 459, 548	3, 575	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	26, 662	2, 265, 440	0. 01176	9 783, 235	9, 218	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	219, 289		•	· ·	·	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	262, 475		•		· ·	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	697, 877		•		· ·	
TE OO OTEOO ACO (NON DICTINOT DADT)	0/4 5/0			م ا		75 00

964, 562

693, 974

636, 315 362, 145 9, 437, 592

28, 220, 123 80, 851, 659

35, 446, 832

43, 967, 480 7, 753, 231

514, 986, 802

0.011930

0. 019578

0.014472

0. 046709

2, 627, 486 365, 716 42, 754, 941

430, 699

0 75.00

38, 025 91. 00 17, 082 92. 00

773, 131 200. 00

76.00

8, 432

75. 00 | 07500 | ASC (NON-DISTINCT PART) 76. 00 | 03330 | ENDOSCOPY

91. 00 09100 EMERGENCY

200.00

OUTPATIENT SERVICE COST CENTERS

Total (lines 50-199)

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Health Financial Systems	ST. VINCENT CAI	RMEL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider Co		Peri od:	Worksheet D	
				From 07/01/2016 To 06/30/2017		narad.
				To 06/30/2017	Date/Time Pre 11/20/2017 12	
		Title	XVIII	Hospi tal	PPS	. 10 piii
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
	,	Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0		O	0	31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		O	0	35. 00
43. 00 04300 NURSERY	0	0		O	0	43. 00
200.00 Total (lines 30-199)	0	0		O	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	14, 931					30. 00
31. 00 03100 I NTENSI VE CARE UNI T	797	0.00		4 0		31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	2, 107	l .		0		35. 00
43. 00 04300 NURSERY	3, 270	l .		0		43. 00
200.00 Total (lines 30-199)	21, 105		4, 20	9 0		200. 00

Health Financial Systems	ST. VINCENT CARME	EL HOSPITAL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT / THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0157	Peri od: From 07/01/2016	Worksheet D Part IV	
			To 06/30/2017	Date/Time Prep 11/20/2017 12:	pared: :48 pm_
		Title XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Nu Anesthetist Cost	rsing School Allied Healt	h All Other Medical Education Cost	Total Cost (sum of col 1 through col.	

			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health		Total Cost	
	·	Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	(0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
54. 01	03480 ONCOLOGY	0	0	(0	0	54. 01
	05402 ULTRASOUND	0	0	(0	0	54. 02
	05700 CT SCAN	0	0	(0	0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
	06000 LABORATORY	0	0	(0	0	60.00
	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
	07500 ASC (NON-DISTINCT PART)	0	0	(0	0	75. 00
76. 00	03330 ENDOSCOPY	0	0	(0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	0	(0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(0	0	92. 00
200.00	Total (lines 50-199)	0	0		0	0	200. 00

	<i></i>	ST. VINCENT CAL				u of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	H COSTS				From 07/01/2016		
					To 06/30/2017	Date/Time Prep 11/20/2017 12	
			Title	: XVIII	Hospi tal	PPS	. 40 piii
	Cost Center Description	Total	Total Charges			Inpati ent	
	0001 0011101 20001 1 pt 1 011		(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of				Charges	
		col. 2, 3 and		7)	(col. 6 ÷ col.	3	
		4)	ĺ	,	7)		
		6.00	7. 00	8.00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	141, 901, 552	0.00000	0. 000000	17, 046, 246	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	30, 507, 609	0.00000	0. 000000	22, 437	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	22, 763, 217	0.00000	0. 000000	540, 312	54.00
54.01	03480 ONCOLOGY	0	0	0.00000	0. 000000	0	54. 01
54.02	05402 ULTRASOUND	0	3, 178, 245	0.00000	0. 000000	149, 000	54. 02
57.00	05700 CT SCAN	0	8, 664, 315	0.00000	0. 000000	564, 400	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3, 817, 140	0.00000	0. 000000	54, 786	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0. 000000	0	59.00
60.00	06000 LABORATORY	0	35, 131, 591	0.00000	0. 000000	4, 245, 315	60.00
65.00	06500 RESPI RATORY THERAPY	0	3, 773, 987	0.00000	0. 000000	1, 009, 045	65.00
66.00	06600 PHYSI CAL THERAPY	0	2, 391, 930	0.00000	0. 000000	562, 452	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0. 000000	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	136, 198	0.00000	0. 000000	54, 011	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	3, 618, 349	0.00000	0. 000000	459, 548	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2, 265, 440	0.00000	0. 000000	783, 235	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39, 487, 463	0.00000	0. 000000	3, 319, 287	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	21, 110, 441	0.00000	0. 000000	6, 023, 371	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	28, 220, 123	0.00000	0. 000000	4, 497, 595	

0 0 0 80, 851, 659

35, 446, 832

43, 967, 480 7, 753, 231 514, 986, 802 0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0 75.00

2, 627, 486 91. 00 365, 716 92. 00 42, 754, 941 200. 00

76.00

430, 699

75. 00 | 07500 | ASC (NON-DISTINCT PART) 76. 00 | 03330 | ENDOSCOPY

91. 00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (lines 50-199)

Health Financia	al Systems	ST	. VINCENT C	CARMEL	HOSPI TAL	-		In Lie	u of Form CMS-2552-10
APPORTI ONMENT THROUGH COSTS	OF INPATIENT/OUTPATIENT	ANCI LLARY SERVI	CE OTHER PA	ASS	Provi der	CCN: 1	5-0157	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared:

			To	06/30/2017	Date/Time Pro 11/20/2017 12	
		Title	XVIII	Hospi tal	PPS	10 piii
Cost Center Description	Inpatient	Outpati ent	Outpati ent	<u> </u>		
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						4
50.00 05000 OPERATING ROOM	0	10, 469, 468				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	4, 813				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 469, 024	0			54. 00
54. 01 03480 0NCOLOGY	0	0	0			54. 01
54. 02 05402 ULTRASOUND	0	692, 385				54. 02
57. 00 05700 CT SCAN	0	1, 909, 907				57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	834, 650	0			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0			59. 00
60. 00 06000 LABORATORY	0	4, 673, 101	0			60.00
65. 00 06500 RESPIRATORY THERAPY	0	320, 838				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	48, 794	0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	715, 846				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	93, 884				70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	1, 609, 018				71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	485, 187				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	2, 020, 968	0			73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0			75. 00
76. 00 03330 ENDOSCOPY	0	3, 909, 915	0			76. 00
OUTPATIENT SERVICE COST CENTERS		7 400 000				04.00
91. 00 09100 EMERGENCY	0	7, 430, 298				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	1, 997, 918				92.00
200.00 Total (lines 50-199)	0	38, 686, 014	l O			200. 00

Health Financial Systems	ST. VINCENT CAR	RMEL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEAD	LTH SERVICES AND VACCINE COST	Provi der CC		Peri od: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Pre 11/20/2017 12	
		Title	XVIII	Hospi tal	PPS	<u> </u>
		·	Charges		Costs	
Cost Center Description		PPS Reimbursed	Cost		PPS Services	

					0 06/30/201/	11/20/2017 12	
			Titl∈	2 XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(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	
	LLARY SERVICE COST CENTERS			1	1		
	OO OPERATING ROOM	0. 127690			0	1,000,010	
	DO DELIVERY ROOM & LABOR ROOM	0. 172729		l .	0	831	
	DO RADI OLOGY-DI AGNOSTI C	0. 239814	1, 469, 024		0	352, 293	
	BO ONCOLOGY	0. 000000	0		0	0	
	02 ULTRASOUND	0. 143024	692, 385	l .	0	99, 028	1
	DO CT SCAN	0. 171155	1, 909, 907		0	326, 890	
	DO MAGNETIC RESONANCE IMAGING (MRI)	0. 443994	834, 650) (0	370, 580	
	OO CARDIAC CATHETERIZATION	0. 000000	0) (0	0	59. 00
	00 LABORATORY	0. 113896	4, 673, 101		0	532, 248	60. 00
65. 00 0650	00 RESPI RATORY THERAPY	0. 521668	320, 838	(0	167, 371	
	00 PHYSI CAL THERAPY	0. 346904	48, 794		0	16, 927	66. 00
67. 00 0670	OO OCCUPATI ONAL THERAPY	0. 000000	0) (0	0	67. 00
68. 00 0680	OO SPEECH PATHOLOGY	0. 260591	0) (0	0	68. 00
69. 00 0690	00 ELECTROCARDI OLOGY	0. 060260	715, 846	,	0	43, 137	69. 00
70.00 0700	00 ELECTROENCEPHALOGRAPHY	0. 091734	93, 884		0	8, 612	70. 00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 152929	1, 609, 018	(0	246, 066	71.00
72. 00 0720	DO IMPL. DEV. CHARGED TO PATIENTS	0. 341032	485, 187	(0	165, 464	72. 00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	0. 316716	2, 020, 968	(10, 807	640, 073	73. 00
75. 00 0750	DO ASC (NON-DISTINCT PART)	0. 177879	0) (0	0	75. 00
76. 00 0333	BO ENDOSCOPY	0. 153926	3, 909, 915	(0	601, 838	76. 00
OUTF	PATIENT SERVICE COST CENTERS						
91.00 0910	DO EMERGENCY	0. 127502	7, 430, 298	(0	947, 378	91. 00
92. 00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	0. 352496	1, 997, 918		0	704, 258	92.00
200. 00	Subtotal (see instructions)		38, 686, 014		10, 807	6, 559, 840	200. 00
201. 00	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		38, 686, 014	.	10, 807	6, 559, 840	202. 00

Health Financial Systems	ST. VINCENT CA	RMEL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0157	Peri od: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Pre 11/20/2017 12	pared: : 48 pm
		Title	: XVIII	Hospi tal	PPS	<u> </u>
	Cos	sts				
Cost Center Description	Cost Reimbursed Services Subject To	Cost Reimbursed Services Not Subject To				

	Reimbursed Reimbursed	
	Servi ces Servi ces Not	
	Subject To Subject To	
	Ded. & Coi ns. Ded. & Coi ns.	
	(see inst.) (see inst.)	
	6. 00 7. 00	
ANCI LLARY SERVI CE COST CENTERS		
50.00 05000 OPERATING ROOM	0 0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0 0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 0	54. 00
54. 01 03480 ONCOLOGY	0 0	54. 01
54. 02 05402 ULTRASOUND	0 0	54. 02
57. 00 05700 CT SCAN	0 0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0 0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0 0	59. 00
60. 00 06000 LABORATORY	0 0	60. 00
65. 00 06500 RESPI RATORY THERAPY	0 0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0 0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0 0	67. 00
68.00 06800 SPEECH PATHOLOGY	0 0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0 0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0 0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0 0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0 3, 423	73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0 0	75. 00
76. 00 03330 ENDOSCOPY	0 0	76. 00
OUTPATIENT SERVICE COST CENTERS		
91. 00 09100 EMERGENCY	0 0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0	92. 00
200.00 Subtotal (see instructions)	0 3, 423	200. 00
201.00 Less PBP Clinic Lab. Services-Program	0	201. 00
Only Charges		000 00
202.00 Net Charges (line 200 +/- line 201)	0 3, 423	202. 00

Health Financial Systems	ST. VINCENT CARME	L HOSPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL.	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0157	Peri od:	Worksheet D

From 07/01/2016 | Part V 06/30/2017 Date/Time Prepared: 11/20/2017 12:49 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (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 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 127690 7, 160, 922 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 172729 100,085 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0. 239814 54 00 0 1, 320, 041 54 00 0 54.01 03480 ONCOLOGY 0.000000 0 0 54.01 54.02 05402 ULTRASOUND 0.143024 263, 128 0 54.02 57.00 05700 CT SCAN 0. 171155 0 547, 680 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.443994 270, 238 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 59.00 06000 LABORATORY 2, 675, 425 60.00 0.113896 0 60.00 06500 RESPIRATORY THERAPY 0. 521668 231, 810 65 00 0 65 00 06600 PHYSI CAL THERAPY 66.00 0.346904 72, 470 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0. 260591 68.00 526 0 06900 ELECTROCARDI OLOGY 68, 836 69 00 0.060260 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.091734 92, 439 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 152929 1, 802, 730 71.00 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 341032 0 428, 283 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.316716 1, 124, 355 0 73.00 75.00 07500 ASC (NON-DISTINCT PART) 0. 177879 0 7, 885, 694 0 75.00 03330 ENDOSCOPY 0. 153926 2, 355, 230 0 0 76.00 76.00 0 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 0 127502 0 5, 116, 969 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 352496 0 833, 429 0 92.00 0 200. 00 200.00 Subtotal (see instructions) 32, 350, 290 Less PBP Clinic Lab. Services-Program 201.00 201.00 0 Only Charges 202.00 Net Charges (line 200 +/- line 201) 0 32, 350, 290 0 0 202.00

Health Financial Systems	ST. VINCENT CARME	L HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0157	From 07/01/2016	Worksheet D Part V Date/Time Prepared:

				To 06/30/2017	Date/Time Pre	
		Ti tl	e XIX	Hospi tal	Cost	•
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	914, 378	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	17, 288	0				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	316, 564	0				54.00
54. 01 03480 ONCOLOGY	0	0				54. 01
54. 02 05402 ULTRASOUND	37, 634	0				54. 02
57. 00 05700 CT SCAN	93, 738	0				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	119, 984	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	304, 720	0				60.00
65. 00 06500 RESPIRATORY THERAPY	120, 928	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	25, 140	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	137	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	4, 148	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	8, 480	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	275, 690	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	146, 058	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	356, 101	0				73. 00
75.00 07500 ASC (NON-DISTINCT PART)	1, 402, 699	0				75. 00
76. 00 03330 ENDOSCOPY	362, 531	0				76. 00
OUTPATIENT SERVICE COST CENTERS	•		•			
91. 00 09100 EMERGENCY	652, 424	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	293, 780	0				92.00
200.00 Subtotal (see instructions)	5, 452, 422	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	5, 452, 422	0				202. 00

Heal th	Financial Systems	ST. VINCENT CARME	L HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0157	Peri od:	Worksheet D-1	
				From 07/01/2016 To 06/30/2017	Date/Time Pre	narod:
				10 06/30/201/	11/20/2017 12	
-			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room day				14, 931	1. 00
2.00	Inpatient days (including private room day				14, 931	2. 00
3.00	Private room days (excluding swing-bed and	l observation bed day	ys). If you have only pr	rivate room days,	0	3. 00
	do not complete this line.					
4.00	Semi-private room days (excluding swing-be				13, 175	4. 00
5.00	Total swing-bed SNF type inpatient days (i	ncluding private roo	om days) through Decembe	er 31 of the cost	0	5. 00
	reporting period			04 6 11	0	, ,,,
6.00	Total swing-bed SNF type inpatient days (i		om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter Total swing-bed NF type inpatient days (in		m days) through Docombor	21 of the cost	0	7. 00
7.00	reporting period	ici during pri vate 100i	ii days) tiii ougii beceiibei	31 OF THE COST	U	7.00
8. 00	Total swing-bed NF type inpatient days (in	octuding private room	m days) after December 3	R1 of the cost	0	8.00
0.00	reporting period (if calendar year, enter		ii days) arter becember e	or the cost	O	0.00
9.00	Total inpatient days including private roo		o the Program (excluding	swing-bed and	3, 905	9.00
,, 00	newborn days)	days app sab. s	o the riegiam (exercaring	g om ng boa ana	0,700	,, ,,
10.00	Swing-bed SNF type inpatient days applicab	ole to title XVIII or	nly (including private m	room days)	0	10.00
	through December 31 of the cost reporting			,		
11.00	Swing-bed SNF type inpatient days applicable	ole to title XVIII or	nly (including private r	room days) after	0	11. 00
	December 31 of the cost reporting period ((if calendar year, er	nter 0 on this line)			
12.00	Swing-bed NF type inpatient days applicabl		X only (including privat	te room days)	0	12. 00
	through December 31 of the cost reporting					
13. 00	Swing-bed NF type inpatient days applicabl				0	13. 00
	after December 31 of the cost reporting pe					
14.00	Medically necessary private room days appl	icable to the Progra	am (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)				0	15.00
16. 00	Nursery days (title V or XIX only)				0	16. 00
17 00	SWING BED ADJUSTMENT	anni anhi a ta anni a	oo through Docombon 21 o	£ +bo ooo+	0.00	17. 00
17. 00	Medicare rate for swing-bed SNF services a reporting period	ippircable to service	es through December 31 (or the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services a	annlicable to service	os after December 21 of	the cost	0.00	18. 00
10.00	reporting period	ippircable to service	es aiter becember 31 of	the cost	0.00	10.00
19. 00	Medicald rate for swing-bed NF services ap	nnlicable to services	s through December 31 of	the cost	0.00	19. 00
17.00	reporting period	pricable to services	3 through becomber 31 of	the cost	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services ap	pplicable to services	s after December 31 of 1	the cost	0.00	20.00
	reporting period					
21.00	Total general inpatient routine service co	st (see instructions	s)		23, 238, 204	21. 00
22. 00	Swing-bed cost applicable to SNF type serv			ting period (line	0	22. 00
	5 x line 17)	_	·			
23.00	Swing-bed cost applicable to SNF type serv	vices after December	31 of the cost reportin	ng period (line 6	0	23. 00
	x line 18)					
24. 00	Swing-bed cost applicable to NF type servi	ces through December	r 31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)	6. 6 .			_	
25. 00	Swing-bed cost applicable to NF type servi	ces after December 3	31 of the cost reportino	g period (line 8	0	25. 00
24 00	x line 20)				0	2/ 00
26.00	Total swing-bed cost (see instructions)	of cwing had cost	(line 21 minus line 24)		22 220 204	26.00

DRAFT IT AIL PROVIDER COMPORENTS INPATITED TOXS INPATITED TOXS INPATITED TOXS Inpatient days (including private room days, excluding swing-bed and nentorn days) 14, 931 2.0 1, 931 2.0
1.00 Inpatient days (including private room days, and swing-bed days, excluding newborn) 14,931 1.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 14,931 2.00 private room days (excluding swing-bed and observation bed days) 15,00 do not complete this 19 (excluding swing-bed and observation bed days) 15,00 do not complete this 19 (excluding swing-bed and observation bed days) 16,00 location of the cost reporting period (ir called and private room days) through December 31 of the cost reporting period (ir called and private room days) through December 31 of the cost reporting period (ir called and private room days) after December 31 of the cost reporting period (ir called and private room days) after December 31 of the cost reporting period (ir called and private room days) after December 31 of the cost reporting period (ir called and private room days) after December 31 of the cost reporting period (ir called and private room days) after December 31 of the cost o
14.931 2.00 Injestient days (including private room days, excluding swing-bed and newborn days) 17.00 Private room days (sectuding swing-bed and observation bed days). If you have only private room days, do not complete this line. Semi-private room days (sectuding swing-bed and observation bed days) through December 31 of the cost of the c
7.00 private room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this line. 8.01 private room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this line. 8.02 Semi-private room days (excluding swing-bed and observation bed days) after December 31 of the cost reporting period. If cost and the private room days and the private room days after December 31 of the cost of the cost in the private room days after December 31 of the cost operating period. If cell endar year, enter 0 on this line). 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calledar year, enter 0 on this line). 8.01 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calledar year, enter 0 on this line). 8.01 Total swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and newborn days). 8.02 Total inpatient days applicable to the Program (excluding private room days). 8.03 Inpatient days applicable to the swing-bed SMF type inpatient days applicable to the swing-bed NF type inpatient days applicable to the swing-bed NF type inpatient days applicable to the swing-bed SMF type inpatient days applicable to services through December 31 of the cost reporting period (line swing-bed SMF services applicable to services through December 31 of the cost reporting period (line swing-bed SMF services applicable to services after December 31 of the cost reporting period (line swing-bed cost applicable to SMF type servi
4.00 not complete this line. 5.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 6.00 Intal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Swing-bed SNF type inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 14.00 Medicare rate for swing-bed SNF services applicable to Program (excluding swing-bed days) 15.00 Total specember 31 of the cost reporting period (including private room days) 16.00 Swing-bed SNF services applicable to services after Decem
Semi-private room days (excluding swing-bed and observation bed days) 13.175
Total is wing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period of the cost reporting period of the calendar year, enter 0 on this line) Total inpatient days including private room days after December 31 of the cost reporting period of (if calendar year, enter 0 on this line) Total inpatient days including private room days after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days applicable to title XVIII only (including private room days) Through December 31 of the cost reporting period (see instructions) Total inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total period of Fixed Properting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to titles V or XIX only (including private room days) Medically necessary private room days applicable to the Program (excluding swing-bed days) Medically necessary private room days applicable to the Program (excluding swing-bed days) Medical ry necessary private room days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medicarly necessary private room days applicable to services after December 31 of the cost reporting period (including private room days) Medicarly necessary private room days applicable to services after December 31 of the cost reporting period (line 6 x
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and Setup of the cost reporting period (see Instructions) Total inpatient days applicable to the title XVIII only (including private room days) Through December 31 of the cost reporting period (see Instructions) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inursery days (title V or XIX only) Total nursery days (title v or XIX only) Total general inpatient nursery days (title v or XIX only) Total general inpatient nursery days (title v or X
reporting period (if calendar year, enter 0 on this line) 7.00 Totals wing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 8.00 Total inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) applicable to the Program (excluding swing-bed and 3, 905 reporting period (including private room days) applicable to the Program (excluding swing-bed and 3, 905 reporting period (see instructions) 8.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 8.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 8.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 8.01 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 8.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 9.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 9.01 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 9.02 Swing-bed SWI (title V or XIX only) 9.03 Swing-bed SWI (title V or XIX only) 9.04 Swing-bed SWI (title V or XIX only) 9.05 Swing-bed SWI (title V or XIX only) 9.06 Swing-bed SWI (title V or XIX only) 9.07 Swing-bed SWI (title V or XIX only) 9.08 Swing-bed SWI (title V or XIX only) 9.09 Swing-bed SWI (title V or XIX only) 9.09 Swing-bed SWI (title V or XIX only) 9.00 Swing-bed SWI (title V or XIX only) 9.00 Swing-bed SWI (title V or XIX only) 9.00 Swing-bed SWI (title
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5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 25.00 x line 20) 25.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Conceral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Conceral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Conceral inpatient routine service cost/charge ratio (line 27 ÷ line 3) Conceral inpatient routine service cost/charge ratio (line 27 ÷ line 38) Conceral inpatient routine service cost/charge (line 30 ÷ line 4) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (line 29 ÷ line 3) Conceral inpatient routine service cost (lin
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24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERNTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 31.00 Average private room per diem charge (line 29 + line 3) 32.00 Average semi-private room per diem charge (line 30 + line 4) 33.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 3 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204 27, 00 23, 238, 204 27, 00 23, 238, 204 27, 00 24, 00 24, 00 24, 00 24, 00 24, 00 24, 00 24, 00 24, 00 25, 00 24, 00 25
7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Onumber 23, 238, 204 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 27.00 28.00 29.00 30.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204)
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27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 29. 00 Private room charges (excluding swing-bed and observation bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 + line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204) 27. 00 28. 00 29. 00 30. 00 30. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 37. 00 38. 00 37. 00 38. 00 39. 00 30. 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) O 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) O 29. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) O 29. 00 Average private room per diem charge (line 29 + line 3) O 20. 00 Average semi-private room per diem charge (line 30 ÷ line 4) O 20. 00 32. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) O 20. 00 32. 00 Average per diem private room cost differential (line 34 x line 31) O 20. 00 32. 00 Average per diem private room cost differential (line 34 x line 31) O 20. 00 32. 00 33. 00 Average per diem private room cost differential (line 34 x line 31) O 20. 00 32. 00 33. 00 Average per diem private room cost differential (line 34 x line 31) O 20. 00 32. 00 33. 00 Average per diem private room cost differential (line 34 x line 31) O 20. 00 32. 00 33. 00 Average per diem private room cost differential (line 34 x line 31) O 20. 00 32. 00 33. 00 Average per diem private room cost differential (line 34 x line 31) O 20. 00 32. 00 33. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37.
General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204) 28. 00 29. 00 30. 00 31. 00 32. 00 32. 00 33. 00 Average per diem private room cost differential (line 30 x line 30) Average per diem private room cost differential (line 3 x line 31) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204) 37. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204)
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204) 37.00 27 minus line 36)
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204) 37.00 23.00 37.00 37.00 38.00 37.00 3
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204 27 minus line 36) 37.00
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204 27 minus line 36)
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 238, 204 37.00 27 minus line 36)
PART II - HOSPITAL AND SUBPROVIDERS ONLY
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,556.37 38.00
39.00 Program general inpatient routine service cost (line 9 x line 38) 6,077,625 39.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 41.00 Total Program general inpatient routine service cost (line 39 + line 40) 6,077,625 41.00
STOREGORAL PROGRAM DEDECAL INDALLED FORMINE SERVICE COST LITTE AUT LITTE AUT

Heal th	h Financial Systems ST. VINCENT CARMEL HOSPITAL	In I	ieu of Form CMS-2	2552-10
	JTATION OF INPATIENT OPERATING COST Provider CCN: 15-01	57 Peri od:	Worksheet D-1	
		From 07/01/20 To 06/30/20		pared:
			11/20/2017 12	
	Cost Center Description Total Total Average	Hospital Program Day	PPS rs Program Cost	
	Inpatient Cost Inpatient Days Diem (co		(col. 3 x col.	
	col .		4)	
42.00	1.00 2.00 3.00 NURSERY (title V & XIX only) 0	0.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	0.00	0 0	42.00
43.00) INTENSIVE CARE UNIT 3,353,875 797 4,	208. 12	04 1, 279, 268	43. 00
44. 00				44. 00
45. 00 46. 00				45. 00 46. 00
		935. 25	0 0	
	Cost Center Description		1.00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		1. 00 8, 290, 795	48. 00
	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		15, 647, 688	
	PASS THROUGH COST ADJUSTMENTS			
50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D	, sum of Parts I a	nd 954, 884	50. 00
51. 00		D, sum of Parts I	773, 131	51. 00
	and IV)	•		
52. 00	,		1, 728, 015	
53. 00	Total Program inpatient operating cost excluding capital related, non-physician a medical education costs (line 49 minus line 52)	nestnetist, and	13, 919, 673	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION			
	Program di scharges		0	
55. 00 56. 00	1 2 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4		0.00	55. 00 56. 00
57. 00	,	inus line 53)	Ö	57. 00
58. 00	,		0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated a market basket	nd compounded by t	ne 0.00	59. 00
60.00		sket	0.00	60. 00
61. 00			0	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or amount (line 56), otherwise enter zero (see instructions)	1% of the target		
62. 00			0	62. 00
63. 00			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost re	norting pariod (Sa	e 0	64. 00
04.00	instructions) (title XVIII only)	portring perrod (se		04.00
65. 00		rting period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title	XVIII only) For	0	66. 00
00.00	CAH (see instructions)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		00.00
67. 00		st reporting perio	d 0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost	reporting period	0	68. 00
	(line 13 x line 20)	roportring porrod		00.00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (lin	e 37)		70. 00
71. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	,		71. 00
72. 00 73. 00	,			72. 00 73. 00
74. 00				74.00
75. 00	· '	B, Part II, colum	n	75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)			76. 00
77. 00				77.00
78. 00				78. 00
79. 00	1 33 3 7	0 minus line 70)		79. 00
80. 00 81. 00		o minus inte /9)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (line 9 x line 81)			82. 00
83.00	,			83.00
84. 00 85. 00				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)			86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		4 75/	07.00
87. 00 88. 00			1, 756 1, 556. 37	
	Observation bed cost (line 87 x line 88) (see instructions)		2, 732, 986	

Health Financial Systems	ST. VINCENT CA	RMEL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2016 Fo 06/30/2017	Date/Time Pre 11/20/2017 12	pared: :48 pm_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	3, 079, 261	23, 238, 204	0. 13250	9 2, 732, 986	362, 145	90.00
91.00 Nursing School cost	0	23, 238, 204	0.00000	2, 732, 986	0	91.00
92.00 Allied health cost	0	23, 238, 204	0.00000	2, 732, 986	0	92.00
93.00 All other Medical Education	0	23, 238, 204	0.00000	2, 732, 986	0	93. 00

	Financial Systems	ST. VINCENT CARM			u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0157	Peri od:	Worksheet D-1	
				From 07/01/2016 To 06/30/2017		
			Till VIV		11/20/2017 12	:49 pm
	Cost Center Description		Title XIX	Hospi tal	Cost	
	oost denter bescriptron				1. 00	
	PART I - ALL PROVIDER COMPONENTS					
1. 00	INPATIENT DAYS Inpatient days (including private r	oom days and swing had da	we eveluding newborn)		14, 931	1.00
2. 00	Inpatient days (including private r				14, 931	
3. 00	Private room days (excluding swing-			ivate room days,	0	
	do not complete this line.			,		
4.00	Semi-private room days (excluding s	wing-bed and observation	bed days)		13, 175	
5. 00	Total swing-bed SNF type inpatient reporting period	days (including private r	room days) through Decembe	er 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient	davs (including private r	room days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year,					
7.00	Total swing-bed NF type inpatient d	ays (including private ro	oom days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient d	ave (including privato re	nom days) after December 3	1 of the cost	0	8.00
0.00	reporting period (if calendar year,		onii days) ai tei beceilibei s	i or the cost	0	0.00
9.00	Total inpatient days including priv		to the Program (excluding	swing-bed and	124	9. 00
	newborn days)					
10. 00	Swing-bed SNF type inpatient days a			oom days)	0	10. 00
11. 00	through December 31 of the cost rep Swing-bed SNF type inpatient days a			nom davs) after	0	11. 00
	December 31 of the cost reporting p	eriod (if calendar year,	enter 0 on this line)	,		00
12.00	Swing-bed NF type inpatient days ap		(IX only (including privat	e room days)	0	12. 00
12 00	through December 31 of the cost rep		(IV (:		0	12.00
13. 00	Swing-bed NF type inpatient days ap after December 31 of the cost repor				0	13. 00
14.00	Medically necessary private room da				0	14. 00
15.00	Total nursery days (title V or XIX	onl y)			3, 270	
16. 00	Nursery days (title V or XIX only)				377	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF ser	vices annlicable to servi	ces through December 31 o	of the cost	0.00	l 17. 00
17.00	reporting period	vices applicable to servi	ces through becember 31 c	i the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF ser	vices applicable to servi	ces after December 31 of	the cost	0.00	18. 00
40.00	reporting period					40.00
19. 00	Medicaid rate for swing-bed NF serv reporting period	ices applicable to servic	es through December 31 of	the cost	0.00	19. 00
20. 00	Medical d rate for swing-bed NF serv	ices applicable to servic	es after December 31 of t	he cost	0.00	20. 00
	reporting period					
21. 00	Total general inpatient routine ser				23, 238, 204	
22. 00	Swing-bed cost applicable to SNF ty 5×1 ine 17)	pe services through Decem	iber 31 of the cost report	ing period (line	0	22. 00
23. 00	,	pe services after Decembe	er 31 of the cost reportir	na period (line 6	0	23. 00
	x line 18)	,				
24. 00	Swing-bed cost applicable to NF typ	e services through Decemb	er 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF typ	e services after Necember	: 31 of the cost reporting	neriod (line 9	0	25. 00
20.00	x line 20)	o services arter becember	or or the cost reporting	porrou (rine o		25.00
26. 00	Total swing-bed cost (see instruction	ons)			0	26. 00
27. 00	General inpatient routine service c		(line 21 minus line 26)		23, 238, 204	27. 00
29 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service c		and absorvation had ab	appace)	0	20 00
28. 00 29. 00	Private room charges (excluding swi		bed and observation bed Cr	iai yes <i>)</i>	0	28. 00 29. 00
30 00					n	30 00

	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14, 931	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14, 931	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	13, 175	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	124	9. 00
	newborn days)		40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
44.00	through December 31 of the cost reporting period (see instructions)		11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	U	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	13.00
14. 00		0	14. 00
15. 00	Total nursery days (title V or XIX only)		15. 00
16. 00	Nursery days (title V or XIX only)	377	
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	23, 238, 204	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	23, 236, 204	
22.00	5 x line 17)	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	23, 238, 204	27. 00
00.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	0	00.00
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	0	
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)		32. 00
	Average semi-private room per diem charge (line 30 + line 4)	0. 00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	23, 238, 204	37. 00
	27 minus line 36)		
	PART II - HOSPI TAL AND SUBPROVI DERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 556. 37	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	192, 990	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	192, 990	41. 00

Provider COX: 15-017	Heal th	Financial Systems	ST. VINCENT CAR	MEL HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
Cost Center Description						Peri od:	Worksheet D-1	
11.00								aarad.
Cost Center Description						10 06/30/2017		
Propertient Cost Impatient Dosy Spient (Col. 1 + Col. 2 + Col. 3 x col.)				Title	e XIX	Hospi tal	Cost	
Col. Col. Col. Col. Col. Col. Col. Col. Col. Col. Co		Cost Center Description						
1.00 2.00 3.00 4.00 5.00 4.00 5.00 4.00 5.00 3.00 4.00 5.00			Inpatient Cost	npatient Days		÷	V	
			1 00	2.00		4.00		
Intensive Care Type Inpatient Deptate Unit S.	42.00	NUIPSERV (title V & YLY only)						42.00
	42.00		2,011,010	3, 210	000.0	1 377	331, 704	42.00
45.00 SURGIAL INTERSIVE CARE UNIT	43.00		3, 353, 875	797	4, 208. 12	2 36	151, 492	43.00
4.6.00 SIRGELOKAL INTERSIVE CARE UNIT	44.00	CORONARY CARE UNIT						44.00
A. C. O. Program Impatient ancillary service cost (Mxst. D-3. col. 3, 11ne 200) 1,935,25 0 0 47.00 1.000 48.00	45.00							45.00
Cost Center Description								
1.00	47. 00		4, 077, 576	2, 107	1, 935. 2	5 0	0	47. 00
		Cost Center Description					1.00	
49.00	48 00	Program innationt ancillary service cost (Wk	st D-3 col 3	line 200)				48 00
PASS THROUGH COST ADJUSTMENTS					ns)			
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts II and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II o 51.00 and IV) 52.00 Total Program excludable cost (sum of Ilnes 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs ((ine 49 minus line 52) 54.00 Program discharges 55.00 Program discharges 56.00 Program discharges 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient cost incomplete decision (line 54 minus line 53) 59.00 Difference between adjusted inpatient cost program (line 18 minus line 53) 59.00 Difference between adjusted inpatient process from prior year cost reporting period (see line 53 minus line 53) 59.00 Difference between adjusted inpatient routine costs through December 31 of the cost reporting period (See line 54 minus line 56), otherwise enter zero (see instructions) 69.00 Difference of the subject of the first patient routine costs (line 64 plus line 65) (title XVIII only). 69.00 Difference between adjusted p	17.00		11 till odgi. 10) (c				1,010,071	171.00
51.00 and Information 0 51.0	50.00		atient routine s	ervices (from	Wkst. D, sum	of Parts I and	0	50.00
and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 53.00 Program inpatient operating cost excluding capital related, non-physician anesthetist, and 54.00 Program of scharges 55.00 Target amount per discharge 50.00 Target amount per discharge 60.00 Target amount per discharge amount per								
1	51. 00		atient ancillary	services (fro	om Wkst. D, si	um of Parts II	0	51. 00
S3.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and modified education coats (line 49 minus line 52) S4.00 Program discharge	E2 00	1	EO and E1)					F2 00
Medical education costs (line 49 minus line 52)				ated non-phys	sician anesth	atist and		
TARGET MOUNT AND LIMIT COMPUTATION 54.00 64.00 75.00 1 1 1 1 1 1 1 1 1	33.00			ateu, non-pny.	si ci ali aliestii	strst, and		33.00
55.00 Target amount per discharge 56.00 Target amount per discharge 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Reli ef payment (see instructions) 63.00 Allowable inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (lite 12 X line 10 yl) 65.00 Instructions) (lite XVIII only). For CAM (See Instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (See Instructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See Instructions) 69.00 Total Medicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Inla 12 X line 19) 69.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Inla 13 X line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Inla 13 X line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Inla 13 X line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 69.00 Cay and the service cost (line 97 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine service costs			/					
56.00 Target amount (line 54 x line 55) 0.56.00 56.00 57.00	54.00	Program di scharges					0	54.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 60.00 61.00 If line 53/54 is less than the lower of lines 55,59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 64.00 Minumble Inpatient cost plus incentive payment (see instructions) 0 65.00 Minumble Inpatient cost plus incentive payment (see instructions) 0 65.00 Minumble Inpatient Cost plus incentive payment (see instructions) 0 65.00 Minumble Inpatient Cost plus incentive payment (see instructions) 0 65.00 Minumble Inpatient Poutline costs after December 31 of the cost reporting period (see instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routline costs (line 64 plus line 65) (title XVIII only). For 0 66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 Total Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 70 + line 2) 71.00 PART III - Available of the Cost of the Cost (line 91 x line 71) 71.00 PART III of Available of Program (line 14 x line 35) 73.00 PART III - Country of the Cost (line 92 x line 71) 73.00 PART III - Program general inpatient routine service costs (line 72 + line 73) 73.								
58.00 Bonus payment (see instructions) 59.00 Lesser of lines \$35/\$4 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines \$35/\$4 or 55 from prior year cost report, updated by the market basket 60.01 Lesser of lines \$35/\$4 is less than the lower of lines \$5, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 60.00 Relider payment (see instructions) 60.00 Relider payment (see instructions) 60.00 Relider payment (see instructions) 60.00 All lowable Inpatient cost plus incentive payment (see instructions) 60.00 Relider swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) title xVIII only) 60.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) title xVIII only) 60.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For 0 66.00 CAH (see instructions) 61.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) title XVIII only) 62.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 63.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 64.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 65.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 67.00 Title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 69.00 Total program general inpatient routine service costs (line 70 + line 2) 69.00 Total title V or XIX								
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1.100 If line 53/54 is less than the lower of lines 55. \$0 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	60.00		cost report, upo	lated by the ma	arket basket		0.00	60.00
amount (line 56), otherwise enter zero (see instructions) 0 62.00	61.00					the amount by	0	61.00
62.00 Relief payment (see instructions) 0 62.00 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (title XVIII only) 67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 37) 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Ajusted general inpatient routine service costs (line 72 + line 73) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital -related costs (line 75 + line 2) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider recor				(lines 54 x	50), or 1% of	the target		
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PROGRAM INPATIENT ROUTINE SWING BED COST 44.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Adjusted general inpatient routine service cost per diem (line 12 x line 35) 72.00 Aggregate charges private room cost applicable to Program (line 14 x line 35) 73.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital -related costs (line 9 x line 71) 76.00 Per diem capital -related costs (line 9 x line 76) 77.00 Aggregate charges to benefic laries for excess costs (from provider records) 78.00 Aggregate charges to benefic laries for excess costs (from provider records) 88.00 Aggregate charges to benefic laries for excess costs (from provider records) 88.00 Total Program routine service co			ont (coo instruc	tions)				
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89. UU UDSERVATION DEC COST (IINE 87 X IINE 88) (See INSTRUCTIONS) 2,732,986 89. 00				line 2)				
	87. UU	Jobservation bed cost (fine 8/ x fine 88) (se	e instructions)				2, /32, 986	89. UU

Health Financial Systems	ST. VINCENT CA	RMEL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2016 To 06/30/2017	Date/Time Prep 11/20/2017 12	pared: :49 pm_
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	3, 079, 261	23, 238, 204	0. 13250	9 2, 732, 986	362, 145	90.00
91.00 Nursing School cost	0	23, 238, 204	0.00000	2, 732, 986	0	91.00
92.00 Allied health cost	0	23, 238, 204	0.00000	2, 732, 986	0	92.00
93.00 All other Medical Education	0	23, 238, 204	0. 00000	2, 732, 986	0	93. 00

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	Financial Systems ST. VINCENT CARMEL ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0157	Peri od:	worksheet D-3	
				From 07/01/2016 To 06/30/2017		
		Ti tl e	e XVIII	Hospi tal	PPS	. 10 piii
	Cost Center Description		Ratio of Cos		Inpati ent	
	'		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				- The second sec	2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS			7, 906, 882		30. 00
31. 00	03100 INTENSIVE CARE UNIT			3, 597, 061		31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT			0		35. 00
43. 00	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 1276			1
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 1727			
54.00	05400 RADI OLOGY - DI AGNOSTI C		0. 2402	· ·		1
54. 01	03480 ONCOLOGY 05402 ULTRASOUND		0. 0000 0. 1430		-	
54. 02 57. 00	05700 CT SCAN		0. 1430	· ·		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0.1711			
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 0000			1
60.00	06000 LABORATORY		0. 0000		1	
65. 00	06500 RESPIRATORY THERAPY		0. 5216			
66. 00	06600 PHYSI CAL THERAPY		0. 3469			
67. 00	06700 OCCUPATI ONAL THERAPY		0.0000			1
68. 00	06800 SPEECH PATHOLOGY		0. 2605			
69. 00	06900 ELECTROCARDI OLOGY		0.0602	· ·		1
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 0917	783, 235	71, 849	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1529			71. 00
72.00			0. 3410			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 3167	16 4, 497, 595	1, 424, 460	73. 00
75.00	07500 ASC (NON-DISTINCT PART)		0. 1778	79 0	0	75. 00
76.00			0. 1539	26 430, 699	66, 296	76. 00
	OUTPATIENT SERVICE COST CENTERS					
91. 00			0. 1286			
92. 00			0. 3524	· ·		
200.00				42, 754, 941		
201.00		(line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)		1	42, 754, 941	I	202. 00

	Financial Systems ST. VINCENT CA				eu of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0157	Peri od:	Worksheet D-3	
				From 07/01/2016 To 06/30/2017		
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00		2)	
	I NIDATI ENT. DOUTINE CEDVI CE COCT CENTEDO		1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		1	4, 952, 842		30.00
31.00	03100 INTENSIVE CARE UNIT			4, 952, 842 953, 013		31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			2, 741, 221		35.00
	04300 NURSERY			354, 971		43.00
43.00	ANCILLARY SERVICE COST CENTERS			334, 771		43.00
50.00	05000 OPERATI NG ROOM		0. 1276	90 7, 083, 406	904, 480	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 1727			1
54. 00			0. 2398		58, 179	
54. 01	03480 ONCOLOGY		0.0000		0	ı
54. 02	05402 ULTRASOUND		0. 1430		7, 295	54. 02
57.00	05700 CT SCAN		0. 1711	55 149, 566	25, 599	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 4439	94 23, 484	10, 427	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON		0.0000	00	0	59. 00
60.00	06000 LABORATORY		0. 1138	96 1, 672, 368	190, 476	60.00
65.00	06500 RESPI RATORY THERAPY		0. 5216	68 395, 891	206, 524	65. 00
66.00	06600 PHYSI CAL THERAPY		0. 3469	04 100, 790	34, 964	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0.0000			67. 00
68. 00	06800 SPEECH PATHOLOGY		0. 2605			
			0. 0602			
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 0917			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1529			
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3410			
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 3167		792, 258	
	07500 ASC (NON-DISTINCT PART)		0. 1778		0	
76. 00			0. 1539	26 177, 736	27, 358	76. 00
	OUTPATIENT SERVICE COST CENTERS					
	09100 EMERGENCY		0. 1275	·		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 3524	96 0	0	92.00

92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)
202.00 Net charges (line 200 minus line 201)

0. 352496

19, 297, 767

92.00

3, 640, 448 200. 00 201. 00 202. 00

Health Financial Systems	ST. VINCENT CARME	L HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0157	Peri od: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/20/2017 12:48 pm

			10 00/30/201/	11/20/2017 12	
		Title XVIII	Hospi tal	PPS	
			•		
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurri	ing prior to October 1 (:	see	2, 875, 482	1. 01
4 00	instructions)			0 400 040	4 00
1. 02	DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 (see	8, 403, 043	1. 02
1 02	instructions)		anian ta Oataban	0	1 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for the structure of the second specific operations of the second specific operati	or discharges occurring	orior to october	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCL fo	or discharges occurring	on or after	0	1. 04
1.04	October 1 (see instructions)	or discharges occurring t	on or arter	U	1.04
2.00	Outlier payments for discharges. (see instructions)			134, 470	2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
3.00	Managed Care Simulated Payments	,		0	3. 00
4.00	Bed days available divided by number of days in the cost repo	rtina period (see instru	ctions)	148. 19	4. 00
	Indirect Medical Education Adjustment	tring portion (and tribute			
5.00	FTE count for allopathic and osteopathic programs for the mos-	t recent cost reporting	period ending on	0.00	5. 00
	or before 12/31/1996. (see instructions)	3 1	3		
6.00	FTE count for allopathic and osteopathic programs which meet	the criteria for an add-	on to the cap	0.00	6. 00
	for new programs in accordance with 42 CFR 413.79(e)		·		
7.00	MMA Section 422 reduction amount to the IME cap as specified (under 42 CFR §412.105(f)	(1) (i v) (B) (1)	0.00	7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified	under 42 CFR §412.105(f))(1)(iv)(B)(2)	0.00	7. 01
	If the cost report straddles July 1, 2011 then see instruction	ns.			
8.00	Adjustment (increase or decrease) to the FTE count for allopa			0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.	79(c)(2)(iv), 64 FR 2634	O (May 12,		
	1998), and 67 FR 50069 (August 1, 2002).				
8. 01	The amount of increase if the hospital was awarded FTE cap slo	ots under section 5503 o	f the ACA. If	0. 00	8. 01
0.00	the cost report straddles July 1, 2011, see instructions.	. 6		0.00	0.00
8. 02	The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachi	ng nospi tai	0. 00	8. 02
0 00	under section 5506 of ACA. (see instructions)	as (8 9 01 and 8 02) (300	0.00	0.00
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	es (8, 8,01 and 8,02) (see	0.00	9. 00
10. 00	FTE count for allopathic and osteopathic programs in the curre	ant year from your recor	de	0.00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.	ent year from your record	u3		11. 00
12. 00	Current year allowable FTE (see instructions)			0.00	
13. 00	Total allowable FTE count for the prior year.			0.00	
14. 00	Total allowable FTE count for the penultimate year if that year	ar ended on or after Sen	tember 30 1997	0.00	
14.00	otherwise enter zero.	ar ended on or arter sep	telliber 30, 1777,	0.00	14.00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
	Adjustment for residents in initial years of the program				16. 00
	Adjustment for residents displaced by program or hospital clos	sure			17. 00
	Adjusted rolling average FTE count	34. 0		0.00	
	Current year resident to bed ratio (line 18 divided by line 4))		0. 000000	
	Prior year resident to bed ratio (see instructions)	, .		0. 000000	
21. 00	Enter the Lesser of Lines 19 or 20 (see instructions)			0. 000000	
22. 00	IME payment adjustment (see instructions)			0.000000	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	
22.01	Indirect Medical Education Adjustment for the Add-on for Secti	on 422 of the MMA			22.01
23 00	Number of additional allopathic and osteopathic IME FTE reside		ec 412 105	0.00	23. 00
20.00	(f) (1) (i v) (C).	one cup stots under 12 o	56. 112.100	0.00	20.00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the	ower of line 23 or line	24 (see	0.00	
20.00	instructions)	Tower or Time 20 or Time	21 (300	0.00	20.00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	
28. 00	IME add-on adjustment amount (see instructions)			0.00000	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions))		0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)	,		0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	29. 01
27.01	Disproportionate Share Adjustment	.,			
30 00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	2. 29	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	21. 2 44,5 (300 11131140	,	14. 68	
	Sum of lines 30 and 31			16. 97	
	Allowable disproportionate share percentage (see instructions))		3. 78	
	Disproportionate share adjustment (see instructions)	,		106, 582	
55	1		ı	.55,562	

CALCUL	Financial Systems ST. VINCENT CARM ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0157	Peri od: From 07/01/2016 To 06/30/2017	worksheet E Part A Date/Time Pre	
				11/20/2017 12	: 48 pm
		Title XVIII	Hospital	PPS On/After 10/1	
			1. 00	2. 00	
25 00	Uncompensated Care Adjustment		/ 40/ 145 524	F 077 402 447	1 25 00
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		6, 406, 145, 534 0. 000069023		
35. 02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (se			
25 02	instructions)		111 147	277 (00	25.02
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amount of the uncompensated care (sum of columns 1 and 2 on line 35.0		111, 147 388, 836		35. 03 36. 00
	Additional payment for high percentage of ESRD beneficiary di	ischarges (lines 40 throu			
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding	discharges for MS-DRGs	1, 480		40. 00
	652, 682, 683, 684 and 685 (see instructions)		Before 1/1	On/After 1/1	
			1. 00	1. 01	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0	0	41. 00
41. 01	instructions) Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)	-DRGs 652, 682, 683, 684	0	0	41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qualitated Medicare ESRD inpatient days excluding MS-DRGs 652, 66		0.00	l I	42. 00 43. 00
44. 00	<pre>linstructions) Ratio of average length of stay to one week (line 43 divided days)</pre>	by line 41 divided by 7	0. 000000		44. 00
45.00	Average weekly cost for dialysis treatments (see instructions	s)	0.00	0.00	45. 00
46. 00	Total additional payment (line 45 times line 44 times line 4	1. 01)	11 000 413		46. 00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	11, 908, 413		47. 00 48. 00
	only. (see instructions)		_		
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions	s)		11, 908, 413	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I am			967, 053	1
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii			0	
53. 00	Nursing and Allied Health Managed Care payment	The Ty see That detroils).		Ö	
54.00	Special add-on payments for new technologies			0	
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of	69)		0	
56. 00	Cost of physicians' services in a teaching hospital (see inti	ructions)		Ö	
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	0	
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	IV, Col. II II ne 200)		0 12, 875, 466	
60.00	Pri mary payer payments			0	1
61.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		12, 875, 466	1
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			1, 203, 272 18, 473	1
64. 00	Allowable bad debts (see instructions)			77, 826	
65.00	Adjusted reimbursable bad debts (see instructions)			50, 587	1
66.00	9 ,	tructions)		20, 556	1
67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	11, 704, 308	1
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	
70.00				0	1
70. 01 70. 50	RURAL DEMONSTRATION PROJECT			0	1
	SCH or MDH volume decrease adjustment			ő	
70. 88	Pioneer ACO demonstration payment adjustment amount (see ins	tructions)		0	1
70. 89	HSP bonus payment HVBP adjustment amount (see instructions)			0	1
70. 89 70. 90	USD bonus payment UDD adjustment amount (see instructions)				
70. 89 70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	
70. 89 70. 90	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)				70. 92 70. 93

	Financial Systems ST. VINCENT CARME ATION OF REIMBURSEMENT SETTLEMENT	Provider CO	N. 15 0157	Peri od:	u of Form CMS-2 Worksheet F	2332 10
CALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Provider CC	JN: 15-U15/	From 07/01/2016	Part A	
				To 06/30/2017	Date/Time Pre	pared:
					11/20/2017 12	:48 pm
		Title	XVIII	Hospi tal	PPS	
			FFY	′ (yyyy)	Amount	
	<u> </u>			0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)			_	_	
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
70.00	the corresponding federal year for the period ending on or aft	er 10/1)			0	70.00
	Low Volume Payment-3				0	
	HAC adjustment amount (see instructions)	0 0 70)			0	
	Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			11, 743, 315	
	Sequestration adjustment (see instructions)				234, 866	
	Interim payments				11, 453, 723	
	Tentative settlement (for contractor use only)	72)			0	
	Balance due provider (Program) (line 71 minus lines 71.01, 72, Protested amounts (nonallowable cost report items) in accordar				54, 726	
75.00	CMS Pub. 15-2, chapter 1, §115.2	ice with			7, 081, 658	/5.00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see inst	ructions)			0	90.00
	Capital outlier from Wkst. L, Pt. I, line 2	i ucti ons)			0	
	Operating outlier reconciliation adjustment amount (see instru	ictions)			0	
	Capital outlier reconciliation adjustment amount (see instruct				0	93. 00
	The rate used to calculate the time value of money (see instructions and the contract of the c				0.00	
	Time value of money for operating expenses (see instructions)	10 (1 0113)			0.00	
	Time value of money for capital related expenses (see instruct	i ons)			0	
			ı	Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount					
	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0.0000000000	0.000000000	101. 00
	HVBP adjustment amount for HSP bonus payment (see instructions	5)		0	0	102. 00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0.0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	0	104.00

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 07/01/2016 Part A Exhi bit 4 To 06/30/2017 Date/Ti me Prepared: 11/20/2017 12:48 pm Provider CCN: 15-0157

							11/20/2017 12	:48 pm
		W/S E Dort A	Amounts (from	Title Pre/Post	XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	Amounts (from E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	C	0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	2, 875, 482	0	2, 875, 482	2	2, 875, 482	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	8, 403, 043	0		8, 403, 043	8, 403, 043	1. 02
4.00	occurring on or after October	4.00			_			4 00
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	()	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	134, 470	0	45, 610	88, 859	134, 469	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	(0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	C	0	0	3. 00
4. 00	Managed care simulated payments Indirect Medical Education Adju	3. 00	0	0	(0	0	4.00
5.00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	(0	0	6. 00
6. 01	instructions) IME payment adjustment for managed care (see	22. 01	0	0	C	0	0	6. 01
	instructions)							
	Indirect Medical Education Adju							l
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7.00
8. 00	IME adjustment (see	28. 00	0	0	(0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	O	0	C	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	C	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	C	0	0	9. 01
	8.01) Di sproporti onate Share Adjustment							
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0378	0. 0378	0. 0378	0. 0378		10.00
11. 00	instructions) Disproportionate share	34. 00	106, 582	0	27, 173	79, 409	106, 582	11.00
11. 01	adjustment (see instructions) Uncompensated care payments	36. 00	388, 836	0	C	618, 301	618, 301	11. 01
	Additional payment for high per	centage of ESF		di scharges				
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	(0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	11, 908, 413 0	0	2, 948, 265 0	8, 960, 148 0	11, 908, 413 0	13. 00 14. 00
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)							
15. 00	Total payment for inpatient operating costs (see	49. 00	11, 908, 413	0	2, 948, 265	8, 960, 148	11, 908, 413	15. 00
16. 00	instructions) Payment for inpatient program capital	50. 00	967, 053	0	246, 433	720, 620	967, 053	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	C	0	0	17. 00
17. 01	Net organ aquisition cost	69.00		4	,		^	17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	(0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	O	0	C	0	0	18. 00

From 07/01/2016 Part A Exhibit 4
Date/Time Prepared: 06/30/2017 11/20/2017 12:48 pm Title XVIII Hospi tal PPS W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 Part A) On/After 10/01 line Ε, Entitlement through 4) 4 00 0 1 00 2 00 3 00 5 00 19.00 SUBTOTAL 3, 194, 698 9, 680, 768 12, 875, 466 19. 00 W/S L, line (Amounts from L) 1.00 2.00 3.00 4.00 5.00 0 20.00 Capital DRG other than outlier 230, 583 911, 107 20 00 1 00 911, 107 680, 524 20.01 Model 4 BPCI Capital DRG other 1.01 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 24,057 7,780 16, 277 24,057 21.00 Model 4 BPCI Capital DRG 21.01 2.01 C 21.01 outlier payments 22.00 Indirect medical education 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) Indirect medical education 23.00 23.00 6.00 adjustment (see instructions) Allowable disproportionate 0.0350 0.0350 24.00 10 00 0.0350 0.0350 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 31, 889 8,070 23, 819 31, 889 25.00 adjustment (see instructions) Total prospective capital 26.00 12.00 967, 053 246, 433 720, 620 967, 053 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 2.00 1.00 3.00 4.00 5.00 27.00 Low volume adjustment factor 0.054464 0. 019643 27. 00 Low volume adjustment 70.96 173, 996 173, 996 28.00 28.00 (transfer amount to Wkst. E, Pt. A, line) Low volume adjustment 70.97 190, 159 190, 159 29.00 (transfer amount to Wkst. E, Pt. A. line) 100.00 Transfer low volume 100.00 adjustments to Wkst. E, Pt. A.

				-	From 07/01/2016 To 06/30/2017	Date/Time Pre 11/20/2017 12	pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1. 00	2. 00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	2, 875, 482	2, 875, 482	2	2, 875, 482	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	8, 403, 043		8, 403, 043	8, 403, 043	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0		D	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see linstructions)	2. 00	134, 470	45, 610	88, 859	134, 469	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	(0	0	2. 01
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0		0 0	0	3. 00 4. 00
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	0		0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)		0		0	0	6. 01
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see instructions)	28. 00	0	(0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	(0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	(-	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0		0	0	9. 01
10. 00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33.00	0. 0378	0. 0378	0. 0378		10. 00
10.00	(see instructions)	33.00	0.0378	0.0376	0.0378		10.00
11. 00	Disproportionate share adjustment (see instructions)	34.00	106, 582	27, 17:	79, 409	106, 582	11. 00
11. 01	Uncompensated care payments	36.00	388, 836	111, 14	7 277, 689	388, 836	11. 01
	Additional payment for high percentage of ESF		•				
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	(0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47. 00 48. 00	11, 908, 413 0	3, 059, 412	2 8, 849, 001 0 0	11, 908, 413 0	13. 00 14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	11, 908, 413	3, 059, 412	8, 849, 001	11, 908, 413	15. 00
16. 00	Payment for inpatient program capital	50. 00	967, 053	246, 433	720, 620	967, 053	16. 00
17. 00	Special add-on payments for new technologies	54.00	0		0	0	17. 00
17. 01	Net organ acquisition cost						17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0		0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0		0	0	18. 00
19. 00	SUBTOTAL			3, 305, 84	9, 569, 621	12, 875, 466	19. 00

Heal th	Financial Systems	ST. VINCENT CA	RMEL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 07/01/2016 To 06/30/2017		pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	911, 107	230, 58	3 680, 524	911, 107	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	24, 057	7, 78	0 16, 277	24, 057	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0350	0. 035	0. 0350		24. 00
25. 00	Di sproporti onate share adjustment (see instructi ons)	11. 00	31, 889	8, 07	0 23, 819	31, 889	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	967, 053	246, 43	3 720, 620	967, 053	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	40, 445	16, 22	3 24, 222	40, 445	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-1, 438	-1, 43	8 0	-1, 438	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31. 01
						(Amt to Wkst	

(Amt. to Wkst. E, Pt. A) 4.00

0 32.00

100. 00

2.00

1.00

Ν

0

70. 99

32.00 HAC Reduction Program adjustment (see instructions)
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

3. 00

Health Financial Systems	ST. VINCENT CARME	L HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0157	Peri od: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/20/2017 12:48 pm
•		Title XVIII	Hospi tal	DDS

			To 06/30/2017	Date/Time Pre 11/20/2017 12	
		Title XVIII	Hospi tal	PPS	. 10 piii
	DART R. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			3, 423	1. 00
2. 00	Medical and other services reimbursed under OPPS (see instructions)	tions)		6, 559, 840	
3. 00	PPS payments	,		5, 505, 719	
4.00	Outlier payment (see instructions)			87, 906	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)	IV ool 12 line 200		0 0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. I Organ acquisitions	rv, cor. 13, 11ne 200		0	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			3, 423	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0, 120	11.00
	Reasonabl e charges				
12.00	Ancillary service charges			10, 807	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			10, 807	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for patients and actually collected from patients liable for patients.	navment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	
10.00	had such payment been made in accordance with 42 CFR §413.13(6		ir a chargebasi's	Ĭ	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	-,		0.000000	17. 00
18.00	Total customary charges (see instructions)			10, 807	18. 00
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	7, 384	19. 00
20.00	instructions) Excess of reasonable cost over sustanary charges (complete only	ly if line 11 eyecode li	no 10) (coo	0	20. 00
20. 00	Excess of reasonable cost over customary charges (complete onlinstructions)	Ty IT TITLE IT exceeds IT	ne ro) (see	0	20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		3, 423	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	0 Cost of physicians' services in a teaching hospital (see instructions)				23. 00
24. 00					24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	r CAH. see instructions)		1, 149, 442	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			4, 447, 606	
	instructions)		- •		
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			4, 447, 606 996	
32. 00	Subtotal (line 30 minus line 31)			4, 446, 610	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)		1, 110, 010	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			130, 608	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)			84, 895	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		82, 102	
37. 00	Subtotal (see instructions)			4, 531, 505	
38.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	•	tions)	Ö	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	39. 99
40.00	Subtotal (see instructions)			4, 531, 505	40. 00
40. 01	Sequestration adjustment (see instructions)			90, 630	40. 01
41. 00	Interim payments			4, 354, 947	1
42.00	,		0		
43.00	Balance due provider/program (see instructions)	acc with CMS Dub. 1E 2	chantar 1	85, 928	
44. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	ice with twis Pub. 15-2,	спартег т,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92. 00	The rate used to calculate the Time Value of Money				92. 00
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems

ST. VINCENT CARMEL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0157

Period: From 07/01/2016 To 06/30/2017

Title XVIII Hospital

Provider CCN: 15-0157

Part I Date/Time Prepared: 11/20/2017 12: 48 pm

Title XVIII Hospital

PPS

Inpatient Part A

Part B

mm/dd/yyyy Amount

mm/dd/yyyy Amount

		Ti tl e	XVIII	Hospi tal	PPS	
		Inpatier	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider	1.00	11, 453, 723	3.00	4, 354, 947	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
2.00	submitted or to be submitted to the contractor for		Ĭ			2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER		0			3. 01
3. 02			0			3. 02
3. 04			0		0	3. 04
3. 05			o o		0	3. 05
	Provider to Program		_			
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53		ļ	0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		11, 453, 723		4, 354, 947	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		11, 400, 720		4, 334, 947	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	1				
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	ı				
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5.03	Provider to Program		0		0	5. 03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	TENTALI VE TO TROOKAW		0			5. 50
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		o o	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		54, 726		85, 928	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		11, 508, 449		4, 440, 875	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
)	1, 00	2. 00	
8. 00	Name of Contractor			1. 00	2.00	8. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	I .		ļi —		

Health Financial Systems ST. VINCENT CARMEL HOSPITAL In Lieu of Form CMS-2552-					
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0157	Peri od:	Worksheet E-1	
			From 07/01/2016 To 06/30/2017		oared:
				11/20/2017 12:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			6, 631	1. 00
1. 00					
2.00					2. 00
3.00					3. 00
4. 00					4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			579, 763, 816	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I			10, 587, 620	
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	certified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00
9.00	Sequestration adjustment amount (see instructions)			o	9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30. 00
31.00	Other Adjustment (specify)			0	31. 00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)	0	32. 00

Health Financial Systems	ST. VINCENT CARME	L HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0157	Peri od: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 11/20/2017 12:48 pm
		Title XIX	Hospi tal	Cost
			Inpati ent	Outpati ent

PART VII CALCULATION OF REINBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES Y OR XIX SERVICES 1,00 2,00					11/20/2017 12	:48 pm
DART VIII - CALCULATION OF RETUBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			Title XIX	Hospi tal		
DART VIII - CALCULATION OF RETUBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				Inpati ent	Outpati ent	
DART VII - CALCULATION OF RETINBUSSIENT - ALL OTHER HEALTH SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICES		PART VII - CALCULATION OF RELMBURSEMENT - ALL OTHER HEALTH SEE	RVICES FOR TITLES V OR XIX			
Inpati ent hospit al /SWF/NF services			TOTAL	OLIVI OLO		
Medical and other services 5, 452, 422 2.00	1 00			4 214 404		1 00
3.00 Organ acquisition (certified transplant centers only) 3.00 4, 316, 694 5, 452, 42 4, 00 5, 00 Inpatient prinarry payer payments 5, 00 6, 00 5, 00 Subtotal (sum of Irines 1, 2 and 3) 5, 00 6, 00 5		'		4, 310, 094	F 4F0 400	1
A. 00 Subtotal (sum of lines 1, 2 and 3) 4, 316,694 5, 452, 422 4, 00					5, 452, 422	1
Inpatient primary payer payments 0 0 0 0 0 0 0 0 0				٩	- 4-0 400	1
0. 00 0utpatient primary payer payments 0. 0. 0. 00 0. 0. 00 0. 0. 00 0. 0				4, 316, 694	5, 452, 422	
1.00 Subtotal (line 4 less sum of lines 5 and 6) 5,452,422 7.00				0		
COMPUTATION OF LESSER OF COST OR CHARGES					0	
Reasonable Charges 8.00 Routine service charges 6., 336, 768 7.00 7	7.00			4, 316, 694	5, 452, 422	7.00
Routine service charges 6, 336, 768 8, 00 0, 00 0, 00 Capan acquisition charges, net of revenue 19, 297, 767 32, 350, 290 9, 00 10, 10, 00 10, 10, 10, 10, 10, 10, 10, 10, 10, 10,		COMPUTATION OF LESSER OF COST OR CHARGES				
9,00 Ancillary service charges 19,297,767 32,350,29 9,00		Reasonable Charges				
9,00 Ancillary service charges 19,297,767 32,350,29 9,00	8.00	Routine service charges		6, 336, 768		8.00
10.00 Organ acquisition charges, net of revenue 0 10.0	9.00				32, 350, 290	9.00
11.00	10 00			I	,	
12.00 Total reasonable charges (sum of lines 8 through 11) 25, 634, 535 32, 350, 290 12.00				0		
CUSTOWARY CHARGES				25 634 535	32 350 290	1
13.00 Amount actually collected from patients	12.00			25, 054, 555	32, 330, 290	12.00
basis 14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16.00 Total customary charges (see instructions) 17.00 Excess of customary charges (see instructions) 18.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 21, 317, 841 26, 897, 866 17.00 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16 (see instructions) 19.00 Interns and Residents (see instructions) 0 0 0 19.00 16 (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12 00		r corvices on a charge		0	12 00
14.00 Amounts that would have been realized from patients Liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413. 13(e) 0.000000 0.000000 15.00 16.00 16.00 17.00	13.00		i services on a charge	٩	U	13.00
a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 15. 00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16. 00 Total customary charges (see instructions) 17. 00 Excess of customary charges (see instructions) 18. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 21, 317, 841 26, 897, 868 17. 00 11 the 4) (see instructions) 18. 00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19. 00 Interns and Residents (see instructions) 19. 00 Interns and Residents (see instructions) 19. 00 Cost of physicians' services in a teaching hospital (see instructions) 10. 00 Cost of physicians' services in a teaching hospital (see instructions) 10. 00 Cost of covered services (enter the lesser of line 4 or line 16) 10. 00 ROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 10. 00 Utilier payments 10. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0	14 00				0	14 00
15.00	14.00			U	Ü	14.00
16. 00	45.00		42 CFR §413.13(e)			45.00
17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 21, 317, 841 26, 897, 868 17.00						
Iine 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 0 0 18.00						
18. 00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 16) (see instructions) 17. 00 19.	17. 00	, ,	ly if line 16 exceeds	21, 317, 841	26, 897, 868	17. 00
16) (see instructions)						
19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 2	18. 00		ly if line 4 exceeds line	0	0	18. 00
20. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 0 20. 00						
21.00				0	0	19. 00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22. 00 22. 00 23. 00 24. 00 23. 00 24. 00 25. 00 24. 00 25. 00 26. 00 26. 00 26. 00 26. 00 26. 00 27. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 28. 00 28. 00 29. 00 27. 00 28. 00 29. 00	20.00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	20. 00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22. 00 22. 00 23. 00 24. 00 23. 00 24. 00 25. 00 24. 00 25. 00 26. 00 26. 00 26. 00 26. 00 26. 00 27. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 28. 00 28. 00 29. 00 27. 00 28. 00 29. 00	21.00	Cost of covered services (enter the lesser of line 4 or line	16)	4, 316, 694	5, 452, 422	21.00
23. 00				rs.		
23. 00	22.00	Other than outlier payments		0	0	22. 00
24. 00 Program capital payments 25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 Total amount payable to the provider (sum of lines 32 and 33) 20. 00 Deductible (see instructions) 29. 00 Titles ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 00 Total amount payable to the provider (sum of lines 38 and 39) 29. 00 Total amount power (line 40 minus line 41) 29. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub 15-2, 29. 00 Consurance 30. 00 Late to the provider (sum of lines 31, 40 minus line 41) 30. 00 Late to the provider (sum of lines 31, 40 minus line 41) 30. 00 Late to the provider (sum of lines 31 minus line 41) 30. 00 Late to the provider (sum of lines 38 and 39)	23.00	Outlier payments		o	0	23. 00
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 40. 00 43. 00 41. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 0 0 0 25. 00 0 0 0 28. 00 0 0 28. 00 0 0 28. 00 0 0 0 30. 00 0 0 0 30. 00 0				0		24.00
26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 30. 00 Eductibles 30. 00 Coinsurance 30. 00 Allowable bad debts (see instructions) 31. 00 Allowable bad debts (see instructions) 32. 00 Utilization review 33. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 36. 00 Subtotal (line 36 ± line 37) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 49. 00 Total amount payable to the provider (sum of lines 38 and 39) 40. 00 Fortested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 26. 00 27. 00 0 0 27. 00 0 0 28. 00 4, 316, 694 4, 316, 694 5, 452, 422 30. 00 30.				0		
27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 4, 316, 694 5, 452, 422 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 4, 316, 694 5, 452, 422 31. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 4, 316, 694 5, 452, 422 31. 00 32. 00 Deductibles 0 0 0 32. 00 33. 00 Coinsurance 0 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 4, 316, 694 5, 452, 422 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 4, 316, 694 5, 452, 422 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 4, 316, 694 5, 452, 422 40. 00 41. 00 Interim payments 4, 316, 694 5, 452, 422 41. 00 42. 00 Balance due provider/program (line 40 minus line 41) 0 43. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00				0	0	
28.00 Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 30.00 Locinsurance 31.00 Coinsurance 32.00 Allowable bad debts (see instructions) 32.00 Utilization review 33.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 33.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 33.00 Subtotal (line 36 ± line 37) 34.00 Direct graduate medical education payments (from Wkst. E-4) 35.00 Linterim payments 40.00 Interim payments 40.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,				٥	-	
29.00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 30.00 Coinsurance 31.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 37.00 Subtotal (line 36 ± line 37) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 4, 316, 694 4, 316, 694 5, 452, 422 38.00 39.00 Total amount payable to the provider (sum of lines 38 and 39) 4, 316, 694 5, 452, 422 40.00 41.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 4, 316, 694 5, 452, 422 40.00 43.00					-	
COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 4,316,694 5,452,422 31.00 32.00 Deductibles 0 0 0 32.00 33.00 Coinsurance 0 0 0 0 34.00 Allowable bad debts (see instructions) 0 0 0 34.00 35.00 Utilization review 0 0 35.00 Utilization review 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 4,316,694 5,452,422 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 4,316,694 5,452,422 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Interim payments 4,316,694 5,452,422 40.00 41.00 Interim payments 4,316,694 5,452,422 41.00 42.00 Balance due provider/program (line 40 minus line 41) 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				4 217 704	•	
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 4, 316, 694 4, 316, 694 5, 452, 422 38.00 49.00 Interim payments 4, 316, 694 5, 452, 422 40.00 41.00 Balance due provider/program (line 40 minus line 41) 90 O 43.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	29.00			4, 310, 094	5, 452, 422	29.00
31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coi nsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 40. 00 Herrim payments 41. 00 Balance due provider/program (line 40 minus line 41) 42. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	00.00					00.00
32.00 Deductibles 0 0 32.00 33.00 34.00 34.00 34.00 34.00 34.00 35.00 Utilization review 0 35.00 35.00 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 4,316,694 5,452,422 36.00 37.00 37.00 38.00 39				0	-	
33.00 Coinsurance 0 0 33.00 34.00 34.00 35.00 Utilization review 0 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 4,316,694 5,452,422 36.00 37.00 37.00 38.00 Subtotal (line 36 ± line 37) 0 0 0 0 0 0 0 0 0)	4, 316, 694		
34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 4,316,694 5,452,422 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 4,316,694 5,452,422 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 0 Total amount payable to the provider (sum of lines 38 and 39) 4,316,694 5,452,422 41.00 41.00 Interim payments 4,316,694 5,452,422 41.00 42.00 Balance due provider/program (line 40 minus line 41) 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				0	-	
35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 4,316,694 5,452,422 36.00 37.00 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 4,316,694 5,452,422 38.00 39.00 0 0 0 0 0 0 0 0 0				0	0	
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 4, 316, 694 4, 316, 694 5, 452, 422 36.00 37.00 39.00 4, 316, 694 4, 316, 694 5, 452, 422 40.00 41.00 Balance due provider/program (line 40 minus line 41) 90 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	34.00	Allowable bad debts (see instructions)		0	0	34. 00
37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 37. 00 4, 316, 694 4, 316, 694 4, 316, 694 5, 452, 422 40. 00 42. 00 43. 00	35.00	Utilization review		0		35. 00
38.00 Subtotal (line 36 ± line 37) 4,316,694 5,452,422 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 4,316,694 5,452,422 40.00 41.00 Interim payments 4,316,694 4,316,694 5,452,422 40.00 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	4, 316, 694	5, 452, 422	36.00
38.00 Subtotal (line 36 ± line 37) 4,316,694 5,452,422 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 4,316,694 5,452,422 40.00 41.00 Interim payments 4,316,694 4,316,694 5,452,422 40.00 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 39.00 4, 316, 694 4, 316, 694 5, 452, 422 41.00 0 42.00 43.00				4, 316, 694	5, 452, 422	38.00
40.00 Total amount payable to the provider (sum of lines 38 and 39) 4, 316, 694 4, 316, 69				n	-,,	
41.00 Interim payments 4,316,694 5,452,422 41.00 42.00 Balance due provider/program (line 40 minus line 41) 0 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				4 316 604	5 452 422	
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 42.00 43.00						
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				l I		
			account the CMC Durk 45 0	9	-	
Chapter 1, 9115.2	43. UU	, , , , , , , , , , , , , , , , , , , ,	TICE WITH CMS PUD 15-2,	١	0	43.00
		μιαρτεί Ι, 3115.2		1		I

Health Financial Systems ST. VINCENT BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0157 Period: From 07/

oni y)					11/20/2017 12	: 48 pm
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	8, 060, 729	0	0	0	1. 00
2.00	Temporary investments	0	0	0	0	
3.00	Notes receivable	0	0	0	0	
4.00	Accounts receivable	48, 282, 894	1	0	0	
5.00	Other receivable	4, 058, 981	1	0	0	
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-20, 595, 159 2, 404, 078	1	0	0	1
8. 00	Prepai d expenses	346, 175	1	0	0	1
9. 00	Other current assets	154, 322	1		Ö	1
10.00	Due from other funds	8, 860, 303	1		0	
11. 00	Total current assets (sum of lines 1-10)	51, 572, 323	0	0	0	11. 00
	FIXED ASSETS					
12. 00	Land	2, 111, 746	1			1
13.00	Land improvements	2, 431, 024	1			
14. 00 15. 00	Accumulated depreciation Buildings	-2, 167, 886 95, 962, 891	1		0	1
16. 00	Accumulated depreciation	-45, 373, 422	1		0	
17. 00	Leasehold improvements	2, 795, 304	1		Ö	1
18. 00	Accumulated depreciation	-2, 173, 252	1	0	Ō	
19.00	Fi xed equipment	15, 333, 450	0	0	0	19. 00
20. 00	Accumulated depreciation	-4, 537, 872	1	0	0	
21. 00	Automobiles and trucks	0			0	
22. 00	Accumul ated depreciation	0 000 440	0		0	
23. 00	Major movable equipment Accumulated depreciation	46, 029, 469	1		0	1
24. 00 25. 00	Mi nor equi pment depreci abl e	-33, 383, 400	0	0	0	1
26. 00	Accumulated depreciation		0	0	0	1
27. 00	HIT designated Assets	Ö	Ö	O	Ö	
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	77, 028, 052	0	0	0	30. 00
21 00	OTHER ASSETS		227 015			21 00
31. 00 32. 00	Investments Deposits on Leases	0		0	0	1
33. 00	Due from owners/officers		0	0	0	
34. 00	Other assets	24, 642, 744		0	Ö	1
35. 00	Total other assets (sum of lines 31-34)	24, 642, 744	1	0	Ō	
36.00	Total assets (sum of lines 11, 30, and 35)	153, 243, 119	227, 015	0	0	36. 00
	CURRENT LI ABI LI TI ES					
37. 00	Accounts payable	6, 417, 977	1		l	1
38. 00	Salaries, wages, and fees payable Payroll taxes payable	3, 736, 115	1	0	0	
39. 00 40. 00	Notes and Loans payable (short term)	190, 987		0	0	1
41. 00	Deferred income			0	0	
42. 00	Accel erated payments	ĺ		J	ĺ	42. 00
43.00	Due to other funds	25, 629, 587	0	0	0	43.00
44. 00	Other current liabilities	7, 502, 680		0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	43, 477, 346	0	0	0	45. 00
47 00	LONG TERM LIABILITIES	1 0				47.00
46. 00 47. 00	Mortgage payable Notes payable	0	1		0	
48. 00	Unsecured Loans		0		0	1
49. 00	Other long term liabilities	19, 940, 261		o	Ö	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	19, 940, 261	I	0	l	1
51.00	Total liabilities (sum of lines 45 and 50)	63, 417, 607	0	0	0	51. 00
	CAPI TAL ACCOUNTS	,				
52. 00	General fund balance	89, 825, 512	1			52. 00
53.00	Specific purpose fund		227, 015			53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,		1		ő	1
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	89, 825, 512			0	1
60. 00	Total liabilities and fund balances (sum of lines 51 and	153, 243, 119	227, 015	0	0	60.00
	[59]	I	I	ı	I	1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0157

					rom 07/01/2016 o 06/30/2017	Date/Time Prep 11/20/2017 12:	
		General	Fund	Special Pu	irpose Fund	Endowment Fund	
		1.00	2.00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		689, 154, 095 85, 983, 071 775, 137, 166		208, 962 208, 962		1. 00 2. 00 3. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	OTHER ACTIVITY GRANT REVENUE RESTRICTED INCOME ROUNDING OTHER ADJUSTMENT	0 0 0 0 0		22, 809 0 0 0 0 0		0 0 0 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TRANSFER TO AFFLIATES OTHER ADJUSTMENT DISTRIBUTIONS NET ASSET TRANSFER TO FROM ALPHA CONSOLIDATION ROUNDING	59, 102, 830 0 10, 000, 126 614, 997, 470 1, 211, 223	0 775, 137, 166	4, 756 C		0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 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)		685, 311, 654 89, 825, 512		4, 756 227, 015		18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0	O	C			1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00	OTHER ACTIVITY GRANT REVENUE RESTRICTED INCOME ROUNDING OTHER ADJUSTMENT		0 0 0 0				5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TRANSFER TO AFFLIATES OTHER ADJUSTMENT DISTRIBUTIONS NET ASSET TRANSFER TO FROM ALPHA CONSOLIDATION ROUNDING Total deductions (sum of lines 12-17)	0	0 0 0 0 0	C			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	o		C			19. 00

Health Financial Systems ST STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0157

			То	06/30/2017	Date/Time Prep 11/20/2017 12:	
	Cost Center Description	I npati ent	1	Outpati ent	Total	10 0
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	44, 992, 6	43		44, 992, 643	1. 00
2.00	SUBPROVI DER - I PF					2. 00
3.00	SUBPROVI DER - I RF					3. 00
4. 00	SUBPROVI DER					4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	44, 992, 6	43		44, 992, 643	
	Intensive Care Type Inpatient Hospital Services	1 , , , , , , ,			11,772,010	
11. 00	INTENSIVE CARE UNIT	5, 697, 1	10		5, 697, 110	11. 00
12. 00	CORONARY CARE UNIT	0,077,	. 0		0,077,110	12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T					14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	14, 087, 2	61		14, 087, 261	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lin				19, 784, 371	16. 00
10.00	11-15)	17,701,5	"!		17, 701, 071	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	64, 777, 0	14		64, 777, 014	17. 00
18. 00	Ancillary services	164, 976, 6		298, 289, 428	463, 266, 092	
19. 00	Outpati ent servi ces	7, 254, 8		44, 465, 908	51, 720, 711	19. 00
20. 00	RURAL HEALTH CLINIC	,,,,,,,	0	0	01, 720, 711	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	ol	0	21. 00
22. 00	HOME HEALTH AGENCY		Ĭ	Ĭ	Ŭ,	22. 00
23. 00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE					26. 00
27. 00	PHYSI CI AN PROFESSI ONAL FEES		0	5, 779, 993	5, 779, 993	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 237,008,4		348, 535, 329	585, 543, 810	
20.00	G-3, line 1)	207, 000,	٠.	010,000,027	000, 010, 010	20.00
	PART II - OPERATING EXPENSES	<u> </u>				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			132, 056, 407		29. 00
30.00	The state of the s		0	, ,		30. 00
31. 00			0			31. 00
32. 00			0			32. 00
33. 00			0			33. 00
34.00			0			34.00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)			o		36. 00
37. 00	CONSOLI DATI NG EXPENSE	1, 211, 2	23	آ		37. 00
38. 00		1,-11,-	0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			0			41. 00
42. 00	Total deductions (sum of lines 37-41)		1	1, 211, 223		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	ransfer		130, 845, 184		43. 00
	to Wkst. G-3, line 4)			22, 212, 101		
		1		'	'	

	Financial Systems ST. VINCENT CARM			u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0157	Peri od: From 07/01/2016	Worksheet G-3	
			To 06/30/2017		
				11/20/2017 12	:48 pm
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		585, 543, 810	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			366, 621, 162	•
3.00	Net patient revenues (line 1 minus line 2)			218, 922, 648	1
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		130, 845, 184	•
5.00	Net income from service to patients (line 3 minus line 4)	ŕ		88, 077, 464	
	OTHER I NCOME			· · · · · ·	
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking lot receipts			0	12.00
13. 00	Revenue from laundry and linen service			0	13. 00
14. 00	Revenue from meals sold to employees and guests			492, 735	1
15. 00	Revenue from rental of living quarters			0	
16. 00	Revenue from sale of medical and surgical supplies to other	than patients		290, 499	
17. 00	Revenue from sale of drugs to other than patients			0	
18.00	Revenue from sale of medical records and abstracts			486	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			1 275	20.00
21. 00	Rental of vending machines			1, 375	•
22. 00	Rental of hospital space			641, 001	
23. 00	Governmental appropriations			0	23. 00
24. 00 24. 01	CONTRACT CERVICE DEVENUE			0	24. 00 24. 01
	CONTRACT SERVICE REVENUE			694, 506 326, 195	
24. 02 24. 03	OTHER MI SCELLANEOUS RVENUE			320, 195 0	24. 02 24. 03
24. 03	INCOME FROM UNCONSOLIDATED ENTITIES			8, 573	
24. 04	OTHER NONOPERATING			11, 135	
24. 06	CONSOLIDATING AMT (BILLING ARRANGE)			1, 211, 223	
24. 07	GOVT CLNC INCENTIVE REV			33, 254	1
24. 07	STATE PROGRAM REVENUE			33, 234	1
	GAIN ON SALE OF PPE			-	24. 09
	Total other income (sum of lines 6-24)			3. 715. 730	

3, 715, 730

91, 793, 194

5, 641, 247

168, 876 27. 03 5, 810, 123 28. 00 85, 983, 071 29. 00

25.00

26.00

27. 00

0 27. 01

0 27. 02

25.00 Total other income (sum of lines 6-24)

LOSS ON UNCONSOLIDATED ENTÍTIES

27.03 DONATIONS
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

26.00 Total (line 5 plus line 25)

27.00

27. 01

27. 02

		CARMEL HOSPITAL		u of Form CMS-2	2552-1
CALCU	LATION OF CAPITAL PAYMENT	Provi der CCN: 15-0157	Peri od: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Pre 11/20/2017 12	
		Title XVIII	Hospi tal	PPS	
				1 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				ł
1. 00	Capital DRG other than outlier			911, 107	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2. 00	Capital DRG outlier payments			24, 057	2.0
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 0
3. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			49. 21	3. 0
4. 00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by 1.01)(see instructions)	y the sum of lines I and I.UI	, corumns r and	0	6.0
7. 00	Percentage of SSI recipient patient days to Medicare Part	t A natient days (Worksheet F	nart A line	2. 29	7.0
7.00	30) (see instructions)	t A patrent days (norksheet E	, part // Time	2.27	, , ,
8. 00	Percentage of Medicaid patient days to total days (see in	nstructions)		14. 68	8.0
9. 00	Sum of lines 7 and 8			16. 97	
10. 00		tions)		3. 50	
11. 00				31, 889	
12. 00	Total prospective capital payments (see instructions)			967, 053	12. 0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instruction			0	
3.00	Total inpatient program capital cost (line 1 plus line 2))		0	
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	
3.00	Total Tilpatient program capital cost (Tille 3 x Tille 4)			0	5.0
				1. 00	
	DADT III COMPUTATION OF EVCEDTION DAVMENTS				l
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
	Program inpatient capital costs (see instructions)			0	
2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums	,		0	2. 0
2. 00 3. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)	,		0	2. 00 3. 00
2. 00 3. 00 4. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions))		0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0 0 0.00	2. 0 3. 0 4. 0 5. 0
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions))) ee instructions)	line 6)	0 0 0. 00 0	2. 0 3. 0 4. 0 5. 0 6. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7)) ee instructions) inary circumstances (line 2 x	line 6)	0 0.00 0.00	2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a) ee instructions) inary circumstances (line 2 x applicable)	ŕ	0 0.00 0 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level) ee instructions) inary circumstances (line 2 x applicable) to capital payments (line 8	less line 9)	0 0.00 0 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14)) ee instructions) inary circumstances (line 2 x applicable) to capital payments (line 8 ver capital payment (from pri	less line 9) or year	0 0.00 0.00 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordicapital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	ee instructions) nary circumstances (line 2 x applicable) to capital payments (line 8 wer capital payment (from pri al payments (line 10 plus lin	less line 9) or year e 11)	0 0.00 0.00 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 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	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, e	ee instructions) Inary circumstances (line 2 x applicable) to capital payments (line 8 wer capital payment (from pri al payments (line 10 plus line enter the amount on this line	less line 9) or year e 11)	0 0.00 0 0.00 0 0 0 0	2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 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	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, of Carryover of accumulated capital minimum payment level on	ee instructions) Inary circumstances (line 2 x applicable) to capital payments (line 8 wer capital payment (from pri al payments (line 10 plus line enter the amount on this line	less line 9) or year e 11)	0 0.00 0.00 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, e Carryover of accumulated capital minimum payment level on (if line 12 is negative, enter the amount on this line)	pee instructions) inary circumstances (line 2 x applicable) to capital payments (line 8 wer capital payment (from pri al payments (line 10 plus line the amount on this line wer capital payment for the f	less line 9) or year e 11)	0 0.00 0 0.00 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 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	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, of Carryover of accumulated capital minimum payment level ov (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	ee instructions) inary circumstances (line 2 x applicable) to capital payments (line 8 wer capital payment (from pri al payments (line 10 plus line enter the amount on this line wer capital payment for the f e instructions)	less line 9) or year e 11)	0 0.00 0 0.00 0 0 0 0	2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0